**Linn, Benton, Lincoln Partners for Health (PFH)**
**Strategic Planning Session**
**Meeting Summary**
**Samaritan Lebanon Community Hospital**
**525 N. Santiam Hwy., Lebanon, OR 97355**
**March 10, 2020**
**10:00 a.m. – 2:00 p.m.**

**Participants: Shelagh Baird** (Samaritan Health Services-SHS/C.H.E.F. Program), **Krystal Boyechko** (SHS/C.H.E.F. Program), **Lauren Burns** (Samaritan Pacific Communities Hospital-SPCH/Diabetes Education), **Jeannie Davis, Ed.D.** (COMP-NW Medical School/Chair, PFH), **Tina Dodge Vera** (OSU Extension Service, Linn County), **Deb Fell-Carlson** (Live Longer Lebanon), **Mac Gillespie** (Benton County Public Health), **Diane Giese** (SHS/C.H.E.F. Program), **Angie Gorman** (Lebanon Community School District), **Julie Jacobs** (OSU Moore Family Center), **Sommer McLeish** (SHS/Community Health Promotion), **Jennifer Meckley** (Lebanon Community School District), **Jolynn Meza Wynkoop** (SHS/Opioid Implementation Grant), **JoAnn Miller** (SHS/Director, Community Health Promotion), **Candace Russo** (OSU Moore Family Center), **Jana Kay Slater, Ph.D.,** (C.H.E.F. Program Evaluator), **Paul Smith** (Strengthening Rural Families), **Aimee Snyder** (Lincoln County Public Health), **Coleman Tanner** (Georgia Health Policy Center, TA Provider), **Libby Tenbush** (Parent-Central Linn Elementary School), **Kim Waldrep** (C.H.E.F. Program Evaluator), **Dena Weber** (Central Linn Elementary School), **Earlean Wilson Huey** (SHS/Equity and Inclusion Manager), **Toby Winn** (Neighbors for Kids), and **Shelley Hazelton** (SHS/Community Health Promotion)

**Conference Call: Sheryl Casteen** (Master Gardner/Planting Seeds of Change), **Brandan Kearney** (Consultant), and **Stephanie Russell** (OSU Extension Service, Lincoln County)

**Welcome:**
Krystal Boyechko welcomed everyone to the meeting and led introductions.

Marty Cahill, CEO, Samaritan Lebanon Community Hospital, stopped by and introduced himself and welcomed everyone.

The Agenda and Purpose for the day was shared.

**Coast to Cascades Community Wellness Network (CCCWN):**
JoAnn Miller shared information on the CCCWN and Linn, Benton, Lincoln Partners for Health.

- The Culinary Health Education Fitness (C.H.E.F.) Program is supported by the CCCWN.
- CCCWN's Mission: To improve community health in Benton, Lincoln and Linn counties by providing leadership and support for regional partnerships.
- CCCWN Vision: To lead and sustain a system of partnerships of agencies and organizations working together to provide integrated services and programs to promote individual and community health.
- CCCWN Structure: 24 members and comprised of a network and a Steering Committee with executive level leadership representing hospitals, county health departments, schools, higher education, federally qualified health centers, community-based organizations, and tribal councils. Membership includes 2 elected officials – Sherriff's Office of Lincoln County and Lincoln County Commissioner.

- The full network meets twice a year and the CCCWN Steering Committee meets every other month.
- Marty Cahill, CEO, Samaritan Lebanon Community Hospital, is the Chair for the CCCWN.
- CCCWN Current Initiatives - C.H.E.F. Program, Opioid Use Disorders, Oral Health, Homelessness, Healthy Homes Initiative.
- The C.H.E.F. program is supported by Linn, Benton, Lincoln Partners for Health, a sub-group of the CCCWN, specifically focused on chronic disease prevention including childhood obesity. (Previously the Linn County Childhood Obesity Coalition. Merged with Benton and Lincoln County to form Linn, Benton, Lincoln Partners for Health.)
    a. It is comprised of a range of entities including, non-profit, school districts, and health care organizations. Many of these organizations have a hand to play in the direct implementation of the C.H.E.F. program.
    b. Linn, Benton, Lincoln Partners for Health meets monthly to review C.H.E.F. grant implementation progress as outlined in the work plan, to assist with special projects brought forth by coalition members and organizing and supporting an annual Community Health Summit. This year's summit is scheduled for April 16, 2020 at Samaritan Lebanon Community Hospital. The summit is on "Generational Poverty." Dr. Donna Beegle will be the keynote speaker. There will be three workshops, including one in Spanish.
- The CCCWN is overseeing three opioid grants and the C.H.E.F. grant.

