2023 IHN-CCO DST Pilot Proposals Crosswalk: Large RFP

		Affordable Housing Resident Services	**Asset Mapping Project**	**Bilingual McKinney-Vento Advocates**	**Emergency Winter Shelter Program**	**Food for Many**	**Healthy Eating Children's Cookbook**	**Improving Access to Quality Education**	**Positive Outcomes for LGBTQ+ Youth**	**Sleep Trailer Safe Shelter**	**Youth Cohort Housing**
Pilot Champion		Applegate Landing, LLC	Pollywog	Lincoln County School District	Lincoln County Health & Human Services	Family Tree Relief Nursery	Furniture Share	Peaceful Gardens Montessori	Jackson Street Youth Services	Sleep Trailer, LLC	Community Outreach, Inc.
Budget		$150,000	$96,295	$103,749	$150,000	$87,286	$125,845	$150,000	$150,000	$120,000	$149,860
Counties	Benton										
	Lincoln										
	Linn										
CHIP SDoH/E Areas	Food Security										
	Housing										
	Transportation										
	Equity										

Applegate Landing Client Services Extension

Affordable Housing Resident Services

Applegate Landing, LLC
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2023 IHN-CCO DST Pilot Project
Requesting $150,000

Executive Summary

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.

Further, many households in affordable housing are segregated and ostracized from the general community. CRC has already shown the positive effect of community building within Applegate Landing as well as the benefit that including local partners and Lebanon residents. This pilot will continue to improve tis aspect of service by engaging residents more and encouraging them to take part in events beyond their immediate family and outside their front door.

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. This pilot program will explore the operating hours of social service availability on site at Applegate Landing and increase activities on site with four primary grant goals:

- Increase the accessibility of social services to include longer hours of operations during the week and opening up Saturday operational hours.
- Increase the number of social events, classes, activities, or get-togethers at AGL by at least one per month.
- Increase the ability to keep households housed by providing additional resources and supports to maintain housing.
- Document the benefit (or lack of benefit) of expanded hours for social services as it relates to the needs of and utilization by low-to-moderate income (LMI) households.

Pilot Description

Applegate Landing is one of only a few affordable housing facilities in Oregon to have a dedicated social service provider partner available on site. As a best practice, this partnership is getting the attention of Oregon Housing and Community Services (OHCS) and Oregon Health Authority (OHA), as it is a deviation from traditional Permanent Supportive Housing models and takes a partnership approach where property developers/owners and service providers can each focus on what they do best. Applegate Landing builds and owners the property while, for the past two years, through CRC, residents can receive a variety of non-compulsory services at absolutely no cost. These services include:

- 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.
- Healthy living: CRC has program partners to provide presentations on healthy cooking and healthy eating practices for residents who may not otherwise have "home economic" skills.
- Peer-Support: scheduling and on-site service by peer partners for mental health and substance use disorder needs.
- Food and Nutrition Support: CRC provides a combination of nutrition support include "Bread and Egg" days where a dozen eggs and a loaf of bread are provided to residents as well as an on-site food pantry where fifteen meals worth of food are offered for those in need.

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.

This pilot program will expand Crossroads Communities' ability to provide services to residents. At present, Crossroads Communities only operates Monday through Friday and, while they are open a half hour longer than the property manager's office during the weekday, there are no representatives on hand to provide assistance during the weekends. Residents have mentioned numerous times that they rely on support and guidance from CRC staff and have asked if there are any plans for it to be open on the weekend. This funding opportunity will allow AGL to contribute to operational costs, which will enable CRC to extend its hours of operation.

While many residents have expressed an interest in utilizing services and supports offered by CRC, most of those who have not made a connection claim “hours of operation” as one of the barriers. Many residents of Applegate Landing are members of “the working poor”, maintaining jobs, but still living near the poverty level. By being open longer in the evening and opening the doors on Saturday, CRC will have an increased presence on site and make it easier for residents to use the offered services.

This pilot program will test the value of having extended hours for resident services and social service connections. Further, it will improve CRC’s capacity to host events and activities, which traditionally draw in a large number of residents, encourage engagement of services, and improve socialization and building of community. While the benefits of having CRC on site are unquestionable, AGL would like to expand their availability and see if more operating hours will result in an even higher level of success in keeping residents housed, stable, and thriving. The anticipated operational goals and expected outcomes are as follows:

- Show an improvement in residents’ ability to stay housed on site, or, if they move out, it is to a better financial and social outcome. Crossroads Communities currently shows a 66% improvement over the industry standard apartment vacancy rate; Applegate Landing and Crossroads Communities believe this can be improved to over 75% with increased operations.
- Improve the capacity for Crossroads Communities to host program partner events. At present, CRC hosts between 2-3 events per month. With additional operational capacity, CRC can add at least one more event per month, ideally on a Saturday when additional residents can be present. These events can be any activity that promotes physical/mental/social wellbeing; such events in the past have included free haircuts, vaccination clinics, health cooking/eating classes, free dental exams, and financial literacy classes.
- Improve the engagement of residents of Applegate Landing, as several households have not found the time or a convenient schedule to utilize CRC’s services and, for those who do use them, increase their ability to access services on a more convenient schedule. AGL anticipates increasing engagement by at least 15%. The inclusion of more events and activities such as computer literacy classes, hygiene education, healthy cooking/living, financial literacy, socialization via arts and crafts, community movie nights, and more. Making additional event funding available for CRC is seen as a major contributor to the success of this objective as these events encourage residents to step outside their household and become part of the community.

Located as the gateway to east Linn County, Lebanon is a small community surrounded by other communities, all suffering a lack of housing, a lack of affordable housing, and a high percentage of population affected by houselessness and homelessness. Nearly 1 in 5 households in Lebanon suffer from poverty (more than 25% higher than the national average) and the median

property value has increased over 50% in the last 3 years (199k to 355k). Service connections are even more difficult for LMI households in rural areas such as Lebanon because transportation is one of the greatest barriers to service. Lebanon is a perfect city for this program to show the efficacy of on-site supportive services available at an affordable housing complex.

At Applegate Landing, most residents qualify for OHP, meaning a large number of them (approximately 90%) will be IHN-CCO members-- this means as many as 92 members can be served through this pilot. BIPOC households are represented at a higher percentage rate at AGL than in the surrounding community (nearly 20% compared to Lebanon's 10%), and there are several households with self-identified LBGTQIA+ members. AGL is also proud to be a veteran-focused housing facility, and 40% of the households have one or more veteran members. Nearly 40% of households also have at least one member who has a physical disability, further identifying the need for on-site services and support for residents.

While Crossroads Communities provides the on-site scheduling, coordination, and hosting of services, it is their connections within the community that empower the services available. Program partners who have been connected to AGL residents include:

- The Lebanon Soup Kitchen: CRC picks up warn meals twice a week and delivers them to AGL residents who are in crisis, are out of SNAP/TANF benefits, or are otherwise unable to prepare their own food.
- Samaritan Treatment and Recovery (STAR) Services: CRC works with outreach officers and peer support specialists in order to help residents dealing with substance use disorder.
- Celebrate Recovery: CRC works with peer support volunteers in order to offer on-site meetings for residents in need of someone to talk to regarding substance use.
- Pacific Northwest Adult and Teen Challenge: CRC has been able to help two residents of AGL transition into an in-patient, closed campus treatment program for substance use disorder while helping their families remain at AGL during their return to sobriety.
- Community Services Consortium (CSC): CRC works with CSC to assist residents who are behind on rent or utility payments in order to help keep them housed. In addition, CSC works with CRC to help refer residents to AGL in order to end homelessness, especially among veterans being served at CSC.
- Willamette University: CRC coordinates healthy cooking/eating classes, which are held once or twice a month at AGL for residents interested in learning about easy to cook, nutritious, inexpensive recipes.
- Oregon Health Authority: CRC has coordinated two COVID vaccination clinics to be run at the AGL health room since opening.

- Linn County Health Department: CRC has coordinated a vaccination clinic provided by the county out of the AGL health room and is looking for future partnership opportunities as well.
- Health Centers of Benton and Linn Counties: CRC has coordinated dental health clinics to be run out of the health room at AGL. These clinics include free services such as an exam, sealants, and fluoride treatments, as well as referrals to care providers for cavities, crowns, and extractions.

While this may seem like an extensive list of services and partners, this is by no means an exhaustive one. Applegate Landing has learned a lot from Crossroads Communities in the three years of partnership, and one of the primary lessons was that there is never a lack of need; there is usually a lack of services. To this end, AGL is dedicated to helping families remain housed, as the benefits from having stable housing are undeniable.

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. This is designed to assist a wider degree of residents, increasing accessibility and equity in care and reduce health disparities.

Many social service organizations operate on weekdays only and, if there are weekend services those are usually limited to outreach or volunteer distribution. While both activities are very important, that usually limits an organization's ability to help. By increasing office hours, Applegate Landing will be introducing full availability of social services to residents at the affordable housing facility in Lebanon as staff will be on hand to help in real time rather than taking a message or leaving a voice mail. This is an innovative change of scope for traditional weekday-only services.

In order to meet the reporting and tracking components necessary for this pilot program's goals and measures, AGL will rely on CRC's expertise in data management and records. CRC currently tracks engagement and services using the OHA REALD (Race, Ethnicity, and Language/Disability) form, as well as committing to adopt the SOGI (Sexual Orientation and Gender Identity) form once OHA completes its design. AGL is proud to partner with an organization dedicated to equality and inclusion in practice as well as in creed. These forms, along with CRC's comprehensive data tracking process during intake and follow-up will assist with data collection and reporting.

Crossroads Communities has five languages represented among its staff and has access to a call-in real-time translation line that can provide a connection time of under 60 seconds to over 140 languages. While Lebanon is largely Caucasian and English-speaking, the availability of services in multiple languages is important, and other than English, Spanish and American Sign Language is used most often by CRC staff; the Hispanic/Latinx population is the second-highest represented demographic in Lebanon, and CRC has many of its brochures and pamphlets available in Spanish.

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. The increased flexibility of access will make it easier for residents to remain housed since supportive services are made available on site, reduce the need for transportation access since a large variety of programs can be accessed where they live, and improve resident access to food and nutritional programs operated less than 100 yards from their front door.

Crossroads Communities remains in constant contact with residents of Applegate Landing. Hours of operations are posted clearly at the office, and, in addition, CRC regularly distributes fliers and news updates to residents in physical format, by word of mouth, and via email (if residents have opted in). This pilot program, when approved, will be announced two weeks before implementation to provide ample time for households at AGL to be made aware of the greater accessibility to service.

This pilot program is important at the state level, helping to explore the expansion of a service model that can be replicated by others, but also for future Applegate expansions. Applegate Landing has been approved for the construction of a sister facility in West Salem; Crossroads Communities is already in early discussions with Pacific Source, the CCO for Marion/Polk to establish service relationships in that community. It is Applegate Landing's intent to maintain the service model created in Lebanon, and fine-tuning programming, services available, and hours of operation will be invaluable moving forward; this grant is pivotal in that aspect.

Applegate Landing and Crossroads Communities are well positioned to operate this pilot program. Key personnel involved include:

- James Lutz, owner of Applegate Landing, LLC, property developer with decades of experience in the construction industry and recent retiree from Gerding Builders.
- Michael Couch, Executive Director of Crossroads Communities, a business professional with over 20 years of experience in the financial industry, and more than 10 years of experience with business management, project management, and operational compliance.
- Kim "KJ" Ullfers, Board President of Crossroads Communities and Lebanon City Council Member (representing Ward 2)
- Rebecca Christy, Board Member of Crossroads Communities and Resources/Health Navigation Services Supervisor at Benton County Health Services
- Crossroads Communities staff, including intake, outreach, supervisory, and one community health worker.

This list of highly capable, highly successful, and highly motivated key personnel are the cornerstone of what will make this pilot a success. Even so, it is imperative to identify and address barriers that may otherwise limit the capacity to complete the pilot successfully. The greatest identified threats to the success of this pilot are as follows:

- Lack of Engagement: Since services are non-compulsory there is no way to guarantee that residents will use programs more or that new residents will sign up. This is not seen as a likely case as the on-site property manager has indicated several times residents wanting to contact CRC over the weekend, and a resident has written a letter (to be provided to the committee on presentation day) requesting extended hours. Further, the inclusion of community activities and events has traditionally done very well at increasing participation among residents, hence the inclusion of more such programming as part of this pilot.
- Staffing: Crossroads Communities does not have the current manpower to account for the additional hours of operation. There is the possibility that CRC will not be able to hire a qualified applicant or applicants. This risk is being addressed, as Crossroads Communities has a pending list of applicants and the timeline for the project will take hiring and onboarding time into account.

Pilot Timeline

The exact timeline for this program's start date will be determined by receipt of funds. The proposed timeframe provided presumes funding as of January 1, 2024.

Mid-October 2023: Applegate Landing will notify Crossroads Communities of the intent to extend operational hours after receiving the intent to award notification.

End of October: Management from Applegate Landing and Crossroads Communities will meet to go over MoU and commitment for extended hours.

End of November: Management from Applegate Landing and Crossroads Communities will meet to confirm plan for rollout in 2024.

December 2023: Crossroads Communities will actively recruit staff with a planned start date of January 1 in preparation for extended hours.

January 1, 2024: Crossroads Communities has committed to start training new staff.

January 13, 2024: Saturday service will begin at Applegate Landing.

January 15, 2024: Extended weekday office hours will begin at Applegate Landing.

Quarterly, starting April 15, 2024: Applegate Landing will collect data from Crossroads Communities to track REALD information, engagement, and activity.

January 15, 2025: Applegate Landing will compile year-end data (Jan-Dec) for first year analysis of successes and shortcomings. This will be used to fine-tune second year operations.

January 24, 2025: Applegate Landing and Crossroads Communities management will meet to discuss any necessary changes or modifications to availability or programming based on first year data.

January 31, 2025: Residents will be notified of any chances to take place two weeks before any changes to scheduling, hours of operations, or modification to services.

February 17, 2025: Program/Operational changes, if any, will go into effect.

December 31, 2025: Program concludes.

Pilot: AGL Client Service Extension

Pilot Start Date:	1/13/2024	Pilot End Date:	12/31/2025
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Crossroads Communities		$128,000.00	$128,000.00
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Resource Costs	**$128,000.00**	**$128,000.00**
Materials & Supplies			
Event Expenses (Food/Drink/Decorations/Utensils/Cups/Plates)		$6,000.00	$6,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$6,000.00**	**$6,000.00**
Travel Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$0.00**	**$0.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Community Health Worker Certification		$1,000.00	$1,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$1,000.00**	**$1,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$135,000.00**	**$135,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	0.00%	$15,000.00	$15,000.00
Total Project Budget		**$150,000.00**	**$150,000.00**

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

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	CRC averages 63 client interactions at AGL per month	CRC to collect data monthly & compile to send to AGL quarterly	This numer will be increased to at least 70.	January-25
	Between 2 and 3 events are held per month at AGL	CRC to collect data monthly & compile to send to AGL quarterly	This number will consistently be 3-4 events per month	January-25
	AGL averages an a resident turnover rate of approx 15%	CRC to collect data monthly & compile to send to AGL quarterly	Apartment turnover rate will drop to <11%	December-25

Asset Mapping Project

Backbone Organization: Pollywog

Primary Contact: LeAnne Trask

Partnering Organizations: Early Learning Hub of Linn, Benton & Lincoln Counties

Billing Address: 6500 Pacific Blvd. SW, LM-128, Albany, OR 97321

Site(s): LBCC Campus, Albany, OR

County(s): Linn, Benton & Lincoln Counties

Priority Area(s): Rural communities in Linn, Benton & Lincoln Counties

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

1) Children at-risk: The Oregon Revised Statute stipulates that children who are at-risk experience chronic and persistent opportunity gaps due to family circumstances beyond their control, which includes geographically isolated families. Of the 271,733 people living in Linn, Benton and Lincoln Counties, approximately 40% of them are located in rural communities and are potentially unable to access healthcare, education, employment, housing, and other important services.

2) Raise up Oregon is a comprehensive state system plan for early childhood, prenatal to age five, that Oregon created in 2019. The plan lays out sixteen objectives that the Governor and her staff want state agencies to work towards, each objective has a list of strategies to achieve that objective, and then various state agencies are listed as being responsible for those strategies.

   Strategy 3.2: Early Learning Hubs engage families and community organizations, prioritizing those who are historically underserved, in the development and implementation of equitable state early childhood policies and programs. (HECC, OHA, ODE, ODHS, OHCS, DELC)
   - Early Learning Council works with Early Learning Hubs to discuss barriers and recommendations to address barriers.

   Strategy 3.3: Early Learning Council engages with the Early Learning Hubs to inform state design and implementation of the early childhood system, and development of council priorities.
   - Early Learning Council partners with Hubs to meet in community to gather information from community organizations and families.

   Strategy 8.2: Increase access to evidence-based, culturally responsive, and culturally specific early childhood programs (e.g. Relief Nurseries, parenting education, home visiting programs) prove to reduce abuse and neglect for families.

   Strategy 9.2: Incentivize developers in rural and other underserved areas to prioritize and work towards meeting the need for affordable housing for local families with young children. (OCHS)
   - Conduct outreach to understand specific housing needs for families with young children in rural communities.

3) Social Determinates of Health: SDH are defined as "the conditions in which people are born, grow, live, work and age". Different organizations and areas of the country have defined those SDH as appropriate for their area, and in our region SDH are

defined as: healthcare access and quality, neighborhood and built environment, social and community context, economic stability, education access and quality.

4) Community Health Improvement Plan (CHIP): The 2022-2025 Regional Health Assessment has identified these priority areas for our Region: access to affordable housing, behavioral health, and equity, diversity and inclusion. The Regional Health Assessment further offered data about the state of Oregon's families in regard to housing, access to medical care, equity, food, mental health, and families.

We believe that each of these targets for improvement will be affected by the asset mapping project that we are proposing. We are asking families in 16 different rural communities to identify resources that they have access to, and to tell us about ones that they don't have access to. We can use that data to implement changes to funding. We can strategically invest in solutions to the problems that our families are experiencing, and we will know that we are operating in our family's best interests because they told us what they need, and we didn't just assume that we know best.

Brief Summary (3-5 sentences in clear, concise, plain language that captures the key points of the proposal):

Pilot Description (~3,000-7,000 words)

Detailed description of the proposed pilot including:

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, a library or a school. This method allows us to glean community knowledge about small cities in our region who need supportive and equitable services.

Our project is to create a series of asset maps in rural communities around 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. These families are geographically isolated and are considered to be underserved and at-risk, according to Oregon statutes that define "at-risk" populations. 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. Each of these sixteen cities has a population of less than 20,000, and have access to two of these facilities: a healthcare center, a library, or a grocery store.

During each asset mapping session, participating families will be asked to place stickers on specific community assets they utilize: health care, dental care, mental/behavioral health, food/groceries, transportation, childcare, places to hang out, places of learning, places for exercise, places of 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.

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. The results of the asset mapping will allow the Early

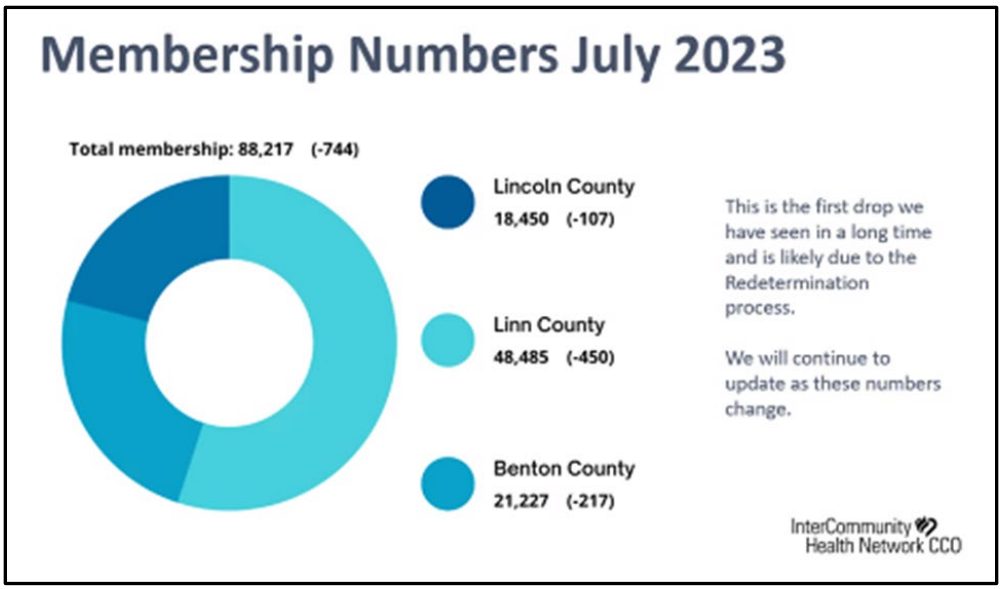
Learning Hub to develop more strategic solutions that will have a higher likelihood of achieving outcomes. In addition, we will be able to share the results of the asset mapping with partners in our region, other state agencies, and the Early Learning Council.

The families living in rural Linn, Benton and Lincoln Counties are experiencing a wide range of issues. In Benton county, for example, which has 35.9% of its population living in rural communities, we are seeing that children are experiencing:

- Food insecurity
- Unmet mental health needs
- Poverty
- Limited access to childcare
- Unmet dental needs
- Lack of preschool services
- Low immunization rates

Asset mapping will allow us to pinpoint which services and resources are unavailable or unmet in a community.

Of the 88,217 Oregon Health Plan members in Linn, Benton and Lincoln Counties, 21,227 reside in Benton County. Benton County's total population is 93,239, and 14,867 are under the age of 18. Roughly 23% of the Benton County population is on the Oregon Health Plan, and in need of services and resources. Linn and Lincoln Counties have even higher numbers (based on population):



Following each asset mapping session, all of the maps and information given to us by the parents will be submitted to Jinguang Linn, M.Stat, the Early Learning Hub's Data and Evaluation Coordinator, who facilitates the EL Hub's Data and Evaluation Workgroup. With the assistance of this workgroup, the data will be sorted and analyzed, and then a report will be created for each city, based on the information collected, including all demographic information that was gathered from the parents. These reports will be able to our partner

organizations, as well as any of the participating families who have requested a copy. This information will also be shared with DELC and the Early Learning Council.

The asset mapping planning and implementation has been assisted by the Early Learning Hub's Health Care Integration Workgroup (HCI). Pollywog facilitates this workgroup, and has been relying on the knowledge and expertise of the 75+ partner agencies who regularly participate in 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. This proposed project has been discussed at numerous meetings, and made partners have 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-CCO Population Insights Program Manager, Katie Walsh, has also been involved and requested to be kept apprised.

The families who will be participating will be "recruited" with newspaper, local childcare agencies, and school newsletter posts, as well as with the help of local partner agencies who we have asked to provide families and attend the session with them. We hope to have a wide range of families attending, and will have a sign-in sheet where we ask parents for their demographic information, such as age, gender, race and ethnicity, marital status, education level, employment status, and socio-economic status. We have also determined that we need to have at least 10 families at each mapping session in order to create a relevant sample size. We also plan to have interpretation available at each session, and will be have our bilingual staff in attendance. We will also be serving a meal to participating families and their children, and providing childcare while the parents are working with us.

