Agenda
Delivery System Transformation Committee

August 24, 2023 4:30 – 6:00 pm

Zoom

1.	**Welcome and Introductions**	**Renee Smith,** Family Tree Relief Nursery	**4:30**
2.	**Transformation Update**	**Charissa Young-White,** IHN-CCO	**4:45**
3.	**Asset Mapping Project**	**Pollywog**	**5:10**
4.	**Emergency Winter Shelter Program**	**Lincoln County Health & Human Services**	**5:25**
5.	**Sleep Trailer Safe Shelter**	**Sleep Trailer, LLC**	**5:40**
6.	**Wrap Up**	**Renee Smith,** Family Tree Relief Nursery	**5:55**

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

Delivery System Transformation (DST) Pilots and Workgroups

Acronym	Project	Sites	Counties	Start	End
AHEAD	Ahead of the Curve	Olalla Center	Lincoln	1/1/2023	12/31/2023
AMP	Amplifying Voices	SHS ArtsCare Program	Lincoln	9/1/2022	12/31/2023
ARCC	Arcoiris Cultural	Olalla Center	Lincoln	1/1/2022	12/31/2023
CRPS	Culturally Responsive Peer Services	Family Tree Relief Nursery	Benton; Linn	1/1/2022	12/31/2023
CSUP	Culture of Supports	North End Senior Solutions	Lincoln	1/1/2021	12/31/2023
DBHS	Decolonizing Behavioral Health Supports	Corvallis Daytime Drop-in Center	Benton; Lincoln; Linn	1/1/2022	12/31/2024
DEC	Disability Equity Center	Disability Equity Center	Benton; Lincoln; Linn	1/1/2021	12/31/2023
EASYA	Easy A	Sol4ce LLC	Benton	1/1/2022	12/31/2024
EOL	End of Life Support	SHS Population Health/CareHub	Benton; Lincoln; Linn	1/1/2023	12/31/2023
FAITH	Faith Communities Engaging Health	Faith Community Health Network	Linn	1/1/2023	12/31/2023
HEALTH	The Health Collective	Lebanon Community Hospital Physical Therapy	Benton; Lincoln; Linn	9/1/2022	12/31/2023
HNS	Health Navigation Station	St. Martin's Episcopal Church	Linn	9/1/2022	12/31/2023
HUBV	Hub City Village 2	Creating Housing Coalition	Linn	7/1/2023	12/31/2024
IATHW	Improving Access with THWs	Unity Shelter	Benton	1/1/2023	12/31/2023
IFCW	Integrated Foster Child Wellbeing	Samaritan Health Services	Benton; Lincoln; Linn	1/1/2019	12/31/2023
MHHC	Mental Health Home Clinic	Samaritan Medical Group	Linn	1/1/2021	12/31/2024
NAMRX	Namaste Rx	Namaste Rx LLC	Benton; Lincoln; Linn	1/1/2022	12/31/2023
NPSH	Navigation to Permanent Supportive Housing	Lincoln County Sheriff's Office	Lincoln	1/1/2020	12/31/2023
OODC	Overcoming Obstacles to Dental Care	Capitol Dental Care	Benton; Linn	1/1/2023	12/31/2024
PUENTE	PUENTES	Casa Latinos Unidos	Benton; Linn	1/1/2022	12/31/2023
TIAH	Transitioning into a Home	Furniture Share	Benton; Lincoln; Linn	9/1/2022	12/31/2024
WELLTM	Wellness Care Team	Family Assistance and Resource Center Group	Linn	1/1/2023	12/31/2023
WnR	Walk 'n Roll	Newport 60+ Activity Center	Benton; Lincoln; Linn	9/1/2022	12/31/2023
WVC	Women Veterans Cohort	Red Feather Ranch	Benton; Lincoln; Linn	10/1/2021	12/31/2023
Workgroups					
COWG	Connect Oregon Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	5/1/21	present
HEWG	Health Equity Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	5/1/15	present
SDoHWG	Social Determinants of Health Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	11/16/17	present
SUSTWG	Sustainability Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	1/26/22	present
THWWG	Traditional Health Workers Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	5/21/13	present

