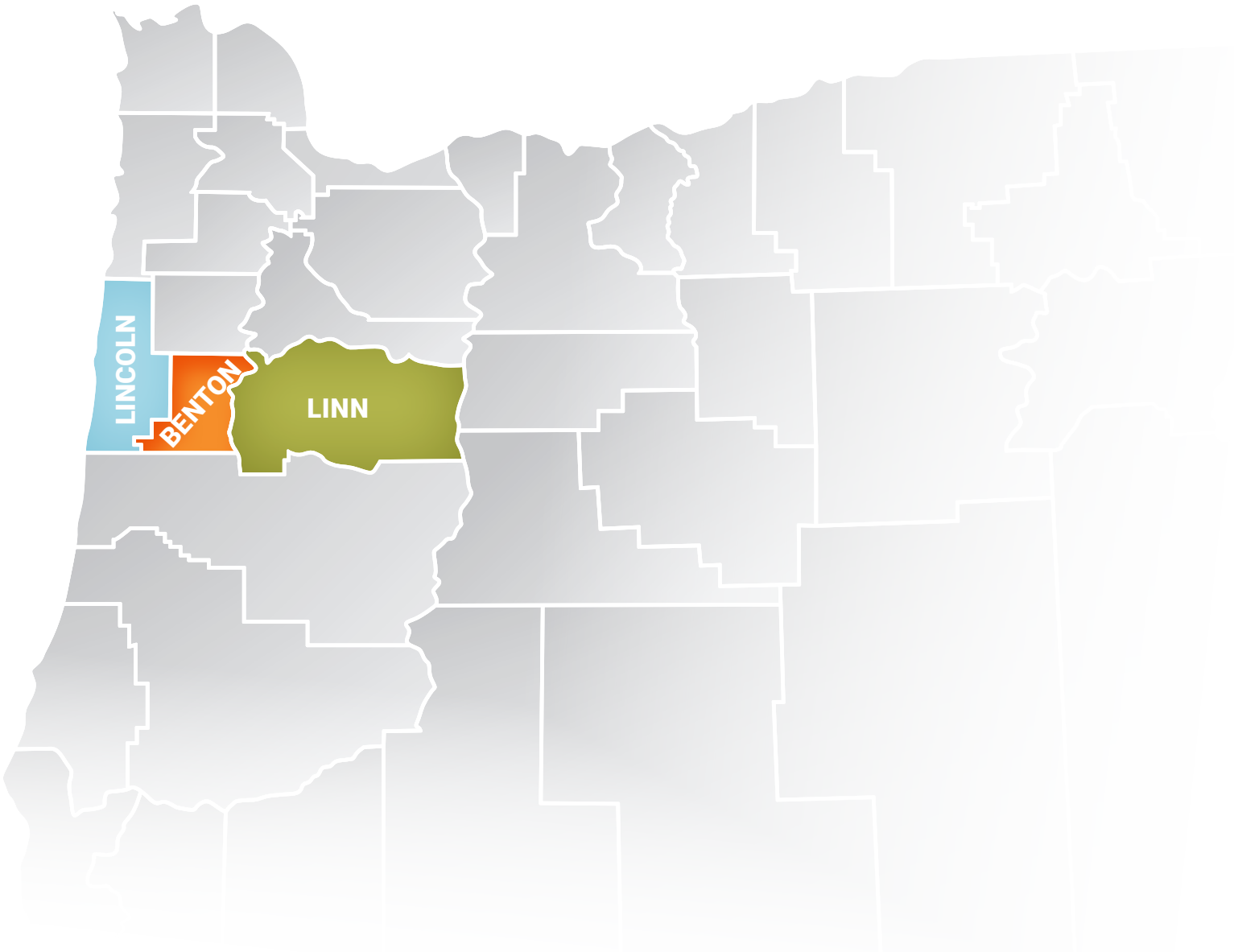
InterCommunity Health Network CCO

IHN-CCO Delivery System Transformation
Pilot Progress Reports

July 2020 to December 2020



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Beck Johnson

BRAVERY CENTER

Summary

Bravery Center is an open, accepting environment where youth can access mental health, educational, vocational, mentorship, and other community resources.

Bravery Center promotes health equity and addresses issues regarding social determinants of health among the lesbian, gay, bisexual, transgender, queer, intersex, asexual, two spirit, and the many other facets of the broader queer community (LGBTQIA2S+) youth in Lincoln County.

Bravery Center offers assistance with LGBTQIA2S+ specific needs, such as assisting youth by connecting with LGBTQIA2S+ affirming healthcare providers, navigating the legal processes for name and/or gender changes, and accessing specialist services such as hormone replacement therapy or gender confirmation surgery.

- Reporting Period: January 2020 to December 2020
- Budget: $150,075
- Partners: Olalla Center for Children and Families, Samaritan Health Services, Lincoln County Health and Human Services, Oregon Department of Human Services, Lincoln County School District, Parents and Friends of Lesbians and Gays (PFLAG), Central Oregon Coast Trans Community (COCTC)
- Highlights
    - Youth Leadership Committee, gender equity trainings, local committee leadership, physical location, hired LGBTQIA2S+ therapist, successful virtual support services

Successes

- Community involvement and partnerships
  - Acting Chair of the Lincoln County PFLAG board of directors
    - Facilitator of bi-weekly support groups
    - Close collaboration and strategic planning
  - Chair of the Coastal Equity and Inclusion Committee: LGBTQIA2S+ Subcommittee
    - Working to identify and support affirming community spaces/agencies/organizations/services
  - Member of the Gender Health Community Network
  - Member of the Lincoln County Transgender Health Task Force
  - Partnership with Central Oregon Coast Trans Community for trans support groups and resources
- Established steering committee and youth leadership committee
- Community outreach meetings winter/spring 2020
- Virtual supports for LGBTQIA2S+ youth
  - Safe chat pace, support, connection to resources
  - Weekly Zoom support group
- Provided 4 trainings for local educational institutions, regional organizations and workgroups - more scheduled for 2021
- Participating in the 2020-2021 DELTA cohort to focus on developing equity leadership skills and Bravery's youth leadership committee
- Identified affirming healthcare and mental health providers in Lincoln County
- Hired a licensed, LGBTQIA2S+ mental health therapist to provide culturally specific services
- Secured a physical location

