



Coast to Cascades Community Wellness Network

November 6, 2024 – 12:00 p.m.

Samaritan Lebanon Community Hospital – Conference Rooms 3, 4

525 Santiam Highway, Lebanon, OR 97355

In Person and Microsoft Teams Meeting

Agenda

Time	Topic	Disposition	Lead
12:00 pm	Lunch/Setup		
12:15 pm	Welcome/Introductions Department Changes Staffing/Department Transition		All Shelagh Baird Taylor Gilmour
12:30 pm	Meeting Summary 5/15/2024	Action	Shelagh Baird
12:40 pm	Consent Calendar Federal Grants Reports HRSA RC-SWAY HRSA Oral Health Co-Location HRSA HIWAY HRSA AVIROC	Action	Shelagh Baird
12:50 pm	Community Health Improvement Plan Process Update	Information	Sara Hartstein
1:05 pm	Strategic Plan Update	Action	Shelagh Baird
1:25 pm	Funding Update/Discussion	Information	Shelagh Baird
1:40 pm	CCCWN Logo Update August CCCWN Steering Comm Minutes Approving Change	Information	Jolynn Meza Wynkoop
1:50 pm	Charter Review Recruitment/New Members	Action	Shelagh Baird
2:05 pm	Measure 110/BHRN Lincoln County Benton County Linn County	Information	Jennifer Beckner Sara Hartstein Michelle Means
2:20 pm	Coalition Updates Regional Oral Health Coalition Partners for Health Regional Mental Health/SUD Regional Overdoses	Information	Shelagh Baird Dr. Jeannie Davis Jennifer Beckner Shelagh Baird

2:35 pm	Additional Business/Announcements	Information	All
2:50 pm	2025 Meetings May – Coast November - Lebanon	Information	Shelagh Baird
3:00 pm	Adjourn		

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Coast to the Cascades Community Wellness Network (CCCWN)

Spring Meeting

Samaritan Lebanon Community Hospital
525 N Santiam Hwy, Lebanon, OR 97355

Virtual Option – Microsoft Teams

10:00 a.m. – 2:00 p.m.

May 15, 2024

Attendance: **Marty Cahill**, SVP-COO-Samaritan Health Services (SHS); **Kayla Armstrong**, Community Services Consortium; **Bruce Butler**, InterCommunity Health Network (IHN)-Coordinated Care Organization (CCO)-SHS; **Emma Deane**, Communities Helping All Negotiate Change Effectively (C.H.A.N.C.E.); **Taylor Gilmour**, VP Foundations-SHS; **Sara Hartstein**, Benton County Health Department; **Wendy Hausotter**, Community Member; **Jennifer Meckley**, Lebanon Community School District; **Linda Mann**, Capitol Dental Care; **Lacey Mollel**, Community Health Centers of Benton/Linn Counties; **Ruby Moon**, Confederated Tribes of Siletz Indians; **Todd Noble**, Linn County Department of Health Services; **Toby Winn**, Neighbors for Kids

Staff/Grant/Coalition Representatives: **Maisa Athamneh**, Grants Administration-SHS; **Shelagh Baird**, Network Director/Oral Health Grant/Community Health Promotion-SHS; **Jennifer Beckner**, Lincoln County Health and Human Services; **Sommer McLeish**, Addressing Violence in Rural Oregon Communities Grant-Community Health Promotion-SHS; **Michelle Means**, Rural Communities Supporting Women and Youth Grant-Community Health Promotion-SHS; **Georgia Smith**, Parenting Success Network-Community Health Promotion-SHS; and **Shelley Hazelton**, Community Health Promotion-SHS

Guests: **Alicia Casey-McCall**, MPH, Research Associate II, Georgia Health Policy Center; **Brandan Kearney**, Consultant; **Christine Mosbaugh**, Community Health Centers of Benton/Linn Counties; and **Coleman Tanner**, MPH, Senior Research Associate, Georgia Health Policy Center

Marty Cahill, SVP-COO, Samaritan Health Services, called the meeting to order at 10:00 a.m. and led introductions.

JoAnn Miller has retired. Shelagh Baird has taken over the Network Director portion of her position on an interim basis.

Meeting Minutes:

The November 29, 2023, CCCWN meeting minutes were presented. **Wendy Hausotter made a motion and Kayla Armstrong seconded the motion to approve the November 29, 2023, meeting minutes as presented. The motion was voted upon and was unanimously approved.**

Consent Calendar: Grant Reports:

Health Resources and Services Administration (HRSA) Rural Communities Opioid Response Program (RCORP) Implementation III Rural Communities Supporting Women and Youth (RC-SWAY) Grant Update:

A written report and Work Plan Highlights for the HRSA RC-SWAY Grant was noted and distributed prior to the meeting.

- NOTE: We have NOT applied for a six-month extension for the RC-SWAY Grant. We have discussed the possibility of a No Cost Extension with our HRSA Project Officer and we are currently working on budget projections to determine how much funding would remain as of August 31, 2024. The uncompleted activity (which is the only allowable reason to request an extension) would be the youth initiative with the boys and Girls club of Greater Santiam. An extension, if approved would likely be between 3-6 months.
- Acosta Services Language Assessment is funded through:
 - a. RC-SWAY - \$2,500.
 - b. AViROC - \$2,500.
 - c. SHS Community Health Promotion Department - \$3,000.
- RC-SWAY and AViROC can only fund activities/services in the rural communities.

HRSA Rural Health Care Services Outreach Program Oral Health Grant Co-Location Project Update:

A written report for the HRSA Rural Health Care Services Outreach Program Oral Health Grant Co-Location Project was noted and distributed prior to the meeting.

HRSA Rural Communities Opioid Response Program – Implementation (RCORP-I) – Helping Impact Women and Youth (HIWAY) Project Grant for Lincoln County:

A HRSA RCORP-I HIWAY Project Grant written report and Work Plan Highlights was noted and distributed prior to the meeting.

HRSA Addressing Violence in Rural Oregon Communities (AViROC) Grant Update:

A written report and Work Plan Highlights for the HRSA AViROC grant was noted and distributed prior to the meeting.

Measure 110 Behavioral Health Resource Network – Linn County Update:

A written report for the Measure 110 Behavioral Health Resource Network for Linn County was noted and distributed prior to the meeting.

Wendy Hausotter made a motion and Kayla Armstrong seconded to approve the consent updates and reports for the HRSA RC-SWAY Grant, HRSA Rural Health Care Services Outreach Program Oral Health Grant, the HRSA RCORP-I HIWAY Project Grant, the HRSA Addressing Violence in Rural Oregon Communities Grant, and the Measure 110 Behavioral Health Resource Network report for Linn County. The motion was voted upon and unanimously approved.

Regional Health Assessment Update:

Taylor Gilmour provided a Regional Health Assessment update.

- The Regional Health Assessment and Community Health Improvement Plan (CHIP) are underway.

- A priority workgroup met to collaborate with a technical writer on the CHIP. The team put together progress measures. Will present to the IHN Community Advisory Council.
- **There were 4 priorities areas identified for the Regional CHIP:**
 - a. Access to affordable housing and homelessness.
 - b. Access to quality care.
 - c. Equity, diversity, and inclusion.
 - d. Behavioral health (including mental health and substance use/misuse).
- **How does the CHIP play into the Network?**
 - a. **Taylor Gilmour** – The hope is that everyone will use the CHIP and we will see how the Network can contribute into as well.

Strategic Planning:

Samaritan Health Services Overview of Current Grants:

Shelagh Baird, Sommer McLeish, and Georgia Smith shared about the different HRSA grants and Parenting Success Network.

- **CCCWN Grants Overview:**
 - a. The Network uses Community Health Needs Assessment, Health Improvement Plans, and available data to inform what grants to pursue.
 - b. Samaritan Health Services acts as the fiscal agent and provides program management.
 - c. Twelve federal and state grants between 2009-2023.
- **Current CCCWN Grants:**
 - a. **Addressing Violence in Rural Oregon Communities (AViROC)** – It is a four-year, \$1.2 million, Health Resources and Services Administration (HRSA) Rural Health Network Development Program Grant.
 - b. **Helping Impact Women and Youth (HIWAY)** – It is a three-year, \$1 million, HRSA Rural Communities Opioid Response Implementation IV Grant.
 - c. **Rural Communities Supporting Women and Youth (RC-SWAY)** – It is a three-year, \$1 million, HRSA Rural Communities Opioid Response Implementation III Grant.
 - d. **Oral Health Co-Location** – It is a four-year, HRSA Rural Health Care Services Outreach Grant.
- This does not include Oregon Parenting Education Collaborative (OPEC) funding for the Parenting Success Network grant and the Behavioral Health Resource Network Measure 110 funding (both are not HRSA grants).
- **Shelagh Baird – Oral Health Co-Location Project Grant:** Integrating oral health into primary health at two critical access hospitals in rural Oregon:
 - a. **Shared about the Benton, Lincoln, Linn Regional Oral Health Coalition of Oregon.**
 - Formed in 2013.
 - Identified common needs throughout the region.
 - Identified current services in the region.
 - Formalized relationship with CCCWN.
 - Reviewed Hospital Data.
 - Identified strategies to address needs.
 - b. **Oral Health Col-Location Project:**
 - May 1, 2021 – April 30, 2025.
 - \$800,000 – Health Resources and Services Administration Rural Outreach Grant.

- Dental services during hospitalization and support services at discharge.
 - Focus on uninsured/underinsured adult patients.
 - Partners: Capitol Dental Care, Lakeside Family Dentistry.
 - Lincoln County Oregon.
- c. The project involves an Expanded Practice Dental Hygienist (EPDH) placed in two Critical Access Hospitals in Lincoln County, Oregon in 2022 and 2023 with Capitol Dental Care. These hospitals are Samaritan North Lincoln Hospital (SNLH) and Samaritan Pacific Communities Hospital (SPCH).
- d. **Oral Health Co-Location Project Continued:**
- EPDH provides education to medical staff.
 - EPDH provides information to uninsured patients to enroll in Oregon Health Plan/IHN CCO.
 - EPDH refers uninsured patients to Lakeside Dental for treatment.
 - EPDH conducts outreach activities.
 - Coalition and Project Director develop a media campaign.
- e. **Day to Day Hospital Services – All patients receive evaluations.**
- Oral cancer screening.
 - Caries risk assessment.
 - Fluoride varnish.
 - Silver diamine fluoride.
 - Cleaning of dentures.
 - Oral health education that is patient specific.
 - Care coordination for treatment.
 - Pain Management – Local anesthetic, temporary fillings, silver diamine fluoride (SDF) for sensitivity, and oral health professional perspective for dental emergencies.
 - Cleaning and treatment – Patients referred to EPDH if interested – Diabetes management, OB/GYN, and Samaritan Treatment and Recovery Services (STARS).
 - Assessment – Full mouth radiographs, periodontal chart, intra-oral photos, prophylaxes, non-surgical periodontal therapy, referrals to dental van or area dentists.
 - Treatment – Patients interested can have treatment on dental van that comes routinely – EPDH can provide stabilization, treatment, dental soft relines.
 - Hospital Departments served – Critical Care, Acute Care, Emergency Department, Labor and Delivery, Diabetes Management, STARS.
 - Education Classes – Diabetes Management, OB/GYN, maternity classes, hospital staff training as needed, online, posters.
- f. **Media Campaign:**
- Contracted with AHM Brands.
 - Lincoln County.
 - Newspaper ads.
 - Social media (Facebook, Instagram, X).
 - Local radio stations – 30-second spots.
 - Posters.
 - Postcards mailed out to community members.
- g. Shared a video, which is on our website. It is in Spanish as well.
- h. Staff satisfaction – Shared quotes about the EPDH.
- i. **Sustainability moving forward:**

- About 20% of the patients, we serve in the hospitals have Oregon Health Plan (OHP) - nearly all IHN members.
- 10-23% of the patients we serve are CDC members.
- Collaborating with Samaritan to determine value proposition for sustainability.
- **Sommer McLeish – Addressing Violence in Rural Oregon Communities Grant:**
 - a. The grant came out of areas identified through our Community Health Needs Assessments.
 - b. **Goals for 2023-2026:**
 - Greater Access (to services).
 - Healthy Families.
 - Healthy Communities.
 - c. Shared child abuse rates.
 - d. **Introducing the AViROC grant:**
 - **Overarching Goal:**
 1. Reduce rates of child abuse, domestic violence, and human trafficking through advocacy, outreach, and education.
 - **Goals:**
 1. Enhance capacity to provide child abuse, domestic violence (DV), and human trafficking prevention and support services.
 2. Increase knowledge around the focus areas through outreach and education.
 3. Expand access to services that address the focus areas.
 4. Sustain the activities and services of the network that address the focus areas through comprehensive planning.
 - Service Area – Rural, Lincoln County, East Linn County.
 - **Target Populations:**
 1. Adults.
 2. African Americans.
 3. Caucasians.
 4. Latino/a/x.
 5. Indigenous Guatemalans.
 6. LGBTQIA2S+.
 7. Native Americans/Tribes.
 8. Communities of color.
 9. School-age children.
 10. Uninsured.
 - e. **AViROC Partners:**
 - **ABC House** - Provides therapy once a week for minors living in rural areas that have experienced violence.
 - **Acosta Services** - Community outreach in Lincoln Co to Spanish- speaking population and Mam-speaking Indigenous Guatemalan population.
 - **Center Against Rape and Domestic Violence (CARDV)** - Provides outreach navigation and support groups for survivors. Implementation of Healthy Relationships curriculum in rural schools.
 - **Linn-Benton Anti-Trafficking Coalition** - Provides support with coordinating the annual Violence Prevention Summit and human trafficking support.
 - **Sarah’s Place** - Works closely with CARDV in developing curriculum for students and coordinating Strangulation Prevention Training.