At each mapping session, we will have the following staff members in attendance:

- A facilitator: welcomes and thanks families for coming, explains the process, and keeps the session on schedule (we plan on each session lasting 2 hours at maximum, including the meal). Our EL Hub Director will fill this role as she has experience with asset mapping in another state.
- Four staff members: two bilingual, two English-speakers, who will sit at each of the tables and help families to orient themselves to the maps and help them find the assets they are attempting to map.
- Two childcare providers: Young Roots has offered to help us with this, and we will be paying their providers for their services and travel time. (LBCC Parenting Education Department has childcare materials that we will be using to entertain the children.)
- Project Manager: a staff member who will be working to make sure that we have facilities, support from community partners, catered food, maps, stickers, and other materials, as well as the maximum number of families that we can possibly get at each session.

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 correlate directly to the SDH outlined in the IHN-CCOs Transformation Grant requirements. If these assets aren't available in a family's community, this becomes a barrier to the 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.

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.

The biggest potential risk to our success is not finding enough families to participate in a community. We need to have 10 families in order to have a relevant sample size, and some of the towns we have selected are very small, such as Alsea with a population of 220, and Monroe with a population of 640. We plan on recruiting as much as possible, but also relying heavily on local partners, local schools, local government, friends and families to help us succeed.

Pilot Timeline (1 page)

In May we held a "mock" asset mapping session of Albany, and invited partners from the Health Care Integration Workgroup to come to the session and participate as though they were local families. This worked out well as many partners actually live in Albany and were happy to attend and get a better understanding of how the process works. We had about 25 people at four different tables pouring over 44"x44" aerial maps of Albany. Participants put down stickers and added notations on the map to help us understand their significance.

This mock session allowed us to determine whether our methods were working, and where we needed to change our processes. We believe that we are ready to begin the actual sessions.

We have determined that there are 16 cities in our Region that meet the criteria previously explained, and those cities were broken up into "rounds" in order for us to keep organized and focused on our goals, and we will work to complete one round each quarter in order to meet our timeline.

The rounds look like this:

Round 1: Harrisburg, Philomath, Lincoln City

Round 2: Siletz (including the tribe), Newport, Monroe, and Mill City/Lyons

Round 3: Toledo, Waldport, Alsea, Brownsville, Sweet Home

Round 4: Scio, Halsey, Depoe Bay, Kings Valley, Lebanon

If we are granted the Transformation funding, our Project Manager will begin contacting the communities in the Round 1 group so that we will be able to begin immediately.

Sustainability Plan (~500 words)

Unlike some solutions, asset mapping is something that will need to be repeated periodically in order to determine if we are reaching our intended families and if things are improving. This will also allow us to be flexible and course-correct if we see that we are not meeting our strategic plan. Asset mapping could be done by any organization, and it could focus on different assets or different sized communities each time, depending on the course set in the Regional Health Assessment.

Asset mapping was developed in 1993 in order to help researchers find a way to speak directly with families and get their input on what they are experiencing in their community. Asset mapping is considered to be "community development strategy." We believe that it is an excellent method to offer families a way to improve their communities, and tell state and local agencies exactly what their community needs.

IHN-CCO LETTER OF INTENT - BUDGET

Pilot Project: Regional Asset Mapping Project

Pilot Start Date:	10/1/2023	**Pilot End Date:**	3/31/2025

Staffing: (Salary & Benefits combined)	
Position:	Total Cost:
Project Manager (.40 FTE)	$29,076.92
Asset Mapping Session Facilitator (2-hour sessions)	$2,352.00
Asset Mapping Session Table Staff (4 employees, 2-hour sessions)	$7,020.80
Child Care Staff (2 contracted employees, 2-hour sessions)	$3,200.00
Subtotal Staffing Costs	**$41,649.72**

Materials & Supplies:	
Items Needed:	Total Cost:
Community Aerial Maps (4 per session)	$1,600.00
Asset Stickers (12 sets per session)	$1,600.00
3x5 Post-its (pack)	$26.00
Sharpie Markers (12-pack)	$12.00
Post-it Super Sticky Easel Pads (6)	$60.00
Subtotal Materials & Supplies Costs	**$3,298.00**

Travel Expenses:	
Description:	Total Cost:
Staff Travel Time (5 staff members)	$9,372.64
Staff Mileage (5 staff members)	$7,755.20
Child Care Staff Mileage (2 contracted employees)	$3,102.08
Subtotal Travel Expenses	**$20,229.92**

Session Expenses:	
Description:	Total Cost:
Meals for Families	$8,000.00
Marketing/Invitations to Sessions	$4,800.00
Facility Rental Costs	$8,000.00
Subtotal Session Expenses	**$20,800.00**
Total Direct Costs	**$85,977.64**
Total Indirect Expenses (12%)	**$10,317.32**
Total Project Budget	**$96,294.96**

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	Round 1	Round 1 Data Reports Created	1st Quarter of 2024	
	Round 2	Round 2 Data Reports Created	2nd Quarter of 2024	
	Round 3	Round 3 Data Reports Created	3rd Quarter of 2024	
	Round 4	Round 4 Data Reports Created	4th Quarter of 2024	
	Round 5 If needed	Round 4 Data Reports Created, if needed	5th Quarter of 2025	

Bilingual McKinney-Vento Advocates

Backbone Organization: Lincoln County School District

Primary Contact: Woody Crobar, HELP Program Coordinator

Partnering Organizations: None

Billing Address: PO Box 1110**,** Newport OR, 97365

Sites:
Compass Center for Youth and Families (Newport, OR)
Waldport Middle and High (Waldport, OR)
Toledo Jr/Sr High (Toledo, OR)
Taft Elementary (Lincoln City, OR)

County: Lincoln County

Priority Area: Healthcare Access for Spanish speaking youth and families identified as Homeless

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity:
Increase access to healthcare by improving understanding of the healthcare provided, increase the percentage of youth empowered in their health, increasing the percentage of members living a health lifestyle, increase health equity

Budget:
$78,697.28 Requested
$103,748.94 Total

Summary:
This proposal seeks to provide Community Health Worker training to two staff within Lincoln County School District's HELP program. These staff, who are bilingual and bicultural, can assist students in families in navigating medical care, communicating with staff in a medical setting, and educating families on basic healthcare needs.

Proposal Narrative

A. Executive Summary

The HELP Program (Homeless Education and Literacy Project), 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 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 community services 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.

This proposal aims to support homeless students and their families through the Lincoln County School District, as defined under McKinney-Vento Law, by providing the following supports and services.

- Funding to allow the continued staffing of Bilingual Advocate positions. This allows those positions to translate and interpret for families, guide them through local services, and educate them about healthcare and medical issues. Medical supports provided by Bilingual advocates will be tracked through the Synergy Student Information System and Google docs from case notes on each student.
- Funding for Bilingual Advocates to provide training to other school district staff and community partners on the specific needs of the marginalized groups they represent. These trainings will be scheduled and planned at the beginning of the school year.
- Funding so that Bilingual Advocates may attend professional development opportunities to learn more about local health services and to receive community health worker training so that Advocates can more easily educate and guide families through the medical system. Training will be tracked, with each Advocate going to at least one community health related event each quarter. The HELP

program will also use funds to establish community health worker training relevant and accessible to Advocates.
- Funding for emergency medical issues identified by Advocates to be used in instances where other funds, insurance, or accessible resources prove to be a barrier to entry. Bilingual Advocates will work with the Program Coordinator to determine how to most effectively use these funds, and their uses will be tracked and reported.
- Funding for office supplies and incidental costs related to Bilingual Advocates including travel costs associated with professional development.

B. Proposal Narrative

The HELP Program (Homeless Education and Literacy Project) is a department within Lincoln County School District. HELP works to identify students experiencing homelessness under the guidelines of McKinney-Vento Law. McKinney-Vento law defines homelessness as lacking a “fixed, regular, and adequate nighttime residence”, and divides living situation into five broad categories:

- Living in a Hotel or Motel
- Living in an unsheltered location or a home without basic amenities like electricity or water
- Living “doubled up” with another family due to economic need or loss of other housing
- Living in a homeless shelter or domestic violence shelter
- Migrant or Asylum seeking students who qualify for one of the above categories

Students are referred to the HELP Program through several different methods. Within the school district itself, staff have the ability to make a “request for support” through Synergy, a database tool that monitors student data. Staff within the district are trained on social emotional needs that may impact student success, and requests are made within different categories of potential needs within the district. These needs are physical/environmental, food security, social/community, health care, and education. Over the course of the 2022-2023 school year 1,799 requests for support were made by staff in Lincoln County School District.

Requests for support made by school staff are monitored by Service Coordinators, who refer those students to different departments and services within the school district. Organizations outside of the school district are able to make referrals to the school district through a form found on the district website. This is most commonly used when partner organizations identify students who meet the criteria for McKinney-Vento homelessness.

Upon receiving a referral and determining that a student qualifies as McKinney-Vento, the HELP program will work with them to identify and remove barriers to school success. This is different for each family that the program works with, and the social-emotional needs of the families the program works with are key to determining how any particular case develops. The voice of students and families is important in guiding the work of the program. HELP’s core philosophy is centered on a holistic approach to

student and family needs. If students do not feel well at home, and subsequently do not feel well in school, they will not be successful learners. HELP can provide some basic necessities such as clothing, hygiene products, gas cards, and supplemental food assistance. Beyond that basic assistance, HELP will connect families with local services and resources who can offer support in ways that the HELP program cannot.

One of the groups with the highest need in Lincoln County School District are recent immigrants, migrants, and asylum seeking families. In 2021-2022, 14% of the District's student population, 712 students, were students who were currently attending English learning classes or had done so within the school district prior. These demographics, in addition to experiencing the barriers one would associate with homelessness, also face barriers associated with not being fluent in English and coming from a different cultural background that lacks many of the supports commonly found in the United States. The HELP program has recently created two new positions, known as Bilingual Advocates, to work with these families and provide specialized support that addresses their specialized needs.

Bilingual Advocates work exclusively with families who do not speak English. The two largest language groups Bilingual Advocates work with are Spanish and Mam Speakers although they will work with any identified family for whom English is not their primary language. These families typically face more barriers to accessing support networks than English speaking families, and the Bilingual Advocate positions have been critical to ensuring they get that specialized support. This level of support varies between cases and agencies. For agencies who can support families directly, Bilingual Advocates can act as a connection to a service. They can explain a service to the family, and connect them directly to someone within an agency. If there are agencies who lack bicultural support or bilingual support the advocates can instead act as that support on the client's behalf. This may include interpreting for a family, translating a document, or simply acting as a trusted support who can advocate for the family as needed.

One of the most common issues encountered by Bilingual Advocates is families who have difficulty accessing health care. This exists in three forms:

- Navigation: Families who need support to set up medical appointments, how to find a doctor, and how to use and sign up for insurance
- Communication: Families who can access medical care, but have difficulty understanding what their medical providers are telling them or have difficulty explaining their medical needs
- Education: Families who, due to a difference in cultural background, need additional education on medical issues

Many of the families Bilingual Advocates work with are recent immigrants, migrants, or asylum seekers. Parents often have literacy that is limited to an elementary school education and have little to no education when it comes to medical practices and what those look like in the United States. This can be difficult to understand if someone has not worked with these communities before, so the below is a few specific examples of questions and issues that HELP Staff have helped these families to navigate:

- A teenager was diagnosed as Type 2 diabetic. HELP staff had to explain what diabetes was, what Insulin was, how to administer it, and how to get more of it.

This included teaching the entire family about sugar in food and what kinds of food have sugar in them. The child had spent two weeks in the hospital as a result of medical complications, but was able to establish a plan that worked for them to attend school again.

- Initially advocates received reports of a child complaining their teeth hurt, which led to a dental exam. This led to teaching about sugar in food: the family had assumed that, because the drinks they were buying at the store had fruit on the labels, that they were healthy. Prior to working with the HELP program no one in the family was regularly using toothbrushes or practicing dental hygiene in any way.
- During the COVID-19 pandemic needing to explain the function of a face mask, and how the mask could prevent particles that couldn't be seen with the naked eye.
- Needing to explain to adults the concept of birth control, the types of birth control, and how they could access the different types of birth control both over the counter and through appointments with their doctor.

These situations are just a few examples of medical issues addressed by Bilingual Advocates in the previous year.

Bilingual Advocates are also adept at helping these clients manage the sometimes difficult and confusing world of eligibility when it comes to what insurance and benefits look like for people who are not yet citizens of the United States. Screening families and helping them establish what they qualify for and how they can access it is the first step HELP staff take when working on medical issues with a family. Different stages of the immigration and asylum seeking process can change what resources and supports are available to families. At times certain resources might be available but using them may impact a family's asylum case or ability to qualify for a different service. Bilingual Advocates maintain a familiarity with these systems and are able to communicate them effectively with families.

As a formal part of their positions, Bilingual Advocates do not currently have formal training on how to navigate the healthcare system or training on how to educate families on basic medical issues. Some of these skills are developed over time, as are basic elements of day to day hygiene and healthcare, but being able to more effectively guide families through the healthcare system and to more effective lifestyle choices are more complex. Being able to provide community health worker training to these Advocates would allow them to more confidently and effectively assist these families.

For those who have not worked with this demographic before it can sometimes be difficult to understand the lack of knowledge that some families possess. Non English speaking communities- especially those of immigrants, asylum seekers, and migrants- can be insular. In working with Mam speakers Bilingual Advocates have noted how little they interact with people outside of their community. There is a tendency to work with the same groups of people day to day, go to certain restaurants or grocery stores as a group, and to attend the same churches and faith based activities on non-work days.

Bilingual Advocates are able to bridge this gap because of both a shared language and a shared cultural background. Currently, the two Bilingual Advocates working within the HELP program are themselves immigrants who have been through the process of coming to the United States, establishing themselves, and familiarizing themselves with

the area and local services. Building a trusting relationship with a service provider can take time, but Bilingual Advocates are able to get through that process much quicker due to that shared background.

The most transformative aspect of this plan is the acknowledgement of how the school district, as an organization, is often the one of the first organizations that these communities will engage with in the United States. In many cases it will be the first time that someone from outside of the social group these families belong to will interact with the children and families on a regular basis. This can reveal medical issues that may have gone unnoticed in the home due to a lack of education. Having a robust system of supports within the school district who can notice these issues early means that students and parents will get connected to medical supports that they may have never known existed.

Bilingual Advocates, who are better educated in healthcare practices so they can better support families, can act as early medical intervention. This is especially relevant given that the communities in question represent such an underserved minority who have difficulty accessing medical support systems on their own. This will not only assist families who need assistance with medical issues directly, but will build the knowledge of systems up within the group itself. It builds the reputation of the school district as a supportive entity who wants to assist families, but also builds up the ability of the families and communities to assist each other in the future.

Pilot Goals:

- **Goal:** Continued support of Medical needs in the Spanish Speaking Community
  Measurable outcome: Bilingual Advocate positions remained staffed through duration of DST Proposed Timeline. Medical supports provided by Bilingual Advocates will be tracked during this time, detailing the number of students and families served and the type of support provided. Reports will be provided at the halfway point in the DST timeline and at the finale of the timeline.

- **Goal:** Bilingual Advocates will receive additional training and professional development. This training will cover healthcare systems and how to best access medical care as well as basic training on common medical issues to better address questions from community members. This will include training as a Community Health Worker.
  Measurable outcome: A training plan will be provided, detailing what trainings the Bilingual Advocates have attended, at set intervals throughout the timeline of the project.

- **Goal:** Increased knowledge and ability of the underserved community (Homeless Students and Families who speak a language other than English) to navigate the healthcare system as well as increased knowledge of medical issues.
  Measurable outcome: Surveys of the community will be conducted during the beginning window of the plan and the end of the plan. Questions will be asked about how the respondents feel navigating the healthcare system, if they feel that

this knowledge has improved while working with Bilingual Advocates, and if they have used this knowledge to help others in their community.

- **Goal:** Increase the number of homeless students and families served by Bilingual Advocates. In the 2022-2023 school year Bilingual Advocates served 84 families.
  Measurable outcome: A higher number of families will be served in the timeline of the proposal (1 school year).

Population and community served:

The primary population to be served by this proposal is Homeless Students and families, as identified under the McKinney-Vento Act, who speak a language other than English. Lincoln County has one of the highest rates of student homelessness in Oregon. In 2021-2022, 12.1% of students (630 individuals) within the Lincoln County School District were identified as Homeless. 28% of these students (176 individuals) identified as Hispanic.

Larger Model, Similar Projects, and Community partners:

School district staff have the ability to submit requests for support through an internal system. These let school staff connect students who may need supports to staff within the district trained to do that. The HELP Program works with homeless students, and Bilingual Advocates within this program work with those families to connect them to services and provide education on medical issues. Bilingual Advocates, using knowledge gained from working with families, can then help to train school staff to better respond to issues and notice early warning signs.

The closest similar project to this locally is Arcoiris Cultural, who has been a frequent partner of the HELP program in the past. Arcoiris has access to funds to help cover medical issues directly for families, but also has transportation options for families who cannot access needed services in Lincoln County. Arcoiris is a frequent support in the event that the HELP program cannot find resources or navigate issues.

This project would not have any partners with a direct, defined role. The nature of the HELP program and the case by case nature of the families means that it is often difficult to define a direct role between organizations that can always exist in every scenario. The HELP Program and Bilingual advocates work with most of the service providers in Lincoln County and maintain a knowledge of what supports they can provide for families. Working partnerships are maintained with numerous other agencies (Juvenile Justice, Health and Human Services, HUD, Samaritan House, Grace Wins Haven as some examples) but for the purposes of this plan there would be no official partnerships.

Health Equity:

The goals of this plan are for a marginalized community to have greater access to healthcare, to better understand the healthcare system, and to be able to more confidently navigate these systems. The community served, through the efforts of Bilingual Advocates, will be empowered to take charge of their own healthcare needs in a system where they face barriers. This will in turn strengthen the entire community at large as knowledge of these systems and how to navigate them becomes more commonplace.

Social Determinants of Health:

Social determinants of health are used to train district staff on identifying the initial needs that families might have. If someone in a school building identifies a need at any level- a teacher, front desk secretary, coach, or any other staff person- they have the ability to send a report and have someone follow up with that student. The school district tracks all of these requests, along with the needs identified in each request.

Program Management:

The proposal will be managed by the HELP Program, a department within the Lincoln County School District. The department is made up of 11 staff- one program coordinator, one Bilingual Customer support staff, four McKinney-Vento Advocates, two Bilingual Advocates, and three JOY Program staff. The primary staff involved with the project will be the Program coordinator and two Bilingual Advocates.

The Program Coordinator will be responsible for compiling reports and communicating with any staff from DST. The coordinator is also responsible for exploring new community relationships with potential partner or referral based organizations.

The School District's business department will be responsible for receiving funds and for the accounting of those funds in accordance with school district guidelines.

The two Bilingual Advocates will be responsible for administering the bulk of the work through the project. They will be the ones working to identify and connect with families, determine their needs, and how to best connect and educate them on local supports that can help meet those needs. In doing this they will track the families and students they work with, the types of support they offer, and the appointments they undergo with families.

This can then inform training undertaken within the district as well as future district policy. The data can tell us what the most significant gaps and challenges are, and where we might be able to focus our educational efforts to best serve families.

Strategic/Long Term Plans

The HELP Program's ultimate goal is to remove barriers to student success faced by homeless students. This includes issues that have nothing to do with the school system itself. If a family is in danger of losing housing or is facing a medical issue or doesn't have enough food on the table this trickles down into an impact on education. The HELP Program, and by extension the entire school district, have a vested interest in making sure that the students and families we work with are healthy and able to learn.

Bilingual Advocates who are able to demonstrate value in their services, and provide a higher level of support, make funding in the future for these positions more likely through both the school district and other grants and funds. The HELP Program is a grant funded program.

Community

The HELP program has brochures placed across the county detailing the services offered and contact information for the program (in both English and Spanish). Program members attend events after school and on weekends intended to drive outreach and get the word out about what it is the program does and how it can help. Within the school district itself every staff person receives training each year on the services offered by the program and how staff can best connect students with services.

Outreach also happens to other organizations within the community. The program coordinator attends groups like the interagency planning team and affordable housing partnership to discuss program updates and new services across the board. It is likely that, during the timeline of the proposal, new partnerships will be identified and explored.

Risks and Barriers

The primary risk of the plan is the unknown needs of families. All of the current experience the program has says that medical issues are one of the largest issues faced by these families, as well as one of the more time consuming and resource intensive processes to address, but there is always a chance that this does not hold true over time as new families enter the district.

Staffing is also a challenge. A large amount of the current work being done by the Bilingual Advocates works because of the skills and backgrounds of the staff within that program. If those staff left for other work and needed to be replaced it would be difficult to replace them with someone who has the same skill set and background.

Lincoln County is a rural area. There are certain kinds of medical supports and medical services that just aren't in Lincoln County. This is a current issue, and is unlikely to change, but in some circumstances we might be exploring how to solve a health access issue that may have limited solutions or limited funding available to fix. This is a barrier to families accessing services, but may ultimately prove to be valuable data in the future if it is found that Lincoln County simply lacks a way to access certain kinds of healthcare for these families.

C. Pilot Timeline

To capture accurate information and to track the progress of the plan over time, data will need to be captured at the end of two concurrent school years. This forms the basis for the timeline as below

Jan 1st 2024 – July 31st: Pilot Launch and preparation

After beginning to receive funds, initial community health worker training will be pursued and scheduled to occur during the remainder of the 2023-2024 school year. Bilingual Advocates will have completed training or been in the pursuit of completion of this training by the start of work in August 2024. A community survey will be conducted in May of 2024 to determine a baseline for the healthcare needs of the communities served.

August 1st 2024 – June 30th 2025: Pilot Implementation and Data Tracking

Bilingual Advocates, having had training, will now implement it within the program and in their work with families. Throughout the course of the year advocates will track the number and type of medical supports provided to families. During May of 2025, a second community survey will be conducted to evaluate how community members feel about the services received through the program and how they have impacted their access to healthcare and knowledge of it.

July 2025: Pilot Review

A report will be compiled and presented that details the difference in survey responses between the beginning and end of the program, the number of families served, and the nature of the services received. This data will be presented to the DST committee at the conclusion of the pilot.

Intermediate reporting on the status of the plan and current data can be provided at intervals to DST throughout the 2024-2025 school year, as outlined in the pilot progress report.

D. Sustainability Plan

School Districts can act as an early intervention system for issues within the home that parents might not be familiar with or might themselves not understand. This pilot recognizes that schools are likely the first time children will spend a significant amount of time outside of their home. Teachers and other school district staff may be able to identify and recognize issues that parents could not. This is especially true when talking about marginalized communities who may have less education about medical issues and the medical system. Connecting these families with staff who understand their background so they can help navigate the system helps to remove barriers and increase understanding of medical issues and the healthcare system.

The HELP Program Coordinator is also the McKinney-Vento Liaison, a position which exists by law in every school district in the county. If a McKinney-Vento program is able to incorporate a Bilingual Advocate position and see success in reaching out to this community, it shows a pathway for other school districts to do the same. Funds for Bilingual Advocates and their work also come from the Oregon Department of Education through the McKinney-Vento Subgrant as well as the Student Success Act. Demonstrating the effectiveness of this position through data reporting to the state demonstrates not just the continued need for the position, but for the expansion of the position to other districts and areas of the state.

HELP is also the beneficiary of several charities and fundraisers within Lincoln County. Donors include the Board of Realtors, Food Share, Booster Clubs, 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.

3. Budget Worksheet

See Attached

4. SMARTIE Worksheet

See Attached

Pilot Description (~3,000-7,000 words)

Detailed description of the proposed pilot including:

- Clear pilot goals, how they will be measured, and expected pilot outcomes.
    - This should communicate how the pilot is innovative and transformational, as well as how it will achieve its goals.
- Describe the population and/or community that will be served by the pilot.