Challenges

COVID-19 has presented unique challenges for Bravery due to the constraints around conducting in-person events, outreach, and services

- Bravery has a physical location, but has been unable to open due to COVID-19
- Difficult to contact youth during school closures
- Limitations of virtual platforms
  - Currently unable to provide meals
- Many healthcare providers and service agencies are (understandably) focused on COVID-19

Goals

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By	Progress to Date
EQUITY: Lack of resources for LGBTQ+ youth	Participation numbers, tracking activities, clinical data.	Bravery Center open and providing services to LGBTQ+ youth.	June 2020	Space rented at Lincoln City Cultural Center 18 engaged youth - 3 youth leaders PFLAG board of directors leadership (Jan 2020) Community Conversations outreach activities (Jan-Feb 2020) Lincoln County School District GSA outreach (Feb-March 2020) Began virtual support (April 2020) Established Youth Action Committee (April 2020) Began trans support groups in partnership with COCTC (June 2020) Virtual Pride celebration (June 2020) Hired LGBTQ+ therapist to provide services (August 2020)
EQUITY: Lack of identified LGBTQ+ affirming healthcare providers	Track outreach activities, seminars/workshops, provider surveys.	Identified LGBTQ+ healthcare providers, training/outreach to healthcare providers on LGBTQ+ health equity.	December 2020	Member of the Lincoln County Transgender Health Task Force (Winter 2020) Collaborative partnership with Integrity Women's Health Clinic for providing trans-affirming care (fall 2020) Collaboration with the Gender Health Community Network to add to and distribute database of affirming providers and services (2020)
SOCIAL DETERMINANTS OF HEALTH: Food insecurity within LGBTQ+ youth population	Youth surveys, tracking number of meals, monitoring food pantry.	Reduced food insecurity within LGBTQ+ youth population.	December 2020	No progress to report
SOCIAL DETERMINANTS OF HEALTH: Homelessness within LGBTQ+ youth population	Youth surveys, data from CSC housing assistance.	Reduced homelessness within LGBTQ+ population.	December 2020	Initial conversations with Oregon Department of Health and Human Services: Child Welfare around affirming foster homes for LGBTQ+ youth (December 2020)

Sustainability

- Mental health services began summer 2020
    - An affirming mental health provider has been hired to begin to provide individual, group and family services for Bravery youth, as well as LGBTQIA2S+ adults
- Training/speaking fees
- Bravery held its first successful fundraiser in winter 2020
- Grant funds received from the Trinity United Methodist Women's Group, Linn-Benton Health Equity Alliance (Bravery was awarded a second round of funding from LBHEA), and Pride Foundation
- Additional grant funds pending from WayOut Foundation
- Donations from individuals and local businesses
- Shared funding with Olalla Center's Community Health Program through our shared community outreach work within marginalized communities

Conferences and Presentations

Date	Presentation	Details
2/11/2020	Issues in Queer & Trans Healthcare	Samaritan IHN-CCO Administrative Team - Corvallis, OR Collaborated with COCTC to provide training around queer and trans basics (e.g., language and pronoun usage), as well as specific issues facing queer and trans people in the healthcare system
3/9/2020	Supporting LGBTQIA2S+ Students	Career Tech Charter School - Lincoln City, OR Provided “LGBTQIA2S+ 101” training to academic and administrative staff to broaden understanding on topics such as terminology and pronouns, build queer equity, and help them better serve and support their LGBTQIA2S+ students
5/14/2020	Gender Health Equity Training	IHN-CCO DST - Webinar Collaborated with local and regional members of the trans community to provide training on language, pronouns, transgender identity, and equity issues related to the healthcare system
6/24/2020	Gender Health Equity Training	DevNW - Webinar Collaborated with local and regional members of the trans community to provide training on language, pronouns, transgender identity, and equity issues related to housing and other social services

Stories from the Field

Although the Bravery youth have longed to meet in person, connection and support in virtual space has really taken off!

One teen reached out to peers for their thoughts about people who chose to use “neo-pronouns.” The response was positive, and the youth felt safe enough to come out with new pronouns - xe/xim! The support was warm and immediate. In our next Zoom support meeting, this youth stated that being part of Bravery has had a huge impact.

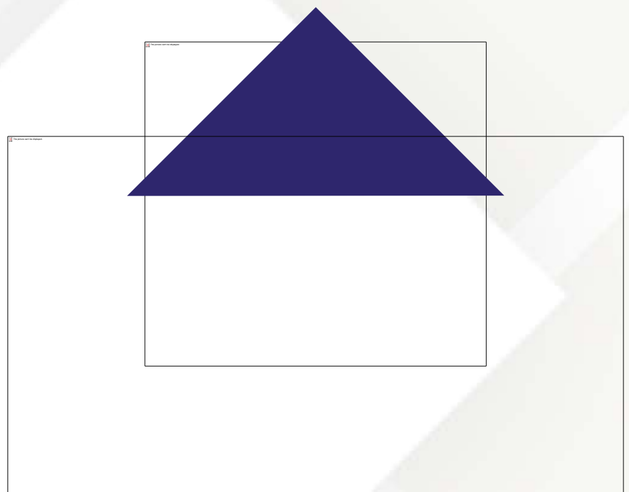
Another youth has stepped up as a shining example of brave leadership. He is involved several activities and leadership roles throughout the community, and quickly stepped up to become involved with Bravery’s youth leadership team. With Bravery’s glowing recommendation, he also became a youth board member with our local PFLAG chapter and is eager to become involved with community outreach, education, and youth peer support.