- f. Shared accomplishments.
- g. **Quick numbers (first 6 months):**
 - o Number of patients served – 21.
 - o Number of navigation events – 17.
 - o Number of Domestic Violence support groups – 5.
 - o Number of school presentations – 11.
- h. Shared resource sheets – Bring to community forums, local, statewide, national events.
- i. **Wendy Hausotter** – Do you have connections with veteran organizations – higher risk groups?
- j. **Sommer McLeish** – Will check about connecting with veteran groups/additional high-risk groups.
- k. **Coming soon:**
 - o Community Forum/Focus Groups in Lincoln County. Did a Zumba class, primarily in Spanish. Next week will take out to dinner Mam speakers to help them to complete their survey.
 - o Strangulation Prevention Training (5/3/24). Completed this training. 98 people registered for the event.
 - o 2024 Violence Prevention Summit (5/17/24). Rebecca Bender will be the keynote speaker.
- l. Media Campaign. Contracted with AHM Brands.
- **Georgia Smith – Parenting Success Network (not HRSA Grant):**
 - a. Parenting Success Network links community resources and families through a coordinated planning process. Also, are a resource for parenting educators, offering access to curriculum materials, training opportunities, and information about best practices.
 - b. Works in connection with Linn-Benton Community College and Early Learning Hub, and Oregon Parenting Education Collaborative.
 - c. Oregon Parenting Education Collaborative (OPEC) – Shared Mission and Vision.
 - d. It is a coalition of organizations in Linn, Benton, and Lincoln Counties – Build a coordinated system of parenting education, including the infrastructure to sustain enduring efforts, increase access, quality, and quantity of Parenting Education opportunities, cultivate new cultural norms around parenting education, support healthcare systems to develop the health and wellbeing of patients.
 - e. Healthcare integration – SHS, Oregon Community Foundation, Parenting Success Network. Funded through Oregon Community Foundation.
 - f. Referrals – Over 20 warm handoffs from providers in Lincoln County this past quarter.
 - g. Shared the different partnerships. Is very culturally diverse. Is thankful for all the community partners.
 - h. Shared different activities, series, and workshops. Looking to go into Charter schools.
 - i. Programs built from kindness - Emergency Disaster Preparedness, Opportunities for charter school families, “Healthy You Healthy Family”- SHS and SamFit, “Healthy Me Healthy We”- Prenatal.
- **Shelagh Baird – Helping Impact Women and Youth Grant (HIWAY):**
 - a. **HIWAY Grant:**
 - o HRSA – Rural Communities Opioid Response Program (RCORP).
 - o Implementation IV Grant.

- Expands substance use disorder (SUD)/opioid use disorder (OUD) prevention, treatment, and recovery services in Lincoln County.
 - \$1 million for 3 years.
 - September 1, 2022 – August 31, 2025.
- b. Why focus on substance use disorder /opioid use disorder? Every life in our community is important and valued and overdoses are taking lives. We are receiving data from our hospitals. There are overdoses happening out there in the communities and we are not hearing about all the overdoses. Non-fatal hospital overdose data was shared from 2018-March 2024.
- c. **HIWAY goals - Overarching goal:** Reduce morbidity and mortality associated with substance use disorders, including opioid use disorder, in Lincoln County.
- **Goal 1-** Strengthen and sustain SUD/OUD services for pregnant women, women of childbearing age, and youth of all races and ethnicities including LGBTQIA2S+ populations in Lincoln County.
 - **Goal 2 -** Strengthen and expand SUD/OUD **prevention services** in Lincoln County.
 - **Goal 3 -** Strengthen and expand SUD/OUD **treatment and recovery services** in Lincoln County.
- d. Shared HIWAY partners and partner roles – **Confederated Tribes of Siletz Indians**-Role: Youth SUD Prevention, **Samaritan House**-Role: Childcare, SUD, support services, **Partnership Against Alcohol and Drug Abuse (PAADA)**-Role: Youth SUD Prevention, **Lincoln County Sheriff’s Office**-Role: Overdose prevention and education, **Reconnections Counseling**-Peer Support Services, **Lincoln County Health and Human Services**-Role: Overdose prevention and education, **Northwest Coastal Housing**-Role: Housing, **Olalla Center**-Role: Youth SUD Prevention, **Faith, Hope and Charity**, **SPCH**-Role: Screening/Referrals, **SNLH**-Role: Screening/Referrals, **Samaritan Medical Group**-Role: Screening/Referrals.
- e. **PAADA Youth Leadership Academy:**
- Spring 2023 Youth Leadership Academy – March 16, 2023 – 51 youth from Lincoln County School District.
 - Fall 2023 Youth Leadership Academy – October 23, 2023 – 68 youth from Lincoln County School District.
 - Spring 2024 Youth Leadership Academy – April 4, 2024 – 48 youth from Lincoln County School District.
 - Topics included: restorative justice practices, there is an “art” to leadership, how the media targets youth with substance use promotion, drug prevention/overdose prevention, putting leadership into practice, skillsets vs shortcuts, sober parties, and how to engage others in leadership tasks.
- f. 2023-2024 Stigma Reduction Media Campaign - Goal: Reduce stigma associated with substance use disorders and addiction and encourage individuals to find the help they need. Individuals are encouraged to contact our partner organizations whose information is listed on the CCCWN’s Recover webpage: <https://cccwn.org/recover/>
- g. Regional Behavioral Health Resource Network (BHRN) partners funded through the State of Oregon (Senate Bill 755) to provide trauma-informed, culturally specific, and linguistically responsive service in the communities they serve. Services provided through the Benton, Lincoln, and Linn County BHRNs and other partnering organizations include the following:
- Harm reduction services.

- Peer support services.
- Housing services.
- Screening and behavioral health needs.
- Low barrier substance use treatment.
- Supported employment services.
- h. **2023-2024 Stigma Reduction Media Campaign:**
 - December 2023 – March 2024.
 - Linn, Benton, and Lincoln Counties.
 - TV ads, radio ads, Facebook/Instagram ads, and billboards.
- i. Shared a video with one of the models for the campaign. Local individuals were the face of the campaign.
- j. **Looking ahead in 2024:**
 - Engage law enforcement in Lincoln County for collaborative training opportunities.
 - Planning for final dollars allocated to media & outreach.
 - 1. Seeking input on methods for community engagement.
 - Community Conversations (SUD/ODU stigma-reduction method).
 - 1. Discussing with UR Medicine Recovery Center for Excellence.
 - 2. Guest presenter and training opportunity in May 2024.
- **Shelagh Baird – Rural Communities Supporting Women and Youth Grant:**
 - a. \$1 million HRSA grant.
 - b. **Overarching goal:** Reduce illness and death related to substance use disorder among women and youth in rural East Linn County.
 - c. Started September 1, 2021, and concludes on August 31, 2024.
 - d. **Partners:** Samaritan Lebanon Community Hospital & Clinics (SLCH), Samaritan Treatment and Recovery Services (STARS), Family Tree Relief Nursery (FTRN), Linn County Health Department Alcohol & Drug Program (LCAD), and Community Health Centers of Benton and Linn Counties (CHCBLC).
 - e. **Shared successes:**
 - Provision of culturally appropriate education to enhance understanding of evidence-based strategies for substance use disorder.
 - Stigma reduction among women and youth, at-risk individuals.
 - Enhanced harm reduction services.
 - Increased availability and distribution of Naloxone.
 - Strengthen follow-up services after discharge.
 - Expanded access to medication assisted treatment (MAT) in primary care clinics and hospital.
 - Addressing workforce issues – hired and retained additional Peer Support Specialists.
 - Improved discharge coordination for individuals transitioning from inpatient treatment facilities and the criminal justice system – connects clients with home and community-based services, including case management, housing, employment, food assistance, transportation, medical and behavioral health services, and support from faith-based organizations and sober/transitional living facilities.
 - Nurturing Parenting curriculum from Family Tree Relief Nursery.
 - Samaritan Treatment and Recovery Services.
 - Linn County Alcohol and Drug - Support for adolescent substance use disorder treatment and early intervention, including Leisure Skills and group-focused learning for recovery.

f. **Shared challenges:**

- Workforce.
- Syringe exchange.
- HCV treatment.
- Stigma.
- Drug related bacterial infections, viral hepatitis (A, B, and C), and syphilis.

Strategic Planning Process

Coleman Tanner and Alicia Casey-McCall led discussions around the strategic planning process for the CCCWN.

- The objectives included:
 - a. Prioritize Network focus areas.
 - b. Provide a method to determine which funding opportunities to prioritize.
- The Mission and Vision of the CCCWN was shared.
 - a. **Mission:** To provide leadership to enhance the health of communities through the development and support for collaborative regional partnerships and community health programs in Benton, Lincoln, and Linn Counties.
 - b. **Vision:** Lead and sustain a system of partnerships of agencies and organizations working together to provide integrated services and programs to promote individual and community.
- **Taylor Gilmour** – The group that was convened to develop a Regional Community Health Assessment and Community Health Improvement Plan (CHIP) was called the Partnership for Community Health.
- **Coleman Tanner** – Both she and Alicia Casey-McCall looked through the Regional Community Health Assessment and there is alignment. Human Trafficking is not called out specifically in the Regional Community Health Assessment.
- **CCCWN Priority Areas/Community Focus Areas:**
 - a. Pregnancy Prevention and Prenatal Care.
 - b. Housing.
 - c. Chronic Conditions.
 - d. Oral Health.
 - e. Access to Care and Workforce.
 - f. Behavioral Health and Mental Health.
 - g. Violence Prevention.
 - h. Equity, Diversity, and Inclusion (Network Value).
 - i. Food Access.
 - j. Tobacco Prevention.
 - k. Substance Use Disorder (SUD).
- **Georgia Smith** – Works with the queer community. There are systems in place that are not equitable at the base level – Programs not diverse and equitable. What about the under-represented population – Do not see Black females, LGBTQIA2S+. We need to work on programming and communication. This is important as well.
- **Alicia Casey-McCall** – Diversity, Equity, and Inclusion is an overarching concept that fits across all organizations. Also, did not see that we have a “Value Statement.”
- **Coleman Tanner** – Did you get to CHIP goals around Diversity, Equity, and Inclusion?