    - Be sure to address how the pilot intends to focus on IHN-CCO members and include an estimate of how many IHN-CCO members will be served.
- Provide a detailed description of the approach that the pilot will be taking. This could be an intervention, model, activities, etc. Be sure to address similar projects, if there are any, that already exist in the local community or tri-county region.
- List all community partners and how they will be supporting the pilot.
- Provide a clear, detailed health equity plan for the pilot.
    - This should demonstrate a strong understanding of health equity concepts and a commitment to doing the work.
    - Include a description of how the pilot intends to reduce health disparities, as well as how health equity data will be tracked.
- Explain how the pilot will address social determinants of health.
- Describe the individuals that will be carrying out the pilot, their experience, and responsibilities.
- Describe how the project fits into your organization's strategic or long-range plans.
- Describe how members of the community will hear about your project.
- Describe potential risks or barriers to success and how the pilot plans to address them.

Pilot Timeline (1 page)

Provide a timeline of key activities and goals.

Sustainability Plan (~500 words)

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

Pilot: Funding for Bilingual McKinney-Vento Advocates

Pilot Start Date:	1/1/2024	Pilot End Date:	6/30/2025
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Funding to provide emergency or timely medical services when not covered by other sources		$6,000.00	$3,000.00
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Resource Costs	**$6,000.00**	**$3,000.00**
Materials & Supplies			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$0.00**	**$0.00**
Travel Expenses			
Travel for professional development of Bilingual Advocates		$6,000.00	$1,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$6,000.00**	**$1,000.00**
Meeting Expenses			
Meeting expenses and other professional development			
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Community Health Worker Courses and fees for Bilingual Advocates		$3,000.00	$2,500.00
Other Professional Development and meeting expenses		$1,000.00	$2,000.00
		$0.00	$0.00
	Subtotal Training & Development	**$4,000.00**	**$4,500.00**
Other Budget Items			
Services provied by Bilingual Advocates, for the target population, to		$59,736.00	$91,345.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$59,736.00**	**$91,345.00**
Total Direct Costs	**Rate (%)**	**$75,736.00**	**$99,845.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	3.91%	$2,961.28	$3,903.94
Total Project Budget		**$78,697.28**	**$103,748.94**

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

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	# of Students served by Bilingual Advocates	Monitoring number increase over time	Current number improved upon over timeline	End of proposal
	# of Medical trainings attended by BL Advocates	Recording of what trainings and meetings attended	Quarterly training in addition to 1 community health worker training	End of proposal
	Ability of families in accessing medical care	Surveys conducted at start and end of timeline	Growth over the course of the timeline	End of Proposal
	Funding Spent on medical needs unsupported by other resources	Tracking of medical related purchases and reason for doing so	Better understanding of eligibility barriers	End of Proposal

Lincoln County Oregon Emergency Winter Shelter Program

Backbone Organization: Lincoln County Health and Human Services

Primary Contact: Jayne Romero

Partnering Organizations: Housing Authority of Lincoln County

Billing Address: 36 SW Nye Street, Newport, Oregon 97365

Site(s): Newport & Lincoln City (Site Control Underway)

County(s): Lincoln

Priority Area(s): Houseless, Unsheltered Population

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

Four priority areas have been identified (approval pending) for the 2022-2025 Regional Health Assessment include Access to Affordable Housing, Behavioral Health, Access to Care, and Equity, Diversity and Inclusion. Information provided in the program proposal outlines how the project ties to all three of these priority areas.

Budget: Brief Summary (3-5 sentences in clear, concise, plain language that captures the key points of the proposal):

The cost of standing up two emergency no-low barrier winter shelter facilities is estimated at $698,820. Personnel costs total $400,292 and include a fulltime coordinator and 2 support staff per shift for each shelter. Additional expenses are budgeted for rent, materials and supplies, indirect costs, and equipment and total $298,528. Funding approved by this DST-IHN initiative will support the wages of part time shelter workers along with 10% associated indirect costs; with funding in excess of the $150,000 requested in this proposal coming from the Lincoln County general fund ($110,000), Lincoln County ARPA funds ($240,000), Lincoln County HHS Behavioral Health ($125,000), contributions from municipalities, and additional grant funding. If the total funding needed to support two shelters is not obtained, the County HHS Department will stand up one shelter and arrange for transportation support through the county transit department to assist unhoused individuals to access available shelter beds.

Proposal Narrative

Project Description/Approach:

The purpose of this proposal is to request Delivery Service Transformation (DST) funding support from the IHN-CCO to contribute towards the development and operation of a daily no barrier/extremely low barrier, emergency/walk in winter shelter program. There is a critical need to develop consistent, emergency overnight shelter for people experiencing houselessness in Lincoln County. There are no nightly winter emergency shelters in operation in the County.

In the recent past, temperature-triggered warming shelters have operated during extreme conditions in both Newport and Lincoln City by non-profit organizations. Both organizations have identified challenges including, but not limited to, the unpredictable nature of the weather resulting in scheduling/volunteer commitment challenges, drug use/sales in the shelter, security issues stemming from conflicts among participants, problems reported by facility sponsors, and lack of overall funding. Further, given the often-severe nature of winter weather on the central coast that includes nighttime temperatures in the 30s and 40s range, pelting rain and gale force winds, freezing temperature alone is an inadequate measure on which to base decisions about opening a warming shelter. According to the Center for Disease Control, hypothermia can occur even at temperatures above 40 degrees Fahrenheit, and victims are often people who remain outdoors for long periods of time, including those who are unhoused.

The proposed winter shelter program will be operated by Lincoln County, through its Health and Human Services (HHS) Department, and be available October 1 through March 31, ideally in two locations in the county (Newport and Lincoln City). Hours of operation will be nightly from 6:00 p.m. to 7:00 a.m. During the hours of operation, the shelter will be managed and supervised by paid employees. Two employees will always be present. Through partnerships with churches, non-profit organizations and interested citizens, volunteers will be recruited to provide additional support and oversee specific services that will be made available to participants (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). The Shelter Coordinator position is currently posted and includes a preference for an applicant that is bi-lingual. Translation and interpretation support will be provided as needed. The program has also reached out to Centro de Ayuda and Arcoiris Cultural for advice on strategies that can be adopted to ensure services provided are culturally appropriate.

If funding is sufficient, two facilities will be operated, one in Newport and one in Lincoln City. Ideally, each facility will have the capacity to support up to 50 people on any given

night. A search is ongoing to identify and secure facilities in both cities that meet ADA standards, have adequate bathrooms, showers, community space, kitchen facilities, storage, and parking space. When possible, the facilities will also be available for day shelter support at least two days per week. This will depend upon whether the county has full time control of the site, or if the county must partner with a church to access nighttime use. As of the writing of this proposal, a facility has been located in Newport, while the search continues for Lincoln City.

Regarding personnel, it is proposed to have a permanent, full time Shelter Coordinator that manages all shelter activities. Primary responsibilities will focus on operating the winter shelter facilities between the months of October and through the end of March. April through September the work will be focused on volunteer recruitment, developing community partnerships, generating supply donations, grant writing, and developing operational policies and procedures. As of the writing of this proposal, the position has been posted by the county and interviews have started for the selection of the Shelter Coordinator.

Additionally, the Shelter Coordinator will coordinate the facility personnel. This will include the need for eight (8) additional part time staff per facility (at two per shift, two shifts per evening, seven days/week, with each person working three to four shifts per week). They will be compromised of “Shelter Hosts,” who oversee the shelter operations and act as hosts to greet guests at the door and provide facility information and security. Others, along with volunteers, will act as “Meal Coordinators,” arranging for meals for shelter guests and/or “Logistic Coordinators” assigned the task of providing services in support of the shelter operations from shopping for shelter necessities, arranging transportation, etc. When possible, part time staff will be hired from among the unhoused individuals who would otherwise access the shelter for support. This will provide members of the unhoused community with a modest income while building a resume leading to more permanent employment.

In addition to addressing the urgent need for emergency shelter, the program will also provide hands on referrals to supportive services. The County HHS Department directly provides primary healthcare (through its Federally Qualified Health Centers), behavioral health treatment and crisis response, harm reduction, medication assisted treatment, and a variety of health education programs. HHS also coordinates one of the County’s two Behavioral Health Resource Networks (BHRNs) and has strong referral ties to the organizations that make up both BHRNs. Referrals pathways to these existing services will be developed and offered to shelter guests. And, as noted above, HHS is a sister department to other County departments that can bring supports and resources to those that access the shelters as well. In addition to service supports, shelter participants will also be referred to transitional shelters and other housing related supports to carve a pathway from unhoused to permanently/sustainably housed. Furthermore, information and linkages to employment opportunities will be made, including (as noted above) hiring shelter guests to serve as part time staff for the operation of the shelter program.

As mentioned earlier, the shelter will provide no barrier/extremely low barrier access to the program. Individuals will not be excluded because of substance use but will be prohibited from using or selling substances on site at the shelter. Recent reports

suggest that houseless individuals who are found deceased on the streets often have substances in their systems. Additionally, the shelter will not discriminate based on race, gender identity, sexual orientation and/or religion.

In the day-to-day operation of HHS services, translation and interpretation support is standard practice. This support will also be integrated into the winter shelter program.

Creating a shelter is a key (and missing) link in the Lincoln County housing and service support continuum and will transform our systems by building our capacity to offer shelter and connect the unhoused to supportive services. Developing this shelter program will include establishing new connections and referral pathways among non-profit organizations, government entities, the faith based community, health care, housing and other providers in our community and encourage increased coordination among the many entities that serve our unhoused population.

It should be noted that Lincoln County is a HB4123 pilot (see below) and through this process is recognized as having a need for a holistic approach to addressing the needs of the houseless community.

Population/Community to be Served:

The program will serve unhoused and unsheltered adults. Depending upon the facilities that are secured, families with children may be served in shelter facilities if dedicated entrances are available and safety can be assured. Otherwise the program will offer hotel vouchers to families with children.

According to the Point in Time (PIT) counts for 2022, Lincoln County had 160 individuals experiencing homelessness. Of those numbers, 75 individuals were sheltered, 32 were in transitional housing and 53 were without shelter. Knowing that the PIT count does not accurately reflect the area's true homeless population counts for several reasons, we offer the additional data:

Lincoln County continues to have many unhoused or underhoused youth as seen in the McKinney-Vento year over year counts – with 754 of our community's youth impacted by housing instability in 2021-2022.

According to a recently compiled Shelter to Housing Continuum for Lincoln County, there are currently 100 shelter/transitional housing units. The existing beds/units are consistently at maximum capacity with each organization having a waiting list. In addition, the Housing Authority of Lincoln County has a waiting list of 330 individuals for the Housing Choice Vouchers. These numbers reinforce that the unsheltered population is considerably higher than the point in time count for Lincoln County.

In addition, the research done by the strategic consultant Morant McLeod for the HB4123 consolidated plan estimates that the number of unhoused individuals in Lincoln County is around or exceeding 2,000 (see graphic below).

The size of the unhoused population across Lincoln County is believed to be around 2,000 individuals

	ESTIMATES	KEY ASSUMPTIONS	LIMITATIONS
School Data Estimate Method	1,748	There is a relationship between the number of unhoused adults and children that are known via PIT and school district counts.	Individuals without children may be under-represented.
Community Size Estimate Method	1,420	There is a relationship between the size of the unhoused community in Yachats and the size of the unhoused community in the rest of Lincoln County.	Larger cities may be under-represented.
Under & Over 18 Allocation Estimate Method	3,101	The children to adult allocation is consistent between unhoused communities and the rest of the county.	Individuals without children may be under- or over-represented. Children under the age of 5 may be under-represented.

Mean	2,090
Standard Deviation	+/- 891

MORANT MCLEOD Morant McLeod Economics Group | Lincoln County School District | US Census Bureau, 2021 ACS 5-Year Estimates 6

Morant McLeod has done extensive in-person interviews with 37 individuals experiencing homelessness in Lincoln County during the last two months. Their data is also informed by in person visits to the area service providers. According to a presentation to the Lincoln County Homeless Advisory Board on July 12, 2023, the firm demonstrated that “Many within the unhoused community are currently working, recently without permanent housing, or actively searching for both housing and gainful employment. It’s common for them to reach dead-ends in their pursuit.”

Based on Morant McLeod’s field research, the average age of the unhoused community is 46 years (with a range of 19 to 72 sampled), it's been an average of two years and eight months since the most recent date of employment, and an average of three years and seven months since the most recent date of permanent housing.

In addition, the research also shows that at least 48% of those interviewed report they have had difficulty receiving local housing services. Alarmingly, 86.5% suffer from one or more serious health concerns, including 46% with a mental health condition and 58% percent with a history of anxiety, depression or bipolar disorder.

On average, research participants have gone 2.7 years since their last medical visit, report having vision concerns for an average of 4.8 years and have had dental concerns for 4.1 years.

Sentiments collected from individuals that were unhoused during the firm's research include:

- “I want a roof over my head, or maybe a boat, RV, or apartment...anything to get off the streets in the winter”
- I want to “get into a house, back on my feet, and find a full-time job...but it’s impossible when you’re camping”
- and “I would like an apartment or even a shelter, I don’t want a homeless camp.”

Community Partners:

The problem of houselessness is a community wide problem, and a community wide response is needed in order to bring compassion and support to fragile individuals living on the edge of society. This Winter Shelter effort truly has broad-based community support ranging from traditional service providers to the faith-based community to municipalities to local businesses. As noted, the program will be run by the County HHS department, which includes the service divisions of behavioral health (treatment, skill building, case management and peer support), primary care/community health centers (including medication assisted treatment), public health (harm reduction, maternal/child family support, communicable disease prevention and health education) and developmental disabilities. Additionally, through the Behavioral Health Resource Network (BHRN)/Measure 110, the County has strong collaborative relationships and referral pathways with agencies that include: Northwest Coastal Housing (Project Turnkey housing in both Lincoln City and Newport), C.H.A.N.C.E. Recovery (peer support), Community Services Consortium (training and employment), Phoenix Wellness Center (substance abuse treatment), Reconnections (substance abuse treatment and project turnkey housing), and the Confederated Tribes of the Siletz.

Outside of HHS, the County has a strong partner in the Housing Authority of Lincoln County (HALC). HALC is taking the lead in locating and securing shelter sites and working to engage a broad range of community partners. And, through their management of HUD funded Housing Choice Vouchers (formerly the Section 8 program), HALC can offer a pathway to affordable housing. Other non-profits that have supported the unhoused in the past have indicated an interest in providing day shelter services in the emergency shelter settings (space permitting) and/or have indicated an interest in providing housing navigation services.

The faith-based community has opened their doors for temperature triggered shelters in the past. In a meeting held on July 31, 2023, churches including the following agreed to consider transitional space, provide volunteer support, and/or assist with cooking and supply drives: St Stephens Episcopal Church, Sacred Heart Catholic Church, Atonement Lutheran Church, and Newport Presbyterian Church.

Beyond the service delivery related partners, efforts are underway to secure financial partners as well. The County Board of Commissioners has approached the region's municipalities for funding support, and efforts are underway to approach local businesses as well as national chains to solicit help for funding or supplies to support the operation of the winter shelter program. Additionally, we are working collaboratively with the community action agency to form a tri-county continuum of care for the Linn, Benton, Lincoln regional area.

This effort truly is a community collaborative operation, and funding support from the DST IHN-CCO grant program will help ensure it gets off its feet.

Outcomes and Measurable Goals:

Providing emergency shelter addresses both immediate and long-term health outcomes for unhoused individuals. In the short term, shelter provides a safe, warm space where people can rest, stabilize and tend 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. A more targeted list of outcomes and goals are as follows:

Outcome 1: Unhoused individuals do not die on the streets.

Goal:

- The number of unhoused individuals found dead "on the streets" between 10/1/23 and 3/31/24, is lower than compared to each of the prior two years

Outcome 2: Permanent emergency no barrier/extremely low barrier shelter is available in two accessible locations in Lincoln County.

Goals:

- Two locations are operational by 10/1/23
- There is combined capacity to support up to 100 people per night in the shelter program.

Outcome 3: Shelter participants are linked to housing and support services.

Goal:

- A data collection process is established to gather base line information related to the following:
    - Number of individuals referred to transitional and other housing resources.
    - Number accepted into transitional beds.
    - Number of referrals made to health care, behavioral health, substance abuse and employment resources.
    - Number of ER visits by unhoused individuals

Outcome 4: Community support is mobilized to provide volunteers and supply resources for the Emergency Winter Shelter Program.

Goals:

- 75% of volunteer slots are filled each night.
- Supply drives are launched in at least 10 locations.
- Evening meal support is secured every night for both settings.
- Continental breakfast support is secured every day for both settings.

Outcome 5: Programmatic aspects of the winter shelter are defined, written and implemented.

Goals:

- A program advisory council, comprised of community partners, is established and operational.

- A program manual defining shelter rules, policies, activities and referral procedures is completed.
- A strategy for hiring part time staff, to some extent from among the unhoused population, is developed.
- Volunteer recruitment is initiated. Volunteers are trained and then scheduled on a rotating basis.
- Community support is secured for volunteers and meal preparation.

Health Equity Focus:

It is well known that people experiencing houselessness are at increased risk for developing and leaving untreated any number of serious health conditions. As noted earlier in this proposal, 86.5% of the Lincoln County houselessness community suffer from one or more serious health problems, with 68% having three or more conditions (Morant McLeod). As noted above, Morant McLeod field research suggests that, on average, unhoused individuals have not had a medical appointment for 2.7 years. Yet, 78% have medical insurance, mostly from the Oregon Health Plan. Additionally, based on the 2022 Point in Time (PIT) counts and current U.S. Census data, Hispanic, Black and Native American populations are overrepresented in people experiencing houselessness in Lincoln County.

A no-low barrier shelter for our unhoused individuals will provide a starting point for this vulnerable population to access services. It is common for people experiencing houselessness to be hesitant to engage with institutions and other “official” systems, especially the Hispanic/Latino population. Creating a safe, trusted shelter space can encourage connection with and service to people who are ready to seek support.

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 and access the service and supports that will enable them to do so.

Also, it should be restated that this program will be operated by the County HHS Department. HHS offers directly, or through partnerships, a wide range of health-related services and supports, which will be available to shelter participants.

In the past year HHS staff have all had four hours of Diversity Equity and Inclusion (DEI) training and the department has participated in a nearly nine-month DEI assessment. This has been facilitated by a national DEI-focused consulting group (Health Resources in Action) with a focus on bringing health equity to diverse, disabled and disenfranchised populations. Recommendations identified in the assessment are being incorporated into a new HHS three-year strategic plan.

Tie to Social Determinants of Health:

According to Healthy People 2030, the Social Determinants of Health (SDOH) "...are the conditions in the environments where people are born, live, learn, work, play, worship, and age that effect a wide range of health, funding, and quality-of-life outcomes and risks." Examples of determinants of health, well-being and quality of life provided by Healthy People include, but are not limited to, safe housing, transportation, racism, discrimination, violence, education, job opportunities, income and access to nutritious foods. Unhoused individuals do not have easy access to these things and, as a result, they experience significant health disparities and other inequities.

Providing emergency, no- low barrier shelter to unhoused individuals ties to each of the SDOH determinants listed above. Not only does this address people's immediate need for safe reliable shelter (and essential needs like access to phones and a physical mailing address) but is also provides a "door" to connect to the Oregon Health Plan (OHP), primary care and behavioral health, and other services and supports that will improve their housing stability and overall health. As noted previously, HHS operates many of the key services needed by individuals experiencing houselessness and has strong partnerships with our service providers that offer other services/supports needed by his population. Through this new program, HHS will bring full access to its services and align the systems in our community those offered by its partners.

Data collection procedures will be developed to assess and catalog service needs reported by shelter participants. Additionally, data collection regarding number and type of referrals made with and on behalf of participants will be tracked and recorded. The intent will be twofold: 1) to identify the needs of the people accessing emergency shelter for future planning and collaboration, and 2) to track the efforts provided by the program to link people to the services they need.

Individuals Carrying out the Pilot (experience and responsibilities):

Jayne Romero and Karen Rockwell will take the lead in implementing the Emergency Winter Shelter Program.

Jayne Romero, MS (Univ of KY), MPH (UNC @ Chapel Hill), has served as the Director of the Lincoln County Health and Human Services (HHS) Department, the largest department in Lincoln County government, since June 2021. Services offered by HHS have been described elsewhere in this proposal. Romero has 40 years of work experience in the health and human services arena, beginning her career in direct services (in state psychiatric hospitals) and 35 years of upper and executive level management experience in both governmental and non-profit organizations. Of relevance to this program proposal, Jayne has served as the Director of Programs in a large behavioral health and housing-oriented non-profit whose mission is to serve the unhoused, and she served as the Executive Director of a large multi-service organization serving "homeless and near homeless men, women and children" in a large urban area.

Karen Rockwell, Executive Director of HALC, has over 20 years of nonprofit organizational leadership, program development, and administration experience. She

currently manages HALC's 242 units of affordable housing and 570 Housing Choice Voucher (formerly Section 8). Rockwell is active in housing circles, recently being appointed to Governor Kotek's Housing Production Advisory Council and participates on the Board of Directors of Innovative Concepts for Families, Inc., is an Advisory Council representative for Community Services Consortium and a member of the National Association of Housing and Redevelopment Officials. She is a Certified Public Housing Manager with an MA in Nonprofit Management from Hamline University in St. Paul, MN.

Relationship to Organizational Strategic Plan(s):

The operation of a no/extremely low barrier emergency winter shelter ties to efforts taking place county-wide to develop a coordinated strategic plan to address homelessness. Lincoln County is one of eight pilot counties created by Oregon HB4123. As part of this legislation, Lincoln County received a $1 million dollar planning grant to develop and implement a coordinated plan to strengthen the counties response to homelessness. The County, along with representatives from the Cities, have formed the Lincoln County Homeless Advisory Board (LCHAB.org). The Board is chaired by Commissioner Claire Hall and the office is administered by the Housing Authority of Lincoln County. Through a competitive process the Board selected a consulting firm, Morant McLeod, to study the situation, collect and analyze the available information/data, and develop a consolidated strategic plan. On July 12, 2023, this strategic plan was presented to the Advisory Board. The plan calls for an approach that includes development of a continuum of housing options (e.g., emergency shelter, transitional housing, supportive housing, affordable rental/subsidized housing, affordable home ownership, and private market rental/home ownership), economic supports (ranging from skills development, to education, to industry certifications, to career and professional development), and service supports (e.g., emergency services, medical care, access to food and clothing, legal services, rent and utility support).

On a seven-phase housing continuum, the first step out of houselessness is "Emergency Shelter and/or Winter Shelter" progressing to "private Market Rental $ Home Ownership." A major identified gap is the absence of no/extremely low barrier emergency winter shelters in the County. Funding for this proposal would support the County's efforts to stand up a permanent winter shelter, which is critical to helping unhoused individuals move towards stable and sustainable housing.

In addition to the tie this program has to a county wide strategic planning effort, it also ties to planning underway in the County. The County and partners like the Housing Authority of Lincoln County are currently developing more than 75 units of affordable housing; a referral-only transitional shelter, Hope House, has just opened; and additional Project Turnkey with 38 transitional housing units, are coming online in Newport. Creating a no-low barrier emergency shelter leverages this increase in our housing capacity as a first step in accessing housing and other stabilizing services. It is an important piece of the shelter to housing continuum that will be added to our community.