**2019 County Health Rankings and Roadmaps:**
Information on the 2019 County Health Rankings and Roadmaps was noted. Information is from the Robert Wood Johnson Foundation Program.

- Benton County – Health Outcomes – 2
- Benton County – Health Factors – 1
- Linn County – Health Outcomes – 18
- Linn County – Health Factors – 17
- Lincoln County – Health Outcomes – 31
- Lincoln County – Health Factors – 29

**2019 Pediatric BMI Data (From Samaritan Health Services):**
The 2019 Pediatric BMI data from presented.

***Table 3.*** Percentage of pediatric patients in each category across the tri-county region.

| | BENTON | LINCOLN | LINN | Total |
|---|---|---|---|---|
| **Underweight** | 3.71% | 3.22% | 3.13% | 3.27% |
| **Healthy** | 65.15% | 58.73% | 61.34% | 61.71% |
| **Overweight** | 15.34% | 17.51% | 15.89% | 16.05% |
| **Obese** | 15.80% | 20.55% | 19.64% | 18.96% |
| **Total** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |

- The age range was 2 to 19. There were around 19,000 patients.
- Overweight and obesity numbers are up.

- The CDC formula is used for determining the BMI.

**2019 Adult BMI Data (From Samaritan Health Services):**
The 2019 Adult BMI Data was presented.

***Table 3.*** Percentage of adult patients in each category across the tri-county region.

| | BENTON | LINCOLN | LINN | Total |
|---|---|---|---|---|
| **Underweight** | 1.77% | 1.34% | 1.04% | 1.30% |
| **Healthy** | 33.65% | 23.06% | 20.41% | 24.42% |
| **Overweight** | 29.88% | 28.73% | 27.64% | 28.47% |
| **Obese** | 34.70% | 46.87% | 50.90% | 45.81% |
| **Total** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |

- There were around 48,000 adult patients. Information is not broken down by insurance.

**Community Health Data:**
Community Health Data was shared.

| Map the Meal Gap | 2017 Feed America Gap | | |
|---|---|---|---|
| | Total Population | Food Insecurity Rate | Food Insecurity Number |
| Linn | 121,074 | 13.5% | 16,300 |
| Benton | 88,249 | 14.6% | 12,880 |
| Lincoln | 47,307 | 14.2% | 6,700 |

**CHIP Priorities:**
Chip priorities were discussed.

- Linn County
    a. Community Resiliency: mental health, substance use, and community well-being
    b. Healthy Neighborhoods: housing, food access, and transportation and equity
    c. Reproductive and Sexual Health
- Benton County
    a. Healthy Food Systems
    b. Housing, Transportation, and Development
    c. Mental Wellbeing and Community Resiliency
    d. Communicable Disease Prevention
- Lincoln County
    a. Healthy Lifestyles: nutrition/food access, physical activity, smoking, and healthy lifestyles
    b. Mental Health Promotion and Community Resilience
    c. Substance Abuse Prevention

**Samaritan Goals and Priorities:**
Samaritan goals and priorities were noted.

- **Goal 1: Healthy Families – Increase physical activity, fitness and access to nutritious foods for children and families.**
  *GSRMC, SAGH, SLCH, SPCH, SNLH Priorities:* Poverty, Food Insecurity
- **Goal 2: Greater Access - Increase access to medical, dental and mental health supports and services in the community.**
  *GSRMC, SAGH, SLCH Priorities:* Access to medical care, Access to dental care, Access to mental/behavioral health care, Chronic Disease, and Substance Use Prevention & Treatment
  *SPCH/SNLH Priorities:* None defined.
- **Goal 3: Better Networks - Increase social supports for families.**
  *GSRMC, SAGH, SLCH Priorities:* Homelessness, Housing, Transportation,
  *SPCH/SNLH Priorities:* Homelessness-Adult Shelter
- **Goal 4: Healthy Kids - Increase services and supports for children.**
  *GSRMC, SAGH, SLCH, SPCH, SNLH Priorities:* Child abuse and/or neglect
- **Goal 5: Healthy Teens - Increase services and supports for adolescents.**
  *GSRMC, SAGH, SLCH Priorities:* Access to medical care, Access to dental care, Access to mental/behavioral health care, Chronic Disease, and Substance Use Prevention & Treatment
  *SPCH/SNLH Priorities:* Child abuse and/or neglect, Poverty, Food Insecurity
- **Goal 6*:* Healthy Senior**s - **Increase social support for seniors.**
  *GSRMC, SAGH, SLCH Priorities:* Access to medical care, Access to dental care, Access to mental/behavioral health care, Chronic Disease, and Substance Use Prevention & Treatment
  *SPCH/SNLH Priorities:* Poverty, Food Insecurity