- a. **Sara Hartstein** – “Yes,” not finalized goals/priorities yet. Work with community to prioritize areas. CHIP should be both – Address all priority areas and separate priorities in addition.
- **Sara Hartstein** - There were 7 key themes that came out of the Regional Community Health Assessment. We collaborated with the community to narrow them down to 4 due to capacity. At this stage we are writing goals. Strategies have been created. With the CHIP, Chapters are flushed out and hope to be completed by July 2024. We can look what we have done and align our priorities with the CCCWN.
- **Taylor Gilmour** – These 4 key themes from the Community Health Assessment included: Housing, Access to Quality Care, Behavioral Health, and Inclusion, Diversity, Anti-Racism, and Equity (IDARE).
- **Strategy Headings:**
 - a. **Housing**
 - H1. Expand housing units.
 - H2. Expand supportive services.
 - H3. Improve housing data.
 - b. **Access to Quality Care**
 - AQC1. Grow and sustain workforce.
 - AQC2. Oregon Health Plan optimization.
 - AQC3. Expand supportive services.
 - c. **Behavioral Health**
 - BH1. Build community resilience.
 - BH2. Grow a healthy workforce.
 - BH3. Improve care coordination.
 - d. **Inclusion, Diversity, Anti-Racism, and Equity (IDARE)**
 - IDARE1. Improve equity and well-being.
 - IDARE2. Increased education and accountability.
 - IDARE3. Improve data quality.
- **Access to Affordable Housing – H2 – Strategies:**
 - a. H2. Expand supportive services: Expand and sustainably fund services for shelter, transitional, and/or permanent housing.
 - b. **Strategies:**
 - H.2.1. Partner with InterCommunity Health Network Coordinated Care Organization (IHN-CCO) to fund supportive services positions that are culturally and linguistically appropriate. Examples: Delivery System Transformation (DST), Supporting Health Through Reinvestment (SHARE) Initiative, and direct contract.
 - H2.2. Partner with existing workforce at housing and shelter locations.
 - H2.3. Identify and apply for sustainable grant opportunities at state, federal, and private levels to strengthen shelter, transitional, and/or permanent housing support services.
- **What is the SHARE Initiative?**
 - a. **Bruce Butler** – It is a profit-sharing mechanism - Investing a portion of IHN-CCO net income or reserves back into the community.
- **Coleman Tanner** – Behavioral Health and Mental Health and SUD – Do we want these all together or separate out?
 - a. **Georgia Smith** – There is overlap and separation. Parenting Success Network takes a soft approach.

- b. **Sara Hartstein** – The group thought SUD/Mental Health and combined Behavioral Health was priority. Behavioral Health is a priority. Heard overlap and different needs. We can put together and pull apart. Sub-needs are prevention and access to treatment. Could be pulled out on its own. It is a big area.
 - c. **Jennifer Beckner** – We should keep SUD separate. It is so big. Behavioral Health is huge on its own.
 - d. **Ruby Moon** – There are also different resources and do have separate goals.
 - e. **Committee members agreed to just include Behavioral Health/Mental Health.**
- For Housing – Need to include housing units, supports, and data.
- Separate out Access to Care and Workforce. Can be confusing.
- Workforce should include Oregon Health Plan optimization and supportive services.
- Add Healthy Families.
- **The group recommended the revised list of priority areas:**
 - a. **Pregnancy Prevention and Prenatal Care.**
 - b. **Housing – Housing units, supports (partner, Medicaid), and data.**
 - c. **Chronic Conditions.**
 - d. **Oral Health.**
 - e. **Workforce (Oregon Health Plan optimization and supportive services).**
 - f. **Behavioral Health and Mental Health.**
 - g. **Access to Care.**
 - h. **Violence Prevention.**
 - i. **Equity, Diversity, and Inclusion (Network Value).**
 - j. **Food Access**
 - k. **Tobacco Prevention.**
 - l. **SUD.**
 - m. **Healthy Families.**
- Recap - The 7 key themes from the Regional Community Health Assessment include Access to Affordable Housing and Houselessness, Access to Quality Care, IDARE, Food Insecurity/Access, Healthy Youth and Families, Mental Health, Substance Use and Misuse.
- **Reflect:**
 - a. What are the data telling us?
 - b. Where is there the greatest need?
 - c. Where is there the greatest inequity?
 - d. Where do we have capacity?
 - e. Where do we have momentum?
 - f. Does it address upstream issues?
 - g. Where is the biggest opportunity for the Network? What are we positioned to address?
- CCCWN members were asked to place 3 dots on their top priority areas.
- **Coleman Tanner** – Those areas that rose to the top included:
 - a. **Workforce.**
 - b. **Diversity, Equity, and Inclusion.**
 - c. **SUD.**
 - d. **Mental Health/Behavioral Health.**
- **Lacey Mollé** – With workforce, we need to look at the whys. If we are investing in access to care and we do not have the workforce, we will not be successful.
- **Ruby Moon** – There are initiative behind different areas. They may not be seen. Like food access, we are seeing increased issues around this. Need to connect with resources that exist and see the real gaps.

- **Lacey Mollel** – Thinking of 1115 Waiver and strategic initiatives.
- **Ruby Moon** – Does know that SUD needs addressed. We do get funding around SUD. It has momentum behind it.
- **Sara Hartstein** – How many priorities do we hope to have in a strategic Plan?
 - a. **Coleman Tanner** – We do not want to have too many. Recommend narrowing down to the top 3-5.
- **Sara Hartstein** – Growing a healthy workforce came out strong in the CHIP process around Behavioral Health – One of the biggest struggles.
- **Christine Mosbaugh** – What time are we looking at and to what end?
- **Ruby Moon** – Love the line up of the CHIP. Likes following Samaritan Health Services (SHS) timeline of every 3-years (like with needs assessments) to work together as a region and to continue the work.
- **Sara Hartstein** – Recommend staying in alignment and keep cycles together.
- **Alicia Casey-McCall** – Keep in line with the long-range goals in a 3-year cycle. Work toward a larger goal related to workforce. Goals and objectives mindful of time limit.
- **Taylor Gilmour** – Diversity, Equity, and Inclusion as a value statement – Would it preclude as having as a priority area?
 - a. **Coleman Tanner** – “No,” it would not preclude. Do not see as part of Mission/ Vision called out. You have a Steering Committee. Have them review the Mission and Vision and incorporate funding opportunities – Tied in. Most ask how to address inequities.
 - b. **Alicia Casey-McCall** – With Equity, Diversity, and Inclusion, can look at data collection as a priority area.
 - c. **Georgia Smith** – Where data collection is important, strengthening relationship is also particularly important.
- **Coleman Tanner** – We should look at and tag into who is missing at the table. Are there people that need to be here and at the table?
- **Christine Mosbaugh** – We have those continuously represented and mixing in new people is good.
- **Coleman Tanner** – Are there folks that need to be a partner – With Equity, Diversity, and Inclusion, Workforce, Behavioral Health/Mental Health, and SUD? Look at gaps and see where the Network partners are?
- **Christine Mosbaugh** – Lincoln County also has a Community Health Center – Thinks of that as a resource. She is with the Community Health Centers of Benton/Linn Counties.
- **Jennifer Beckner** – Is with Lincoln County Health and Human Services and represents the Lincoln County Community Health Center. She takes information back to the Director’s group. Runs the Bridges to Recovery Program through the Community Health Center.
- **Coleman Tanner** – Looking at the top 4 goals/priority areas – Workforce, Behavioral Health/Mental Health, Equity, Diversity, Inclusion, and SUD think of operationalizing the focus areas.
 - a. What are current objectives regarding the focus area?
 - b. What would we like to see happen in the next 3-5 years regarding this focus area?
 - c. Who do you need on board? (Partners, experts)?
 - d. What partner will lead the work?
- The IDARE Goals and Strategies and the Behavioral Health Strategies and the Access to Quality Care Strategies from the Regional Community Health Needs Assessment were shared as well (*Access to Affordable Housing was noted on page 9 of these minutes*).

- **IDARE1 – Goal – Improve equity and well-being:** Change systems, remove barriers, nurture equity, and improve well-being.
The “Goal Summary” and “Regional Health Assessment Data Points” was noted.
 - a. **IDARE1. Strategies – Improve equity and well-being:**
 - IDARE 1.1. Develop community-driven practices which embed equity principles in the removal of institutional barriers.
 - IDARE 1.2. Improve equitable access to culturally and linguistically appropriate service (CLAS) providers.
 - IDARE 1.3. Increase the number of culturally and linguistically appropriate service providers by removing institutional barriers and uplifting communities into these roles.

- IDARE2 – Goal – Increase education and accountability:** Increase inclusive, diversity, antiracism, and equity and gender justice (GJ) education and accountability measures in the system of services.
The “Goal Summary” and “Regional Health Assessment Data Points” was noted.
 - b. **IDARE2 Strategies – Increase education and accountability:**
 - IDARE 2.1. Grow and maintain a healthy behavioral health provider workforce by addressing retention strategies, burnout, and recruitment. Example: For retention and recruitment, support career development opportunities such as internships, mentorships, and culturally specific peer supports.
 - IDARE 2.2. Build accountability measures for providers and community members.
 - IDARE 2.3. Provide resources (e.g., funding) and supports to community members around participation in decision-making bodies and advocacy.

- IDARE3 – Goal – Improve data quality:** Improve the process of collecting, using, owning, and sharing data.
The “Goal Summary” and “Regional Health Assessment Data Points” was noted.
 - c. **IDARE3 Strategies – Improve data quality:**
 - IDARE 3.1. Change strategies for gathering data to reflect inclusion, diversity, antiracism, and equity and gender justice.
 - IDARE 3.2. Centralize and coordinate data collection.
 - IDARE 3.3. Disaggregate data using a combination of quantitative (statistical) and qualitative data (people’s experiences).

- **Behavioral Health – Strategies – BH2. Grow a healthy workforce:** Increase access to responsive, transformative behavioral health services and supports that are culturally and linguistically appropriate.
 - a. **Strategies:**
 - BH 2.1. Grow and maintain a healthy behavioral health provider workforce by addressing retention strategies, burnout, and recruitment. Example: For retention and recruitment, support career development opportunities such as internships, mentorships, and culturally specific peer supports.
 - BH 2.2. Reduce barriers of access to care including the physical barriers of transportation, rural and tribal needs, and culturally appropriate and gender-affirming treatment options. Example: Support funding for existing community service providers, CBOs, tribal organizations/support (term TBD), and non-clinical settings.

- BH 2.3. Create learning opportunities for providers that increase awareness around cultural competence and the unique health needs of marginalized (under-resourced) (term TBD) communities.
- **Access to Quality Care – Strategies – AQC1. Grow and sustain workforce:** Grow the regional health care workforce in innovative, supportive, and sustainable ways.
 - a. **Strategies:**
 - AQC 1.1. Sustainability – Increase the number of all levels and types of healthcare providers in the region (and particularly in rural areas). Focus areas include addressing institutional barriers, prioritizing meaningful strategies for recruitment and retention of diverse talent, and exploring innovative ideas to address provider burnout.
 - AQC 1.2. Grow an electronic, closed loop referral system between community and clinical services that supports community partners in accessing resources, meeting patient needs, gathering standardized data, and expanding community-based care.
 - AQC 1.3. Create sustainable funding mechanisms for effective community-based care delivery. Examples include establishing reimbursement guidelines and fee schedules.

CCCWN members were asked to break into groups and discuss one of the priority areas.

- **Workforce:**
 - a. Help grow our own (example: Career Center, Community College).
 - b. Opportunity to pull funds together for training – Peer Support, Community Health Worker (CHW), Certified Alcohol Drug Counselor (CADC) Specialist, Certified Prevention Specialist.
 - c. Support from non-profit agency – Identify long-term funding to support position.
 - d. Peer Support is important – Connect peer support to resources for funding (Example: Emergency Department (ED), law enforcement).

Questions/comments followed:

- a. In growing our own, where is there different healthcare training/workforce opportunities?
 - Marion County – Medical Assistant Program. Model from Marion County through Willamette ESD Career Center.
 - Linn-Benton Community College (LBCC) – Build around Community Health Workers.
 - Lane County – Work to develop partnerships – Hybrid programs – Dental assistant.
 - Legislation – There are Senators that put in for workforce development – Qualified Mental Health Associate (QMHA), Medical Assistant, Dental Assistant, Expanded Practice Dental Hygienist (EPDH).
 - Look at uncounted/unrepresented groups.
 - Peer Support Specialists, CHW, CADC, and others – Trainings to support growing our own. Could we pool funds to do so?
- b. When talking about non-profit agency and long-term funding, this might be outside 3-year cycle and Peer Support and resource for funding for that.
- c. Service providers and non-profit agency grant funded programs and staff – Sustainability issues and need to identify long term funding – Also, need to provide staff with lived experience with support for secondary trauma.