Delivery System Transformation Committee (DST) 2023 Calendar

January	5	Racial Equity Training		
	19	Strategic Planning: Racial Equity Discussion, Charter, and Roles & Responsibilities		
February	2	CDP	TTH	Charter Review & Priorities
	16	CCP	HUBV	Engagement
March	2	DSDP	PBHT	Engagement
	16	PEER	OBFY	RFP & Priorities
	30	WINS	DDDW	RFP & Priorities
April	13	RFP Discussion		
	27	RFP Finalization		
May	11	Scoring Exercise		
	25	Pilot Expansion Requests	Pilot Updates	
June	8	CAC UPDATE	IHN-CCO Health Equity Plan Review	
	22	LOI DECISIONS		
July	6	CAPACITY BUILDING DECISIONS		
	20		Pilot Updates	
August	3	SMALL RFP DECISIONS		
		Regional Planning Council August 10		
	17	RFP PRESENTATIONS		
	24	RFP PRESENTATIONS		
	31	RFP PRESENTATIONS		
Sept	14	RFP DECISIONS		
	28	PSLS		Workgroup Updates
October		**Regional Planning Council October 5**		
	12			
	26		Pilot Updates	
Nov	9			
Dec	7			

KEY

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

DST Attendance and Voting Records

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

Name	R&R	Voting Sept 14 (13 to vote)
Abby Mulcahy	Yes	9
Allison Hobgood	Yes	11
Andrea Myhre	Yes	9
Annie McDonald	Yes	16
Bettina Schempf	Yes	11
Britny Chandler	Yes	9
Bryn McCornack	Yes	6
Carissa Cousins	Yes	3
Deb Fell-Carlson	Yes	11
Dee Teem	Yes	3
Dick Knowles	Yes	20
Elizabeth Hazlewood	Yes	11
Emma Chavez Sosa	Yes	18
Erin Gudge	Yes	19
Georgia Smith	Yes	1
Jay Yedziniak	Yes	2
Karen Weiner	Yes	17
Linda Mann	Yes	10
Melissa Isavoran	Yes	15
Michael Couch	Yes	17
Mike Jerpbak	Yes	14
Paige Jenkins	Yes	6
Paulina Kaiser	Yes	12
Priya Prakash	Yes	1
Rebekah Fowler	Yes	20
Renee Smith	Yes	17
Ricardo Contreras	Yes	1
Rolly Kinney	Yes	20
Roslyn Burmood	Yes	13
Sara Jameson	Yes	21
Shannon Rose	Yes	21

Stacey Bartholomew	Yes	17
Susan Trachsel	Yes	14

Minutes
Delivery System Transformation Committee (DST)
August 17, 2023 4:30-6:00 pm
Teams (online)

Present			
Laurel Schwinabart	Beck Fox	Alicia Bublitz	Charissa Young-White
Allison Hobgood	Arianna Pennington	Artemis Leona	Chloe Stewart
Cole Ray	Danny Magana	Deb Fell-Carlson	Dick Knowles
Emma Chavez	Erin Gudge	Greg Moore	James Lutz
Rolly Kinney	Karen Weiner	Larry Eby	LeAnne Trask
Michael Couch	Michelle Maddux-Robinson	Miranda Tasker	Paulina Kaiser
Rebekah Fowler	Roslyn Burmood	Sara Jameson	Shannon Rose
Stacey Bartholomew	Susan Trachsel	Todd Jeter	Woody Crobar

Transformation Update

Melissa Isavoran is no longer with IHN-CCO.
Beck Fox will represent IHN-CCO as the co-chair of the DST with Renee Smith being the primary.

Presentations

Community Outreach, Inc.
Youth Cohort Housing

Q&A
Q: Michael: How does the 6 beds differ from the 12 beds?
A: The 6 bed is designed for participants to step into independence. Supervision is by a peer house manager. In the 12-bed program, participants have constant supervision.

Q: Miranda Tasker: If someone meets the age requirement but has a child, are they able to utilize the program?
A: We haven't entertained that but maybe it could be scaled in the future for people with children.