How will the Community Hear About the Project:

As previously stated, the plan has been presented by Jayne Romero, HHS Director, to the Lincoln City Council, the Lincoln County Board of Commissioners, the entire County HHS staff, County department heads, and the Lincoln County Homelessness Advisory Board. There has also been a tremendous amount of time spent to outreaching directly with community service providers and faith organizations. In addition, the local news outlets have been receptive to covering the project and several articles have been published (see a few examples below):

https://www.thenewsguard.com/news/winter-shelters-2-proposed-in-lincoln-county/article_f8a63e8a-2b2c-11ee-a0b3-d334cd2dc2fe.html

https://www.newportnewstimes.com/news/county-hopes-to-create-winter-shelters-for-the-homeless-population/article_1ee8b5ca-2c9d-11ee-8fef-ef5394d3a8b6.html

https://yachatsnews.com/lincoln-county-racing-to-open-its-first-two-emergency-winter-shelters-by-october-but-faces-hurdles-with-staffing-locations-and-services/

KLCC's "Think Out Loud" program has contacted the County about an on-air program in October, when the shelter opens.

Given the tremendous interest in this program, it is anticipated that presentations will continue to be made to groups throughout the county (especially those with something to contribute to the effort) and the media. Once a full-time coordinator is hired outreach will start to philanthropic oriented groups, like the Elks, Rotary and Chamber organizations.

Outreach to unhoused individuals will occur through direct communication with people known to be unhoused by county and agency staff currently serving these individuals, posters in community settings known to be frequented by unhoused people (for example, grocery stores or day use navigation spaces), and outreach to known encampments. Information about the shelter will also be provided to law enforcement officials to share with unhoused individuals they encounter.

Potential Risks:

The obvious potential risk is that funding support will be inadequate to sustain the operations of the program years into the future. However, given the broad-based community engagement that has occurred around the development of this program, that seems unlikely. Financial commitments have been made at the county level, future grant opportunities are on the horizon, and talks with leadership at the IHN-CCO and Samaritan Health Plan have been launched to support the program in future years. In addition, with the high level of concern state-wide funding is also more readily available (compared to previous years) both through Oregon Housing and Community Services as well as through Oregon Health Authority.

Another risk is NIMBYism and the negative media coverage that can generate. But the lead partners in this endeavor, the County HHS department and HALC, have experience to bring to this type of reaction and will address any issues that present.

Another risk is safety in the shelter's themselves, and policies and procedures will be developed to ensure the safety and security of shelter guests and staff, including the development of quick response procedures with local law enforcement personnel.

Pilot Timeline

A timeline of key activities and goals.

Activity:	Target Date:
Fund raising/grant writing	7/1/23 and ongoing
Shelter Coordinator Position Hired	8/30/23
Identify transitional locations to serve until permanent locations are set up	8/15/23
Supply drives started with partners and businesses	8/22/23
Resource needs identified (supplies)	8/28/23
Food provision needs and resources identified and secured	8/28/23
Volunteer needs and recruitment strategies identified/launched	9/1/23
Part time staff recruitment and hiring launched	9/1/23
Program manual including policies/procedures written	9/15/23
Staff and volunteer training program created/launched	9/15/23
Staff/volunteer schedules planned; commitments secured	9/20/23
Feeding plan developed, scheduled, with commitments secured	9/20/23
Needs assessment, linkage, and other data base systems created.	9/25/23
Shelter sites outfitted for use -Transitional	10/1/23
Permanant shelter sites outfitted for use	1/1/24
Advisory Council Made up of Commuity Partners Created	6/1/24

Sustainability Plan

As noted above broad-based community support, both financial and resource oriented, has been and will continue to be solicited for ongoing operation of this shelter program. Financial commitments have been made by the Lincoln County Board of Commissioners and the HHS Department. Talks are underway with IHN-CCO and Samaritan Health Plan leadership to explore strategies for future sustainability. Ongoing financial commitments are being solicited from elected officials and managers from the county's cities. Financial contributions are being solicited from larger companies operating within the region and resource donations will be solicited from organizations and large outlets like Walmart and Fred Meyers. Funding for standing up the two facilities is expected from grants recently submitted to the Oregon Health Authority and there are known future grant opportunities on the horizon that will be pursued. Toward

this end, the county has set aside funding to support future grant writing projects. It should also be noted that the County has also already provided $40,000 in funding to purchase beds, mattresses and other equipment needed to operation the winter shelter program.

Pilot: Emergency Winter Shelter Program

Pilot Start Date:	**9/1/2023**	**Pilot End Date:**	**4/15/2024**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Program Coodinator		$107,034.00	$0.00
16 Part TIme Shelter Support Staff (850 each person annually)		$293,257.00	$136,363.64
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Resource Costs	**$400,291.00**	**$136,363.64**
Materials & Supplies			
Miscellaneous expenses (translation services, office supplies, staff travel, training, and supply needs not met by donations)		$30,000.00	$0.00
Furnishings and Equipment		$50,000.00	
Food expenses ($25,000 per facility)		$50,000.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$130,000.00**	**$0.00**
Travel Expenses			
Mileage Reimbursement		$5,000.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$5,000.00**	**$0.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$0.00**	**$0.00**
Other Budget Items			
Facility Costs ($50,000 per facility)		$100,000.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$100,000.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$635,291.00**	**$136,363.64**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$63,529.10	$13,636.36
Total Project Budget		**$698,820.10**	**$150,000.00**

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

Other sources:
Lincoln County General Fund
IHN-CCO
Lincoln County Behavioral Health
Multiple Grant applications applied for and pending

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	No permanent emergency shelter in Lincoln County	Ongoing attention give to securing sites in both Neport and Lincoln City. Progress tracked of efforts to to set up and outfit sites once locations are secured.	2 emergency winter shelters in Lincoln County open from October 1 through March 31	January-24
	Deaths of houseless people outside in the last year	Monitor death reporting through vital statistics	No houseless people die due to lake of sufficent shelter	March-24
	Emergency Department (ED) visits by unhoused people 10/1/23 - 3/31/24 for the prior 2 winters	Collaboration with both hospitals to gather data	Reduction in ED visits by 20%	March-24
	Temporary warming shelters have barriers to access	Monitor incidents at shelter and plan for deescalation techniques. Track prevelance of incidents within the shelter. Develop training program to address de-escalation strategies.	Incident report tracking. Participation in de-escaltion training program tracked for staff and volunteers.	March-24
	One temporary warming shelter closed and the other has reported barriers for operation	Two Shelters are operational. Track success of volunteer recruitment and supply drives. Track success of hiring needed part time shift staff.	Fully staffed and a large pool of volunteers	March-24
	No culturally appropriate shelters for hispanic/latino individuals	Partnerships with Centro de Ayuda developed. Translation services available each night. Bi-lingual staff hired for shift support	Diverse and bilingual staff every night at shelter and/or translation support easilty accessible versus online support.	March-24
	No collaborative stakeholder group at present that brings culturally diverse and socioeconomic perspectives to the table	Monitor to determine partners who are interested in and/or central to the successful operation of the winter shelter program.	Advisory council established	June-24

Food For Many

Backbone Organization: Family Tree Relief Nursery

Primary Contact: Renee Smith

Partnering Organizations: To be identified

Billing Address: PO Box 844, Albany, OR 97321

Site(s): 1305 Hill Street SE, Albany, OR

County(s): Linn County

Priority Area(s): Access to healthy food

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: HL1 Increase the percentage Members who are living a healthful lifestyle.

Budget: $87,285

Brief Summary (3-5 sentences in clear, concise, plain language that captures the key points of the proposal):

Food for Many is the first year in a multiyear project that will positively impact the food desert in South Albany. The long-term goal is to bring together community leaders and residents to create a culturally relevant food resource that will meet the growing needs of the diverse South Albany neighborhoods. This first year of the project will focus on understanding the food desert from multiple perspectives and sharing this information with community stakeholders. The second part of the capacity building project will bring together community members in a collective impact model to plan a new resource that will meet the food needs of IHN-CCO members and the community.

Executive Summary

Over the last decade food access in Albany has impacted access to healthy food for families. Historically, grocery stores were spread throughout the community, with healthy foods easily accessible to families. With the development of Heritage Mall, chain grocery stores re-located to a central area within a mile of each other. Two years ago, the food pantry serving the south side of Albany moved to the North side of town, ending up with both food pantries being located within a mile of each other. This perfect storm created a food desert for neighborhoods in South Albany. Many IHN-CCO members live in these neighborhoods and without easy access to affordable healthy foods, many IHN-CCO members and their families experience food insecurity.

The **Food for Many pilot** will include a systems view of the issue, advocating for change with the city and lay the ground work for a community based, culturally relevant food community space based upon a collective impact model bringing community based organizations, faith based organizations and IHN-CCO food pantry users together to plan food and nutrition services for the Southside of Albany. Family Tree will be the backbone agency and lead the work relying on like-minded community organizations to collaborate in the systems research and analysis, advocate with city and planning for an additional community food resource. The outcome will be a template and process that other organizations in other communities could use to assess the same issue across the IHN-CCO region.

The multi-year project's first-year goals are:

- Research and assess current food resources in Albany including all sizes and types of grocery stores and food pantries including the voice of IHN-CCO food pantry users.
- Prepare and share findings with local civic groups, community-based organizations, and the City of Albany.
- Bring together collaborative group of food champions to evaluate community food needs and design culturally relevant food supports based upon community need and end user's feedback.

Family Tree will lead in the food environment assessment. Family Tree will then bring together a team of community-based organizations, food champions and food pantry users to analyze and create multiple communication pieces that will be used in advocating with the city of Albany and civic groups. Next, based upon feedback from the IHN-CCO end users, the group will work to design and plan a new culturally relevant community food resource that will meet the needs of needs of IHN0CCO users living in South Albany. The second year of the pilot will focus on implementing the plan and operating the first stage of a new community food resource. The transformational elements include a system level view of the problem and looking for multiple solutions while educating and advocating at the city for strategies that can be used for community action. This project will require collaboration and community coordination as no one community based organization has all the resources to complete the whole project. The goal will be to leverage the strengths and resources of multiple organizations to work together for the greater whole. We are not aware of another community food resource with this organizational structure in our area.

Project Description

As described in the executive summary, the project will include a systems view of the issue, advocating for change with the city and lay the groundwork for a community based, culturally relevant food community resource based upon a collective impact model bringing community-based organizations, faith based organizations and IHN-CCO food pantry users together to plan food and nutrition services for the Southside of Albany. In the first year, the pilot will impact several 100 IHN-CCO members allowing them to share their ideas and needs for food resources in South Albany.

Phase One Environmental Scan

Phase one of the project will be researching and learning about the food environment and food bank system in Albany. This will include:

- Researching and documenting grocery stores of all kinds and their locations throughout Albany.

- Meeting with Linn Benton Food Share to learn about the current food pantries in Albany and how they support community members and IHN-CCO members.
- Meeting with each current food pantry and learning about what is currently offered and what gaps they see in the food bank services in Albany.
- Meet with multiple community organizations that serve IHN members to understand the food issues their clients/members experience with a focus on communities of color and other vulnerable communities in Albany.
- Share information about this project and explore interest in the organization's willingness to share a feedback survey with the community members that access their food banks.
- Through these meetings identify and bring together a 3–5-member steering committee.
- Connect with organizations that serve our communities of color to identify the barriers and challenges facing communities in accessing food resources.

The goal for the first phase is to get a systems view of food resources in south Albany including grocery stores, convenience stores and food pantry resources and document the existing food resources and services in Albany and start to identify what is working and identify the gaps and needs. Through these conversations we hope to identify and invite 2-4 individuals who would be willing to serve as a collaborative steering community for the project.

Phase Two Feedback from Community Members

Phase two will include feedback from foodbank users through interviews, surveys, and focus groups. The project coordinator will work with existing foodbanks, community organizations, faith communities and other community groups to gather feedback and information regarding.

- The needs, gaps and challenges community members face when accessing current foodbank services.
- What barriers do specific communities face when accessing current food bank services?
    - Focus will include feedback from communities that experience health disparities including our Indigenous community, Latino community, Ability community and the LGBTQ+IA communities.
- What types of foods/resources would they most like to see in foodbanks

The goal for this phase is to get a clearer picture on what is important to foodbank users and non-users including a cultural relevance lens to better understand the gaps, so that a plan can be developed to meet those needs and close the identified gaps.

Phase Three: Community Advocacy and Systems Change

Once the research is complete, a communication document will be created that will tell the story of food resources in south Albany. This product will include information expressed in several types of formats and styles. Once the communication products are completed, the group will design and implement a community advocacy plan including presentations to the city and other civic groups in Albany.

Phase Four: Building the Plan

Phase four will include building the core group of community partners and culturally diverse community members to organize and develop the plan. Together the group will analyze and evaluate the feedback and information gathered in phase one and two. Based upon this information the group will create a mission statement and service plan for the food resource. This phase will include:

- Finding diverse community partners
- Designing culture and goals for the pantry
- Determine locations.
- Researching funding sources available
- Determining policies and procedures for the pantry
- Ensure pantry design fills gaps and reduces barriers as identified in assessment.

The planning group will seek feedback from community members throughout the process ensuring that the design will meet the expected culturally relevant outcomes.

Phase Five Seeking Feedback on the Plan

Phase five will include sharing the plan with various groups of IHN members through community presentations, surveys, and interviews to ensure that the plan:

- Will have cultural relevance for the communities the food pantry will serve.
- From a food pantry user's perspective decreases current barriers they are experiencing

Phase Six Financial Supports

During phase five, the program coordinator will collaborate closely with community organizations identifying any areas of resources that could share the funding for the food pantry. This would include an exploration with IHN-CCO on types of alternative payments or payments in lieu of claims that may be possible in the next iteration of OHA's CCO programs. This would include the possible use of existing systems such as UNITUS for referrals, tracking and submittal of claims for food resources provided to their members.

During the pilot year, the group would evaluate if the plan was on track and ready to apply for a second-year pilot that would implement the created plan. If so, the group would put forth a second follow up pilot for funds to implement and plan and start a new food pantry as designed by the group.

Community Partners

Currently, we do not have any committed community partners. As outlined above, the first phase of the pilot would be used to share information about the project and connect with potential partners for the project. We plan on connecting with a wide variety of community partners including faith communities, social service organizations, family support programs, peer service programs, behavioral health programs, housing programs, early childhood and family support programs, the YMCA, the Albany Boys and Girls Club, youth organizations, Greater Albany Public Schools, United Way of Linn, Benton and Lincoln Counties, and any other organization that serves IHN-CCO members. Our goal is to have a robust diverse group of partners that would assist in the planning and implementation of the project. Using a collective impact model, Family Tree would serve as the backbone organization and support with administrative and project coordination. Partners would support with ideas, resources, feedback, and guidance in developing the food pantry plan for implementation. This model will

support a wide variety of ideas, knowledge and expertise in the various planning and activities needed for the food pantry's design and implementation.

Impact on Social Determinants of Health

Food insecurity is defined as a lack of consistent access to enough food for an active, healthy life and has a major impact on the health and development of individuals and families. There are many studies and reviews of research that show that consistently finds that food insecurity has a direct impact on poor health outcomes. Food insecurity particularly impacts children, and it has been found that food insecure children are at least twice likely to report being in fair or poor health and are at least 1.4 times more likely to have asthma as compared to food secure children. Additionally, research has found that food insecurity in children is associated with increased risks of some birth defects, anemia, cognitive problems, poorer general health, behavior problems, depression, suicide ideation and worse oral health. Additional research has shown that food insecurity impacts non senior adults as well with decreased nutrient intakes, increased rates of mental health problems and depression, diabetes, hypertension, and poor sleep. Mothers who are food insecure are over twice as likely to report mental health problems and over three times as likely to report oral health problems compared to their food secure peers. (Food Insecurity and health Outcomes, Craig Gunderson and James P Ziliak, Health Affairs, Vol. 34, No.11)

In addition, research indicated that the prevalence of food insecurity of underrepresent groups in the US has been statistically higher than the national average for all US households, In 2020, the rate of food insecurity was higher for Hispanic (17.2%) than for White, non-Hispanic households and Hispanic/Latino children were more than twice as likely to live in food-insecure households as White children. (The Determinants of Food Insecurity among Hispanic/Latinx Households with Young Children, Advance in Nutrition, Volume 14, Issue 1, Elder Garcia Varela, Megan A. McVay, Karla P Shelnutt, May R. Mobley.)

Closer to home, the Oregon Kids Count Data Cards published by Our Children Oregon and the Casey Foundation indicate that 18.5% of children living in Linn County experience food insecurity and that 14% of the children in Linn County live in poverty.

From the research above, we can extrapolate that many IHN-CCO members experience food insecurity as well. This project's aim is to not only bring additional food resources into an area of Albany that does not have easy access to a food pantry but also to share information and advocate for more action by the City of Albany in finding multiple strategies to positively impact this food desert. Currently, the two largest food pantries in Albany, FISH and Salvation Army are located on the North side of Pacific Highway, leaving a large area of neighborhoods unserved by a pantry that is close to their neighborhoods. This project's goal would be to locate the new food resource in this area, making it more easily accessible to neighborhoods and offer ideas and advocacy for change beyond just a community food resource.

Health Equity Plan and reduce health disparities.

One of the main outcomes of this pilot is to assess how the food desert is impacting South Albany and share these findings with the City of Albany. Additionally, we want to advocate for the City to join in finding solutions to his overarching community issue. We recognize that one community food resource will not change the system that created the food desert. It will however, meet the immediate needs of IHN-CCO and community members that need food resources. This project will create an implementation plan for a community food resource that will meet the needs and reduce barriers for IHN-CCO members, especially those in underserved communities.

Those that are closest to the issue and services are best positioned to help address them. Based upon this belief, this project will gather information from our organization's experiences working with vulnerable families including families in the Latino and LGBTQIA+ communities and how our limited supplemental food boxes have impacted their families. Additionally, we will connect with other organizations that serve other communities of color to understand the needs of the specific cultures around food and access to food.

To ensure we understand the needs of these IHN-CCO members, we plan on offering focus groups, interviews, and surveys to learn more about what families want and need from a food bank. We know that it is essential that the foods, service delivery, policies and procedures for

this culturally responsive food resource meet the needs of our vulnerable community members with a focus on what is important to the community and fill any existing gaps.

Our goal is to ensure that we hear feedback from the individuals that use food banks and use this information in the planning. We plan to offer several avenues for feedback and want to include food pantry users in the planning phases and on the community planning committee. We will offer support such as transportation vouchers, stipends, and other identified supports so that individuals can participate more easily.

Staff leading the Pilot

Family Tree plans to leverage our current Director of Operations, Cammie Freitag, to begin the project development and will add a program coordinator to collaborate closely with Cammie in leading the project. These two staff will connect with the community and move the project forward. Additionally, we will utilize our Community Health team, Ashely Greiner, and Rachel Thome to share information about the project in area health fairs and community events. Executive Director Renee Smith with work closely with the team and stay connected with the project and provide guidance and financial oversite of the project.

Family Tree Strategic plan

Over ten years ago, Family Tree staff continually shared with the Executive Director that families were struggling with food needs. Month after month, staff shared the same needs of the families with which they were working. Based upon this feedback, Family Tree worked with Linn Benton Food Share to start a school based supplemental food pantry. This meant that any person/family connected with Family Tree could access a small, limited food pantry at any of our sites. What started as four shelves of canned foods has grown into a warehouse space with 100s of pounds of both shelf stable and limited fresh foods available for the monthly supplemental boxes. During COVID, Family Tree increased their food supplies and added reheat meals to our food resources. Based upon feedback from participants, 90% of which are IHN-CCO members, we continue our supplemental food pantry but hear the request for more culturally relevant foods and a larger full pantry designation. This has been a goal for the staff and board members alike.

While Family Tree has made progress in our goal, there are many issues that limit our ability to operate a full food pantry. Lack of space and lack of volunteers are two critical resources we lack. Our hope is that through a collective impact model, with collaboration from multiple organizations including a faith-based organization we may be able to overcome these two barriers.

We know it will take time to create the template for a culturally relevant food resource that ensures not only a pantry, but a pantry filled with food choices, policies, and procedures that meet the needs of our underserved communities in South Albany.

How will community members hear about the project?

We will use a variety of strategies to share the information about his project. First, we will share with the families we serve and ask for their assistance in gathering information about their needs. Then, we will work with existing food banks and resources to share information about the project and how they can get involved in sharing their ideas and needs. We will connect and network with community partners and ask them to share information about the project.

We will also leverage our social media platforms sharing about the project and ask our network of partners to share with their social networks. As we build our collaborative network, the information will be amplified.

Part of the project will involve community presentations to service groups and civic organizations. The creation of the communication product will assist us in ensuring we have a multimedia product that can be used in many ways to tell the story of the needs and the project.

Risk/Barriers to success and how to address them.

There are several potential risks or barriers to the project. First, we may find that the local food banks lack the capacity or interest in sharing information or experiences with us. We hope that this is not the case but recognize that community-based organizations face limitations on the amount of time they can devote to tasks outside of the operation of their food resource. If this is the case, we will leverage other organizations that we have existing relationships with to

serve community members that access food banks and find out their experiences and knowledge.

A second potential barrier could be reaching food bank users to gather feedback. Again, we will connect with our clients and ask for their feedback as well as with other organizations we work with often. The feedback will be virtual so we will be able to share it through our online networks and through our social media. We will collaborate with our partners to offer focus groups and listening sessions with support for individuals that attend through gas cards and gift cards.

Another potential barrier may be that the City of Albany lacks the ability to change the food desert in South Albany. We are unsure of the reception and what they can do to change the environment in that area of Albany. Regardless of their ability, we will continue to tell the story and talk about the needs of the community.

Finally, there is always the risk or barrier of funding for the second and third phases of the project. While we do not know exactly what these barriers might be, we will keep our minds open to new ways to fund food resources and look for partners to build it with us.

Timeline

Date	Action	Goal
January 2024	Hire and onboard Program coordinator	Hire Program Coordinator position by 1/31/2024
February-March 2024	Phase One and Two • Design Assessment • Gather assessment information and meet with community partners. • Hold focus groups. • Implement survey. • Begin compiling data and information	Design assessment by 2/28/2024 Hold 3 focus groups by 3/30/2024. Distribute and receive back survey by 3/15/2024. Analyze data by 3/30/2024
April 2024	Phase Three • Create communication product with contract to share the findings in visual formats. • Design and implement social media campaigns around food resources and needs. • Schedule and attend presentations at civic and service organizations. • Set meetings with Mayor and City council members. • Meet with city planners regarding zoning needs and history of food resources. Phase Four • Identify and recruit members for planning team	Create and complete communication product by May 15/2024 Identify 3 members for steering committee by 4/30/2024. Begin presentation by 5/15/2024. Meet with city staff by 5/30/2024
May-August 2024	• Run social media campaign. Phase Four • Recruit members for planning team • Hold meetings to build vision and mission of group. • Review assessment • Begin developing plan for food resource. Phase Five • Gather feedback on the plan. • Update plan as needed. Phase Six • Create and submit IHN pilot for potential food resource start in 2025	Run social media campaign starting 6/1/2024. Have first steering committee meeting by 6/15/2024. Develop plan by 8/30/2024
Sept-December 2024	Phase Six • Continue to explore funding sources for ongoing food resource	Identify 3 funding sources for 2nd year project by 10/31/24

Sustainability plan

If funded, this pilot will end after one year and/or when the outcomes for the planning project are completed. The second phase of the project will include identifying funding to put the plan into action. We plan to apply to be a second-year pilot to implement the plan.

We will also continue to identify other funding streams for the project including potential funds in lieu of claims possibilities through IHN-CCO and OHA in the next format of CCOs. We will also look for traditional ways to gain food resources through grants and community donations.