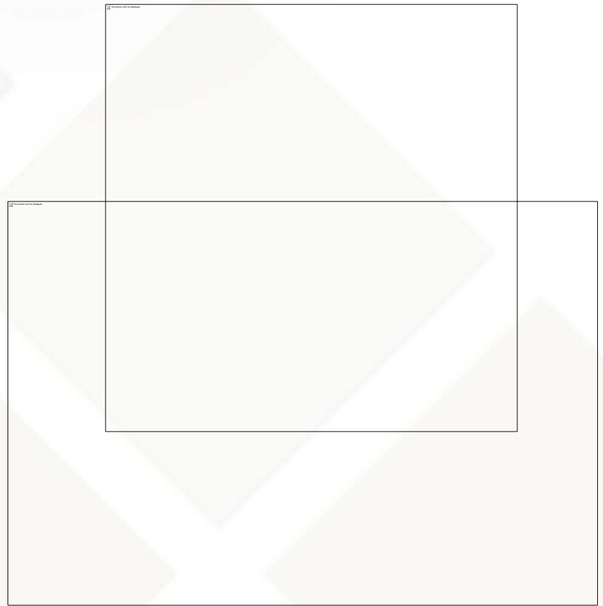
CREATING HOUSING COALITION

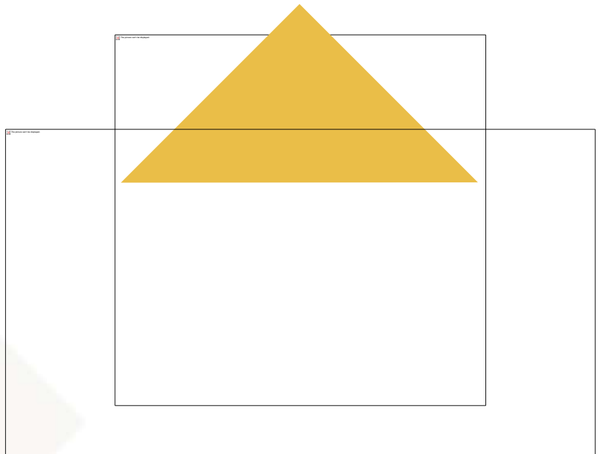
ALBANY, OREGON | 501(C)3

PRESENTS

HUB CITY VILLAGE







CREATING HOUSING COALITION

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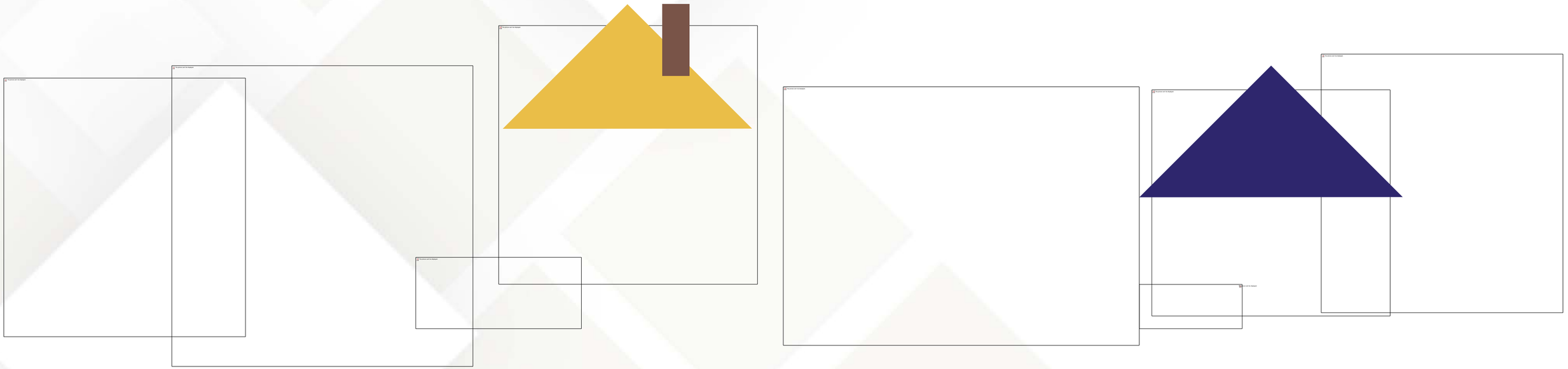
CREATING HOUSING COALITION

SUMMARY:

Creating Housing Coalition provides the infrastructure for Hub City Village to address the shortage of affordable housing in Albany. The village will include health navigation services to provide a stable residence to individuals and families.



CREATING HOUSING COALITION

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Reporting Dates: July 2020-December 2020

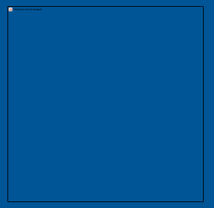
BUDGET OF $67,499

HIGHLIGHTS

- Feasibility Study
- Partnerships
- Political Will

LEARNING

- Land Is a terrible thing to waste
- 2020 was hard all the way around
- Momentum is helped by the right partners



COMMUNITY PARTNERS AND CONTRIBUTORS

Albany Area Habitat for Humanity

Community Services Consortium

Linn Benton Housing Authority

Albany Partnership for Housing

Samaritan Health Services

SquareOne Villages

Blitz Home Builders

Westby Consultants

Benu Creative

Helping Hands

Pacific Power

Parr Lumber

C.H.A.N.C.E.

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SUCCESSES:

- Partnership building
- Potential donations of up to one third of project budget identified. In early 2021 additional resources were found to reach feasibility threshold
- There are a few land options that seem promising & we're doing due diligence
- Political backing from Mayor and State Representative
- Seeking unhoused residents for advisory group
- CDBG Grant application for land acquisition

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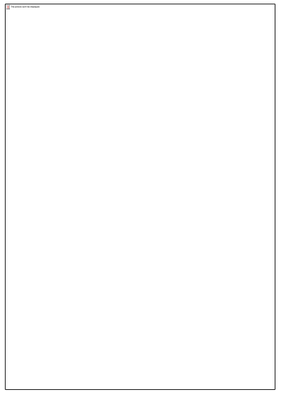
CHALLENGES:



- COVID-related loss of outreach chair, new grant writing chair
- Difficulty finding a permanent, skilled media specialist
- Continued extended time completing tasks due to collaboration challenges, distance, and lack of technical skills in users
- Land acquisition has been challenging due to lack of affordability and negotiation with land owners