Q: Susan T: What % will be IHN-CCO members. What services are provided in Lincoln County?
A: Currently not many IHN members in the YA program. Most are under or not insured. Maybe 10%. Lincoln County is served through referrals.

Bilingual McKinney-Vento Advocates
Lincoln County School District

Q: Susan T: What is the budget for?
A: Staffing for (2) .5 FTE

Q: Alicia: What is the greatest health needs you are seeing?
A: Reproductive health and dental

Q: Michael: Is it possible to bring in a tri-lingual (adding Mam) staff person?
A: We have received funds from other sources for other language access.
Q: Shannon: You are asking for $103.000 but your budget is $78,000. Should these numbers be flipped?

A: Yes, total cost is $103,000. We are only asking for $78,000 because we have funding from another source to cover the balance.

Healthy Eating Children's Cookbook
Furniture Share

Q: John: Is this in addition to the current food program?
A: We just started doing fresh meet because of a grant.
Adding the cookbook to the school districts which will also include information on resources.
Currently it's just Furniture clients who receive food boxes, but it will expand to families within the school district.

Q: Roslyn: What age range to qualify?
A: Cookbooks: Elementary school aged children. Food boxes: anyone with low-income.

Q: Susan T: How will you get food boxes to Lincoln County
A: Community Partners will assist. We have been in contact with them. The school districts will deliver cookbooks.

Affordable Housing Resident Services
Applegate Landing, LLC

Q: Susan: It looks like most of the funds will go to Community Crossroads. What for? How many FTE?
A: Funding will support expanded hours of operations (Saturdays) to assist tenants who work during normal weekday business hours.

ASSET MAPPING PROJECT

Pilot Summary and Goals

- We will be holding 16 asset mapping sessions in 16 rural communities throughout Linn, Benton and Lincoln Counties, inviting families to participate. Sessions will consist of families placing stickers that represent specific assets, such as grocery stores, childcare centers, libraries, etc. on large aerial maps of their communities.

- Goal #1: We need to gather at least 10 families at each asset mapping session in order to have a relevant sample size. We also want the families to represent a cross-section of those living in the community.
- Goal #2: We want to gather data from these sessions to create maps of the services and resources that are available in each of these communities. We also hope to determine what services and resources are unavailable in their community.
- Goal #3: We want to analyze the collected data and prepare reports that can be used by service organizations, local and state government, and others to invest in improvements in these communities.

Member and Community Need

- Of the 271,733 people living in our region, approximately 40% of them live in rural communities.
- Each community that we plan to asset map is geographically isolated because they live in a rural community, and they are potentially unable to access healthcare, education, employment, housing, and other important services.
- These communities also have small pockets of communities of color, families with special needs, families in poverty, and LGBT individuals.
- There are 88,217 IHN-CCO members in our region. In Benton County alone roughly 23% of the population are on the health plan: 21,227.
- The children living in our region are experiencing: food insecurity, unmet mental health needs, poverty, limited access to childcare, unmet dental needs, lack of preschool services, and low immunization rates.

System Transformation

How is your proposal transformational?

- Asset Mapping was created in the 1990s as an innovative research method that allows the community members to explore, describe, and map its assets, and then use these maps and family dialogue to develop solutions to the gaps in resources that the mapping uncovers.

Who are you partnering with for this project:

- The Health Care Integration Workgroup (75+ regional partners)
- The Data and Evaluation Workgroup (25+ regional partners)

What will we learn from this project:

- We will begin to see a picture of what it is to live in a rural community, and we will develop a better understanding of what is lacking in their community.
- We will be able to develop a strategic investment plan to improve the lives of those living in rural settings. We will also be able to inform the decisions that are being made by other agencies, local government, and state agencies.

Leadership and Partnerships

Describe your project leadership and their roles.

- We will have a Project Manager who will be responsible for implementing our plans, organizing our asset mapping sessions, and making sure that we have the staff and supplies in place to convene a session. We have made detailed analysis of these rural communities and tried to create a plan that will give us “apples-to-apples” data to work with when we are done.
- We have a Data and Evaluation Coordinator with a Masters in Statistics who can take the data, analyze it, and sort it into useful and clear results that will inform our funders when we begin working on a strategic plan.