- d. Needing to expand peer support into other agencies (ED, law enforcement) – Good practice and will help support with sustainable funding.
 - e. Delivery System Transformation funding through IHN-CCO has helped fund training hubs – Benton County – Albany had para-medicine program.
 - f. Can take up-front investment and may not be billable positions. Communities are working on getting billable services.
 - g. Agree with the need to identify sustainable funding source to maintain staff and programs. Discuss creative payment models with IHN-CCO.
 - h. <https://www.willamettecareeracademy.org/>
 - i. [Workforce Development | Workforce Development | Resources | Oregon Coalition of Local Health Officials \(oregonclho.org\)](#)
 - j. <https://ihntogether.org/transforming-health-care/health-related-social-needs/community-capacity-building-funds/>
 - k. <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/OHP-Waiver.aspx>
 - l. <https://ihntogether.org/wp-content/uploads/sites/4/HRSN-Community-Capacity-Building-Funds-Request-for-Proposal.pdf>
- **Mental Health/Behavioral Health:**
 - a. Training.
 - b. Retaining workforce.
 - c. Pathways – Continuum of Care; define and educate where to get what service. Focus areas – Youth/families, equity and inclusion, and training opportunities.
 - **Diversity, Equity, Inclusion:**
 - a. Request for Proposal (RFP)/Memorandum of Understanding (MOU) – Percent of funding to go to diversity, equity, inclusion.
 - b. Accountability/maintenance.
 - c. Marketing.
 - d. Use success of others (Value statement or other).
 - e. Change together.
- Discussion followed:**
- a. Be equitable.
 - b. Incorporate people not in room – Ties into trauma informed.
 - c. How to show up in space and how space changes – Growth of the whole.
- **Substance Use Disorder:**
 - a. Meet people where they are (less focus on getting people into the system).
 - b. Safe and cultural appropriate services (trauma informed).
 - c. Rely on local organizations (lean on partnerships and those agencies working with people).
 - d. One stop shop(s) for services.
- Discussion followed:**
- a. If we can get people into treatment and recovery, they may come out and help others – Reconnections Counseling has certification program.
 - b. **Ruby Moon** – Likes the one stop shop for services and having workers/professionals meet individuals at that place.
 - c. **Georgia Smith** – Could we have more than a one stop shop – One stop shop(s)?
- **Coleman Tanner – Establishing Funding Criteria:**
 - a. Aligns with mission and vision.
 - b. Aligns with identified priority areas.
 - c. Funding amount.
 - d. Administrative burden.

- e. Application process.
- f. Level of competition.
- g. Realistic (Network has the capacity, expertise, resources).
- h. Lead organization.
- **Coleman Tanner** - The Strategy Screen handout was shared. Keep 4-5 screening criteria.
 - a. Before implementing a new strategy, your organization will need to evaluate the strategy using specific decision-making criteria: its “strategy screen.” The specific criteria of the strategy screen depend on the organization’s mission competitive advantage(s), and situation. The criteria will be different for each organization and may need to change over time as your organization adapts to changes in the environment.
 - b. Basic criteria include that the strategy must support your organization’s mission (assuming that your mission does not need to change) and differentiating factor(s).
 - c. You should include additional criteria, as you see fit. Examples include requiring that the strategy must meet specified financial criteria, such as, a new program must pay for itself, quality criteria, such as, new services must be of high quality, criteria related to your organization’s geographic and customer scope, and the requirement that it position your nonprofit as a leader.
- **Homework** – Create “Value Statement” – Diversity, Equity, and Inclusion.

Adjourn:

With no further business to discuss, the meeting was adjourned at 2:00 p.m.

Respectfully Submitted,

Shelley Hazelton

Community Health Promotion



Coast to Cascades Community Wellness Network Meeting Rural Communities Supporting Women & Youth (RCSWAY)

November 2024

Samaritan Lebanon Community Hospital requested \$1,000,000 to implement the Rural Communities Supporting Women and Youth (RC-SWAY) project to reduce morbidity and mortality related to substance use disorder and opioid use disorder in rural Linn County, Oregon. Under direction of the RC-SWAY consortium, we will strengthen and expand SUD/ODU prevention, treatment, and recovery activities throughout rural Linn County.

Partners on the project include Samaritan Lebanon Community Hospital & Clinics (SLCH), Samaritan Treatment and Recovery Services (STARS), Family Tree Relief Nursery (FTRN), Linn County Health Department Alcohol & Drug Program (LCAD) and Community Health Centers of Benton and Linn Counties (CHCBLC).

RCSWAY Reporting

PIMS Report – Final

- PIMS Y3R1 (September 1st, 2023-February 29th, 2024) was submitted to HRSA March 29th, 2024.
- PIMS Y3R2 (March 1st, 2024-August 31st, 2024) was submitted to HRSA September 30th, 2024.

Biannual Progress Report – Final

- Y3R1 Biannual Progress Report (September 1st, 2023-February 29th, 2024) was submitted to HRSA April 2nd, 2024.
- Y3R2 Biannual Progress Report (March 1st, 2024-August 31st, 2024) was submitted to HRSA September 30th, 2024.

Sustainability Plan – Final

- Sustainability Plan Report 3 was submitted to HRSA September 30th, 2024.

Closeout Report– Final

- The final Close out Report is due to HRSA 90 days after the extension end date, 02/29/2025.

Year 3 Budget

- RCSWAY SUD initiatives will continue in rural East Linn County until February 28, 2025 (per the HRSA six-month extension approval).
- The RCSWAY media campaign is active in rural East Linn County. Initiatives aim to raise awareness about Substance Use Disorder (SUD), reduce stigmas and biases related to SUD among women, youth, and other marginalized populations, and promote SUD as a disease. Billboards and media efforts will be active until November 2024.
- RCSWAY funds allocated to purchase maternity items for women admitted to Samaritan Labor and Delivery and STARS in Lebanon continues to be offered to women needing supplies for pre and after birth. The funds were also utilized to procure necessary infant items.
- Ralston Academy hosted an event to raise awareness about Substance Use Disorder (SUD). The event focused on educating attendees about SUD awareness and prevention, featuring volunteers who shared their insights from lived experiences. RCSWAY funds were used to purchase sweatshirts promoting SUD awareness.

Prevention, Treatment, & Recovery Activities	Responsible Persons	Timeline	Progress
<p>Ib. Hire or assign Peer Support Specialists and Peer Support Group Leader to implement RC-SWAY peer support activities.</p>	<p>STARS FTRN</p>	<p>Q1</p>	<p><u>STARS</u> <u>03/01/2024-10/31/2024</u> PSS Christina Sechrest continues to offer support services to women and youth in rural east Linn County.</p> <p><u>09/2024</u> <u>FTRN</u> <u>03/2024-05/2024</u> Rachel Thome was hired through non-grant funds and will be joining Lynette in the RC-SWAY rural area. Peer support groups have been successful and are expanding attendance, including in other counties (Multnomah), with up to 15 peers in each group, which is an unprecedented number of participants.</p> <p><u>06/2024:</u> FTRN PSS groups have been successful and are gaining traction. We have expanded the attendance by including participants from other counties, such as Multnomah. We have had up to 15 peers in attendance as well as supervisors and newcomers to the field.</p> <p><u>07/01/2024-08/31/2024</u> Rachel and Lynette Cavanaugh have continued to support individuals within the east Linn area.</p> <p><u>09/01/2024-10/31/2024</u> FTRN continues to offer Support Group every Thursday at 9am to a wide variety of peers in multiple counties including the Tri- County area</p>
<p>Ic. FTRN, STARS, LCAD, CHCLBC, will develop and distribute culturally and linguistically appropriate education material for family members and caregivers on SUD/ODU prevention, treatment and recovery.</p>	<p>FTRN STARS LCAD CHCLBC</p>	<p>Q1-Q12</p>	<p><u>STARS</u> <u>06/2024</u> In May, the STARS PSS made significant strides. They attended the Sources of Strength Wellness Fair, where they distributed STARS Pamphlets and provided RCSWAY education. They connected with 150 community members and 20 community partners in a commendable effort. Additionally, they extended their reach by providing SUD education and resources to Obria, the Pregnancy Resource Clinic, the Teen Center, and FAC.</p> <p><u>07/01/2024-08/31/2024</u> In July and August 2024, STARS PSS distributed education materials at various events in rural East Linn County where Naloxone materials, STARS pamphlets, and other SUD outreach/awareness materials. Additionally, education and resources were provided to Obria, the Pregnancy Resource Clinic in Albany, the Teen Center, and at the Family Assistance and Resource Center. STARS attended the Live Longer Lebanon meeting in August where community agencies met to discuss SUD resources and events within the communities, educational information was provided to participating individuals by InterCommunity Health Network (IHN) participants who discussed financial assistance to individuals within Rural east Linn County.</p> <p><u>FTRN</u> <u>06/30/2024</u> FTRN provided 8 women with evidence-based Nurturing Parenting curriculum. Parent Café support groups are still being continued and now offered at a local park with children-friendly activities to accommodate mothers who bring their children (weather permitting).</p>

			<p><u>7/01/2024-08/31/2024</u> 7 children and 10 women were provided with educational materials from an evidenced-based Nurturing Parenting curriculum. Parent Café support groups are still being held weekly in Lebanon.</p> <p><u>09/2024</u> Currently Rachel is working with 1 female with 2 children and providing evidence based Nurturing Parenting curriculum. Parent Café support groups are still being held weekly in Lebanon at the Crossroads facility.</p> <p><u>LCAD</u> <u>06/2024-08/31/2024</u> LifeSkills training and education were not able to be provided to elementary and middle school youth in Rural east Linn County because of the school district's summer break.</p> <p><u>09/2024-10/31/2024</u> No updates</p>
lg. FTRN will continue to conduct on-going drug take-back programs throughout the year.	FTRN	Q1-Q12	<p><u>FTRN</u> <u>06/2024 Updates:</u> FTRN primarily uses the Sheriff's station for clients' medication takeback needs, utilizing the Med-Project medication drop box to dispose of unwanted medications.</p> <p><u>07/01/2024-08/31/2024</u> FTRN primarily uses the Sheriff's satellite office located at the courthouse for clients' medical takeback needs while still utilizing the Med-Project medication drop box to rid of unwanted medications. Ongoing). FTRN launched a 17-week SUD Nurturing Parenting curriculum on August 27 and 6 people were in attendance. FTRN will continue to host Weekly Parent Cafes.</p> <p><u>09/01/2024-10/31/2024</u> FTRN continues partnership with the local Sheriff's Office to offer a safe disposal site for unwanted medications. Mail-back envelopes are also available for clients to send medications for safe destruction.</p>
lh. FTRN will continue to provide Nurturing Parents, evidenced-based parent education workshops, and classes for parents and caregivers impacted by SUD/ODU.	FTRN	Q1-Q12	<p><u>FTRN</u> <u>07/01/2024-08/31/2024</u> FTRN launched a 17-week SUD Nurturing Parenting curriculum that began August 27th; 6 people were in attendance. FTRN continues to host the weekly Parenting Café support group.</p> <p><u>09/01/2024-10/31/2024</u> The Nurturing Parenting class in Linn County Continues on Thursdays from 5-7PM along with the Parent Café support group that continues on Wednesdays at 1PM at Crossroads in Lebanon.</p>
li. LCAD Program will continue to provide and expand evidenced-based LifeSkills Training in elementary and middle school classrooms. Lebanon Community School District 9	LCAD RALSTON ACADEMY	Q2, Q3, Q5, Q6, Q7, Q9, Q10, Q11, Q13, Q14	<p><u>LCAD</u> <u>03/2024-08/31/2024</u> LCAD provided the following LifeSkills classes to rural elementary and middle schools: Green Acres 4th Grade: 47 students; 5/3/2024 Hawthorne 6th Grade: 51 students; 5/2/2024</p>