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
Specific Measurable Attainable Relevant Time-Bound	Need to develop policy and procedures	Consult with lawyers, city planning, partners, etc	Written policy and procedures to guide CHC in creating stable framework	In Progress – 1st quarter 2021
	Need to choose clients who will reside in village	Consult with health partners for referral recommendations for village occupancy	Defined referral process based on health needs and income	Referral process in progress – 2nd quarter 2021
	Need village governing/norm policy	Consult with partners	Written policy and increased community confidence in project	Presentation complete 9/2020
	Expand community partners	Recruit health and construction partners	Increase partners from five to 25	Have more than 20 partners in place
	Design print promotional materials	Design and print promotional materials	Business cards logo, brochures printed for promotion of CHC	Mar-20
	Design visual and video promotional materials	Hire videographer Establish on-line presence	Video produced and on-line presence in place for promotion and procuring donations	5/1/20 for website
				Video hope to be completed by 4th Quarter 2021 (Covid)

MEASURES

CREATING HOUSING COALITION

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SUSTAINABILITY

We are laying the groundwork for a village community that will sustain itself through the financial and self-governing structure created in this process of development. Through our efforts to collaborate with government entities and individuals, our goal of funding the construction costs of this village are foreseeable. This allows for monthly and yearly costs to be minimized and met by fees paid by the residents. These fees cover housing and utilities, as well as current and future maintenance. House size, solar power and community gardens contribute to the small environmental footprint. Transportation will be minimized due to site location and relation to other services. Social capital enables residents to reduce their own consumption needs and increase interdependence through cooperative engagement and skill development. Mental and physical well-being increase and a peer-trained health navigator provides the bridge to community health resources.

Activities and Presentations

Date	Conference/Presentation	Details
Sep-20	Westby Consultants	Westby Consultants begin engagement with CHC board – capturing mission/vision/values and setting goals for feasibility study.
Oct-20	Westby Consultants	Interview of Board members to prioritize process of community interview engagement.
11/2020-12/2020	Westby Consultants	Interviews with 22 people
Dec-20	Mayor Elect Discussion	New mayor pledges to make our project a central part of his vision for addressing the affordable housing issue in Albany.
6/2020-12/2020	Monthly General meeting presentations and Bimonthly Executive Board meetings and committee meetings continue	Work on all aspects of negotiations, program development, land identification and outreach engagement.

CREATING HOUSING COALITION

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Changes in leadership within the community and CHC board have led to increased partnerships

STORIES FROM THE FIELD

- Helping Hands Shelter found a new director and she is very excited about the idea of a village because she knows that a shelter is not a long-term solution and Albany has been relying on shelters for too long.
- The new mayor is highly enthusiastic about our work and our project is a highlight of his vision for Albany. He has facilitated collaboration with the state representative from our district and is encouraging the city council and community to be strategic and innovative to meet this pressing need.
- During the feasibility study, we found partners very interested in donating structures in the village and supporting financially.
- We found a very possible collaboration with the city for property that is slated to be divested.

Carissa Cousins, M.D., MPH

Amy Hamann, BS, HDFS

Capri Kirkpatrick, RN, BSN

Integrated Foster Child Wellbeing

Summary

Develop a model of care to achieve the mission of the program of coordinating care for high-need foster children

Key components are coordinating services, intensive care coordination, and establishing sustainability

- Reporting Period: July 2020 to December 2020
- Budget: $223,177
- Partners: Samaritan, IHN-CCO, DHS, Old Mill, Linn County Mental Health, Lincoln County Mental Health, Dental Care Organizations, Every Child, CASA, ABC House
- Highlights of the Quarter
  - Starting services in Lincoln County
  - Community wide Youth and Children in Foster Care Workgroup meetings
  - Rebranding to reflect scope or work *“Encompass, Together for Health and Wellness” Care coordination for children in Linn, Benton and Lincoln Counties*
  - Learning experience: Be patient, take deep breaths

Successes

- Starting services in Lincoln County, two part time community health workers; thank you to all the partners who helped move this forward
- Over 150 children in Linn and Benton Counties served
- Integration of data tracking into Epic, reducing duplication of efforts
- Community partners coming together using Collective Impact Model to improve the lives of children and youth in foster care
- Met metric for Linn and Benton Counties?
- Providing care beyond the metric
  - Care beyond the first 60 days
  - Helping families: in-home placements, reunification, guardianship

Challenges

- Multiple partners
- Lots of opportunities for improvements and only so much time
- Intensive Care Coordination
- Additional funds for foster children, care coordination requirements
- COVID has shifted priorities, funds

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Assess needs of foster families and foster children.	Number of families and children participating in the assessments of needs	Focus groups and surveys to foster families	To be completed in the first quarter.	Completion of focus groups and surveys.	Focus groups for foster parents held. Due to lack of interest, foster youth group was not held. Summary report generated from the focus groups and available upon request. On-line survey completed in December, summary report available upon request. Results will help guide program development and services
Assess medical providers, mental health providers, dental and developmental providers needs and capabilities.	Number of providers from each field participating in needs/ capacity assessments.	Planned meetings with medical, mental health, dental and developmental/ educational providers.	To be completed in the first quarter.	Completion of meetings, structed feedback that will guide development of model/s of care.	Pediatricians in the IHN-CCO area prefer to remain the child's PCP with assistance from a child abuse/ foster care expert for children with more complex needs or who do not have an established PCP, preference to have a care coordination team specifically for foster children. Assessment regarding needs at the coast is ongoing. Meetings with multiple clinics to discuss integration of foster child care coordination into their individual clinic system.
Establish tiered level of care system.	Tiered levels of care created.	Examine existing needs in all domains for children in care, determine levels of needs for services.	To be completed in the first/second quarter.	Tiered levels established.	Experimenting with tiering system.
Determine medical, mental health, dental needs, developmental assessments and current capacities and alternative strategies.	Number of medical, mental health, dental and developmental assessments that need to be completed on average monthly.	Analysis of existing cases integrated with tiered levels of care.	To be completed in the first/ second quarter.	Number of medical, dental, mental health and developmental assessments needed per month on average established.	Approximately 10 children in each Linn and Benton County come into care per month, average of 5 children per month in Lincoln County, each needing initial medical and dental appointments within 30 days and mental health within 60 days. Approximately 450 children (300 in Linn and Benton and 150 in Lincoln) who would benefit from care coordination