Hospitals are required every 3 years to do a Community Health Needs Assessment along with a Community Benefit Plan Implementation Strategy.

The question was asked on programs funded. This can be found on the SHS website – Type Community Benefit, Community Benefit and Initiatives, Community Benefit and Grants, and Social Accountability Grants. It will list the different organizations that received Social Accountability funding through the different SHS hospitals.

**C.H.E.F. Program:**
Information was shared on the C.H.E.F. program.

- The C.H.E.F. program is supported by a federal HRSA grant.
- There are 11 CATCH sites.
- There are 11 Tasting Table sites.
- Approximately 3,300 kids were reached at the CATCH sites.
- There were 53 completed cooking classes (the goal is to complete 69 courses by the end of the grant – June 30, 2020).
- There have been 823 cooking class participants (goal to reach 1,300 by the end of the grant).
- There have been 89 community volunteers and medical students trained (goal to train 96 by end of grant).

- Ms. Slater noted for the evaluation throughout the grant they have been present observing classes and attending meetings. They are using a continuous improvement model and collecting quantitative data to measure the impact. There are surveys and interviews with adults and kids. The survey model is after Cooking Matters. Some of the results from the adult survey included:
    a. Question related to Volunteers skill set and confidence in talking with patients. It was 37% pretest and went up to 79% at the end of class.
    b. Question related to how they felt about their basic cooking skills prior to class. It was less than ½ and went up over 80% at the end of class.
    c. Question related to managing kid's behavior during class. It was 26% pre-test and 60% at the end of class.
    d. There was 47% that felt they could purchase food on a budget, and this went to over 80% at the end of class.
    e. Medical students – At pretest there were a small number that indicated they did not talk to their patients about diet and nutrition, and at the post-test all students (100%) indicated they would talk to their patients so some level about diet and nutrition.

  Kids survey:
    a. Year 1 and Year 2 showed increases in variables.
    b. There were about 73% that though at the beginning of class they could make a snack out of fruit and this increased to 90% at the post-test.
    c. Among culinary education participants, the percent of children who said they tried a new vegetable over the past two weeks increased from 26% before taking the course to 50% after taking the course.
    d. It was discovered in the Year 1 that we weren't seeing an increase in proper hand washing so this was changed immediately and showed 44% pretest knowing how to properly wash hands to 74% post-test.
- The question was asked related to the cooking class sites and income or types of attendees for the classes. Krystal Boyechko does a monthly report. Cooking classes have been held in different counties and places such as Sweet Home and Lebanon at the High Schools, Boys & Girls Club, Lebanon Soup Kitchen. Classes have been held at the Library in Monroe and Alsea, and in Lincoln County at the Center for Health Education, Neighbors for Kids, Lincoln City, etc.

Attendees were asked if there were any reflections they would like to share:

- Classes offered in Spanish have been successful.
- Food insecurity statistic seem low especially in Lincoln County. Feeder schools have 90% food insecurity. Difference in county level data. Benton County has higher food insecurity. It includes students at the University, and it depends on where you are at in Benton County. Seniors also don't always access food stamps.

**SWOT Analysis:**

**What initiatives is your organization currently implementing to address chronic disease prevention?**

Attendees broke into groups and discussed **Strengths** (What resources, expertise, skills, etc. does Partners for Health have to help us accomplish our goals), **Weaknesses** (What does Partners for Health need or lack that is necessary for us to accomplish our goals), **Opportunities** (What are existing or emerging opportunities Partners for Health can take advantage of to advance our efforts), and **Threats** (What barriers could make it difficult or prevent Partners for Health from accomplishing our goals)?