<p>Alternative High School Program, Ralston Academy, will provide prevention training and activities to high school students.</p>			<p>Riverview 4th Grade: 69 students; 4/19/2024 Hawthorne 4th Grade: 42 students; 4/25/2024 Hawthorne 6th Grade: 51 students; 4/23/2024 Hawthorne 6th Grade: 51 students; 4/30/2024 Foster 6th Grade: 45 students; 4/23/2024 Foster 6th Grade: 45 students; 4/25/2024 Foster 6th Grade: 45 students; 4/30/2024</p> <p>09/24/2024 LCAD provided the following LifeSkills classes to rural elementary and middle school youth: Scio 6th Grade: 57 students</p> <p><u>RALSTON ACADEMY</u> 07/01/2024-10/31/2024 Ralston Academy hosted an event to raise awareness about Substance Use Disorder (SUD). The event focused on educating attendees about SUD awareness and prevention, featuring volunteers who shared their insights from lived experiences. RC-SWAY funds were used to purchase sweatshirts promoting SUD awareness.</p>
<p>Ik. Clinicians, Peer Support Specialist, and primary care providers will identify and screen individuals at risk of SUD/ODU and connect them to prevention, harm reduction, early intervention services, referral to treatment and other support services.</p>	<p>SLCH and clinics FTRN STARS CHCBLC</p>	<p>Q1-Q12</p>	<p><u>STARS</u> 06/2024 Updates: STARS PSS conducted 24 new screenings, sent 121 referrals, of which 76 were new referrals, and connected with 21 individuals.</p> <p><u>FTRN</u> 07/01/2024-08/31/2024 FTRN completed 1 screening during the reporting period; there were 4 women who were connected to outside agencies for A&D services.</p> <p>09/2024 In September, 1 ASAM Screening was completed; we continue to connect with outside treatment agencies who provide A&D Services.</p>
<p>Ij. Primary care clinics will continue to implement Screening Brief Intervention and Referral (SBIRT), Alcohol Use Disorder Identification Test (AUDIT), and Drug Abuse Screening Test (DAST) screening for all age-appropriate patients. LCAD will advocate for schools to screen middle and high school youth using the SBIRT.</p>	<p>SLCH and clinics CHCBLC LCAD</p>	<p>Q1-Q12</p>	<p><u>LCAD</u> 08/2024: There have been no updates. LCAD continues advocating for schools to use screening tools like the SBIRT when they consider referring to us for early intervention or treatment. (LCAD does not use SBIRT as they are a treatment organization - LCAD uses other assessment tools)</p> <p>09/01/2024-10/31/2024: LCAD continues advocating for schools to use screening tools like the SBIRT when they consider referring to us for early intervention or treatment.</p>
<p>2d. RC-SWAY will continue to strengthen the service integration model between physicians, mental health providers, dentists, local law</p>	<p>PD-DC SLCH STARS FTRN</p>	<p>Q1-Q4</p>	<p><u>STARS</u> 06/2024-08/2024 STARS PSS maintains ongoing contact with the Maternity Care Coordinator, Gaby Esquivel, at SLCH Labor and Delivery, for L&D referrals. PSS continues to work with the Teen Center and the Boys and Girls Club of</p>

enforcement and service providers to reduce barriers to treatment and recovery.

LCAD
CHCBLC

Lebanon, offering Narcan, providing outreach and education services at local prevention, treatment and recovery events, like Recovery in the Park in Albany. There, the STARS PSS connected with community agencies, including the Jackson Street Youth Authority in Albany, distributed Naloxone flyers and treatment, recovery, detox and residential community contacts for women and youth. PSS continues to support Sweet Home Community Resource Officer Sean Morgan on outings in the community several times a month. Sweet Home PD refers people to STARS. PSS continues to attend monthly Community Court in Sweet Home and assists clients in rural east Linn County. PSS continues to support the FAC Shelter, Pregnancy Resource Center, and other Rural east Linn community agencies to promote a partnership in shared resources and knowledge and reduce the stigma of SUD. STARS PSS regularly attends Live Longer Lebanon meetings and has been invited to participate in the Faith Community Health Network. The PSS continues efforts to support mothers through the HIV Alliance in Salem, connecting them to housing and medication through care coordination. STARS PSS worked with Jackson Street Youth Authority, provided housing, food, cell phones, prevention, treatment, and recovery services to youth, and help them get off the streets. PSS at STARS have been in contact with the Community Resource Officer from Lebanon, Dala Johnson, as well as Sean Morgan from Sweet Home.

09/2024

FTRN

06/2024-08/2024

FTRN continues to work closely with Sweet Home Community Courts and local law enforcement to connect people to local services.

09/01/2024-10/31/2024

FTRN continues to work closely with SH Community Courts and coordinates well with all local resources in connecting clients with those services.

CHCLC

06/2024 Updates:

CHCLC Community Health Worker (Clinic Health Navigator) attends community court to support patients and others who need care coordination through engagement in treatment.

LCAD

08/2024

LCAD partnered with Capitol Dental Care to offer oral health screening and cleaning services, including follow-up recommendations for clients with OHP/IHN. Approximately 12 individuals were provided dental services. LCAD continues to partner with rural law enforcement and other outreach programs to help refer more women and youth struggling with SUD/ODU to available services.

09/2024-10/31/2024

LCAD is working to develop additional supports with the Ralston Academy in Lebanon. The idea is to utilize approximately 25k in RC-SWAY grant funds that was distributed to Ralston Academy, for the purpose of adding additional counseling support for alcohol and drug early intervention and/or treatment. Currently that is being considered by the Linn County Health Services administration.

<p>2e. Peer Support Specialists will conduct outreach efforts to Maternity Care Coordinators to assist pregnant women in navigating the treatment and recovery system.</p>	<p>SLCH, STARS, FTRN</p>	<p>Q2-Q12</p>	<p><u>STARS</u> 06/2024 Updates: STARS PSS connected with the new Maternity Care Coordinator, Gaby Esquivel, at SLCH Labor and Delivery. STARS PSS continues working with SLCH Labor and Delivery despite receiving 0 referrals from MCC or Labor and Delivery since 04/01/2024 due to maternity care coordination staffing changes.</p> <p><u>07/01/2024-08/31/2024</u> The STARS PSS continues working with SLCH L&D MCC to assist women who are referred to the STARS Program. STARS PSS also helps connect pregnant women with local resources to provide the support they need during and after delivery, such as housing, food, and transportation services. Baskets containing maternity wear and infant supplies, such as clothing and bibs, have been provided to women at SLCH L&D and to those served through the STARS Program.</p> <p><u>FTRN</u> <u>06/2024-08/2024</u> FTRN continues providing educational handouts to multiple agencies, supporting women in treatment services, offering transportation, and assisting with appointments.</p> <p><u>09/01/2024-10/31/2024</u> Handouts continue to be provided to multiple agencies. Supporting women in treatment and providing transportation assistance to and form appointments and inform agencies of the Parent Café Support Group.</p>
<p>2f. Peer Support Specialists will conduct outreach efforts to schools and youth serving agencies to assist youth in navigating the treatment and recovery system.</p>	<p>FTRN</p>	<p>Q2-Q12</p>	<p><u>FTRN</u> <u>06/2024</u> FTRN delivered presentations focused on youth at two local schools. Youth PSS Carter continues to engage in the YST panel and connects youth to services that meet their needs.</p> <p><u>08/01/2024-10/31/2024</u> Carter and other FTRN continues to attend the YST panel.</p>
<p>2g. Mental Health/SUD Clinicians will facilitate entry of local middle and high school youth into early intervention and treatment services to reduce stigma.</p>	<p>LCAD RALSTON ACADEMY</p>	<p>Q3, Q12</p>	<p><u>LCAD</u> <u>05/2024</u> LCAD assisted 8 young people in Rural east Linn County, 6 of whom received early intervention services. Although none transitioned into treatment, they are receiving early intervention support services.</p> <p><u>06/2024-08/2024</u> Section 2g: Early Intervention services by month: Hours have been low in east Linn County, partly due to a provider being out on medical leave but also because fewer youth were engaging in services and/or receiving referrals with the end of the school year.</p> <p>March: Early Intervention Hours: 2.08 hours <u>04/2024</u>: Early Intervention Hours: 13.41 hours <u>05/2024</u>: Early Intervention Hours: 5.82 hours <u>06/2024</u>: 0 hours <u>07/2024</u>: 0 hours <u>08/2024</u>: 0 hours <u>09/2024</u>: Early Intervention Hours: 6.62 Hours</p>

			<p><u>RALSTON ACADEMY</u> <u>09/2024-10/31/2024</u> Ralston Academy hosted an event to raise awareness about Substance Use Disorder (SUD). The event focused on educating attendees about SUD awareness and prevention, featuring volunteers who shared their insights from lived experiences. RCSWAY funds were used to purchase sweatshirts promoting SUD awareness.</p>
<p>2j. Peer Support Specialists will assist individual, family and caregiver referrals and connections to home and community-based and social support services available in the community.</p>	<p>STARS FTRN CHCBLC</p>	<p>Q1-Q12</p>	<p><u>STARS</u> June Updates: STARS PSS referred 121 individuals for the following services: treatment services: 21; employment services: 1; prenatal/postpartum: 3; recovery housing: 16; transportation: 7; CARDVA: 2; Mental Health: 5; Community Recovery/agency: 21; referred to Services: 24; connected to Services: 21. <u>July Updates</u> # of connections:104; # of people referred to direct services: 44; # of referrals: 93; # of people connected to services: 39; # of screenings:44 <u>09/2024</u></p> <p><u>FTRN (Receiving Referrals)</u> <u>06/2024-7/31/2024</u> # of referrals from FTRN PSS:4 # of connections from FTRN PSS (people connecting to those services you refer them to):4 # mothers currently receiving services from FTRN: 4 (all are engaged in SUD treatment services, with a combined number of 5 children in the homes). # of connections:104 # of people referred to direct services: 44 # of referrals: 93 # of people connected to services: 39 # of screenings: 44</p> <p><u>08/2024</u> # of connections:5 # of people referred to direct services: 5 <u>09/2024</u> # of referrals from FTRN PSS 32 across all contracts including SWAY and 1 in SWAY with 2 children # of connections from FTRN PSS 32 # of mothers Currently receiving services from FTRN PSS 15 across all contracts # of connections 32 # of people referred to direct services 32 #of referrals 32 # of people connected to services 32 # of screenings 32</p> <p><u>LCAD (Referring Out)</u> <u>03/2024-08/2024</u> Employment Services: 69</p>

			<p>Recovery Housing: 27 Transportation: 19 Mental Health Treatment: 22 Self-Help Groups: 227</p>
<p>3a. Peer Support Specialists will outreach to Linn County Probation and Parole and local residential treatment facilities to connect people to housing and other services.</p>	<p>STARS FTRN</p>	<p>Q2-Q12</p>	<p><u>STARS</u> <u>03/01/2024-08/2024</u> Sean Morgan, Community Resource Officer with the Sweet Home PD, provided 12 referrals to STARS. PSS continues to attend the monthly Community Court in Sweet Home, connecting clients to the STARS program, SUD/OD and BH treatment services, and community resources in Rural east Linn County, such as the FAC Shelter, Pregnancy Resource Center, Hope Center, and other Rural east Linn community agencies. PSS is working towards developing knowledge and partnerships in shared resources, additionally aiming to reduce the stigmas associated with SUD. # of referrals to Childcare services: 0 # of referrals to Employment Services: 7</p> <p><u>FTRN</u> <u>03/01/2024-07/2024</u> FTRN continues to work with the Community court in Sweet Home to help people access SUD/OD resources in Rural east Linn County. We currently have 0 clients we are working with; these numbers fluctuate regularly due to the courts' needs. FTRN continues screening individual needs and providing SUD/OD resources while attending the courts. FTRN receives referrals from the Linn County Jail and meets with and provides services to clients while they are incarcerated.</p> <p><u>07/01/2024-08/01/2024</u> FTRN is currently collaborating with the Community Court in Sweet Home to help people navigate resources in the Linn County area. Although the number of clients we are working with is currently 0, this figure often changes in response to court needs. FTRN is also involved in screening individuals' resource needs while they attend court sessions. Additionally, we have been receiving referrals from Linn County Jail and meeting with clients during their incarceration, aiming to provide them with services upon release.</p>
<p>3b. Peer Support Specialists will be assigned to the SLCH /emergency department, jails, residential treatment facilities and schools.</p>	<p>STARS FTRN</p>	<p>Q2-Q12</p>	<p><u>STARS</u> <u>03/01/2024-08/2024</u> Community Resource Officer Sean Morgan and STARS PSS work together regularly to serve those referred to STARS by Sweet Home PD. PSS is focusing on building stronger relationships with SHS ED staff, both medical and non-medical, to connect with and refer to the STARS program and other treatment and recovery services post-discharge. One of the primary challenges is connecting with patients admitted to the ED or discharged from the ED for SUD/OD. This is due to communication barriers between ED staff and PSS, stigmas associated with receiving help, or PSS being unable to contact the patient directly (phone/email). # of referrals to Childcare services: 0 # of referrals to Employment Services: 7 # of referrals to Prenatal/Postpartum services: 5 # of referrals to Recovery Housing: 37 # of referrals to Transportations to treatment: 31</p>