A broader component of sustainability will be the commitment and involvement of cross collaboration with community organizations and partners. We hope that through these connections and alignment that a collection of food champions can leverage funding through their resources to support the project.

Once the project is completed, we will create a summary document with the project process, milestones, plan, and things we learned in the process so that other organizations in other communities could use the template to design and implement their own collective impact project.

Pilot: Food for Many

Pilot Start Date:	1/1/2024	Pilot End Date:	12/31/2024
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Program Coordination		$52,000.00	$52,000.00
Community needs/gap assessment		$2,000.00	$2,000.00
Communication product creation		$10,000.00	$10,000.00
		$0.00	$0.00
	Subtotal Resource Costs	**$64,000.00**	**$64,000.00**
Materials & Supplies			
Marketing materials/health fairs		$500.00	$500.00
Survey supplies/materials		$500.00	$500.00
Presentation supplies/printing		$500.00	$500.00
	Subtotal Materials & Supplies	**$1,500.00**	**$1,500.00**
Travel Expenses			
Mielage for presentation, meetings and outreach		$2,400.00	$2,400.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$2,400.00**	**$2,400.00**
Meeting Expenses			
Focus Groups		$1,000.00	$1,000.00
Snacks		$1,000.00	$1,000.00
Incentives		$1,000.00	$1,000.00
	Subtotal Meeting Expenses	**$3,000.00**	**$3,000.00**
Professional Training & Development			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$0.00**	**$0.00**
Other Budget Items			
Food Bank user stipends		$5,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$5,000.00**	**$5,000.00**
Total Direct Costs	**Rate (%)**	**$75,900.00**	**$75,900.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	15.00%	$11,385.00	$11,385.00
Total Project Budget		**$87,285.00**	**$87,285.00**

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

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	Lack of support for pilot coordination	Pilot leader to monitor progress	HIre program coordinator	Meet by 1/31/2024
	Lack of understanding compelling infomration about food desert in South Albany	PIlot leader ensure activiites needed to meet goal are completed; assessment survery, focus groups, interviews with food pantries, interview with other communnity partners	Completion of assessment of food desert and understanding of needs of IHN-CCO members to obtain healthy foods including commercial grocery resources and food bank resources	Meet by 3/31/2024
	Lack of social media resources to share about food insecurity in South Albany	Pilot leader to reveiw progress on development of communication product	Communication plan exisits to share infomraiton on social media, in person and in presentations to stakeholders	Meet by 5/30/2024
	Lack of collaboration thorugh collective impact to determine food resource needs in South Albany	Pilot leader will connect, collaborate and identify potential community members for steering committee	Steering committe in place and ready to develop plan for food resources based upon assessment data	Meet by 6/15/2024
	Lack of plan for new food resource in South Albany	Pilot leader work with steering committee to review assessemtn and build plan to create a new food resource based upon needs of IHN-CCO members in South Albany	Implementation plan complted to launch new food resource in 2025	Meet by 8/30/2024
	Lack of funds to finance new food resource center in South Albany	Pilot leader with steering committee will identify 3 funding sources for new food resource	New food resource will have funding identified for 2025	Meet by 12/30/2024

Healthy Eating Children's Cookbook Pilot Project

Backbone Organization: Furniture Share

Primary Contact: Michelle Robinson

Partnering Organizations: N/A

Billing Address/Site: 4450 Marion St. SE Suite C, Albany OR 97322

Counties: Benton, Linn, and Lincoln

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

HL1-Increase the percentage of Members who are living a healthy lifestyle.

ii. Nutrition, v. Stress, vii. Social Supports

SD3-Increase the percentage of members who have access to healthy food.

i. Food Security, ii. Availability of fresh, affordable produce

SD4-Increase Health Equity

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

ii. Availability of health equity data

Budget: $125,844.84

Brief Summary: Furniture Share is proposing a new pilot project titled "Healthy Eating Children's Cookbook" which provides a children's cookbook, and a healthy food box to promote healthy eating habits and culinary skills among children. The cookbook will feature easy-to-follow recipes with nutritious ingredients, designed to engage children in the kitchen. It will also include colorful illustrations and interactive activities to make cooking a fun and educational experience. Our Healthy Family Thriving Community food boxes provide fresh meat, fruits, and vegetables. Furniture Share aims to foster a love for cooking and empower children to make healthier food choices through this exciting new children's cookbook and the healthy food box we provide to them.

Pilot Goals, Measurement, and Expected Outcomes:

Furniture Share's Healthy Eating Children's Cookbook pilot project seeks to address the importance of healthy eating among children by providing them with a comprehensive resource that combines nutritious recipes, practical cooking techniques, and interactive activities. The Healthy Eating Children's Cookbooks will be included in each "Healthy Families Thriving Community" food box, giving families the food and education of a fun cookbook to cook with children. The pilot project will focus on achieving specific goals and evaluating the effectiveness of the program in engaging children and promoting positive health outcomes.

Goal 1: Improve Nutritional Knowledge
Measurement: Pre- and post-program assessments to measure children's understanding of balanced meals, food groups, and portion sizes.
Expected Outcome: Significant improvement in children's nutritional knowledge.

Goal 2: Foster Healthy Eating Habits
Measurement: Surveys will be given to track changes in children's food choices, consumption patterns, and awareness of healthy eating.
Expected Outcome: Increased consumption of nutritious foods and improved understanding of healthy eating habits.

Goal 3: Enhance Culinary Skills
Measurement: Observation and evaluation of children's participation in cooking workshops to assess their cooking techniques and ability to follow recipes.
Expected Outcome: Improved culinary skills, including proper measurement, food preparation, and basic cooking techniques.

Goal 4: Empower Children to Make Healthy Choices
Measurement: Surveys to evaluate children's confidence in making healthy food choices and their ability to apply nutrition knowledge.
Expected Outcome: Increased confidence and decision-making skills in choosing and preparing healthy meals.

Goal 5: Promote Family Engagement
Measurement: Surveys and feedback from parents and caregivers to assess the level of engagement and the impact of the pilot project on family behaviors and meal preparation.
Expected Outcome: Increased family engagement in cooking and the adoption of healthier eating habits as a result of the pilot project.

Population and Community Served:

The pilot project primarily focuses on serving children and families from low-income and underserved communities, with a special emphasis on IHN-CCO members living in Linn, Benton, and Lincoln Counties. It is estimated that the pilot project will reach approximately

2,280 IHN-CCO members, including children and their families with the cookbooks and food boxes, and 7,720 low-income and underserved children with be provided a cookbook through schools and our community partners.

The community and population served are low-income individuals and families, the vast majority qualify as "extremely" low-income. Our clients are referred by other social service agencies, and many of them require extensive income documentation, up to 90% of our clients are unquestionably categorized as "high needs". Furniture Share is dedicated to serving all clients referred, who are in need or crisis, with clean quality furniture and healthy food. We work closely with more than 240 governmental, educational, religious, and non-profit organizations to ensure our client outreach is serving a population as inclusive, equitable, and diverse as the communities we support. These target populations consist of but are not limited to physically or developmentally disabled, frail, elderly, escaping domestic violence, mental illness, homeless, and those who have previously experienced (or are at high risk for) homelessness, alcohol other drug addictions and persons with HIV/AIDS. Recognizing the importance of furniture both in establishing a true home and in empowering the individual, Furniture Share transfers gently used furniture donations from the community to thousands of people in your community in need, including the following groups: people who have recently transitioned out of homelessness and displacement; individuals escaping abusive situations; and children in crisis transitions.

Of the 5,032 individuals served in 2022:
2,446 were homeless or at risk of becoming homeless
491 were victims of domestic violence
216 were elderly/frail
217 were disabled adults
447 were disabled children
123 had developmental disabilities
417 had alcohol/drug issues
156 had mental illness
519 were veterans

Approach:
Furniture Share's Community Health Improvement Plan for the "Healthy Eating Children's Cookbook" program aims to improve the health and well-being of the community by promoting nutritious eating habits among children and providing Healthy Families Thriving Community food boxes. The plan includes the following key components:

Healthy Eating Children's Cookbook: Furniture Share will develop a comprehensive and innovative cookbook specifically tailored for children. The cookbook will include simple and nutritious recipes, colorful illustrations, and engaging educational content. It will serve as a guide for children to learn about healthy eating and cooking.

Education and Empowerment: The program will focus on educating children about healthy food choices, portion sizes, and cooking techniques through the cookbook's recipes, tips, and interactive elements. Inside the cookbook, nutrition education will be given to teach children about the importance of balanced meals, portion sizes, food groups, and the benefits of incorporating nutritious foods into their diets. Children will be empowered to make informed decisions and actively participate in their own health and nutrition.

Family Involvement: The pilot project will encourage family involvement by providing a food box filled with fresh vegetables, fruits, and basic ingredients to have fun while cooking. We will provide additional recipes, meal-planning tips, and grocery shopping guides. These resources will empower parents and caregivers to support and reinforce healthy eating habits at home.

Partnerships and Outreach: Furniture Share will collaborate with local elementary schools whose students fall into 80% of median income or below and community partners to distribute the children's cookbooks. We will also include the cookbook and Healthy Family Thriving Community food box for every IHN-CCO member we serve. This outreach will ensure broader access to the program and engage a larger number of children and families. These partners will play a vital role in promoting the project, identifying participants, IHN-CCO client feedback, and facilitating engagement.

Areas of Opportunity:
Interactive Elements: Including interactive activities like quizzes and cooking challenges, we can make the cookbook engaging and encourage children to actively participate in the learning process.
Visual Appeal: Incorporating colorful illustrations, appealing food photography, and attractive layouts can capture the attention of young readers and make the cookbook visually appealing.
Allergy and Dietary Considerations: Providing alternatives or modifications for common allergies or dietary restrictions can ensure inclusivity and allow children with specific needs to participate in the fun cooking activities.

Parental Involvement: Including tips for parents on how to involve their children in the kitchen, fostering a supportive and enjoyable cooking environment at home.

Sustainability and Ethical Choices: Introducing concepts of sustainable food practices, such as reducing food waste or choosing ethically sourced ingredients, can educate children about making environmentally conscious decisions while cooking.

By incorporating these concepts and exploring these areas of opportunity, Furniture Share will create an engaging and comprehensive children's cookbook program, providing valuable culinary knowledge and promoting healthier eating habits among children.

Community Partners and Their Support:

The pilot project will work closely with the following community partners:

We collaborate with over 240 social service agencies and non-profit organizations and partner with Albany General Hospital Foundation, Samaritan Albany General Hospital, Good Samaritan Medical Center, Community Outreach, Human Services, and Domestic Violence and Homeless shelters, Linn Benton Housing Authority and other housing organizations who have a vested interest in this pilot project as this program will help them help their client be successful.

Local Low-Income Elementary Schools: Schools will collaborate with Furniture Share to distribute the Healthy Eating Children's Cookbook to students and families, and promote the project within the school community.

Community Centers: Community centers will serve as venues for food boxes and children's cookbook awareness and provide access to the target population. They will support the distribution of the cookbook and facilitate community engagement through their existing networks.

Healthcare Providers: Partnering with healthcare providers will allow Furniture Share to reach families and children who access healthcare services. Healthcare providers can distribute the cookbook, provide nutrition education materials, and promote the project's benefits to their patients.

Health Equity Plan:

Furniture Share's pilot project demonstrates a strong commitment to health equity by addressing disparities and promoting inclusivity. The health equity plan includes the following components:

Access and Affordability: The pilot project will ensure affordability and accessibility for low-income families by providing free copies of the Healthy Eating Children's Cookbook and a healthy food box.

Culturally Relevant Resources: The cookbook and educational materials will be designed with cultural sensitivity, incorporating diverse recipes, spices, and ingredients that reflect the community's cultural backgrounds and preferences. Additionally, we will add the basic spices such as salt, pepper, garlic, and onion powder to each food box. We will also have a community spice rack within our warehouse to help with the diverse recipes where recipients will have an opportunity to choose 3 additional spices of their choosing. The spice rack will include spices but are not limited to cumin, curry, ginger, chili powder, Italian seasoning, turmeric, paprika, basil, etc.

Community Engagement: Furniture Share will actively engage with community leaders, parents, and community organizations to ensure the pilot project is inclusive and aligned with community needs and values. Input from community members will be sought during the development and implementation phases.

Health Equity Data Tracking: The pilot project will collect data related to health disparities, including demographic information to identify and address inequities. Data analysis will help monitor progress and guide ongoing improvements to reduce health disparities.

Addressing Social Determinants of Health:

The pilot project acknowledges the influence of social determinants of health and aims to address them through the following strategies:

Access to Nutritious Food: The project will provide information and resources on accessing affordable, nutritious food options, including delivery of food boxes and children's cookbooks. We will also set aside 10 food boxes with a cookbook every Friday for IHN-CCO client pick-ups.

Community Collaboration: By partnering with local low-income schools, community centers, and healthcare providers the pilot project will leverage existing networks and resources to promote and support healthy eating habits within the community.

Health and Wellness Education: The pilot project will provide nutrition education to empower children and families with the knowledge and skills to make healthier choices. This education will extend beyond nutrition to encompass other aspects of well-being, such as physical activity and stress management.

Inclusivity and Accessibility: Furniture Share will make efforts to accommodate diverse dietary needs and allergies within the cookbook, providing alternatives and modifications. Furniture Share will provide a cookbook and Healthy Family Thriving Community food box to every IHN CCO client we serve. The program will also be accessible to low-income families by offering free copies of the cookbook to community partners and elementary schools within Linn, Benton, and Lincoln counties whose students fall into 80% of the median income or below. We will also add our contact information on the back of each children's cookbook for low-income families who are currently not our clients so that they can reach out to pick up a healthy food box on Fridays. This will extend our reach to more IHN-CCO members that might not know about our services.

Evaluation and Feedback: Furniture Share will gather feedback from participants and community partners to assess the program's impact and make necessary improvements. Evaluation metrics may include changes in children's eating habits, increased knowledge about nutrition, and overall satisfaction with the program and the food box they received.

Sustainability and Long-Term Impact: The Healthy Eating Children's Cookbook program will aim to create a lasting impact on the community's health by promoting sustainable practices, such as reducing food waste, eating fresh foods, supporting local farmers, and emphasizing the importance of environmentally friendly cooking choices.

By implementing this plan, Furniture Share's healthy eating children's cookbook and healthy food box program will contribute to building a healthier community, fostering a generation of children with improved nutritional knowledge and culinary skills.

Healthy Eating Children's Cookbook Team:

Furniture Share's "Healthy Eating Children's Cookbook" pilot program will involve a team of dedicated individuals with different backgrounds and roles to ensure its successful implementation. Here are some of the roles and the associated responsibilities for the team members:

Program Manager: The program manager along with the Executive Director will oversee the entire "Healthy Eating Children's Cookbook" pilot, ensuring smooth operations and effective coordination among team members. Responsibilities include case management, designing the program framework, setting goals and targets, managing resources, monitoring progress, and evaluating outcomes. Create, order, and distribute food boxes and cookbooks.

Nutritionist/Dietitian/Health Coach: A qualified nutritionist, dietitian, or health coach plays a crucial role in promoting healthy eating habits within the community. Their responsibilities are to provide expert guidance on nutrition, meal planning, and creating balanced diets for the cookbooks.

Development Coordinator: The development coordinator acts as a liaison between Furniture Share and the target community. They establish partnerships, engage with local organizations, and promote the program to potential participants. Responsibilities may include conducting community needs assessments, organizing outreach events, coordinating participant recruitment, facilitating communication between community partners, and creating, ordering, and distributing food boxes and cookbooks.

Alignment with Organizational Plans:

The Healthy Eating Children's Cookbook pilot project aligns with Furniture Share's strategic plans and long-range vision. It supports the organization's commitment to community health, well-being, and addressing health disparities through innovative and transformative interventions.

Community Outreach and Communication:

To ensure broad community awareness, Furniture Share will implement the following strategies:

Elementary School Partnerships: Information about the pilot project will be shared with local low-income elementary schools through presentations, newsletters, and meetings with school administrators. Teachers can then disseminate project details to students and families.

Community Events: Furniture Share will participate in community events, health fairs, and parent-teacher association meetings to engage directly with the community and raise awareness about the pilot.

Digital Channels: The pilot project will have a dedicated webpage on our website providing information about the project, access to resources, and updates on the pilot project. Social media platforms, email newsletters, and digital advertising will also be utilized to reach community members.

Word of Mouth: Existing community partners, such as schools, community centers, healthcare providers, and local organizations, will help spread the word about the pilot project through their networks and word of mouth.

Potential Risks and Barriers to Success:

The pilot project acknowledges potential risks and barriers and has strategies in place to address them:

Limited Participation: Potential barriers, such as transportation, language barriers, or conflicting schedules, may affect participation rates. Furniture Share will work closely with community partners to minimize these barriers by offering accessible pick-up or delivery, providing language support, and considering flexible scheduling options.

Cultural Sensitivity: Recognizing and respecting diverse cultural backgrounds and preferences is essential. The pilot project will engage community members, including parents and caregivers, to ensure the cultural relevance and appropriateness of the materials in the children’s cookbook.

Sustainability: The pilot project aims to establish a sustainable model for long-term impact. Strategies include seeking sustainable funding sources, exploring partnerships for ongoing support, and identifying opportunities for program expansion.

Evaluation and Adaptation: Ongoing evaluation will allow for continuous improvement and adaptation to address any unforeseen challenges. Feedback from participants, community partners, and staff will inform adjustments and refinements throughout the pilot.

In conclusion, Furniture Share's Healthy Eating Children's Cookbook pilot project is an innovative and transformative initiative aimed at promoting healthy eating habits and

nutrition education among children and families. With clear goals, robust measurement methods, and expected outcomes, the pilot project aims to improve nutritional knowledge, foster healthy eating habits, enhance culinary skills, empower children to make healthy choices and promote family engagement. By addressing health disparities, incorporating a comprehensive health equity plan, and considering social determinants of health, the pilot project demonstrates a strong commitment to equitable health outcomes. With the involvement of community partners, a dedicated team, and a strategic alignment with organizational plans, Furniture Share aims to make a positive impact on the target population and lay the groundwork for sustainable, community-based interventions.

12-Month Timeline of Activities and Goals for Furniture Share's Healthy Eating Children's Cookbook Pilot Project:

Activities and Goals	Beginning Date for Each Task	Ending Date for Each Task or Activity
Project Initiation- Rolls and Responsibilities	09/01/2023	10/01/2023
Distribute Food Boxes	09/01/2023	09/01/2024
Research and Create Cookbook	09/01/2023	10/01/2023
Case management	09/01/2023	09/01/2024
Order weekly Healthy Food	09/01/2023	09/01/2024
Make healthy food boxes	09/01/2023	09/01/2024
Store Healthy Food	09/01/2023	09/01/2024
Order Cookbooks	10/01/2023	09/01/2024
Locate and contact Drop off locations for cookbooks	10/01/2023	09/01/2024
Distribute Cookbooks	11/01/2023	09/01/2024
Develop and distribute take-home resources	12/01/2023	08/01/2024
Data Collection	12/01/2023	09/01/2024
Evaluation and Analysis	07/01/2024	09/01/2024
Final Report	09/01/2024	09/20/2024

Month 1:

Project Initiation: Hold a project kickoff meeting to introduce the pilot project, establish project team roles and responsibilities, and define project objectives and expectations.

Cookbook Development: Begin developing the content for the Healthy Eating Children's Cookbook, including nutritious recipes, educational content, and interactive activities.

Month 1-12:

Delivery OF Healthy Family Thriving Community food boxes to every furniture client and provide 10 additional food boxes to non-furniture share clients every Friday. Once cookbooks are created, they will accompany every food box.

Month 2:

Cookbook Refinement: Review and refine the content of the Healthy Eating Children's Cookbook based on expert input and feedback, ensuring age-appropriate content and alignment with nutritional guidelines.

Partner Engagement: Engage with local low-income elementary schools, community centers, and healthcare providers to establish partnerships and build relationships.

Cookbook Printing and Distribution: Finalize the design of the cookbook, complete printing, and distribute copies to participating schools, community centers, and healthcare providers.

Month 3-9:

Family Engagement: Develop and distribute take-home resources, such as additional recipes, meal planning tips, and grocery shopping guides, to encourage family involvement and support healthy eating habits at home.

Data Collection: Begin collecting data on participant demographics, nutritional knowledge, culinary skills, and behavior change using surveys, assessments, and observation during workshops.

Cookbook Promotion: Conduct outreach and promotional activities to raise awareness about the Healthy Eating Children's Cookbook and its benefits among the target population and the broader community.

Month 10-11:

Evaluation and Analysis: Analyze the collected data to evaluate the impact of the pilot project on participants' nutritional knowledge, culinary skills, and behavior change. Assess the effectiveness of the workshops and the cookbook in promoting healthy eating habits.

Refinement and Improvement: Use evaluation findings to refine and improve the workshop curriculum, cookbook content, and program delivery for enhanced effectiveness.

Month 12:

Final Report and Recommendations: Prepare a comprehensive report summarizing the pilot project's outcomes, successes, challenges, and recommendations for future program development and sustainability.

Dissemination of Findings: Share the report with community partners, and relevant organizations to showcase the project's impact and provide insights for replication or scaling up.

Throughout the 12-month timeline, there will be ongoing communication, coordination, and collaboration among project team members, community partners, and IHN-CCO members. Regular meetings, progress updates, and feedback sessions will ensure the

successful implementation of the pilot project and pave the way for future program sustainability and expansion.

Sustainability Plan:

Healthy Eating Children's Cookbook is innovative, scalable, and transferable as it is the only program in our service area that provides IHN-CCO members with colorful and educational children's cookbooks and healthy food boxes filled with fresh meat, fruits, and vegetables. Furniture Share plans to continue to promote community awareness and gain new funding through private and individual donors, increase the volunteer base and fundraising events, and enhance collaboration with other referring agencies to increase comfort and safety in our community's underserved populations. To prepare to implement this project Furniture Share will increase community awareness and volunteer support through social media and marketing/networking opportunities.

Furniture Share and its governing board are actively recruiting new board members from diverse backgrounds. Building Furniture Share's capacity is the focus of our future planning. Assisting those who are socially and economically challenged to meet their basic needs and ultimately reach self-sufficiency is always at the forefront of the board discussion and planning.

We collaborate with over 240 social service agencies and non-profit organizations and partner with Albany General Hospital Foundation, Samaritan Albany General Hospital, Good Samaritan Medical Center, Community Outreach, Human Services, and Domestic Violence and Homeless shelters, Linn Benton Housing Authority and other housing organizations who have a vested interest in this pilot project as this program will help them help their client be successful.