Describe any partnerships and collaborative relationships you have.

- 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.

Health Equity

How will you address health equity and reduce health disparities?

- The asset mapping portion of our project is focused on documenting any health inequities or disparities. We know from existing research that rural children, in particular, suffer from unmet dental and healthcare needs, and we specifically ask about those in our mapping sessions. We also ask about mental health and behavioral health services, and if families have access to them. We hope to have a significant cross-section of families for our research samples so that we can determine if the disparities are simply being caused by geographical isolation, or if there are other determining factors such as poverty, racism, or simply a lack of transportation to those services. We believe that our data will allow the IHN and Samaritan to have a more in-depth view of some of our smallest communities, and hopefully they will be able to find funding to remedy the situations.

Definition of Success

- Measures & Outcomes?

We have determined 16 cities that meet our criteria, and we hope to be able to hold an asset mapping session with local families in each of those towns over the coming year (or maybe slightly longer). We have broken those cities up into rounds, and we hope to complete a round each quarter of the coming year.

- How will you paint the picture of your project success?

Our Data and Evaluation Coordinator will be taking the collected data and analyzing it to sort it into actionable information. We expect to have both quantitative and qualitative data to share, and we will then present that data to Health Care Integration, the EL Hub Governing Board, and other partner organizations who have expressed interest in seeing what a deep dive into our less populated communities can tell us about how we should be investing the funding that we have, and where we can make the most difference with what we have.

Sustainability

- How will your project spread lessons learned or best practices to other organizations or regions?

We will be able to present this data to a number of different organizations, such as the Health Care Integration Workgroup, the Early Learning Hub's Governing Board, and the Early Learning Council which works to inform decisions made by DELC and other state agencies. I'm also assuming that the CACs and IHN will want to see our finished data.

- Describe the support your project has from your organization, partner organizations, and the community?

We have cross-sector support from the Health Care Integration Workgroup, and the 75+ agencies that regularly attend our meetings. They have offered support, encouragement and suggestions to this point.

DST Member Questions?

Emergency Winter Shelter Program

Lincoln County, Oregon

Pilot Summary

Open October 1 through March 31 nightly from 6:00pm to 7:00am

Locations planned for Newport and Lincoln City.

Managed and supervised by paid employees of Lincoln County.

Pilot Goals

1. Open two winter shelters in Lincoln County to house up to 100 people by October 1, 2023.
2. Establish a data collection process 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
3. Establish a program advisory council, comprised of community partners.

Member and Community Need

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, or the program will offer hotel vouchers.