			<p><u>FTRN</u> <u>03/01/2024-05/31/2024</u> FTRN received 20 referrals from the Linn County Jail. All referred individuals were informed of the available SUD/ODD services. The outreach worker has also worked closely with Linn County Alcohol and Drug to facilitate screening individuals for treatment services. #of connections: 1 # of total referrals: 1 # of people connected to services: 1</p> <p><u>07/01/2024-08/01/2024</u> FTRN has received 9 referrals from Linn County jail all of whom have been informed of A&D services. The outreach worker has also been working closely with Linn County Alcohol and Drug to help get individuals screened for treatment.</p> <p><u>09/2024</u> FTRN received 4 referrals through Linn County Jail all individuals were informed of SUD/ODD services available to them and assisted with local agencies in order to have them screened for SUD diagnosis.</p>
<p>3c. Outreach and train individuals and agency staff to increase the supply of Peer Recovery Coaches and Peer Support Specialists.</p>	<p>FTRN</p>	<p>Q3, Q7, Q11</p>	<p><u>FTRN</u> <u>03/2024:</u> We are waiting for approval from OHA to conduct a 40-hour class to conduct these classes more regularly. We currently have a peer wellness support class scheduled in May and June.</p> <p><u>04/2024</u> FTRN plans to conduct Peer Wellness classes from May 3-15; 20 people signed up for the trainings. PSS training is also scheduled for June 20.</p> <p><u>05/2024</u> FTRN Peer Wellness classes were held from May 3-15; 20 signed up for the training, and 12 attended. FTRN will conduct several Peer Wellness classes, scheduled for 06/04/2024 (expected participants: 11), 7/29/24 (expected participants: 20), 07/26/2024 (expected participants: 20), and 08/09/2024 (expected participants: 20).</p> <p><u>07/2024-08/2024</u> FTRN Peer Wellness classes were held in July and August, 17th</p> <p><u>09/2024-10/31/2024</u> FTRN is not planning on having another Peer wellness class until after the new year at this time.</p>
<p>3d. FTRN Peer Support Group Leader will provide support groups, counseling and mentoring to Peer Support Specialists connected to the project.</p>	<p>FTRN</p>	<p>Q2-Q12</p>	<p><u>FTRN</u> <u>03/01/2024-05/2024</u> Josh Pankau will facilitate meetings that will cover multiple topics, such as “Ethics,” “Dual Roles,” “Conflicts of Interest,” “Self-Care,” “Motivational interviewing,” and “Stages of change.” 5 PSS will continue to attend weekly Peer Wellness classes. Additionally, 15 PSS have received training from STARS and now at the FTRN Multnomah County location. Activities in PSS groups have increased over the</p>

			<p>last six months.</p> <p><u>06/2024</u> FTRN holds weekly Thursday classes for local and non-local peer support with up to 15 attendees with diverse experience.</p> <p><u>07/01/2024-8/01/2024</u> FTRN still conducts classes weekly on Thursdays for all local and non-local peer support. Attendance continues to increase.</p> <p><u>09/2024-10/31/2024</u> Josh Pankau continues to facilitate the peer support group meeting held on Thursdays at 9 am with a wide variety of attendance across all Tri-County</p>
3e. Support FTRN in expanding access of recovery support services.	PD-DC FTRN	Q2-Q12	<p><u>FTRN</u> <u>03/2024:</u> Services remain the same at this time. We are waiting for approval from OHA to conduct a 40-hour class and hope to conduct these classes more regularly. We currently have a peer support class scheduled in May and June.</p> <p><u>04/01/2024-06/2024</u> Services remain the same at this time. FTRN intends to expand early therapeutic services in Sweet Home and Lebanon, with an emphasis on making them more parenting focused. Weekly Peer Wellness classes continue, with 15 PSS receiving training from STARS and the new FTRN location in Multnomah County. Activities in PSS groups have increased over the last six months. FTRN received referrals for 8 mothers (children aged 1-6). PSS connected with and referred them to SUD/ODU and Mental health services.</p> <p><u>07/01/2024-08/01/2024</u> No expansion of services.</p> <p><u>09/2024</u> No expansion of services at this time</p>

CCCWN Oral Health Co-Location Project

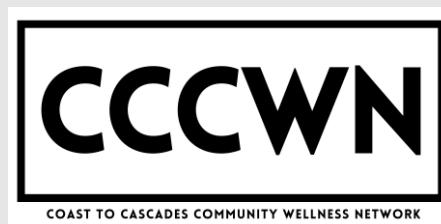
CCCWN Update – November 2024

Reporting Updates

- EPDH has seen 535 patients to date (May 1, 2024 – October 30, 2025) in grant Year 4
 - 274 patients at SPCH
 - 261 patients at SNLH
- EPDH has participated in 7 community outreach events and 3 Medical Teams International dental van events in Lincoln County in grant Year 4 to date.
- Sustainability Report will be due to HRSA by Nov. 15, 2024

Other Updates

- EPDH Leah Hitz will be on maternity leave approximately Nov 22, 2024 – Feb. 14, 2025
 - She has provided key hospital staff with resources for referrals, education materials during her absence.
 - Project Director will work with Capital Dental to identify ways to continue programming.
- AHM Brands is continuing to develop media campaign materials for Spanish-language community members.



Helping Impact Women & Youth (HIWAY)

CCCWN Full Network Meeting Update - November 2024



CCCWN

COAST TO CASCADES COMMUNITY WELLNESS NETWORK

Samaritan North Lincoln Hospital requested \$1,000,000 to implement the Helping Impact Women and Youth (HIWAY) project to reduce morbidity and mortality related to substance use disorder and opioid use disorder in Lincoln County, Oregon. Under direction of the HIWAY consortium, we will strengthen and expand SUD/ODU prevention, treatment, and recovery activities throughout Lincoln County.

Project funding was awarded and began September 1, 2022. The funding was granted for three years and will last till August 31, 2025.

Partners on the project include Samaritan North Lincoln Hospital (SNLH), Samaritan Pacific Communities Hospital (SPCH), Samaritan Medical Group (SMG), ReConnections Counseling (RC), Samaritan House, Inc. (SH), NW Coastal Housing (NWCH), Lincoln County Health and Human Services (LCHHS), Faith, Hope and Charity, Inc. (FHC), Olalla Center (OC), Confederated Tribes of the Siletz Indians (CTSI), Lincoln County Sheriff's Office (LCSO), and Partnership Against Alcohol and Drug Abuse (PAADA).

Updates:

- HIWAY grant partners met on Friday, September 6, 2024 and discussed the questions listed on the Biannual Progress Report (BPR) – Request for Information template.
- HIWAY grant partners submitted data for the BPR and the Performance Improvement Measurement System (PIMS) Report throughout September.
- Both the BPR and PIMS reports were submitted to the Health Resources & Services Administration (HRSA).

Work Plan Highlights _____ = updates

SUD/ODD Activities	Responsible Persons	Timeline	Progress
1i. Partners will develop and distribute culturally and linguistically appropriate education material for family members and caregivers on SUD/ODD prevention, treatment and recovery.	PD/DC, SNLH, CTSI, RCC, FHC, OC, PAADA	Q3, Q7, Q11	<p>In Progress: Educational resource brochures were purchased this year as a way to educate the community on various SUD/ODD topics. The brochures purchased covered the following topics:</p> <ul style="list-style-type: none"> 6 Things Kids Need to Know About Drugs Xylazine: What You Need to Know Opioids & Stigma: Why It Matters and What You Can Do Los opioides y el estigma Naloxone: What You need to know Naloxona: Lo que debe saber Opioid Misuse and Overdose: What friends and family need to know Uso indebido y sobredosis de opioides: Lo que amigos y familiares necesitan saber Opioid Addiction: What everyone should know about treatment and recovery La adicción a opioides: Lo que todos deben saber sobre el tratamiento y la recuperación Dealing with Relapse Vaping, Smoking & Your mental Health Building Resilience and Hope during stressful times The risks of fentanyl & fake pills Los riesgos del fentanilo y las pastillas falsas
1j. Partnerships across the community and region will be leveraged to secure buy-in for project and ensure activities complement and not duplicate existing services. Specific services and activities that will be leveraged to support HIWAY are listed in the Methodology, Foundational Core Activities table.	PD/DC, SNLH, SPCH, SMG, RCC, CTSI LCHHS, OC, FHC, SH, LCSO, PADAA, NWCH	Q1-Q12	<p>PAADA 2024 – Community Education Events. PAADA has worked with partners in Waldport and Toledo to plan and host community education events. Every first Tuesday of the month, there is a presentation that takes place at DaNoble House in Waldport. On each third Tuesday of the month, there is a presentation that takes place at the Trinity United Methodist Church in Toledo. The first class that was offered was presented by Lincoln County Public Health on Xylazine, Fentanyl, and Harm Reduction. Since the start, there have been presentations by Phoenix Wellness on harm reduction and Narcan administration (3/5/2024) and safe storage and disposal of medications (4/1/2024).</p> <p>Faith, Hope, and Charity 2024 - Partnership activity continues to happen in Lincoln County. FHC partners heavily with ReConnections Counseling but has also made connections with the Yaquina Bay Oxford house. FHC has been assisting the houseless community by providing transportation to services, survival gear such as sleeping bags and tents, and food. They have utilized a funding stream to purchase used bikes and have partnered with the Newport Bike Shop to refurbish the bikes and get them running smoothly for clients.</p>
2c. Provide evidenced-based prevention training to coalition youth.	CTSI, OC, PAADA	Q2, Q3, Q5, Q6, Q7, Q9, Q10, Q11	<p>In Progress:</p> <p>The last Youth Leadership Academy, hosted by PAADA, had 43 total attendees with 34 of those being youth. The event took place again at the Center for Health Education in Newport, Oregon. All students attended workshops on Skill Sets vs. Short Cuts, sober parties, and how to engage others in leadership tasks.</p> <p>PAADA has been meeting with the school district to discuss the Fall 2024 Youth Leadership Academy and future academies. Additionally, PAADA hired a new person to take over the 0.5FTE coordinator role for the HIWAY grant. This position is heavily involved with the Youth Leadership Academy planning and the projects that take place at the schools. They are the person going into the schools and meeting with the students. This position is super important as they are the face representing PAADA in the schools and the person who will help with making sure the projects that come out of the YLA are completed. PAADA also received funding from the Oregon Health Authority to do a middle school youth summit for each school, but at a location that is outside of the school building. With funding from the System of Care, PAADA is beginning to look for Juniors and Seniors who could be a part of a Healthy Communities Youth Council. The goal is to have one student from each area throughout the county participate. These youth would then work together to come up with a statement or plan on how the region could become healthier for youth.</p>
2g. LCHHS will coordinate and monitor the purchase and distribution of Narcan.	LCHHS	Q1-Q12	<p>In Progress: 36 boxes of Narcan were distributed to SNLH & SPCH hospital staff/community members during September 2024 Recovery Month tabling.</p> <ul style="list-style-type: none"> 12 boxes were passed out to Inheritance Documentary screening participants on 7/12/2024 at Hatfield. 12 boxes were passed out to Inheritance Documentary screening participants on 7/13/2024 at the Lincoln City Cultural Center. 12 boxes were passed out to community members at the Waldport Hands Across the Bridge event on 9/21/2024. 24 boxes were passed out to community members at the Newport PRIDE event on 9/21/2024.
2h. LCHHS will provide trainings to community and family members on proper use of Narcan and injectable naloxone in multiple languages.	LCHHS	Q4	<p>In Progress: Angell Job Corps Quarterly Resource Fair 8/23/2024</p> <ul style="list-style-type: none"> Board of Commissioners Proclamation and Trainings Session 8/31/2024 PAADA Narcan/Polysubstance Presentation in Waldport 9/7/2024 PAADA Narcan/Polysubstance Presentation in Yachats 9/14/2024

Addressing Violence in Rural Oregon

Communities (AVIROC)

CCCWN Meeting Update –
October 2024



Samaritan Lebanon Communities Hospital requested \$1,200,000 to implement the Addressing Violence in Rural Oregon Communities (AVIROC) project to expand the capacity to improve health outcomes around child abuse, domestic violence, and human trafficking. Through AVIROC, CCCWN/PFH will develop a coordinated approach to addressing these issues by 1) Conducting outreach/education with staff, providers, and the public; 2) Expanding survivor services into our rural and underserved communities.