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Establish parenting support system (biological and foster).	Formalize parenting support for foster and biological families in all three counties.	Define need and establish formal relationships with Family Tree Relief Nursery, Olalla Center and Old Mill to provide parenting support, work with IHN-CCO and the Department of Human Services (DHS) to establish reimbursement for these services.	To be completed in the second quarter.	Defined relationships, Memorandums of Understanding (MOUs) and/or contracts established.	System of Care Youth and Children in Foster Care workgroup has met and this activity as well as other supports for foster children and families will be addressed in future workgroup meetings so that there is no duplication of efforts.
Determine most effective billing strategy for medical, mental health, care coordination.	Effective, sustainable billing/ payment strategy established.	Explore various options for reimbursement/ payment for services based on model/s selected.	To be completed in the third quarter.	Billing/ payment strategies established to ensure sustainability of services.	Ongoing discussions with IHN-CCO and Samaritan Health Plans regarding payment for services. Exploring opportunities at the state level for changes.
Determine staffing needs and write job/ role descriptions.	Roles, care team time needed to provide services established, roles and responsibilities established.	Based on information gathered earlier in pilot, the roles and staffing needs will be established.	To be completed in the third quarter.	Defined roles, service hours needed to provide care and care- coordination.	Most programs have a care coordinator to foster child ratio or 1:250. Care coordinators in Linn and Benton counties with 1:75 ratio, also doing program development and assisting with Lincoln County program. Two part time Community Health Workers for Lincoln County. Ongoing assessment of staffing needs, efficiency.
Establish locations for providing services.	Defined location/s for providing services.	Work with existing facilities, including mobile unit, do determine most appropriate, accessible locations for services.	To be completed in the third quarter.	Established location/s for services.	Determined that children should be seen in their medical home if established. If not established, or needing to change, care coordinators are working with families and physicians for optimal placement.
Write clinic protocols, including scheduling, intake, case management, confidentiality, transitions.	Defined intake process, return on investment (ROI) processes, scheduling, requirements for comprehensive case management for children in care and transitioning out of care.	Will using existing resources from other foster care programs to develop protocols, state laws to define ROI and confidentiality protocol, case management for children in care and transitioning out of care.	To be completed in the third quarter and revised as needed.	Established protocols, scheduling management, confidentiality guidelines and case management.	Workflow protocols defined for Care Coordinators, ongoing development of guidelines and discussions with partners regarding confidentiality and information sharing. Participating in nationwide discussions regarding foster youth and the 21st Century Cures Act.

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Determine best methods to obtain medical records (Primary Care Physician [PCP] assignment and visits/oral health assignment and visits/mental health visits) in a timely manner for all IHN-CCO members served by the pilot.	Within 72 hours of notification, the following data is provided to the pilot from IHN-CCO: PCP assignment Last PCP visit Oral health physician and last visit Mental health visits Any other applicable health information.	IHN-CCO claims and membership data.	As needed.	Pilot receives PCP/Oral/Mental Health information from IHN-CCO for 100% of IHN-CCO members within 72 hours.	Partners meeting regularly to discuss the timely notification of placement of children in care. Contacts within DHS established for information sharing. Weekly meetings with care coordinators, DHS, Mental Health, IHN-CCO and DCOs. Care coordinators are notified within 2 days following shelter hearing, list routinely verified against list from OHA.
Determine most effective case management tool.	Management tool chosen.	Explore existing case management tools and determine the most appropriate for this program.	To be completed in the third quarter.	Case management tool chosen.	Developed system in Epic for documentation and reporting, modifications and reporting tool are ongoing.
Establish MOUs and contracts with partner agencies	MOUs/ contracts completed with partner agencies.	Involve SHS contracts/ legal department and reimbursement to establish contracts/ MOUs with partner agencies.	To be completed in the third quarter.	MOUs, contracts signed.	Not indicated at this time given that information being shared is within the regulations on information sharing for care coordination.
Establish metrics that will be measured.	Defined measurements for care team members, foster parent, foster child and partners established, defining satisfaction with services. Define health outcomes to be measured.	Investigate other foster care programs exploring what metrics and outcomes are measured, define measurements for this program, determine how this will be tracked.	To be completed in the third quarter.	Defined metrics of satisfaction of services and health outcomes.	Metrics as defined by OHA for children in foster care. Additionally monitoring well checks, routine dental care, vaccinations, psychotropic medication follow up.

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Develop templates in Epic, discrete fields for data tracking.	Defined templates for initial, comprehensive and follow up medical visits established in Epic as well as case management templates.	Work with care team, investigate existing templates used by other programs, define discrete fields for data tracking.	To be completed in third quarter.	Defined templates for medical visits, care coordination.	Smart phrases developed and available for providers. Flowsheet developed for care coordinators for data tracking and note writing simplicity.
Trauma informed training for staff, self-care.	All staff trained in trauma informed care (TIC).	Determine most appropriate training for all staff not currently trained in TIC, have staff trained.	To be completed in second and third quarter.	All staff have received training in TIC.	Care coordinators have been trained in TIC, ongoing training will occur.
Develop post visit evaluations.	Post- visit survey for foster parents, foster children and biological families defined.	Work with survey developer to most appropriately select information to be collected on post visit surveys.	Survey to be completed in the third quarter.	Defined surveys for appropriate services.	We will be repeating the on-line survey in two years to see if progress has been made regarding care coordination and communication.
Foster children cared for in clinic.	Number of children seen in clinic and participating in the care-coordination program.	Work with DHS in at least one county to have children seen in at least one location, following the implementation, we will review sustainability and perform ongoing Plan Do Study Act (PDSA) cycles.	To be done in fourth quarter.	Number of children cared for by IFCW program.	Over 150 children have been serviced by the foster child care coordinators in the past 12 months. Starting to provide services for children in Lincoln county as of November 15 2020.

Sustainability

- Working with SHS and IHN-CCO on payment methods
- Exploring billing options for care coordination services

Conferences and Presentations

Details
We have shared or model of care with various CCO’s throughout the state as well as other health systems throughout the country.