Pilot: Healthy Eating Childrens Cookbook

Pilot Start Date: 11/01/2023		Pilot End Date: 10/31/2024	
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Ongoing case management to communicate services and healthy food needs to IHN-CCO members		$28,080.00	$28,080.00
Transport and deliver 1,500 healthy food Boxes IHN-CCO member		$11,250.00	$11,250.00
Transport and deliver 10,000 cookbooks to schools and community partners		$4,212.00	$4,212.00
Provide weekly case management for drop-in food box pick-up services of 780 food boxes		$7,020.00	$7,020.00
	Subtotal Resource Costs	**$50,562.00**	**$50,562.00**
Materials & Supplies			
Purchase meat, fruits, and vegetables for 2,280 food boxes (3 meals for a family of 4)		$22,800.00	$22,800.00
Purchase basic salt, pepper, garlic and onion powder for 2,280 food boxes. 4 spices per 2,280 food boxes ($4.25 for 4 spices)		$9,690.00	$9,690.00
Cultrual diverse spices-3 per food box (4.50 for 3 spices)		$10,260.00	$10,260.00
Maintian client datebase for stats and reporting		$2,400.00	$2,400.00
Purchase 10,000 children cookbooks		$21,900.00	$21,900.00
	Subtotal Materials & Supplies	**$67,050.00**	**$67,050.00**
Travel Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$0.00**	**$0.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$0.00**	**$0.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$117,612.00**	**$117,612.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	7.00%	$8,232.84	$8,232.84
Total Project Budget		**$125,844.84**	**$125,844.84**

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

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	Do not currently provide children's cookbooks to all IHN-CCO clients	Distribute children's cookbooks to IHN-CCO families with deliveries and scheduled pick-ups	10,000 Healthy Eating Children's Cookbooks will be handed out with food box deliveries and pick-ups. We will designate 3,000 per county.	November-23
	Do not currently distribute simple cooking instructions for children	Quality of life, and basic food knowledge will be measured after recieving the food box and children's cookbook.	Provide simple directions and ingredients for IHN-CCO Families to share with their children.	November-23
	Do not currently track IHN-CCO client's understanding and knowledge of the healthy food items that we provide and simple ways to cook them	A survey will be created.	Pre- and post-program assessments to measure children's understanding of balanced meals, food groups, and portion sizes.	May-24
	Do not currently track IHN-CCO clients food choices or awareness of eating habits	A survey will be created.	Surveys will be given to track changes in children's food choices, consumption patterns, and awareness of healthy eating.	April-24
	Do not currently partner with local low- income elementary schools or community centers	We will partner with local schools and community centers. to help with awareness and distribution of the children's cookbooks.	By partnering with local low-income elementary schools and community centers the pilot project will leverage existing networks and resources to promote and support healthy eating habits within the community.	October-23
	We do not currently provide healthy food boxes to local low income schools in the tri county are	We will partner with local schools and community centers to help with awareness and distribution of food boxes.	By partnering with local low-income elementary schools and community centers the pilot project will leverage existing networks and resources to promote and support healthy eating habits within the community.	October-23

Improving Access to Quality Education

Peaceful Gardens Montessori LLC

Primary Contacts: Claire Douglas clairethedouglas@gmail.com

Katie Puppo katie.puppo@gmail.com

Partnering Organizations:
Community Transition Program, Greater Albany Public Schools, Head Start, Casa Latinos Unidos, Dual immersion program, Republic Services

Billing Address: 1617 Belmont Ave. SW, Albany, OR 97321

Website: peacefulgardensmontessori.com

County: Linn

Priority Area: Albany, OR

Focus: Early childhood development, education, social inclusion

Budget: $150,000

The mission of Peaceful Gardens Montessori (PGM) is to provide high quality education and childcare for families of all income levels and cultural backgrounds. Quality childcare and early childhood education are essential for healthy growth and development. PGM provides this kind of quality education in a blended English and Spanish classroom environment. Currently, PGM has children from the ages of 6 months through 6 years (or kindergarten). PGM is seeking to serve more community members in the Linn county area by expanding enrollment capacity and offering community education events aimed at IHN members and underserved populations.

Proposal Narrative

The mission of Peaceful Gardens Montessori (PGM) is to provide quality education and childcare for families of all income levels and cultural backgrounds. PGM's project to improve access to quality education will add two new Montessori guides for the purpose of expanding the school's capacity, host free community education events and bring on a Director of Development and Community Engagement who will build relationships with local organizations and explore opportunities which can sustain the growing school and its mission to serve the extended community.

In order to grow the school and accommodate more students, PGM will bring on two new Montessori guides. While PGM works to open enrollment opportunities to more students, the Peaceful Gardens community will come together to organize enriching educational events available to the public, reaching out to IHN members through community partners which serve underprivileged populations.

A Director of Development and Community Engagement position will be created to facilitate the growth of the school. In order to grow, PGM needs a reliable revenue stream. Tuition alone cannot cover the cost of expanding quality education and childcare to families from all backgrounds. Fundraising is essential for expanding the school and its community outreach. The DOD would drive fundraising efforts, seeking out grant opportunities, community donations and volunteers. This new staff member would also build community partnerships to facilitate connecting IHN members and people from underserved populations with quality education and childcare.

Other than PGM, there is only one other Montessori school in Albany. In surrounding areas, there is one Montessori school in Corvallis (serving students ages 18 months - 6th grade) and no Montessori schools in Lebanon. Most families who would like their children to access Montessori education have to travel to Salem or Eugene as the schools in Albany and Corvallis have long waitlists.

A large barrier to childcare and early childhood education is financial. At PGM, we strive to offer alternative opportunities for families so the financial burden is less severe. Our tuition and childcare rates are competitive for the area. We are able to offer a discount to families with more than one child in our program.

Our community partnerships are continuing to increase as we expand the involvement of parents and family members. In the month of July, we partnered with the Community Transition Program (serving students ages 18-21) through Greater Albany Public Schools and had one of their students visit Peaceful Gardens Montessori to read to the students for story time and teach them songs with dancing. This was very well received by our students and families. We plan to increase these opportunities through the next school year as well.

In addition to the Community Transition Program, we have also partnered with Greater Albany Public Schools to speak to their high school students who are participating in their early childhood education program that the high schools offer. Some of the students involved in these programs were interviewed by Peaceful Gardens Montessori as possible childcare providers while the school is closed in the month of August. The high school students are also invited to visit PGM and volunteer to gain early childhood education experience.
PGM plans to make more connections in the local community to add to the wide array of learning opportunities for students and to be of service to those outside the school who have an interest in childcare, child development and education.

The mission of Peaceful Gardens Montessori (PGM) is to provide quality education and childcare for families of all income levels and cultural backgrounds. We strive to bring awareness to the community through networking and our community partnerships so that students from a variety of cultural backgrounds and socioeconomic statuses can have equal access to Montessori education.
We are a bilingual (Spanish and English) program. Several of our staff are fluent in Spanish and English. Fluency in Spanish and English will be a major consideration as

we consider new staff for the school. We also serve families who speak both Spanish and English in the home. Additional exposure to the second language at school is important so that all children can have equal access to educational opportunities. Studies have shown that children who learn a second language from a young age are able to develop communication skills and a higher degree of literacy. Children who grow up in bilingual environments develop a keen awareness of how language works and have a stronger foundation for learning additional languages in the future. All students at PGM are exposed to both Spanish and English education.

Peaceful Gardens Montessori offers early childhood education and childcare for children ages 6 months - 6 years. We are the only Montessori school in the immediate surrounding area (Albany, Lebanon, Corvallis) to offer Montessori education to children younger than 18 months. Studies have shown that during the first five years of a child's life, their brain is at its most flexible, making it a critical period for learning and growth. Children who receive quality early education demonstrate greater cognitive and socioemotional growth than children who do not. A child's experiences in the 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. These experiences provide the foundation for all future learning, behavior, and health. A strong foundation helps children develop the skills they need to become well-functioning adults. Children who receive early childhood education are 25% more likely to graduate high school and four times more likely to complete a bachelor's degree. They are also less likely to face academic problems, including repeating grades.

Unfortunately, access to this kind of care and education is a privilege largely reserved for families who can pay for private school. Our mission is to open our doors to all families regardless of socio-economic status. 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.

In addition to students of diverse socio-economic and cultural backgrounds, we also serve students who are neurodivergent. The Montessori Method of education provides a nurturing, supportive environment for children of all abilities and learning styles. This includes children with disabilities, including physical disabilities, learning differences in reading, writing, spelling, and/or math, ADHD, and Autism Spectrum Disorder. Our children learn in multi-age classes, with the same teacher, for 3 years. This sustained connection creates a stable, predictable environment for adults and children alike. Students are able to attend to their learning, rather than having to adjust to new people and new routines every year.

Neurodiversity is important in the classroom because it recognizes that each student has unique strengths and weaknesses and that traditional teaching methods may not work for everyone. By embracing neurodiversity, educators can create an inclusive learning environment that allows all students to thrive. Inclusion is such an important piece of education; it can reduce stigma, allow for social learning, increase social acceptance, and improve the social standing of students who are neurodivergent.
By increasing our student capacity to include grades 1-3, we would be offering more opportunities of inclusion for students of diverse socio-economic status, cultural backgrounds, and are neurodivergent.

The constant mental and emotional stress parents experience makes it more difficult for them to treat their children with patience and attention. At Peaceful Gardens Montessori, we offer opportunities for parents to observe their students at school, model the language they hear from the staff, and even take parenting classes if they are interested and able to. Parents of our students have told us that the way we intentionally communicate with the children has impacted their communication at home. We strive to make strong connections between our school and our families. Families have opportunities to get involved in class activities. For example, on a child's birthday, we

have a celebration where parents are encouraged to attend a class birthday celebration and share a picture timeline of their child's life so that we can celebrate each year they have been alive. Parents are also invited to participate in school activities throughout the year; we have hosted potlucks, holiday parties, and school picture events. Family involvement and connection is an important piece for the mission of Peaceful Gardens Montessori.

Montessori education is a method that is based on self-directed activity, hands-on learning and collaborative play. In Montessori classrooms, children make creative choices in their learning.
Traditional classrooms often emphasize disembodied education and memorization with seated book learning. To the contrary, the Montessori approach embraces embodied education, the philosophy that movement and learning are tied together. Montessori learning is hands-on, experiential, and investigative.

More than 100 years of extensive research have demonstrated that the Montessori Method affords children better academic achievement and adult well-being as compared to other traditional or conventional models of education. Students are supported in becoming active seekers of knowledge. Teachers provide environments where students have the freedom and the tools to pursue answers to their own questions.

Montessori supports social-emotional skills. Contemporary research supports the 100-year-old Montessori Method's effectiveness, indicating that children who learn in Montessori classrooms demonstrate stronger social-emotional skills in many areas than children in more traditional environments.

There are very limited opportunities for students to access an alternative method of education. Increasing the educational level of Peaceful Gardens Montessori will transform the educational opportunities that families have for their children in this area.

Peaceful Gardens Montessori has well-trained staff on our team to help execute our vision and make our expansion possible.

Katiemarie Zambrano is PGM's founder and the guide for the toddler classroom. She is a certified Montessori guide and has been working in Montessori schools for 11 years. In September 2022 Kaiemarie opened Peaceful Gardens Montessori as a small preschool, with a passionate mission to create a child-led learning environment and a thoughtful teaching approach that prioritizes a child's holistic growth above all else. She is the school's director, business manager, and toddler room guide. Katiemarie is fluent in Spanish and English. This pilot is the first step in her vision for the expansion of Peaceful Gardens Montessori.

Olivia Fee is the guide for the preschool classroom for students ages 3 years to 6 years. Olivia is a certified Montessori guide and has been working in Montessori education for 10 years. Olivia joined Katiemarie's vision at the start of the 2022/2023 school year.

Natalie Zambrano is Peaceful Gardens Montessori's assistant guide. Natalie supports Katiemarie and Olivia in their classrooms and assists with many other operations of the school. Natalie is fluent in Spanish and English, having grown up in a Spanish speaking home.This first year with PGM was was Natilie's introduction to a Montessori classroom environment. Natalie is in the process of a certified Montessori training course.

A community of volunteers also sustains and supports PGM. Katie Puppo, a parent of two PGM students and Claire Douglas, a friend of the school, are collaborating on fundraising efforts, beginning with the IHN-CCO Delivery System Transformation grant. Katie P. and Claire are helping with this pilot project by organizing a group of parent volunteers, reaching out to various community partners, and facilitating community events (such as fundraising and informational opportunities).
Katie P. currently works for the Greater Albany Public School District as an IEP Writer and has a background as a Special Education Teacher. Claire has hands-on experience with the day to day operations of the PGM.

Peaceful Gardens Montessori will offer childcare to families throughout Linn, Benton, Lincoln counties, who come from a variety of socio-economic and cultural backgrounds.

Goals:

1. Increase the number of staff members to facilitate the addition of more students as capacity allows. With the goal of adding a third classroom to the school, PGM will bring on two new Montessori guides.

2. Provide free education opportunities to IHN members by hosting monthly seminars on topics related to childcare, education and parenting. The seminars will be announced through our community partners who can connect IHN members with the events. The events will cover topics related to child care such as child development, “Love and Logic”, parenting, and the Montessori Method in both home and classroom settings.

3. Establish modes of sustaining the growth and reach of the school by bringing on a Director of Development and Community Engagement who can coordinate community partnerships, and drive fundraising efforts and outreach to the broader community.

In it’s first school year, PGM has partnered with Greater Albany Public Schools’s Community Transition Program (serving students ages 18-21) as well as other Greater Albany Public Schools programs , including the dual immersion program and early childhood programs at the high schools. PGM also partners with the Early Childhood Special Education program through Linn-Benton-Lincoln ESD, Republic Services, and various community volunteers.

The Community Transition Program has partnered with Peaceful Gardens Montessori this year by sending a student to the school to read story time to the children as well as

sing songs and dance with them. We plan to foster the relationship with that program so that we can continue to have students visit the school and interact with the children at PGM.

Katie Puppo has partnered with Peaceful Gardens Montessori as a contact through Greater Albany Public Schools. We have a relationship with South Shore Elementary (the school with the dual immersion program) and have asked that any families interested in early childhood education be put in contact with Peaceful Gardens.
The Early Childhood Special Education program through the Linn-Benton-Lincoln Educational Service District serves families of children ages 3-5 who have diverse learning needs. We have communicated what our program looks like to them and plan to foster a relationship to reach families who may want to access the Montessori curriculum.

A parent of one of our students works for Republic Services. They offer discounted services to Peaceful Gardens and also have offered to bring one of their trucks to the school. They will give our students a tour of the truck and teach them about environmental awareness and the importance of waste management. They will teach our students about the health of the environment and what impact they can have by being aware of recycling options and how to properly dispose of items.
Lastly, we do have various community volunteers who come and visit the school. One of our volunteers offers music time to our students. She will bring her guitar and sing children’s songs. She lets the students hold and touch her guitar and teaches them about what the instrument is and how important music is for our culture. We have volunteers who come and take professional pictures of important school days (such as a holiday party).

Montessori education supports greater health equity (especially mental health) by an approach that fosters appropriate attachment, social-emotional skills, and engagement and cooperative community participation. We strive to raise emotionally healthy individuals. Access to early childhood education is a big factor of the socio-economic

disparities and health outcomes. We plan to track our health equity through student enrollment and parent and community interest outreach.

One of the focuses of Peaceful Gardens Montessori will be to connect families with community resources to help build independence and security. We will connect families with various parenting classes, financial assistance opportunities, and other community events that they may be interested in.

Our pilot is transformational in the way that education is managed. Parents and staff will have a large involvement in the school's mission and future. They will take ownership and invest their time and efforts into making the school function in a meaningful way. Our parents and staff know this community; that is key for developing a strong and healthy educational experience for our students.

We are currently connected with a few community partners who are aware of our mission and pilot project. We plan to maintain those relationships and provide updates to the growth of our program. Our goal is to increase our community partnerships by networking through parent volunteers.

One of the biggest potential risks to our pilot project is financial. While this grant would provide us with the ability to expand our staff, we also need to increase classroom materials in order to meet the needs of all students. We plan to overcome this barrier through community outreach and immense fundraising efforts that are spearheaded by parent volunteers.

Another potential barrier to this pilot project is recruiting the right people for the job. Is crucial to Montessori education that the staff involved are well-trained and that the teachers are educated in the Montessori method. We plan to overcome this barrier by continuous networking and offering on-the-job training for our new guides if they need professional development.

Pilot Timeline

2024

January - Begin hiring process, interviews, hire and onboard DOD before February

February - Professional development training: Outside the school -nto bolster their aptitude for their duties; shadowing local not for profit organizations and attending classes. Inside PGM - Getting acquainted with the philosophy of the school and understanding the vision. The ins and outs of operation and identify potential areas of need. This onboard process will wrap before the end of February and the DODACE will begin fundraising and expanding community partners.

March - Host the first community seminar. Begin the search for new Guides

April - Hire and onboard the first assistant. Host the second community seminar.

May - Assess the progress of the DODACE to plan the budget for the school's expansion project. Host the third community seminar.

June - Search for and hire a second guide. Host the fifth

July - The guides plan their curriculum and class sizes for the 2024/2025 school year based on the progress of the expansion project.

August - Summer vacation, additional professional development programs for all employees will be offered if the employee chooses.

September - Host the fifth Community Seminar

October- Host the sixth Community Seminar

NovemberHost the seventh Community Seminar

DecemberHost the eighth Community Seminar

2025

January Host the ninth Community Seminar

February Host the tenthCommunity Seminar

March Host the eleventhCommunity Seminar

April Host the twelfth Community Seminar

Sustainability Plan

PGM is a small independent school that teaches enrolled preschool students and offers free community classes related to child development. This combination is innovative because it fosters community among the parents of the students. Parents have the opportunity to learn about the kind of communication style and approaches to childcare that make their children so successful at the school. Families who are not able to enroll their kids at PGM can still learn from the philosophy and incorporate it into their parenting.

Peaceful Gardens Montessori is a small preschool with kids from ages 6 months through 6 years of age but it can be scaled up to include older grades of students. The model of PGM is transferable to other projects because there is a high demand for quality early childhood education. PGM's staff are eager to share the approach that makes the school successful. Anyone curious about starting a small school can connect with PGM at the free monthly seminars. The Director of Development and Community Engagement can facilitate ongoing relationships with organizations looking to emulate the success of PGM.

With the creation of the DODACE position, PGM will be able to raise funds and build community connections that will sustain the ongoing school operations, expand to add more grades, and do it all without charging exorbitant tuition.

Pilot: Improving Access to Quality Education

Pilot Start Date:	1/1/2024	Pilot End Date:	7/1/2025
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
increase student ellroment opportunities available to IHN members by adding two in-class guides		$99,600.00	$90,000.00
Facilitate community collaboration by bringing on a Director of Development and Community Engagement		$55,000.00	$40,000.00
Host free community education events, available to IHN members		$1,400.00	$1,200.00
	Subtotal Resource Costs	**$156,000.00**	**$131,200.00**
Materials & Supplies			
Print and digital materials for seminars and workshops		$600.00	$300.00
Class materials for expanded class sizes		$1,500.00	$900.00
	Subtotal Materials & Supplies	**$4,000.00**	**$1,200.00**
Travel Expenses			
		$0.00	$0.00
	Subtotal Travel Expenses	**$0.00**	**$0.00**
Meeting Expenses			
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Montessori Method training courses for new guides		$2,000.00	$1,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$2,000.00**	**$1,000.00**
Other Budget Items			
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$162,000.00**	**$133,400.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	12.40%		$16,600.00
Total Project Budget		**$162,000.00**	**$150,000.00**

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

Activities Monitoring: Improving Access to Quality Education

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	School opperations are funded only by tuition and therefore are limited by families' abilities to pay for childcare	Bringing on a Director of Development and Community Engagement who can coordinate community partnerships, and drive projects to facilitate the growth of the school and outreach to the broader community.	The DODCE will complete onboarding and begin work	March 2024
	School capacity for children is limited to 16 as there are two teachers and one assistant on staff and there is no on-staff substitute	Bringing on two additional Montessori guides to facilitate expanding the school's capacity for children thereby creating opportunities for IHN recipents to access high quality preschool and childcare.	Onboarding two trained guides	September 2024
	PGM staff have heard from parents asking for community education events but the school has not yet hosted any	PGM will host twelve monthly seminars on topics related to childcare, education and parenting. Seminars will be free and promoted through our community partners who can connect IHN members with the events.	The first monthly seminar will be orgainized	April 2024

Positive Outcomes for LGBTQ+ Youth

Backbone Organization: Jackson Street Youth Services

Primary Contact: Lauren Winchester, grants@jacksonstreet.org

Partnering Organizations: Portland State University, Parenting Strengths Network, Linn-Benton Community College, Albany Pride partners

Billing Address: PO Box 285, Corvallis, OR 97339

Site(s): Corvallis House & Albany House (24/7 Shelters), Jackson Street's Mission Central (admin headquarters, downtown Corvallis)

County(s): Linn, Benton

Priority Area(s): Social determinants of Health & Equity: Increase health equity, access to housing

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

Outcomes	*Indicator Concepts*	*Areas of Opportunity*
Increase health equity	n/a (none listed in CHIP document)	Health disparities experienced by members due to age, gender identity, sex, sexual orientation (+ other factors)
Increase % of Members with safe, accessible, affordable housing	Number of homeless students (and number of homeless persons)	Eviction prevention (related to LGBTQ+ youth + parents)

Budget: DST request: $150,000 (Total project: $205,134)

Brief Summary (3-5 sentences in clear, concise, plain language that captures the key points of the proposal):

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—ultimately creating a more accepting, safe community for LGBTQ+ youth (and adults). These services will include: Queer Peers with expanded capacity and new curriculum in Linn and Benton counties, a parenting class for parents/guardians of youth who identify as LGBTQ+, and paid Outreach staff to connect youth with services and facilitate groups.

Pilot Description (~3,000-7,000 words)

This pilot works towards a more inclusive community in the long-term by creating accepting spaces for LGBTQ+ youth and teaching parents/guardians how to support and care for LGBTQ+ youth in their lives. This work is critical, as youth who are LGBTQ+ in the U.S. are at more than double the risk of homelessness compared to non-LGBTQ peers and had over twice the rate of early death among youth experiencing homelessness (Chapin Hall). We will build acceptance and support in the community as follows:

Create a new, inclusive, informational Queer Peers curriculum with Portland State University (PSU). We will measure success using youth participation and feedback in listening sessions (qualitative), the number of youth participating in sessions, and the progress towards developing and implementing the new curriculum within 6, 12, 18, and 24 months of starting this part of the project.

Expected outcomes include:

i. This will contribute to a richer world of LGBTQ+ youth curriculums (very few exist right now that work for youth who are homeless);
ii. youth will report higher emotional and social well-being;
iii. youth will report less boredom and more engagement with curriculum;
iv. Queer Peers facilitator will feel equipped to lead groups effectively.

Expand Queer Peers to Benton County, sustain and grow Linn County Queer Peers. We will measure success by tracking the number of youth attending, consistency of attendance (the number of youth and consistency from individual youth), community partner feedback (qualitative), and youth feedback from surveys and informally (qualitative).

Expected Outcomes:

i. Youth will report higher emotional and social well-being;

ii. Youth will be referred to other supportive/wrap-around services in the Jackson Street continuum or through community partners.
iii. Youth will access hot meals, a safe space, and supportive adults.

Sustain and expand staffing to allow for Queer Peers expansion; connect additional youth with Queer Peers and other programs. We will measure success by tracking turnover in the EOC, SOW, and QPF positions, the number of youth attending both counties' Queer Peers, the number of referrals from the EOC and Queer Peers to other Jackson Street and community partner services, and sustained and expanded relationships with schools across both counties through the EOC.

Expected Outcomes:

i. Queer Peers is consistently delivered for youth in both counties (see outcomes in goal #2).
ii. Relationships with schools in both counties are strengthened; referrals may increase.
iii. Relationships with LGBTQ+ community in both counties is strengthened; more opportunities for partnership may arise.

Design and implement a parenting course for parents and/or guardians of youth who are LGBTQ+ in Linn & Benton counties. Youth who are LGBTQ+ and homeless or at-risk of homelessness may be kicked out or run away due to lack of acceptance in their family's house. There are no parenting courses in our area for parents and guardians of youth who are LGBTQ+, and this course will equip parents to respectfully work with youth in their lives and help keep youth feeling safe in their homes. We will measure success measured by tracking: parent/guardian and youth feedback after course delivery, partner feedback (qualitative), completion and implementation of the course within 24 months, staff feedback (qualitative), number of attendees at each session, and future community interest (qualitative, possibly quantitative via survey).