Project funding was awarded and began July 1, 2023. The funding was granted for four years and will last till June 30, 2027.

Partners on the project include Samaritan Lebanon Communities Hospital (SLCH), Samaritan Pacific Communities Hospital (SPCH), ABC House (ABCH), Acosta Services (AS), Center Against Rape and Domestic Violence (CARDV), Linn-Benton Anti-Trafficking Coalition (LBATC), and Sarah's Place (SP).

Updates:

- *ABC House continues to provide therapy services weekly in-person at the Sweet Home Family clinic.*
- *Center Against Rape and Domestic Violence (CARDV) has started their social media campaign and have new hires to work on the grant!*
- *Acosta Services is working to build an Action Plan to reveal to participants in Spring 2025.*
- *Language Assessment Project completed and findings to be shared at Partners for Health on 11/12.*
- *Bilingual Media Campaign committee finalized details for Partner Toolkit for CCCWN.org website and local marketing on Facebook/Instagram, newspaper ads, audio ads, and billboards in Lincoln and rural Linn Counties.*
- *All reports that have been completed, including carryover requests. Next report is due April 2025.*

Work Plan Highlights:

Quarter 6 (October 1- December 31, 2024)

- Convene monthly meetings of CCCWN/PFH to guide activity coordination among organizations and w/in the Network (ongoing)
- Provide progress reports and project updates to the CCCWN Steering Committee and full CCCWN (8/9, 10/4, 11/29, 2/14, 4/10, 5/15, 6/12, 10/9 and ongoing)
- Provide copies of all required federal reports and documents to the CCCWN Steering Committee and full CCCWN (ongoing)
- Provide counseling for survivors of child abuse at Sweet Home Family Medicine Clinic one day per week (ongoing) Community partner ABC House offers counseling appointments in-person at the new Sweet Home Family Medicine Clinic (started on 2/1/24 at new site).
- Identify ongoing funding opportunities, including eligibility for VOCA and CAMI funding (ongoing)
- Identify best practices in child abuse, domestic violence, and human trafficking prevention and trauma-informed response (ongoing)
- Continue to collect and report data to CCCWN and CCCWN/PFH to ensure continued implementation of and support for strategies that address violence in rural communities (ongoing)
- Conduct classes about sexual violence prevention, including human trafficking, in the context of sexual health education for middle and high school students in rural east Linn Co (Q7) Ongoing facilitating Origins of Violence and Sexual Violence presentations in Middle and High Schools in rural Linn County continues.
- Conduct annual training for CCCWN/PFH members receive training on child abuse, domestic violence, and human trafficking in region (Q5)- Training Schedule: 9/10- ~~CARDV~~, 11/12- Acosta Services, 12/10- Sarah's Place, 1/14-ABC House, and 2/11- Linn/Benton Anti-Trafficking Coalition
- AS, PD, and consultant work with CCCWN/PFH and community to develop Action Plan (Q5-Q8)- Planning for event to rollout the Action Plan
- Provide outreach services and serve as community liaison to connect community members to agencies/services in rural east Linn County (Q5-Q8)- Focus on community presentations, locations for informational materials, and social media posts
- Develop and implement data tools to track incidence of human trafficking identified by participating agencies in Lincoln and east Linn Counties (Q5-Q16)- Currently the Linn-Benton Anti-trafficking Coalition is transitioning to a new chair/leader and activities will pick up once transition is completed.

CCCWN STRATEGIC PLANNING

Draft outline for discussion

I. CCCWN Priority Areas/Community Focus Areas

CCCWN membership has recognized 11 priority areas for community health improvement. These focus areas align significantly with the seven key themes identified in the most recent regional community health assessment. The chart below shows areas of overlap.

CCCWN PRIORITY AREAS	REGIONAL HEALTH NEEDS ASSESSMENT: KEY THEMES
1. Pregnancy prevention and prenatal care.	• Healthy youth and families.
2. Housing.	• Access to affordable housing and houselessness.
3. Chronic conditions.	• Healthy youth and families.
4. Oral health.	• Healthy youth and families.
5. Access to care and workforce.	• Access to quality care.
6. Behavioral health and mental health.	• Mental health.
7. Violence prevention.	• Healthy youth and families.
8. Diversity, equity and inclusion (DEI)	• Diversity, antiracism and equity (IDARE)
9. Food access.	• Food insecurity/access.
10. Tobacco prevention.	• Substance use and misuse.
11. Substance use disorder.	• Substance use and misuse.

CCCWN members have expressed strong support for strengthening and maintaining the alignment of Network priorities with the goals and strategies of regional partners on a three-year cycle. In terms of specific Network priorities over the next three years, CCCWN’s initial strategic planning meeting emphasized four primary focus areas: *Workforce Development*, *Diversity, Equity and Inclusion*; *Mental and Behavioral Health*; and *Substance Use Disorder*. Factors in identifying these priority areas include county, state and regional health assessment data; internal data from Network members and partners; estimates of organizational and systemic capacity; identified disparities and inequities in access to care, quality of care, and health outcomes; public/organizational momentum for change; identified opportunities to address upstream issues; and the Network’s own capacity to serve as an effective partner or leader in driving local, regional and systemic change.

Similarly, CHIP planning have worked with the community to narrow their focus to four areas: *Housing*; *Access to Quality Care*; *Behavioral Health*; and *Inclusion, Diversity, Anti-Racism and Equity (IDARE)*. There is a strong potential to better align CHIP priorities and CCCWN priorities, which often overlap internally and externally.

Workforce

All Network goals rely on developing and retaining a trained and resilient workforce, particularly in the badly understaffed mental and behavioral health fields. Improving access to services without adding adequate workforce will, at best, result in longer waitlists, suboptimal care and worse patient outcomes. DEI/IDARE goals also depend heavily on a diverse and

trauma-informed workforce, especially when it comes to mental and behavioral health care providers; currently, nondominant populations in the tri-county region are too often served by providers who may question or even deny their lived experience of identity-based trauma.

CCCWN WORKGROUP RECOMMENDATIONS

RELATED CHIP STRATEGIES

Workforce should include Oregon Health Plan optimization and supportive services.	
Identify new and emerging regional health care training and workforce opportunities, with a focus on engaging uncounted/unrepresented groups.	<ul style="list-style-type: none"> • IDARE 1.3. Increase the number of culturally and linguistically appropriate service providers by removing institutional barriers and uplifting communities into these roles.
Support new and existing legislation for workforce development.	
Pool funds to support training for Peer Support Specialists, CHW, CADAC, and others.	<ul style="list-style-type: none"> • IDARE 1.3. Increase the number of culturally and linguistically appropriate service providers by removing institutional barriers and uplifting communities into these roles.
Provide staff with lived experience to support workforce members undergoing secondary trauma.	<ul style="list-style-type: none"> • IDARE 2.1. Grow and maintain a healthy behavioral health provider workforce by addressing retention strategies, burnout, and recruitment. Example: For retention and recruitment, support career development opportunities such as internships, mentorships, and culturally specific peer supports. • AQC 1.1. Sustainability – Increase the number of all levels and types of health care providers in the region (and particularly in rural areas). Focus areas include addressing institutional barriers, prioritizing meaningful strategies for recruitment and retention of diverse talent, and exploring innovative ideas to address provider burnout.
Expand peer support into EDs, law enforcement and other agencies.	<ul style="list-style-type: none"> • IDARE 1.3. Increase the number of culturally and linguistically appropriate service providers by removing institutional barriers and uplifting communities into these roles.
Identify sustainable funding sources to maintain staff and programs (e.g., discuss creative payment models with IHN-CCO).	

Strengths and opportunities

- Promising workforce development models include Marion County Medical Assistant Program through Willamette ESD Career Center; the Community Health Workers program at Linn-Benton Community College (LBCC); and Lane County ‘hybrid programs for dental assistants and other providers; and Albany’s para-medicine program.
- Delivery system transformation funding through IHN-CCO has helped fund regional training hubs.

Threats and weaknesses

- New workforce positions may require considerable upfront investment without providing currently billable services.
- Nonprofit and long-term funding opportunities may fall outside the three-year strategic planning window.

Diversity, Equity and Inclusion

DEI/IDARE strategies are crucial to workforce development efforts, the provision and delivery of member and partner services, reaching underserved and/or mistrustful populations, CCCWN’s strategic planning and decision-making, and to the Network’s efforts to expand and sustain its membership. Transforming the health and social services systems to work for all people logically entails transforming CCCWN itself to include under-represented voices and culturally specific advocates and to act on their recommendations (the chart below shows the stages by which dominant-culture organizations typically engage nondominant community members in decision-making and ownership).

The Spectrum of Community Engagement to Ownership

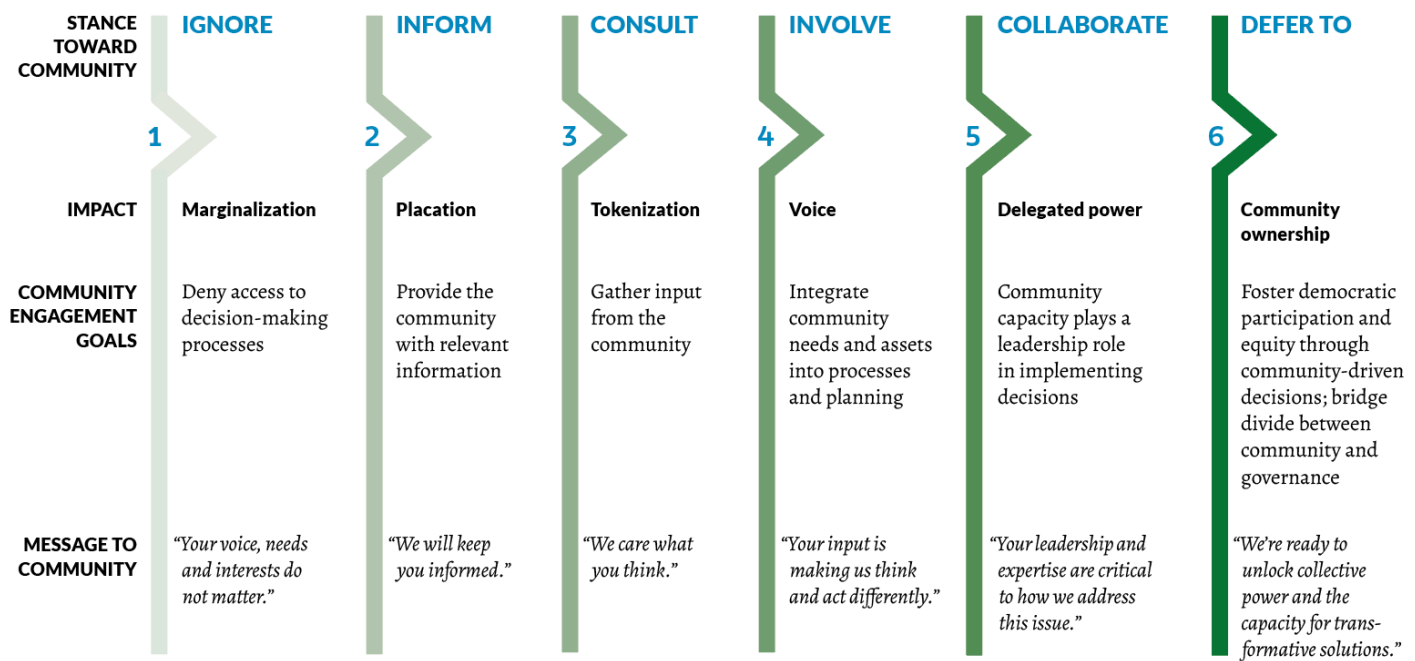


Chart adapted from Community Commons: <https://www.communitycommons.org/entities/3aec405c-6908-4bae-9230-f33bef9f40e1>

CCCWN's initial strategic planning identified the following steps toward transformative—as opposed to superficial, rhetorical or merely performative—DEI work; related CHIP goals and IDARE activities appear in the adjacent column.