Strengths:

- Awareness of the needs of underserved communities – Political support for this and compassion and commitment to serving
- Variety of organizations represented – Neighbors for Kids, LBL overlaps, IHN-CCO, ESD, PSN, Early Learning Hub, DHS, Linn Benton Health Equity Alliance, Regional Oral Health Coalition
- Functional Coalitions that are already working strategically (blending and braiding funds)
- Medical School in region – Higher education – COMP-NW, OSU, LBCC
- Increased partnership
- In-kind contribution of external/partnering organizations
- Commitment from individual partners – Volunteers
- Community Summit
- Samaritan Health Services as major medical provider in the region
- Regional data/Coalitions
- Dedicated facilities (Schools – After school sites – Churches)
- Community gardens – Lebanon - Throughout counties
- Flexibility and expand or shift focus – Data-driven
- Platform to replicate/expand programs – Live Longer Lebanon – From one local to another – Knowledge brokering – Translating successes
- Growing season – Agricultural availability
- CCCWN leadership and influence
- Unite Us – Resource Referral Platform

Weaknesses:

- Mental health rep
- Diverse data collection
- Technology (Apps)
- Community resource contact information
- Policy development – Organization, state – Systems approach - Capacity building
- Local business involvement
- Data – case study (take data we have – Supplement with qualitative – Stories/case studies
- Lack of resources that respond/serve immediate community needs
- More members at the table/diverse members – Outreach to community and professional organizations – Take out to the communities
- Attendance – Increase/consistency
- Geographic locations of meetings (spread across county)
- Marketing/publicizing to reach new members and those served
- Communication – Modes and access
- Better coordination/aligned efforts of members – Fragmented efforts – Silos
- Too grant and funding stream (C.H.E.F., CATCH, etc.) – Focused/driven

Weaknesses:

- What are Partners for Health's Mission – Where is that statement and how do we fit within CCCWN (Samaritan focused) – Who should be included based on Mission
- Integrate other data sources (CHIP)
- Lack of data collection methods/tools

Opportunities:

- Programming in Albany and Lincoln County
- Rural Education Grants
- Student Success Act/Preschool Promise – Expand early childhood education funding and intervention and parenting education
- IHN-CCO – Health Transformation funds
- ODE Child Nutrition – Farm to School grants and procurement
- Housing – Affordable housing (Apartments in Newport) – Warming shelters, homeless shelters, day shelter
- Affordable housing partners (Lincoln County)
- 5-2-1-0 messaging
- Faith Community Nursing
- Hunger/needs/desire for programs – Ready for providers
- Capacity building around PSE – Sharing resources, skills with each other/networking
- Public Health Accreditation – CHIPS in counties
- Public Health modernization
- Community Health Groups – Marketing and coordinating efforts – Opportunity to broaden Coalition
- Living wage
- Paid family leave
- Social determinants – Generally
- Affordable childcare
- Training that creates common goals, strategies, outcomes
- Knowledge of existing community resources (mapping, Unite US programs)