Current Capacity

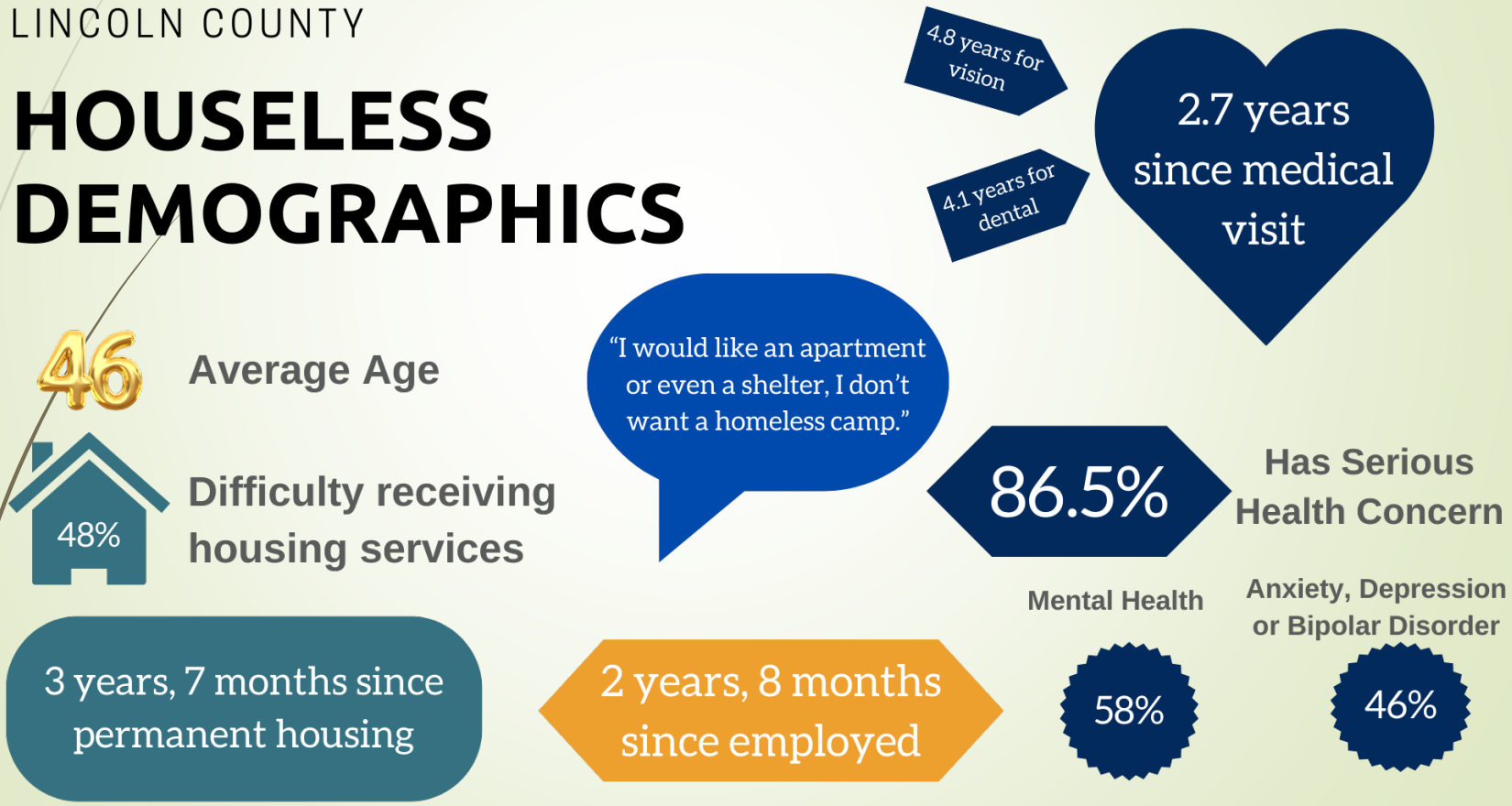
- 100 shelter / transitional housing units.

Community Need

- 2,090 estimated houseless people in Lincoln County.
- 330-person waiting list for housing vouchers
- 754 Youth impacted by housing instability
- Recognized through HB4123 as having a need for a holistic approach to addressing the needs of the houseless

Member and Community Need

Source: Morant McLeoud houseless survey, 2023



Member and Community Need

Quotes from field survey

"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"

System Transformation

- Lincoln County Homeless Advisory Board is a new group with all municipalities represented. This will provide a 5-year strategic plan and local research to help guide decisions.
- New Behavioral Health Resource Network (BHRN) brings multiple mental health and addictions providers together for service coordination.
- The local Hispanic and Indigenous Latin American population is severely undercounted in homeless research. Partnering with Olalla and Centro de Ayuda will help reduce the stigma and fear for those who are houseless.

System Transformation

Preventing ED visits is a known way to prevent excessive costs.

Innovation – Lincoln County is one of the 8 pilot counties for HB4123.

Leadership and Partnerships

- This project is led by Lincoln County Health and Human Services and Housing Authority of Lincoln County.
  - **Health and Human Services** works with all residents of Lincoln County and will manage staffing
  - **Housing Authority of Lincoln County** provides low-income housing services and is actively working towards more affordable housing in Lincoln County.
- This project involves many agencies, governments, non-profits, and business from across the entire county.

Health Equity - Diversity

Health Equity is at the forefront of any planning done by Health and Human Services.

- Bilingual/Bicultural preferred hiring practice is listed in all job descriptions.
- Just finished a nine-month DEI assessment with Health Resources in Action.
  - Focus on bringing health equity to diverse, disabled and disenfranchised populations.
- Setting baseline staff knowledge about Diversity, Equity, and Inclusion.