Stories from the Field

- “It's been really wonderful having you coordinate these things for our foster kids-obviously very beneficial for the children, but also so very helpful me personally and I'm sure all our clinic staff.” *Samaritan Physician*
- “If all the people involved in the foster program were like you guys (certifier from Linn DHS & foster child care coordinator) I would take any child that ever needed a home.” *Foster mom*
- “I’m so glad you are doing this in Lincoln County, our kids really need this. We know how it’s helped for the kids in Linn and Benton.” *Community partner in Lincoln County*
- *Care notebook being given to a mother when her children were reunified*: “This is so helpful, I know what’s been going on with their care.”

Presenters

Navigation to Permanent Supportive Housing

Summary

Develop Permanent Supportive Housing targeting the gap areas due to federal regulations around homelessness

Enhances existing projects within the housing continuum with a more robust referral system hub supported by the current and expanding cohort of partners involved

- Reporting Period: July 2020 to December 2020
- Budget: $124,516
- Partners:
- Highlights of the Quarter
  - choose 1-3 highlights
  - choose 1-3 learning experiences

Successes

- Reconvened regular partner meetings in August 2020 following long delays during the onset of the COVID-19 pandemic.
- Referral platform discussions occurred amongst partners and a presentation date was set with UniteUS for January 2021.
- Conversations and early development of MOU document for key partners began.

Challenges

COVID-19 caused substantial delays in progress as many partners were focused on other duties

Goals

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By	Progress to Date
N/A	Document all IHN-CCO members served by the pilot	Tracking completed	12/31/2020	No clients served to date
N/A	Actively participate in at least one DST Workgroup	Attendance high	12/31/2020	No meetings attended to date
Permanent Supportive Housing Cohort with siloed services	Regular meetings; increased number of community partners for wrap around services	Identify and network development of community partners for wrap around services	12/31/2020	Key partners are in place, network is being developed as are MOUs for services and referrals
Existing higher functioning supportive housing	Beta Test of existing supportive housing projects	Improved care coordination of housing/social services with the PCPCH clinical care	12/31/2020	Framework still in development stage
Community Partners providing independent services	Regular meetings; increased number of community partners for wrap around services	Formalize Care Coordination Partnerships	3/31/2020	Meetings and engagement underway with strong participation with key partners after long delays through July due to COVID-19 pandemic
Sheriff's Office convener of Permanent Supportive Housing Cohort	Regular Meetings; Strategic Planning	Assessment of Needs, Data Sharing Operations, MOU Development	6/30/2020	Framework for strategic planning meetings is being discussed by key partners and will be addressed in partner MOU
Discussion of aligned referral process	Strategic Plan; MOU development	Implementation of referral process; Formalize care coordinator contracts	9/30/2020	Underway, framework is in development and has been shared amongst key partners, input and feedback has occurred, final draft expected in Spring 2021
Identification of strategy, goals and outcomes	Goal evaluation	Assessment of outcomes, process evaluation to develop long term implementation plan	12/31/2020	No services delivered to date.

Sustainability

- Partnership MOUs to deliver wrap around services
- Client engagement
- Seamless referral system
- Case management

Skills and Connections to Support Housing

Andrea Myhre
Valerie Kyle

Summary

Support Housing pilot is implementing a program to increase the skills, knowledge, and confidence of residents to help permanently break the cycle of homelessness and increase their self-sufficiency and well-being

The end result will be greater stability for residents and less incidence of expensive services and offer a template for increasing Permanent Supported Housing for our community

- Reporting Period: January 2020 to March 2020
- Budget: $49,929
- Partners: Linn Benton Housing Authority, Community Services Consortium, Property Management Companies
- Highlights of the Quarter
  - Retained 92% of clients in Permanent Housing – 47 adults, with three children
  - Moved 10 people into Permanent Housing (not CHF housing)
  - Build successful navigation paths for housing
  - Limitations of not being able to meet with people in person

Successes

- Helped clients navigate housing application process
- Helped clients maintain housing support (paperwork deadlines, understanding documentation), built cooperative relationships with LBHA, CSC staff
- Staff completed the SOAR SSI certification process
- Mediated roommate conflicts
- Communicated COVID-related information, none of our residents have been positive for COVID
- Regularly distributed newsletters on a variety of skills topics

Challenges

We had to suspend in-person classes due to the pandemic

Clients not interested in completing tasks (getting their credit score), hard to motivate people without mandating, also pandemic a stressful time

Really saw the importance of in-person meetings with our clients

Partners either not present in person or very distracted by the challenges of the pandemic (health care providers)

Goals

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By	Progress to Date
Individuals are chronically homelessness	6-month, 12-month housing status updates (CSC)	Individuals stay in housing with support, are permanently housed	12/31/2020	We have maintained an 92% retention rate of either keeping people in our housing or exiting them to permanent housing.
Lack of skills in managing money, healthy communication, caring for themselves, and engaging in the community	Self-reporting survey administered after each round of skills program	Increase in stability, well-being, financial management, and employment/volunteering and engagement in the community	7/31/2020	Not completed due to pandemic
Ineffective, inefficient communication with health care providers, mental health providers, on health care status	Self-reporting survey administered after 6 months, 9 months of program	Timely, efficient, effective communication with health care providers	12/31/2020	Not completed due to pandemic
Nonexistant or chaotic management of health conditions resulting in frequent, costly interventions such as ED visits and hospital stays to manage physical, mental health conditions	Tracking of residents hospital stays and ED visits	More preventative care such as PCP visits, adherance to treatment plans, reduction in intensive interventions such as ED visits, Behavioral Health Unit and hospital stays.	12/31/2020	Not completed due to the pandemic, however, have been coaching clients in using MyChart and telemedicine. Set up computer for Tele-Health at Van Buren