Expected Outcomes:

i. Parents and guardians feel more equipped to engage respectfully and productively with youth who are LGBTQ+ in their lives.
ii. Youth feel more supported and respected by their parents/guardians.
iii. Youth feel less need to run away due to lack of acceptance at home; the number of youth running away or at risk of running away decreases over time.
iv. Attendees of the course refer other adults to the course.

Population served

This pilot will serve youth who are LGBTQ+ and their families, parents, and/or guardians—particularly the ones who are located rurally in Linn and Benton counties and youth/families who are considered low-income or homeless. Jackson Street's services particularly target youth who are experiencing homelessness or at-risk of homelessness, and these youth often are IHN-CCO members or qualify to be members. Jackson Street assists youth who qualify to sign up for OHP and other benefits.

This pilot lowers financial and transportation barriers to attendance wherever possible, offering transportation for rural youth via Jackson Street's Activity Van (driven by an approved driver on staff) and taxi company MOUs, public transportation, and ridesharing as necessary. Additionally, this program will provide hot meals to adults at parenting classes and youth at Queer Peers, which can be an important service for youth or families who may not otherwise have access to quality food. Finally, adults participating in parenting classes will receive a $40 childcare voucher (per family) each week to offset the cost of childcare (e.g. babysitters) required to watch youth or other children in the home while they attend the class. By recognizing and lowering barriers, Jackson Street seeks to make services even more accessible to the low income and/or homeless youth and families most in need of these services.

At least 50% of youth across Jackson Street's continuum who responded to the insurance question in intake surveys last year were IHN-CCO members. That number may be low, as not all youth are aware of their health insurance options at intake, and others choose not to answer.

Approach

Jackson Street uses evidence-based models and national standards to design programming and curriculum. *Positive Youth Development* offers youth a chance to improve competence, confidence, connection, caring, and character by focusing on their strengths in community settings. *Harm Reduction* looks for ways to minimize physical, emotional, and mental harm while building trust with youth (e.g. providing safe needle disposals or sexual wellness supplies). *Trauma-Informed Care* respects that every person has their own trauma and seeks to reduce possibility for re-traumatization at every opportunity. Finally, Jackson Street centers youth voice by seeking out youth input through multiple avenues on program design and updates.

These models will be incorporated into four key activities for this project:

1. We will work with PSU to develop a new curriculum for Queer Peers and implement it in both counties. Very few curricula exist for LGBTQ+ youth that are based in best practices and useful for settings like Queer Peers (not schools), and current Queer Peers attendees are tired of the OneCircle curriculum that we have used for several years. We will host 8 three-hour listening sessions with 10 youth, providing transportation and food, and pay the youth $25/hour as contractors for their time and contributions. This format has worked well in the past for other similar projects, and youth input from them has been valuable. Using those sessions and our models named above as a basis, we will work with PSU to create a Queer Peers curriculum.
2. Leveraging our history and lessons learned from facilitating Queer Peers in Linn County, we will identify a regular location and time to host Benton County Queer Peers. One of the LGBTQ+ youth support groups in Benton County has closed down, and county partners have asked Jackson Street to fill that gap. Queer Peers meets weekly, facilitated by a Jackson Street staff member, and offers hot food and a place for youth to talk about daily life issues together. We are the only provider for such services in Linn County and will be one of two providers for Benton County.
3. We will expand our staffing to accommodate this expansion sustainably. The EOC position has facilitated Queer Peers in Linn County, but hiring a Queer Peers facilitator will allow both the EOC and QPF to expand their respective work without burning out. Hosting Queer Peers in two counties and building our school outreach program will create opportunity for more referrals, so the additional Street Outreach Worker will step in to aid with the increased volume of referrals and youth needs. Key steps include writing a QPF job description, posting all three jobs, recruiting and hiring, and training.
4. Using feedback from the youth listening sessions, we will work with Parenting Strengths Network (PSN) to create curriculum based on youth and parent needs. We will host two 8-week sessions with Linn-Benton Community College's support, providing childcare vouchers and hot meals each week to reduce barriers to attending. There are no parenting courses for parents and guardians of LGBTQ+ youth in the area, and it is a large gap that many partners would like to see filled.

Jackson Street is the only service provider for youth experiencing homelessness between Eugene and Portland, and services for LGBTQ+ youth and families who are low-income and/or at-risk of homelessness are few and far between, when they exist. Jackson Street works hard to meet those

youth and families where they are—providing transportation, meals, and other services to remove barriers to participation.

Partners will include:

Portland State University (PSU): We have worked with PSU 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 locally or nationally. PSU is a strong partner with a skillset that will create a refined, youth-driven, engaging curriculum.

Parenting Strengths Network (PSN) will partner with us to write the parenting course curriculum. We have previously partnered with them to design parenting courses for Jackson Street and are confident in their ability to design thoughtful, engaging curriculum for adults.

Linn-Benton Community College (LBCC) will provide childcare vouchers and hot meals each week for the two 8-week sessions of parenting classes in order to remove barriers to attendance.

Health Equity Plan

LGBTQ+ youth are 120% more likely to be 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, and providing hot meals, childcare vouchers, and transportation assistance supports youth and families' attendance as well.

Rural isolation contributes to the lack of acceptance/hostility that LGBTQ+ youth in both counties encounter. This programming offers youth a sense of solidarity and community and brings together adults from across the community to bridge some of that isolation. As we build relationships, we will build a more welcoming community.

Jackson Street centers youth voice in all programming decisions, and the

youth listening sessions plus intake and exit surveys will be the primary guide for this program's design and adjustments. Additionally, staff and leadership have lived experience with homelessness and reflect the youth in race, gender identity, sexual orientation, and cultural aspects, which we use to create diverse, equitable, welcoming, inclusive programming. In the long run, the parenting and Queer Peers curricula can be translated into other languages to meet other cultural groups' needs nationwide.

Staff model inclusive communication by sharing pronouns, offering translation and interpretation when needed, and by encouraging bilingual youth and staff to communicate in their first languages with each other.

Short term data will be collected through intake and exit surveys that measure social and emotional wellbeing, safe shelter, permanent connections, and education and employment data for youth. Parents and guardians will also have intake and exit surveys with questions around feeling equipped to parent youth who are LGBTQ+ and their understanding of this community. Jackson Street will monitor the intersections of youth who are homeless, at risk of homelessness, and runaway and also LGBTQ+ in our services over time and advocate for more community-wide efforts to collect data on the health and safety of LGBTQ+ individuals.

Social Determinants of Health

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 are more likely to complete school, find employment, and experience 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.

Ultimately, this program will increase self-acceptance and acceptance of peers for youth as well as familial acceptance and celebration of LGBTQ+ identities in homes. We are working to build a strong community that has parenting tools to welcome and accept youth and to build a community that protects and encourages youth and adults who are LGBTQ+. As a result, we expect to see lower mental health crises rates for LGBTQ+ youth and fewer instances of feeling the need to run away from home.

Responsible Individuals/biographies

Kendra Phillips-Neal has 20+ years of experience in this field and will lead our project design and development in the initial stages. She is transitioning from the role of Program Director to Executive Director and will own the long-term vision and contracting for this project.

Anna Bontrager, Outreach Manager, will oversee the EOC, SOW, and QPF positions. She has 5+ years of experience at Jackson Street and spent much of that time managing the Outreach Program.

The Queer Peers Facilitator will plan and implement weekly meetings of Queer Peers in both counties, build rapport with youth, and oversee the Peer Facilitator—an older youth who works as a contractor to assist with Queer Peers facilitation and gain leadership experience.

The fourth Street Outreach Worker will connect with youth through Street Outreach, help meet youth needs as they are referred to Jackson Street through the EOC and Queer Peers, and drive the Activity Van so youth have transportation to and from Queer Peers each week.

The Education Outreach Coordinator connects with faculty, staff, and counselors at each school to ensure they know who is eligible for Jackson Street's services and how to refer youth. The EOC hosts pop-up resource opportunities at schools and builds rapport with youth to refer them to Queer Peers and other services.

Jackson Street's leadership team consists of people with lived experiences with homelessness, LGBTQ+ people, people of color, and people from a range of ethnic and cultural backgrounds. Staff that work with youth directly also reflect youth in these ways, and Jackson Street offers incentive pay to staff who are bilingual in languages that the youth we work with speak. The Board of Directors added two young adult members in the summer of 2022 as part of its commitment to centering youth voice.

Organizational long-term plans

Jackson Street's long-term vision is to end youth homelessness locally and lead the movement to end youth homelessness nationally. Until the injustice in our system is rectified, pathways to youth homelessness will continue to exist, so our service continuum is designed to meet youth where they are at, and to ensure that any experience of homelessness is brief and one-time.

Youth who are LGBTQ+ are more likely to run away or be kicked out of their home, particularly due to a lack of acceptance or outright hostility from

family members. This project builds a more inclusive community by starting with individual youth, parents, and guardians so that someday in the future, all youth will have safe homes and welcoming, accepting communities.

As Jackson Street leads the nation in ending youth homelessness, we have to identify gaps in resources and work to fill those. Creating transferable, scalable curriculum for parents/guardians and youth in peer settings like Queer Peers will support youth and families across the nation.

Community outreach/input

The Education Outreach Coordinator will continue to build relationships with schools so that we can connect with youth and refer them to services in Jackson Street's continuum, including Queer Peers. The existing Queer Peers in Linn County, Jackson Street's Outreach, Shelter, and Next Steps connections to youth in Benton County, and our visible community presence (online and through events, flyers, etc.) will all be avenues for youth and parents/guardians to connect with Jackson Street's parenting class and Queer Peers. Additionally, we will leverage our existing relationships with PSN and LBCC to reach a wider network of parents and guardians. With time, the parenting class and Benton County Queer Peers will serve enough people to generate their own recommendations from past attendees too.

Our existing social media channels, newsletters, Youth Ambassadors (youth advisory board), and Community Ambassadors (adults in the community) will also be used to spread the word about these opportunities.

Risks/barriers

Slow hiring and staff turnover have been common across nonprofits in our area, including Jackson Street. We contract with a company that reviews job descriptions annually to recommend pay and benefit increases, and we have implemented proactive hiring tools through Indeed and other platforms. A dedicated HR professional and Staff Trainer work to improve staff's experience and retention.

In the event that one of our partners cannot complete curriculum development on time, we will work with them to determine if what was developed thus far could be useable in a smaller scale and/or identify other partners who could complete the work (possibly even in-house).

Potential barriers to youth, adult participation include:

a. Transportation – we will provide education (e.g. bus schedules and how to ride it), transportation vouchers, and transport youth with Activity Van and an approved driver;
b. Food – hot meals will be served at Queer Peers, youth listening sessions, and the parenting course each week;
c. Childcare – $40 vouchers will be available for parenting course attendees each week
d. Accessibility needs – we will choose buildings that are physically accessible, neutral/safe as possible (e.g. not at the police station); translation/interpretation are available; marketing will be in English & Spanish; we will work to identify and remove other barriers.

Pilot Timeline (1 page)

0-3 months:

- Hire and train SOW, EOC, QPF[1]
- Initiate youth listening session process – determine timing, place, youth participation
- Engage PSN, PSU to start curricula design (contract process)
- Initiate MOU process with LBCC for parenting course implementation

3-6 months:

- Determine location, timing for Benton Co. Queer Peers
- Create and distribute Benton Co. Queer Peers information/flyers
- Host first (and successive) Benton Co. Queer Peers; continue hosting Linn Co. Queer Peers
- Engage with current and new school relationships to strengthen referrals process, connect with youth and parents
- Host listening sessions with PSU

6-8 months:

- Support curricula design as needed
- Assess Queer Peers participation in both counties, address barriers

8-12 months:

- Plan parenting courses (timing, location), advertise (use Jackson Street lists, schools, PSN, other resources in the community to reach a wide audience)

[1] SOW- Street Outreach Worker; EOC – Education Outreach Coordinator; QPF – Queer Peers Facilitator

When curricula are ready (12 months as a goal):

- Implement in Queer Peers in both counties
- Host two 8-week sessions of parenting class
- Collect feedback (surveys), adjust as appropriate

Long term:

- Engage with other partners in the state, etc. to implement curricula

Sustainability Plan (~500 words)

This pilot creates curricula and expands on a model (Queer Peers) that can be implemented in other communities across the state and nation. These curricula don't exist currently—there are very few resources for LGBTQ+ peer support groups not based in schools (and those in schools are often threatened by legislation), and community parenting resources related to LGBTQ+ youth especially are few and far between nationally. Creating these resources advances the well-being of LGBTQ+ people everywhere and creates tools for queer communities nationwide. While community-building is best in person, these tools would even be implementable in hybrid or online formats, increasing their transferability and scalability.

Queer Peers is replicable model, as we will demonstrate by expanding into Benton County. This will give us a first-hand way to troubleshoot starting a new group (help us better support expanding it to other places).

The project is innovative because it addresses LGBTQ+ youth homelessness at one of the roots of the issue (parents/guardians kicking them out). The parenting course also is useful for parents whose kids might not be LGBTQ+ but have friends who are, buffing our community's protective factors through chosen family and increasing the number of safe adults around. Finally, the youth-centered nature of the programming, built on listening sessions and other feedback, allows the programming to be flexible, address real needs, and be innovative in its approach.

Other organizations with a vested interest in this pilot include:

- County health departments and juvenile departments: this project will decrease the number of youth running away, facing abuse, and/or dealing with suicidal ideation and other mental health crises due to hostility in the home over LGBTQ+ identities
- Schools: increased well-being and safe homes mean youth can focus on school, succeed, graduate on time, thrive socially and academically

- The local LGBTQ+ community and families: are invested in our community well-being and especially the well-being of youth who are LGBTQ+ and developing in their identities.

Resources and organizations contributing to the success of pilot:

- Schools and school districts (counselors, teachers, admin staff, etc.) help refer youth to Jackson Street programs like Queer Peers;
- Keith Kolkow x Pride partners in the community – supportive queer mentors for Queer Peers, working with Jackson Street to expand Outreach and workforce options for LGBTQ+ youth
- Youth Ambassadors (Jackson Street's Youth Advisory Board) advocates for Queer Peers and connects peers to Jackson Street at their schools and in their friend circles

Jackson Street has been expanding its programming for the last 20+ years and has a strong track record of piloting programs and folding them into its operating budget. A wide array of government and private grants and contracts and generous community support ensure the continued success of our programs. Creating these curricula will mostly be one-time costs (until we create the sequels!), and personnel costs will be folded into our future grant planning needs. We will continue to leverage partnerships like the one with LBCC to offer food and childcare vouchers to class attendees—or other barrier-removing services that we identify as necessary.

This request for DST funding is part of the total project cost. We have another pending grant application to cover the Street Outreach Worker salary already, and we will use a mixture of grant funding and general operating funds to support the remaining program expenses to ensure its success.

Pilot: Positive Outcomes for LGBTQ+ Youth - Jackson Street Youth Services

Pilot Start Date:	**1/1/2024**	**Pilot End Date:**	**12/31/2024**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Sustainable staffing for youth programs, referrals		$114,278.00	$71,581.00
Youth listening sessions to guide program development		$4,500.00	$0.00
Queer Peers curriculum - developed with PSU		$50,000.00	$50,000.00
Parenting Course curriculum - developed with PSN *(note: there is no cost associated with this line item)*		$0.00	$0.00
	Subtotal Resource Costs	**$168,778.00**	**$121,581.00**
Materials & Supplies			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$0.00**	**$0.00**
Travel Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$0.00**	**$0.00**
Meeting Expenses			
Food & childcare vouchers for Parenting Classes		$9,600.00	$8,854.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$9,600.00**	**$8,854.00**
Professional Training & Development			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$0.00**	**$0.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$178,378.00**	**$130,435.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	15.00%	$26,756.70	$19,565.25
Total Project Budget		**$205,134.70**	**$150,000.25**

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

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	New curriculum options don't exist; youth are bored with current options.	Contract process with PSU; youth listening sessions; regular check-ins with PSU team throughout design period	New, inclusive, youth-informed Queer Peers curriculum created and implemented	January 2025
	Queer Peers currently meets in Linn County but not Benton County.	Hire Facilitator; identify time and location for QP Benton County; maintain attendance at Linn County QP	Queer Peers will be meet in Linn and Benton counties.	June 2024
	Jackson Street has 3 Street Outreach Workers, vacant Education Outreach Coordinator; Queer Peers is facilitated by EOC.	Create Queer Peers Facilitator job description; recruit for positions; hire and train efficiently	Jackson Street will hire and train a 4th SOW, EOC, and Queer Peers Facilitator.	April 2024
	Jackson Street has partner/referral relationships with most schools in Linn and Benton counties.	EOC will connect with schools to strengthen and maintain relationships, host pop-up resource opportunities for youth and refer youth to services	Strengthen at least two of our weaker school relationships and maintain other current relationships.	January 2025
	No parenting resources for parents of LGBTQ+ youth in tri-county region.	MOU process with PSN and LBCC; regular check-ins with those partners about progress; referrals from other organizations for parents/guardians; feedback via survey and informal from attendees.	Offer 2 sessions of 8-week parenting class specific to parents/guardians of LGBTQ+ youth	Curriculum by March 2024; second session complete by December 2024

Sleep Trailer Safe Shelter

Backbone Organization:	• Sleep Trailer LLC
Primary Contact:	• Jason Christensen
Partnering Organizations:	• Crossroads Communities, and others as part of the first year collaboration plan

Billing Address: P.O. Box 3361 Salem 97302

Site(s): Lebanon, Albany, Lincoln City, 4th site looking.
(Proposed sites finalized through collaboration and planning period)

County(s): Linn, Benton, Lincoln.

Priority Area(s):

- Providing Safe Places to Sleep
- Increase collaboration and partnerships/participation in Lincoln, Linn & Benton County
- Connecting to resources in the community for next steps
- Improve ability to find individuals and connect
- Rural community impact
- Disparity in care for rural communities
- Toxic Stress
- Mental/physical health improvements
- Decreasing Environmental Trauma

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

1. **Increase the number of safe places to sleep, and have privacy**
    a. Indicator concepts:
        i. Number of beds made available to that community
        ii. Number of people who participate and use the resource
        iii. Length of stay (1 night vs several consecutive nights)

iv. Percentage increase in participants reported hours of sleep per night
v. Percentage of participants that report improved health (decreased stress, improved sleep, access to additional resources gained, stabilization felt, or plans made for next steps)

2. **Make connecting to resources easier because people are easier to locate**
    a. Indicator concepts
        i. Number of intake and services provided
        ii. Number of resources offered or made available
    b. Areas of Opportunity
        i. Partner organizations and resources that come and present or are offered at site.

3. **Improve Health outcomes for participants and community**
    a. Indicator concepts
        i. Self reported improvements of sleep and stability, decreases in stress, improvements in physical and mental health.
    b. Areas of Opportunity
        i. Increasing number of partner collaborations and supplies/resources offered

Pilot Contacts	Name	Email
Primary	**Jason Christensen**	**jason@sleeptrailer.com**
Proposal	**Jason Christensen**	**jason@sleeptrailer.com**
Managing/oversight	**Michael Couch**	**Michael.couch@crossroadsc.org**

Summary

1st year we will build coalitions and collaborate strengthen existing relationships and develop new ones. We will locate and solidify 4 placement locations in 4 different cities.

2nd year Sleep Trailer will provide at least 8 mobile beds (possibly 16-24 with fundraising). Crossroads communities will provide management and oversight and attempting to connect them to next resources and improved health options.

Pilot Description

Sleep Trailer LLC will provide the mobile sleeping shelter. Each shelter comes with at least 8 beds (we hope to fundraise that first year and build 1-2 more trailers to increase that to 16 or 24). Each sleeping space comes with a locking door, washable interior with a drain in the floor for easy cleaning and disinfecting. C02/smoke detectors located in each space and vents on each side for passive air flow. There is a locking window for egress with a privacy film. This allows people from inside to see out, but people outside cannot see in. It is also equipped to provide heating or cooling depending on the season and needs for that area, each space has a supply and return air valve that can be open or shut to regulate the space temperature.

- We will look for project partners and communities to provide bathroom and sanitation services. If attempts are unsuccessful, Sleep Trailer will provide these services.

- Crossroads communities will provide management and oversight of the project checking people in/out each day and providing intake and surveys to see where people are at and help connect them to next steps and resources.

- The first year of the project is all about data gathering and coalition/partner building. This will entail locating and finalizing locations for placement and connecting with resources in that area.

- In Oregon (and all across the country), we are experiencing a housing crisis where too many people are experiencing homelessness. This crisis comes with increased stress and unsanitary/unsafe living conditions that lead to increased health concerns and problems. There are other marginalized communities within that group that can often be overlooked. We plan to be a resource to marginalized communities and communities at large with the focus of this Project being on Linn, Benton, and Lincoln Counties.

Sleep Trailer LLC and Crossroads communities are the two initial partners (See above on how they will be supporting). The first year of the pilot is set aside to increase partnerships with cities/counties, organizations, and others to build a coalition intended to better support individuals in these designated communities. We hope to do this by discovering needs and connecting people to crucial resources by having a steady place where people can be found when such resources are located that fit their individual needs.

This pilot will be focused on harm reduction and safety, as well as enhancing access to quality health services. We do this by providing non-judgmental supportive environments that respects autonomy of

the participants. Although drug/alcohol use will not be permitted on site, being under the influence will not be a disqualifier to participate as long as they can be respectful and safe to other participants and follow Crossroads simple list of promises for use.

Stability in housing is a fundamental piece for health stability and improvement and impacts overall stress and mental health, especially when you factor in lack of sleep. Sleep Trailer Safe Shelter Project can be a starting place to connect to important resources, help individuals sleep better and subsequently improve mental and physical health. We feel this pilot could be a launchpad for people who are wanting to take those next steps towards improvement.

Goal partners include organizations that can perform onsite health screenings, vaccinations, medical consultations, preventative educational programs surrounding improved hygiene, mental health awareness/support, substance and abuse rehabilitation, and employment opportunities to lead more full and healthier lives.

We will also look for and partner with groups that provide support in affordable housing, social services, and groups that specialize in working with and connecting marginalized communities and connecting them with resources and feeling safe. Through this we hope to help people attain optimal health and well-being.

Surveys will be taken at the beginning and end of peoples' stay to determine if there were improvements in health (decreased stress, improved sleep, access to additional resources and social determinants gained, stabilization felt or plans made for next steps)

We also hope to increase community awareness and improve community social networks to develop more supportive communities that can positively influence overall mental health and resilience. This project gives the community something they can see and rally behind. In our short pilot project, we saw an overwhelming amount of support and changes to hearts and feelings. We hope we can increase that and change the stereotypes and feelings members in the community have towards people that experience homelessness.

Pilot project Leaders

Jason Christensen

- Bi-lingual, Siletz Tribal member who has grown up in Oregon, has a bachelors degree in business management with an emphasis in finance. Works with people with intellectual & developmental disabilities as a behavior specialist, in 2016 worked as the associate director for Tandem Northwest for 6 years before stepping down to start Sleep Trailer LLC. Jason is over the project planning and providing the Sleep Trailers and required resources as well as coalition and partner building.

Michael Couch

- Executive Director for Crossroads Communities, and serves on various boards. Michael has over 20 years of experience in the financial industry and over 10 years in business management, admin and project management. Michael (through Crossroads Communities) will oversee management and oversight. They will also play a large role in partner and coalition building.