Health Equity - Access

A no-low barrier shelter for our unhoused individuals will provide a starting point for this vulnerable population to access services.

Hesitency to engage with institutions is commone for people experiencing houselessness. It is even more common among our Hispanic and Latino population.

Hispanic, Black and Native American populations are overrepresented but undercounted among people experiencing houselessness in Lincoln County.

Health Equity – Social Determinants of Health

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 basis 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.

Definition of Success

Measures & Outcomes

1. Unhoused individuals do not die unsheltered outside.
2. Permanent emergency no-barrier/extremely low barrier shelter is available at two accessible locations in Lincoln County.
3. Shelter participants are linked to housing and support services.
4. Community support is mobilized to provide volunteers and supply resources for the Emergency Winter Shelter Program.
5. Programmatic aspects of the winter shelter are defined, written and implemented.

Sustainability

Broad-based community support, both financial and resource oriented

- Lincoln County Board of Commissioners
- Lincoln County HHS
- Housing Authority of Lincoln County (Office on Homelessness)
- Oregon Health Authority (grants)
- Lincoln County Jail (food)
- Lincoln County Transit
- Lincoln County Parole & Probation (referrals)
- HHS Mental Health Crisis Response Team
- Lincoln County Public Health – Harm Reduction
- Lincoln Community Health Center
- Confederated Tribes of Siletz Indians
- Local municipalities
- Behavioral Health Resource Network (BHRN)
- Local Churches
- Samaritan Health Plan and IHN-CCO in talks now
- Financial contributions and resource donations are being solicited from larger companies operating within the region.

Sustainability

Budget


DST Member
Questions?

Sleep Trailer Safe Shelter Project

a bed for every head

PILOT SUMMARY AND GOALS

- Providing individual lockable places for people to sleep and keep their belonging during the day. Allowing them time/space to stabilize and focus on their physical and mental health needs and next steps.
- Increase health outcomes of participants through improved housing stability, increases in sleep and feelings of safety. Decreases in stress from participants.
- Show how an innovative mobile and emergent solution can be an asset for people in communities throughout Oregon and the country. Providing a "blue" print for future success and help.
- Increase partnerships and collaboration with resources in various communities and giving a starting place.

Member & Community Need

Houseless Crisis

We have a large shortage of affordable housing available for people. Housing instability increases stress and physical/mental health issues. Individuals experiencing homelessness are more likely to use OHP and have increased health issues.

Within the houseless community, there are other marginalized communities that may have added difficulty finding support or resources due to color, disabilities, or sexual preferences.

Sleep Trailer aims to support all people without discrimination. We believe that safety and improved regular sleep can make significant improvements of mood, mental health, and physical health.

Combine this with improved access to other resources for health/nutrition/ hygiene, affordable and permanent housing and we believe we can make substantial impacts in the lives of participants and in the community at large

Transforming and changing the way

Nothing like this is currently being done. This provides a mobile option that has the capacity to meet people where they are at and familiar with. This means rural communities and other areas that are often overlooked can have a realistic resource to offer the people in their own communities.

This could be a pilot program that others across the state and country look to in the search for solutions and a 'blue'-print for how it could be done effectively. This has the potential to change the conversation and outlook for people all across the state and country.

We have received a lot of attention from cities and organizations that are very Interested to get involved and learn results from a longer pilot as they look for solutions for their communities

Transforming and changing the way

This project gives us a better opportunity to learn how to Improve future builds and have a bigger impact for participants and community

What we can learn/gain from this pilot:

- Improved health and stability of participants
- How to better improve the physical and mental health of participants
- How to Improve sleep quality and reduce stress
- Accessibility options/ideas and use
- Long term viability
- New partnerships and introductions could help facilitate future builds/projects and collaboration as we look for solutions

Leadership and Partnerships

Project Champion: Jason Christensen (Sleep Trailer LLC)

Organization: Crossroads Communities and Sleep Trailer

Although Jason is the project champion crossroads communities provides the management and oversight of the project

We are planning to create (and have planted seeds) to better develop relationships with the Siletz Tribe, city councils and leadership in cities like Lebanon, Albany, Lincoln City, and hope to expand and strengthen those relationships as we finalize locations for placement and look for more partners and resources.