Sustainability

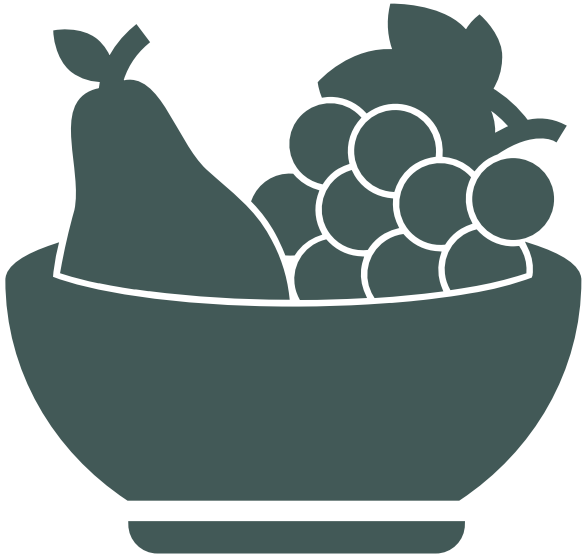
- Have leveraged COVID funding opportunities for housing support and services to enable us to hire a fourth case manager, with a fifth soon to be hired.
- Changed a person's job description to focus on housing and skills training
- In the last three months, we have applied for three million in funds to support more PSH units in the community
- We still have not cracked the shell of figuring out Medicaid reimbursement for case management. We believe changes are coming with the Oregon Medicaid Waiver, brought our case to IHN for review.

Stories from the Field

- Helped one client navigate MyChart for his chronic health condition and vaccine evaluation for COVID
- Mediated roommates situation around dogs which ended up being all-encompassing, including a better understanding of each other's personal habits and interactions. Ended with roommates establishing better communication and boundaries with each other.
- Helped a resident get into non-CHF housing who never thought they would be able to move. He is now is a very nice unit and is able to focus on his health (living in a group setting was not great for him). He still stays in touch with CHF staff for support.

Presenters

Wellness in Neighborhood Stores



Summary

Linn County Public Health (LCPH) and OSU Center for Health Innovation (OSU) are partnering with convenience store owners and managers on tobacco environmental and health impact assessments

Opportunity exists for convenience store owners and managers to grow as partners in the larger health ecosystem to improve healthy eating and food security

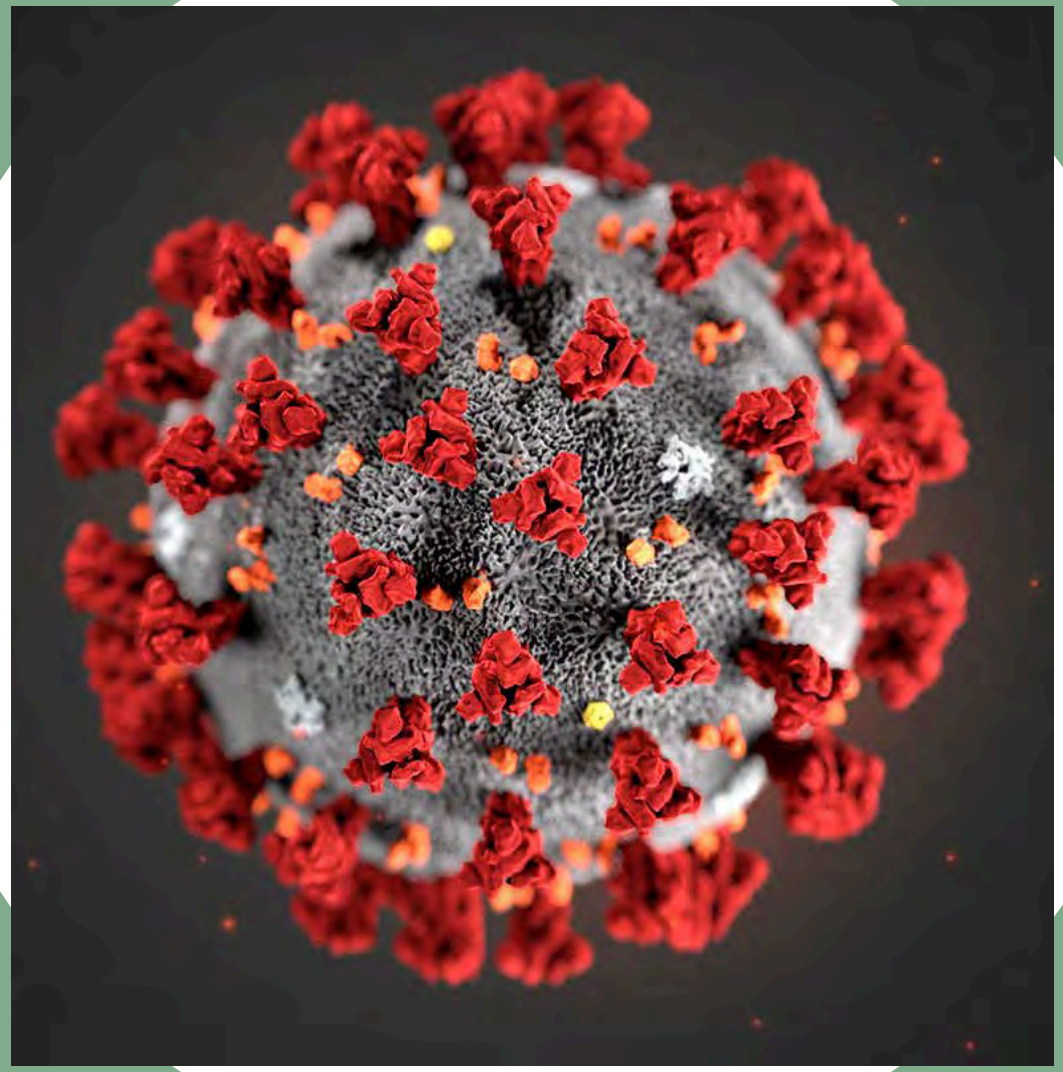
- Reporting Period: July 2020 to March 2021
- Budget: $99,485
- Partners: OSU Center for Health Innovation, Linn County Public Health
- Highlights
  - The project remains on hold until we are able to safely resume community activities, per Linn County, OSU, and OHA guidelines
  - COVID-19 put a big stop to this project, given our team's involvement in the response, and the fact that much of the work needs to take place in small stores.