Sleep Trailer LLC's long-term plan is to be an asset to communities all over Oregon and the country. We desire to create a path that gets people off the street now, while affordable housing and other housing options are found or created through partners like Crossroads Communities and other potential partnerships created through this pilot project. We do this by showing the benefits and how it can be an asset and impact lives through this pilot project. This will give us a greater amount of data and feedback for improvements and future builds that can either be sold or leased to communities throughout the state and country giving thousands of people a safe place to sleep. Through this pilot, we will be able to offer close to 2,900 nights of safe sleep to people in our community and that's assuming the use of just one trailer. Sleep Trailers can also be an asset to communities in other ways including but not limited to emergency/disaster relief plans, firefighters fighting forest fires, and many others.

The bright blue trailer does a great job of capturing attention and curiosity, and we will have signs set up to help give more information and direct questions. We will post flyers and relay information to community partners and community organizers. If the project gets approved, news stations that we have developed relationships with have asked to do stories and share information. We also hope to share the success of the project via social media where we currently have around 165,000 followers. This means that this project has the potential to have far reaching impact all over the country and could ultimately impact thousands of lives. We can teach communities how to support people now and provide immediate impact while affordable housing and permanent housing solutions are built or found.

Risks and barriers

Finding locations for placement: getting city councils to agree on anything is always an issue when it comes to the topic of people experiencing homelessness. Many differing opinions produce conflict, often due to stereotypes and pre-conceived beliefs. For our short pilot project, we addressed this by using private property (a local church parking lot in Lebanon) instead of city owned. We also worked directly with the city manager first instead of going through city councils. Once approved and the project was underway, we invited city council members and city leaders to tour the site helping to change perspectives and beliefs in attempt to build bridges for future collaboration. People are often afraid of what they do not know and so we found if you can help them see in a low risk situation, their opinions and beliefs can quickly change. We will likely start the project in Lebanon where we have a lot of support and possible placement locations. This will also give some time for other communities to see it working before it comes to their area.

Finding participants for new programs as well as locations for placement can be a challenge. We plan to do outreach before the program starts to help locate willing participants making it more effective from the start. The year of coalition and partner building will be crucial to this process. Having Crossroads Communities involved will help immensely as they have existing relationships with many involved in these communities. I also have a good relationship with the Siletz Tribe as a member and have been working with their housing development team. I hope to be able to strengthen and develop that relationship.

There is always risk when working with people, especially when they are in high stress situations and are experiencing trauma or are in survival mode. This is why creating a space that feels safe and non-judgmental is so important. We will carry insurance for the pilots. Outreach will be important to locate and identify possible program participants before the trailer(s) arrive. Having staff that can be sensitive/empathetic to these situations can be of great value.

Community member initial hesitation can be a barrier as people have many pre-conceived beliefs and bias about the houseless community. Informing them that this is not a permanent placement but only for a few short months and then will be gone does a lot to hold back a majority of the feelings community members have. After the project many community members see and learn that their fears and concerns were not warranted. Often times through a project like this some critics become your biggest supporter. We will work hard to develop relationships with neighbors and businesses in the area to find solutions if problems do arise.

Sustainability Plan

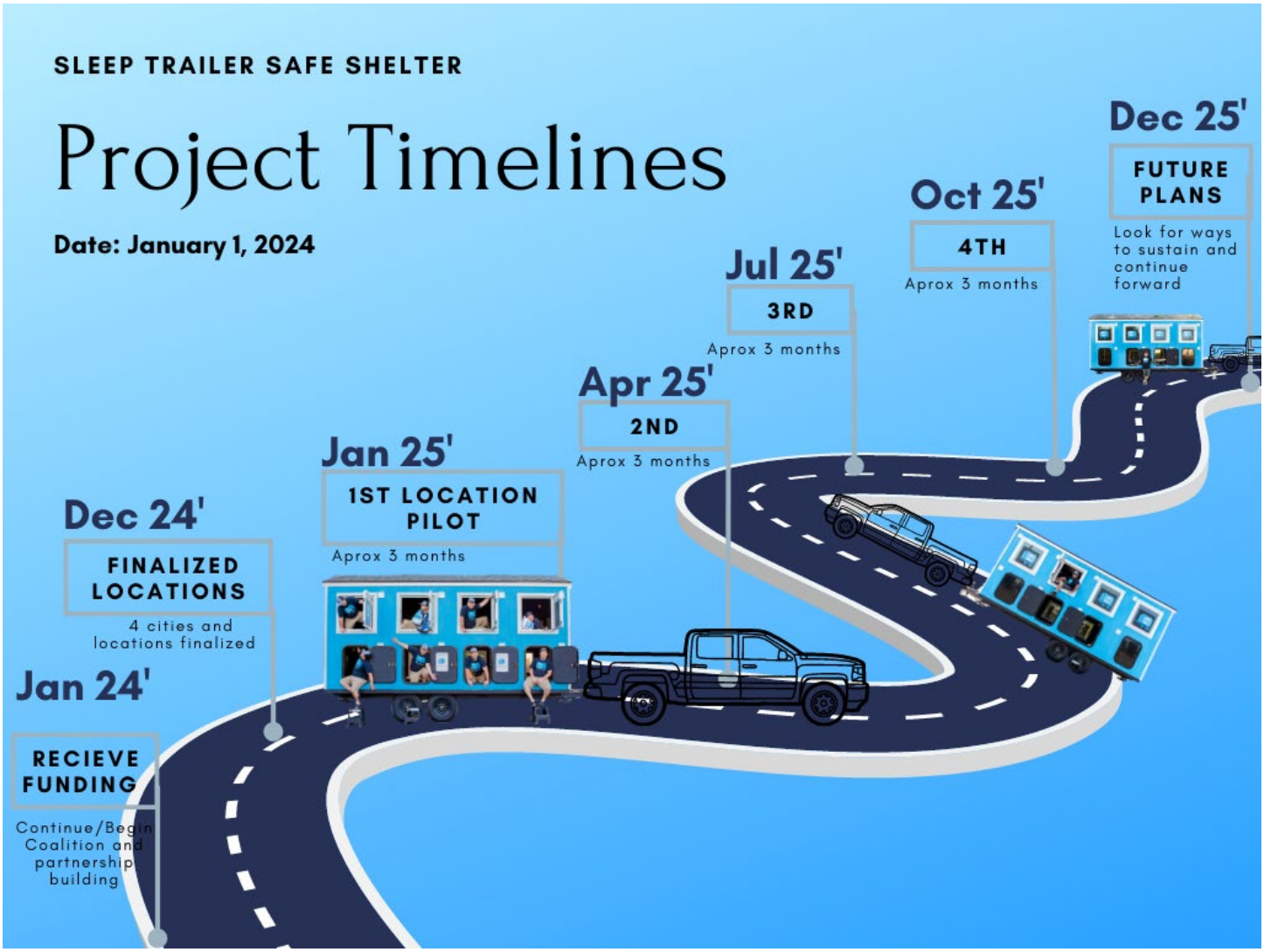
There is nothing currently being used that is quite as mobile and flexible to meet people where they are at, especially for rural communities that often get overlooked for resources. This project is as scalable as one could imagine and all it would take is the construction of more trailers. Once created there is no limit to how many people could be helped and communities benefited. A successful pilot project opens the door for other organizations and communities to pattern similar plans. One of our future dream goals is to partner with Crossroads Communities and similar organizations so that when they get contracts to build more affordable housing, we could run a Sleep Trailer Project on site (or somewhere near in the community) while the affordable housing is being built. We can get people off the street immediately and into a safe private sleeping space where they can stay until the affordable housing is completed. This gives people a direct path out of homelessness; from living on the street, to Sleep Trailer, and then to affordable housing and permanent housing. Simultaneously connecting them to crucial resources needed to improve their overall mental and physical health.

Once a pilot is completed, future fundraising becomes much easier as it is no longer a possible concept but an actual working solution. People want to invest and support things that are proven to help the crisis. We can do this by accepting donations through our non-profit fiscal sponsor (Crossroads) or by having organizations sponsor trailers through logos/advertisement on the trailer designated to be used in their communities. These can then be leased or sold to communities at a significantly reduced cost. We have also set aside funds to help secure additional grants and funding for future projects and adding additional beds to increase our reach and impact in communities.

SLEEP TRAILER SAFE SHELTER

Project Timelines

Date: January 1, 2024



Pilot: Sleep Trailer Project

	1/1/2024	Pilot End Date:	12/31/2025
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Management Staffing and oversight of Sleep Trailer Project through Crossroads communities		$60,000.00	$60,000.00
Lease of Sleep Trailer for year		$30,000.00	$30,000.00
Space rentals/lease for trailer placement or community meetings/trainings		$5,000.00	$5,000.00
Insurance		$5,000.00	$5,000.00
	Subtotal Resource Costs	**$100,000.00**	**$100,000.00**
Materials & Supplies			
Outreach Materials and Supplies		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$0.00**	**$0.00**
Travel Expenses			
Mileage reimbursement		$4,000.00	$4,000.00
Fuel		$6,000.00	$6,000.00
Vehivle Maintenance		$0.00	$0.00
	Subtotal Travel Expenses	**$10,000.00**	**$10,000.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Outreach and partnering/collaboration		$5,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$5,000.00**	**$5,000.00**
Other Budget Items			
Sustainabilty (Financial services, Grant finding and writing to continue with future projects)		$5,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$5,000.00**	**$5,000.00**
Total Direct Costs	**Rate (%)**	**$120,000.00**	**$120,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	0.00%	$0.00	$0.00
.		**$120,000.00**	**$120,000.00**

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

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	Health status varies per person	improved physical and mental health for those participating in the project for more than 4 nights (entry/exit surveys).	80% of participants self reporting improvement of better sleep, decrease in stress or access to resources and next steps.	December-25
	0 current additional beds and private sleeping spaces	provide at least 8 beds in 4 different locations and cities for 3 month periods (hoping to fundraise to add more beds to have 16-24)	Will have provided/offered over 2,800 available nights of safe Sleep	March 25, June 25, Sept 25, Dec 25
	Zero current participants	Number of individuals that participated in the program. Monitored through intake/surveys and check ins	Over 80 Participants staying various amounts of time	December-25
	1 current partnership for Sleep Trailer LLC	Number of partnerships monitored by signed agreements or collaboration of supplies/ resources/ locations/ services.	4 partner organizations providing space and another 10 connecting resources and collaboration supports	December-25
	No program exists like this, (we are targeting smaller communities with less resources)	Locate 4 locations and sanitation services for placement of the Sleep Trailer(s)	Develop relationships and colaboration to set up future possible placements on a more semi/permanent basis for each participating community	November-24
	Offering resources and next steps. varies depending on area and outreach and resources available	at time of intake/enrollment when needs are assessed.	100%	December-25
	Underserved persons have a high rate of behavioral, mental/physical health and social challenges	Recruitment and priority given to those of underserved communities. Attendence/participation tracked as well as entry and exit surveys.	Increased opportunities for next steps for all participants including those of underserved communities.	December-25

Youth Cohort Housing

Backbone Organization: Community Outreach, Inc. (COI)

Primary Contact: Greg Moore

Partnering Organizations: Oregon Youth Authority (OYA); Jackson Street Youth Services (JSYS)

Billing Address: 865 NW Reiman Ave. Corvallis, OR 97330

Site(s): COI office (see billing address); offsite housing location (TBD)

County(s): Benton County

Priority Area(s): Increase the percentage of Members who have: Safe, accessible, affordable housing.

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: Increase the percentage of members who have safe, accessible, affordable housing (Indicator Concepts: Number of homeless persons; Areas of Opportunity: Social Determinants of Health claims data); Increase health equity (Areas of Opportunity: Health disparities experienced by members due to age, disability, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc.)

Budget: $150,000

Brief Summary (3-5 sentences in clear, concise, plain language that captures the key points of the proposal): Following the success of our YA dorm, COI is expanding our services for young adults aged 18-25. We aim to procure an offsite location to house a small cohort (6 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.

Pilot Description (~3,000-7,000 words)

Detailed description of the proposed pilot including:

- Clear pilot goals, how they will be measured, and expected pilot outcomes.
    - This should communicate how the pilot is innovative and transformational, as well as how it will achieve its goals.
- Describe the population and/or community that will be served by the pilot.
    - Be sure to address how the pilot intends to focus on IHN-CCO members and include an estimate of how many IHN-CCO members will be served.
- Provide a detailed description of the approach that the pilot will be taking. This could be an intervention, model, activities, etc. Be sure to address similar projects, if there are any, that already exist in the local community or tri-county region.
- List all community partners and how they will be supporting the pilot.
- Provide a clear, detailed health equity plan for the pilot.
    - This should demonstrate a strong understanding of health equity concepts and a commitment to doing the work.
    - Include a description of how the pilot intends to reduce health disparities, as well as how health equity data will be tracked.
- Explain how the pilot will address social determinants of health.
- Describe the individuals that will be carrying out the pilot, their experience, and responsibilities.
- Describe how the project fits into your organization's strategic or long-range plans.
- Describe how members of the community will hear about your project.
- Describe potential risks or barriers to success and how the pilot plans to address them.

Currently, COI's young adult program consists solely of our YA dorm which has space for 12 clients. This dorm is consistently fairly full and, in recent months, we have had nearly all of our OYA contract beds filled at any given time. And last fiscal year, 41% of exits from our YA dorm were positive.

Clients in our YA dorm transition directly to independent living upon exiting from our program, which can be an abrupt change and can leave former clients feeling overwhelmed and/or isolated. The cohort housing project will give us an opportunity to expand our capacity to serve young

adults and create a gentler interim step between our supportive dorm environment and independent living.

Success will be determined by the following metrics:

- The YA cohort housing program will expand COI's capacity to serve young adults aged 18-24 experiencing poverty, homelessness, and/or other barriers by 6 beds.
- 80% of youth in cohort housing will exit to stable housing.
- Young adults in YA cohort housing will have the opportunity to practice independent living skills while still receiving support so that they may obtain housing and maintain stability after departure from our program.

All of COI's services are designed for people who are experiencing homelessness and/or living on low- to extremely low-incomes and our young adult program specifically serves youth aged 18-24.

COI primarily serves Benton, Linn, and Lincoln counties. Our office and shelter are located in Corvallis but each of our programs has a different relationship to our community partners and a different level of presence throughout our primary service area. Like the rest of our Transformative Shelter program, the YA dorm's clients primarily come from Corvallis as well as a few from Albany. Unlike the rest of the housing program, however, the YA program accepts clients from all over the state of Oregon through our contract with OYA.

A common barrier that many of our clients face is that they are under- or uninsured due to lack of income, employment, and homes. During the last fiscal year, the vast majority of our YA dorm clients listed OHP as their insurance provider while only three (3) reported being IHN members. If we can help our clients secure employment and housing, more of them may be able to choose to engage with IHN.

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.

The YA dorm provides wraparound services to ensure success as youth transition from temporary or chronic homelessness to stable housing. Case managers use a client-centered, goal-oriented process that focuses on building a relationship of mutual respect and providing clients with educational and employment opportunities. We provide a full continuum of services to those staying in housing including medical and dental care, substance abuse and mental health counseling, life and job skills classes, crisis counseling, affordable childcare, and food pantry (residents can access the food pantry 24 hours a day and there are no limits on how much food a resident may use). Our partnerships with Blue Sun, the Oregon Department of Human Services STEP services program, Community Services Consortium Youth Services (a fellow STEP services provider), and Linn Benton Community College (another fellow STEP services provider) allow our clients to engage with meaningful education, employment, and other related services while in housing, and COI has an onsite state certified childcare so that young adults with children are able to focus on their goals. Additionally, COI hosts Rent Well classes, and young adults also attend life skills classes with a focus on independent living skills such as budgeting, cooking, and mindfulness.

Following the success of our YA dorm, COI is expanding our services for young adults aged 18-25. We aim to procure an offsite location to house a small cohort (6 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 feeling 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 dorm and life outside of our programs.

In order to maintain some structure and provide guidance to the rest of the cohort housing clients, COI will select a Peer Support House Manager. The appointed Peer Support will ideally 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 exiting our programs.

We are currently piloting a similar project for our veterans program, Good 2 Go. We have transitioned our veteran clients in our housing program into an offsite house where they can live and share camaraderie with their peers. We are also working to transform the ground floor and basement areas into a Veterans Navigation Center where our veterans' program case managers can establish their own office space and community partners can regularly drop in to hold office hours.

We've found that peer support and building community with their fellows is very important to veterans and, as such, we've designed this space to facilitate precisely those kinds of opportunities for our veteran clients. This project is still relatively new (we just had our first residents move in earlier this year) but is already showing great promise and our Good 2 Go team is thrilled to continue exploring and improving the veteran cohort housing model.

Similarly, because we've found that camaraderie and developing relationships with peers is especially important for our young adult clients as well, this population was a natural next choice for expanding our cohort housing project.

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.

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.

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.

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 young adult 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, and positive outlets for stress while also 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.

As part of the process for intake into our Transformative Shelter program (of which the young adult program is a part), COI collects self-reported demographic data from all of our young adult program clients including race and ethnicity, income level, gender, and insurance provider. We use this data to determine our success in serving different demographics within the homeless population.

For example, since opening the YA dorm, 14% of clients in this program have identified as non-binary and many more have identified as transgender (we track our transgender clients according solely to their gender identity, i.e., male or female). Some of our most successful YA dorm clients worked to legally change their name and/or gender or started medically transitioning during their stay in our dorm.

COI has been providing for the basic needs of the most vulnerable members of our community since 1971. Helping our clients access services that are often out of their reach—such as affordable preventative healthcare, counseling, and stable transitional housing—allows our clients to make progress toward stability and self-sufficiency in all areas of their lives.

Providing access to these holistic services will also help keep our YA clients out of emergency services and, ultimately, reduce the cost burden on local healthcare providers and the rest of the community.

The key personnel in implementing this project will be the case manager assigned to the YA cohort housing project and the peer support house manager. Case managers at COI must have a Bachelor's degree in Social Work or a Bachelor's degree in Human Services; a Masters of Social Work is preferred. They must also have a minimum of three to five years' experience working as a case manager in human services working with one or more of the following groups: veterans, individuals experiencing homelessness, mental health related issues, substance abuse, domestic violence, HIV/AIDS related issues, and/or folks living in poverty. The Peer Support House Manager will ideally be an alum from our YA dorm who was able to exit the program successfully and can share their experience with the rest of the residents. The case manager and Peer Support House Manager will work together to help clients navigate services and provide support to meet each client's unique needs.

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.

This project will be a natural extension of our existing young adult-specific programming and will create another step on our YA clients' journey to long-term stability. 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.

This program will give priority to existing clients in our YA dorm who have been with us for a minimum of four months and are employed/enrolled in an educational opportunity. Additionally, any clients who come to us through OYA must be off their papers before they may transition to our youth cohort housing. Achieving these benchmarks will show that our clients have already made progress toward their goals and that they are ready to take the next step toward independent living.

We strive to make our presence and the services we offer known throughout the community primarily through our partnerships, participation in local groups, regular publications (such as our annual Gifts of Caring catalog fundraising campaign), and our online presence.

While we have learned a great deal about working with this age group and had tremendous success adapting our YA program to be as effective as possible, we are still learning how to best serve this demographic every day and we anticipate that this pilot project will have a similar learning curve. To make implementing this project as smooth as possible, we will use everything we have already learned about working with youth (e.g., offering choices to our clients to grant them a greater sense of agency and allow them to practice self-advocacy), listening to client feedback, and constantly collaborating to evaluate the project's successes and troubleshoot any difficulties.

There is also the potential logistical barrier of having difficulty locating and securing an appropriate location for our peer cohort housing group. We plan to engage a real estate professional to help us navigate this process quickly and with care.

Pilot Timeline (1 page)

Provide a timeline of key activities and goals.

- **Pilot start date:**
  - January 1st, 2024
- **Begin case management procedure development:**
  - January 1st, 2024
  - To be completed by end of March 2024
- **Identify candidate for Peer Support:**
  - By end of February 2024
- **Begin Peer Support orientation & training:**
  - By early-mid March 2024
  - To be treated as ongoing process completed around approx. end of June 2024
- **Locate house & execute lease:**
  - By end of March 2024
- **Furnish house:**
  - By mid-late April 2024 (within approx. 14-21 days of securing house)
- **Move Peer Support and first residents into house:**
  - By start of May 2024
- **Begin intensive 1-year project evaluation*:**
  - By late December 2024-early January 2025
  - To be completed by end of January 2025
- **Pilot end date:**
  - December 31st, 2025
  - Pilot activities to continue as planned between 1-year evaluation through pilot end date

***Evaluation and implementation of improvement strategies is to be treated as an ongoing process throughout the entire project pilot period; the 1-year mark evaluation is to be treated as a major check-in and opportunity for the entire team to consider feedback and problem-solve together.**

Sustainability Plan (~500 words)

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

Initial start-up costs will be largely supported by grants and other opportunities. After these initial expenses have been handled, this program should be more sustainable and easily incorporated into COI's broader program budgets (case management, food, and housing).

Once clients have moved in, they will be expected to pay rent (approx. $400/month) to help sustain the house and keep the program going. This will give clients an opportunity to practice paying rent and landlord relations while also building a base rental history which will make it easier for them to obtain housing outside of our program.

If the program is successful, we may be able to expand our cohort housing opportunities in the future.

Pilot: Young Adult Cohort Housing

Pilot Start Date:	January 1st, 2024	Pilot End Date:	December 31st, 2025
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Case Manager .5 FTE		$50,000.00	$50,000.00
Peer Support House Manager 1 Part-Time		$40,000.00	$40,000.00
Real Estate Professional and Lease Deposits		$10,000.00	$10,000.00
Maintenance Expenses		$5,000.00	$5,000.00
	Subtotal Resource Costs	**$105,000.00**	**$105,000.00**
Materials & Supplies			
Food $3/Day/Person		$13,140.00	$13,140.00
Furnisihings		$7,500.00	$7,500.00
Household Supplies		$5,000.00	$5,000.00
	Subtotal Materials & Supplies	**$25,640.00**	**$25,640.00**
Travel Expenses			
Transportation		$596.00	$596.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$596.00**	**$596.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Employment Training and Preparation		$2,000.00	$2,000.00
Professional Training Fees for Staff		$3,000.00	$3,000.00
		$0.00	$0.00
	Subtotal Training & Development	**$5,000.00**	**$5,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$136,236.00**	**$136,236.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$13,623.60	$13,623.60
Total Project Budget		**$149,859.60**	**$149,859.60**

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

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Timely Inclusive Equitable	COI's YA dorm has space for 12 young adult clients	COI will lease and furnish an offsite location that can house six additional young adult program clients	Increase capacity to serve young adults by 6 beds	5/1/24
	Last fiscal year, 41% of exits from our YA dorm were positive--by creating gentler interim step between our dorm and independent living, we aim to increase our success rate for serving young adults	As with the rest of our Transformative Shelter program, the reason for a client's exit will be recorded upon their exit from the youth cohort housing program and categorized as a positive (e.g., exiting to their own housing) or negative exit (e.g., exited due to curfew violations); success will be measured by the rate of positive exits	80% of youth in cohort housing will exit to stable housing	12/31/25
	Clients in our YA dorm transition directly to independent living upon exiting from our program, which can be an abrupt change and can leave former clients feeling overwhelmed and/or isolated	YA cohort housing clients will continue to have access to COI's comprehensive suite of services including case management and affordable healthcare while practicing the independent living skills they've learned in a new environment	YA cohort clients will have the opportunity to practice independent living skills while still receiving support so that they may obtain safe, stable housing and maintain stability after departure form our program	12/31/25