Cross-sector collaboration is a big part of our path to success with Sleep Trailer LLC, Crossroads Communities (Non-profit) and First Christian Church. We are in conversations with Siletz Tribe, and introductions to several city councils and city leaders and various organizations that we feel will be great resources for the project. .

Leadership and Partnerships

About Jason Christensen 'Project Champion'

- Siletz Tribal Member
- Father of 3 from Albany OR
- Works with individuals with intellectual & developmental disabilities as a behavior specialist writing behavior support plans.
- Also worked as the associate director for Tandem Northwest (Salem area non-profit) for 6 years, stepped down in 2022 to focus more time on Sleep Trailer LLC
- in 2016 saw an increase in individuals experiencing homelessness and felt the need to get involved and offer what he felt was a solution that could help break behavior patterns and offer an opportunity to take next steps. Started designing and finding manufacturing for his concept.
- Bachelor's Degree in business management with and emphasis in finance

Health and Equity

First come first serve:

- **Priority for marginalized communities**
- **Repeat participants invited to keep their belongings inside**

Agreement for participation completed at intake.

- **Learn/identify needs and possible next steps**
- **Find resources to connect that participant might not be aware of**

Looking for partners and collaborations to support the following:

Access to basic healthcare
(health check ups, vaccinations, treatments for common illnesses)

Mental Health Support
(support groups, counselors, and mental and behavioral health professionals)

Substance Abuse Treatment

Housing Assistance

Transportation Support

Others

Health and Equity Continued

Other ways we plan to reduce health and equity disparities.

Culturally Sensitive care:

We recognize the importance of culturally sensitive care, we plan to have staff that are trained to understand and respect the diverse backgrounds and unique needs of our participants

Data Collection and Analysis:

Regularly collecting and analyzing health data among our guests helps us to identify trends, disparities and areas that require more targeted intervention.

Collaboration with healthcare provider

Creating strong partnerships with healthcare providers and community health organizations would allow us to coordinate care effectively and address specific health needs of our guests.

Health Education and Nutrition Programs

Connecting to groups, resources, or education for better hygiene, disease prevention, and healthy lifestyles including balanced and nutritious meals, while they stay even beyond their stay.

Defining Success

 # people helped: helping as many people as possible to have a safe place to sleep. Our base goal is at least 20 per site (80 total) or full capacity each night.

Connections made: how many people we are able to connect to next steps and next resources

Increase in health and overall well-being by those that participate in the pilot (self reported)

Reduced need for emergency services.

Talking with neighbors and communities and getting feedback. Helping to change negative stereotypes.

Defining Success Continued...

- How many partnerships are able to be formed through this project?
- What types of cross-sector collaborations were able to be made?
- Have we been able to set up future projects or improvements with these partners?

What does this change?

This project has the potential to have a substantial impact for the people in these communities. One of the most powerful ways to promote change and progress is to provide hope and path to a brighter future..

- **health improvements for participants and connections to next steps/resources**
- **Setting an example and blueprint for how other communities can implement similar supports**
- **partnerships and collaborations that can be a force for future or ongoing partnerships, and community improvements or projects.**
- **Provide proof of concept and increase ease for fundraising to build more beds in the future and expand our reach and ability to impact communities**

Sustainability

- an 'after-action report' will be completed to share with community members and others interested in learning more
  - This will contain #'s of people supported, # nights offered and used
  - Participants' feedback, success stories and lessons learned
  - ways to improve potential future projects
  - how health was improved or impacted

- We will also share the data and lessons learned through our social media and youtube pages so they can reach a wider audience.

- Look to find/create future projects to continue forward, and expand capacity to increase overall impact and flexibility.

- This project should open a lot of doors and opportunities to grow. We have earned over 165,000 followers on social media from the idea/prototype alone. With a proof of concept, we hope to be able to fundraise much easier and continue to be an asset to communities across the country.

- There is a large need for emergent and temporary solutions while more permanent solutions are found or created like through our partnership with Crossroads Communities.

DST Member Questions?