Successes

- Building the team, shared learning at the intersection of practice and research
- Navigating program outcomes: food insecurity v. food behaviors v. health behaviors v. health outcomes
- Characterizing and assessing a store that promotes food security
- here

Challenges

- From March 2020 to March 2021, every member of the team has been detailed to COVID-19 response.
  - Linn and Benton Co. partners on emergency response;
  - OSU partners on TRACE-OSU and responding to LPHA requests, now leading vaccine initiatives.
  - OSU prohibitions on activities.
- No-cost extension through December 31, 2021.
- Project funds are ‘holding’ at OSU and Linn County until resumption is possible in Spring or Summer 2021.



Goals

Goals	Activities	Measures	Met By	Progress to Date
Engage IHN-CCO member shoppers to learn about member needs and behaviors in the retail space	Work with IHN-CCO members to assess shopper needs and behaviors	# of key informant/focus groups conducted	12/31/2021	
	Identify convenience stores in Linn County proximate to highest number of IHN-CCO members	List of top twenty stores that are closest to the largest amount of members	12/31/2021	Done
	Complete agreements with stores to participate in assessments	# of completed agreements (5)	12/31/2021	
Collaborate with stores to assess and implement store level changes	Partner with store owners and managers to complete WINS assessments	# of completed store assessments (5)	12/31/2021	
	Hold bimonthly meetings with store partners to review assessment results and provide technical assistance on policy and environmental changes	Meeting every other month with store partners (5)	12/31/2021	
	Assist stores in implementing healthy store-based changes.		12/31/2021	
Evaluate and revise toolkit	Conduct process evaluations with participants	Completed evaluations	12/31/2021	
	Use evaluations to revise components of toolkit	Toolkit revisions	12/31/2021	
	Finalize WINS Toolkit 1.1	Final toolkit	12/31/2021	
Increase number of WIC/SNAP certified stores in Linn County	Partner with store owners to work towards WIC/SNAP	At least two stores move towards WIC/SNAP certification	12/31/2021	

Sustainability

- Well-planned, thoughtful store-based changes that are acceptable and interesting to store owners/managers and shoppers are inherently a sustainable place-based strategy
- Linn Co PH will operationalize store-based change support
- OSU and Linn Co PH hopes to scale this effort once an acceptable pilot program/toolkit is developed

Conferences and Presentations

Date	Meeting	Details
JAN 2020	Meeting of CCOs with Jennifer Chandler, Oregon Health Authority	RP and AEM responded to request for information about Linn WINS at a meeting of CCOs who are working on systems changes to promote food security.
FEB 2020	OSU College of Public Health and Human Sciences Community Advisory Council	AEM presented Linn WINS effort at Dean Javier Nieto's request to members of the CPHHS Community Advisory Council at Portland University Day
JAN 2021	Oregon State University Ignite Sessions	AEM presented Linn WINS "Community science for store-based changes to promote food security" at January 2021 university-wide Ignite symposium
OCT 2021	Oregon Public Health Association; Corvallis, OR	Next year, when we have more to report, we plan to submit an abstract/proposal to the Oregon Public Health Association annual meeting.

Stories from the Field

- As of March 12, 2021, the project remains on hold. We hope to resume work in Spring or summer 2021 and are committed to successfully completing the project.

Presenters

Wellness to Smiles

Summary

Addresses barriers to nutritious affordable food, housing, and oral health by improving the collaboration between oral health care and social services in Lincoln County

A community-based dental care team including an Expanded Practice Dental Hygienist (EPDH), Dental Assistant/Community Health Worker (CHW) and teledentist will provide oral health services, education and navigation, and also utilize teledentistry

The overarching goal of the pilot is to coordinate systems among community partners to reduce health disparities and improve oral health and overall health outcomes for IHN-CCO clients

- Reporting Period: July 2020 to December 2020
- Budget: $100,214
- Partners: SNAP ED, HALC, Food Share of Lincoln County and Centro de Ayuda
- Highlights
  - Virtual nutrition education and gift card incentive
  - COVID related barriers
  - SDOH screenings and referrals
  - No-fund extension

Successes

- Providing dental services at 3 sites
- Partnership with OSU Extension to provide
  - virtual nutrition education and grocery gift cards
  - lettuce grow kits
- On-site produce provided
- Dedicated program partners
- One-year no-fund extension
- SDOH screenings and referrals

Challenges

- Client participation
- Providing services during COVID
- Program promotion

Goals

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By	Progress to Date
2019 Data	Increase overall dental utilization by all IHN-CCO clients assigned to the Advantage Dental Clinic in Newport by a 3 percentage point increase from previous measurement year	3 percentage point increase (42.79% 2019)	12/31/2020	25.95%
2019 Data	Increase overall dental utilization by pregnant IHN-CCO clients assigned to the Advantage Dental Clinic in Newport from previous measurement year	24.44% 2019	12/31/2020	6.82%
2019 Data	Reduction in ED visits from previous measurement year for nontraumatic dental pain by IHN clients assigned to the Advantage Dental Clinic in Newport, and corresponding cost savings associated with ED visits	1.50% 2019	12/31/2020	1.43%
2019 Data	Increase overall dental utilization by adult IHN-CCO clients assigned to the Advantage Dental Clinic in Newport from previous measurement year	37.38% 2019	12/31/2020	25.88%
2 sites	Increase access points to oral health care in Lincoln County using teledentistry	5 sites	12/31/2020	3 sites
NA	Ensure that clients who receive a teledentist exam during Dental Days and are identified as “high-risk” with a dental emergency (ie signs of cavitated lesions or existing signs of infection) receive follow up care from their PCD within 24 hours to 6 weeks depending on level of dental urgency	85%	12/31/2020	Due to lack of participants, no high-risk patients have sought services at the 3 locations.

Sustainability

- Advantage Dental from DentaQuest continues the use of teledentistry as an enterprise initiative which provides support from Executive Leadership
- Dedicated program partners

Conferences and Presentations

Date	Conference	Details
October 12, 2020	Oregon Public Health Association	Presented at the poster session on the Wellness to Smiles Project

Stories from the Field

- Participant was grateful as she planned on making stew for dinner that night and was provided the necessary ingredients on-site, so she didn't need to purchase them.