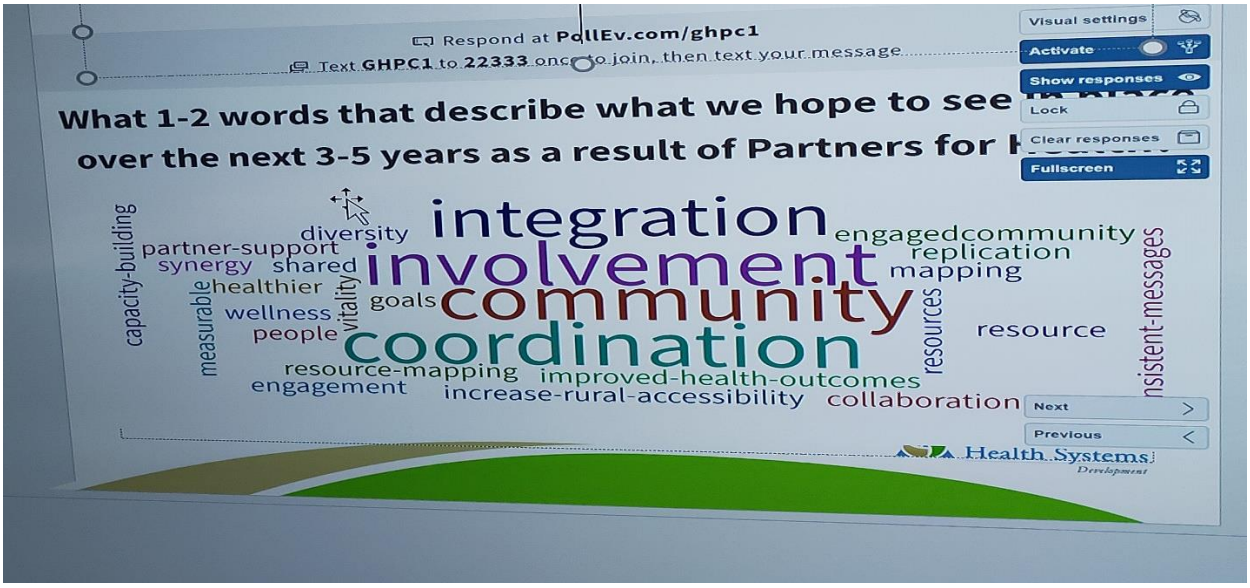
Threats/Barriers:

- Apprehension to participate (families)
- Sustainability
- Limited reach with diverse populations
- Transience in vulnerable populations
- Consistency of implementation – Times/place – Planning
- Reactivity vs. Proactivity
- Time – Too busy
- Competing emergent issues (e.g. suicide, overdose, behavioral health, etc.)
- Lack of resources and services (people, money, time, housing, professionals)
- Reactionary – Response to crisis
- Communication – Modes – Open door policy to membership
- Transportation/geography
- Political climate – Public Charge
- Lack of coordination/alignment
- Lack of healthcare access

Threats/Barriers:

- Lack of sustained, durable, un-soiled investment in prevention
- Too Samaritan centric – Broaden the base

**What is 1-2 words that describe what we want to see in place over the next 3-5 years as a result of Partners for Health** (PollEv.com was used to generate words – The biggest words on the screen were the words entered many times).




(Integration, involvement, community, coordination, capacity-building, diversity, partner support synergy, shared, vitality, healthier, measurable, people, goals, resource-mapping, engagement, wellness, improved-health-outcomes, increase-rural-accessibility, collaboration, resources, engaged community, replication, mapping, resources, resource, consistent messages)

**What actions will move us toward our Vision? What do we hope to see in place in the next 3-5 years as a result of our action?**

Communication, Outreach, and Branding:

- Communicate goals clearly
- Marketing development
- Increase visibility and outreach
- Expand yearly Community Health Summit (Include Community Resource Fair)

Growth and Develop Partnerships:

- Add additional leaders of partners to the group (example: DHS, Mental Health, Substance Abuse, CSC)
- Build upon existing networks
- Sustain/grow membership
- Continue to build up community partnerships
- Need for organizational mapping

Structure Operation:

- Think outside the box
- Have fun together – Goat yoga 😊
- Expand access to Partners for Health through technology (video conference, common calendar of event, meeting notes)
- Build consistency of programs (Available regularly to meet needs of community members)
- Revisit meeting timing and structure
- Mission statement
- Coordinate with existing planning efforts
- Align CHA/CHIP with Partners for Health – Pull goals/data from regional CHA/CHIPS – Be the linkage
- Improve data collection and data base (Example: for funding, who collects, include tech, where to store)
- Update our goals

Capacity Building:

- Identify successful programs and process (Particularly PSE and implementation)
- Support translation – Identify core components, resources needed, training needed – Provide TA and resources
- Identify/organize local champions – Provide capacity building
- Access current resources in the area – Build/support – Sustainability efforts
- Work on all levels of policies – System focus
- Outreach getting programs out
- Local funding opportunities (Review monthly tool kit)
- Increase access to grants available and applicable

It was suggested to create a Google document.

**Next Meeting:**
There was discussion on having a meeting in April. It was agreed to meet April 22, 2020 from 1:00 p.m. – 3:00 p.m.

**Adjourn:**
The meeting was adjourned at 2:00 p.m.

Respectfully Submitted
Shelley Hazelton
Community Health Promotion
Department Assistant