CCCWN WORKGROUP RECOMMENDATIONS

Incorporate achievable and accountable EDI goals into the Network's mission and value statements.

Create a request for proposal/memorandum of understanding specifying a percentage of Network funding to be allocated to DEI efforts.

Marketing should communicate DEI values.

Improve data collection relating to underserved and marginalized population and DEI goals (Note: This entails strengthening relationships with culturally specific, community-based organizations; the practice of collecting data without welcoming deeper collaboration from the partners who provide it is a long-time complaint of organizations and advocates serving nondominant populations.)

Identify which currently excluded stakeholders and providers need to be at the table when deciding how to identify and resolve issues of nonrepresentation, barriers to access, historical and ongoing experiences of institutional trauma, and community mistrust. (Note: Partners providing this information should be remunerated and, ideally, have decision-making power. Existing members should recognize and accept that this may entail changing the nature of the "space" in which CCCWN has previously operated.)

RELATED CHIP STRATEGIES

IDARE 2.2. Build accountability measures for providers and community members.

IDARE 1.1.1. Develop community-driven practices which embed equity principles in the removal of institutional barriers.

IDARE 2.3. Provide resources (e.g., funding) and supports to community members around participation in decision-making bodies and advocacy.

IDARE 2.3. Provide resources (e.g., funding) and supports to community members around participation in decision-making bodies and advocacy.

- IDARE 3.1. Change strategies for gathering data to reflect inclusion, diversity, antiracism, and equity and gender justice.
- IDARE 3.2. Centralize and coordinate data collection.
- IDARE 3.3. Disaggregate data using a combination of quantitative (statistical) and qualitative data (people's experiences).
- BH 2.3. Create learning opportunities for providers that increase awareness around cultural competence and the unique health needs of marginalized (under-resourced) communities.

BH 2.3. Create learning opportunities for providers that increase awareness around cultural competence and the unique health needs of marginalized (under-resourced) communities.

IDARE 2.3. Provide resources (e.g., funding) and supports to community members around participation in decision-making bodies and advocacy.

CCCWN WORKGROUP RECOMMENDATIONS

Recognize that some marginalized people will continue to avoid health and social services institutions, and identify ways to deliver the services, resources and education they need through culturally specific partners they already trust. (Note: In many cases, this may entail empowering, trusting and funding these organizations to make their own decisions.)

Engage culturally specific partners and Network members in setting meaningful standards for DEI accountability and maintenance. (Note: To be effective and trustworthy, accountability measures require formal input from end users of the services and their advocates rather than institutional self-policing.)

RELATED CHIP STRATEGIES

- BH 2.2. Reduce barriers of access to care including the physical barriers of transportation, rural and tribal needs, and culturally appropriate and gender-affirming treatment options. Example: Support funding for existing community service providers, CBOs, tribal organizations/support (term TBD), and non-clinical settings.
- IDARE 1.1. Develop community-driven practices which embed equity principles in the removal of institutional barriers.
- IDARE 1.2. Improve equitable access to culturally and linguistically appropriate service (CLAS) providers.
- IDARE 1.3. Increase the number of culturally and linguistically appropriate service providers by removing institutional barriers and uplifting communities into these roles.

- IDARE 2.2. Build accountability measures for providers and community members.

Mental Health/Behavioral Health

CCCWN’s workgroups agreed that although SUD technically falls under this heading, it’s a wide-ranging issue that may have separate resources and goals and therefore requires its own focus area. While this is a somewhat different approach from CHIP, both approaches have similar goals and strategies. The workgroup assigned to the topic identified *youth/families, equity and inclusion, and training opportunities* as significant needs in this area.

Mental/behavioral health issues among marginalized communities are often compounded by experiences of institutional trauma, neglect, abuse, and/or lack of access to respectful and compassionate care within hospitals and other systems. People who don’t feel safe in these spaces are unlikely to seek care from them regardless of their access to or awareness of resources; reaching these patients will likely require increased support for trusted, culturally specific organizations.

CCCWN WORKGROUP RECOMMENDATIONS

Increase trauma-informed, linguistically and culturally appropriate training.

Create workforce retention strategies, especially in rural areas.

Define pathways along the continuum of care to educate providers and community members on where to get appropriate mental/behavioral health services.

RELATED CHIP STRATEGIES

- BH 2.2. Reduce barriers of access to care including the physical barriers of transportation, rural and tribal needs, and culturally appropriate and gender-affirming treatment options. Example: Support funding for existing community service providers, CBOs, tribal organizations/support (term TBD), and non-clinical settings.
- AQC 1.1. Sustainability. Increase the number of all levels and types of health care providers in the region (and particularly in rural areas). Focus areas include addressing institutional barriers, prioritizing meaningful strategies for recruitment and retention of diverse talent, and exploring innovative ideas to address provider burnout.
- IDARE 1.2. Improve equitable access to culturally and linguistically appropriate service (CLAS) providers.

Substance Use Disorder

People with SUD have often experienced trauma, identity-based discrimination and other inequitable treatment, as well as involvement in the criminal justice system. Many of them complain of dismissive, disrespectful, traumatizing interactions with regional providers as well as substandard or inadequate care. Provider bias against people using substances is pervasive enough that even people who do *not* have SUD report being designated by ED staff as “drug-seeking” patients on the basis of what these staff perceive as an “unconventional” appearance.

While eradicating stigma among providers and staff is a necessary step in providing appropriate care, people who hold multiply stigmatized identities or who have experienced egregious mistreatment within the “official” health and social services systems may still be unwilling to see these providers as safe. For these reasons and others—including lack of transportation and the difficulty of navigating support systems—the SUD workgroup emphasized the value of bringing services to people through trusted community-based partners, using such methods as hub-and-spoke mobile providers, one-stop facilities and street outreach.

CCCWN WORKGROUP RECOMMENDATIONS

Meet people with SUD where they are instead of focusing on pulling them into existing systems.

Consistently provide safe, trauma-informed, culturally appropriate services and referrals to people with SUD.

Delegate outreach and services to local community-based organizations that have already built trust with people who have SUD. Fund and support their work without visibly linking it to hospitals, county agencies or law enforcement.

Partners could develop, fund and staff one-stop sites where people can access multiple services and types of assistance (e.g., coordinated care, medication management, housing and food assistance, MAT, harm reduction services, navigation services, mental/behavioral health services, legal assistance, translation/interpretation, and other resources) without having to travel to multiple locations.

Improve pathways for people who connect with recovery services to become peer support specialists or other types of providers or community-based advocates (cf. ReConnections Counseling program in Lincoln County).

RELATED CHIP STRATEGIES

- BH 2.2. Reduce barriers of access to care including the physical barriers of transportation, rural and tribal needs, and culturally appropriate and gender-affirming treatment options. Example: Support funding for existing community service providers, CBOs, tribal organizations/support (term TBD), and nonclinical settings.
- BH 2.3. Create learning opportunities for providers that increase awareness around cultural competence and the unique health needs of marginalized (under-resourced) (term TBD) communities.
- AQC 1.1. Sustainability. Increase the number of all levels and types of health care providers in the region (and particularly in rural areas). Focus areas include addressing institutional barriers, prioritizing meaningful strategies for recruitment and retention of diverse talent, and exploring innovative ideas to address provider burnout.
- o AQC 1.2. Grow an electronic, closed loop referral system between community and clinical services that supports community partners in accessing resources, meeting patient needs, gathering standardized data, and expanding community-based care.
- Create sustainable funding mechanisms for effective community-based care delivery. Examples include establishing reimbursement guidelines and fee schedules.
- BH 2.1. Grow and maintain a healthy behavioral health provider workforce by addressing retention strategies, burnout, and recruitment. Example: For retention and recruitment, support career development opportunities such as internships, mentorships, and culturally specific peer supports. AQC 1.1. Sustainability – Increase the number of all levels and types of health care providers in the region (and particularly in rural areas). Focus areas include addressing institutional barriers, prioritizing meaningful strategies for recruitment and retention of diverse talent, and exploring innovative ideas to address provider burnout.
- IDARE 2.3. Provide resources (e.g., funding) and supports to community members around participation in decision-making bodies and advocacy.
- IDARE 1.3. Increase the number of culturally and linguistically appropriate service providers by removing institutional barriers and uplifting communities into these roles.



**Coast to Cascades Community Wellness Network (CCCWN)
Steering Committee
Held Virtually - Microsoft Teams
2:00 p.m. – 3:00 p.m.
August 14, 2024
Meeting Summary**

Attendance:

Marty Cahill, Maisa Athamneh, Shelagh Baird, Emma Deane, Jeannie Davis, Ed.D., Taylor Gilmour, Sara Hartstein, Wendy Hausotter, Sommer McLeish, Michelle Means, Jolynn Meza Wynkoop, Thien Nguyen, and Shelley Hazelton

Guest:

Brandan Kearney, Consultant

Welcome:

Marty Cahill called the meeting to order and welcomed everyone.

Safety Moment:

Marty Cahill asked if anyone would like to share a safety moment.

- **Taylor Gilmour** – Toward the end of August and first part of September kids are back in school. It will be darker in the mornings and evenings. We want to make sure and wear appropriate safety gear and have a heightened awareness.

Meeting Summary:

The April 10, 2024, and the June 12, 2024, CCCWN Steering Committee meeting minutes were presented. **Wendy Hausotter made a motion and Dr. Jeannie Davis seconded the motion to accept both sets of meeting minutes as presented. The motion was voted upon and unanimously approved.**

Federal/State Grants Reports:

Health Resources and Services Administration (HRSA) Rural Health Care Services Outreach Program Oral Health Co-Location Project Grant Report:

Written reports for the HRSA Rural Health Care Services Outreach Program Oral Health Co-Location Project Grant report were noted and distributed prior to the meeting.

HRSA Rural Communities Opioid Response Program (RCORP) Implementation III Rural Communities Supporting Women and Youth (RC-SWAY) Grant Report:

Written reports for the HRSA RCORP RC-SWAY Grant and Work Plan Highlights were noted and distributed prior to the meeting.

HRSA Rural Communities Opioid Response Program – Implementation (RCORP-I) – Helping Impact Women and Youth (HIWAY) Project Grant for Lincoln County:

Written reports for the HRSA RCORP-I HIWAY Project Grant and Work Plan Highlights were noted and distributed prior to the meeting.

HRSA Rural Health Network Development Grant Addressing Violence in Rural Oregon Communities (AVIROC) Project Update:

A written report for the HRSA Rural Health Network Development Grant Addressing Violence in Rural Oregon Communities Project and Work Plan highlights was noted and distributed prior to the meeting.

Wendy Hausotter made a motion and Dr. Jeannie Davis seconded the motion to approve and accept the HRSA Rural Health Care Services Outreach Program Oral Health Co-Location Project Grant reports, HRSA RC-SWAY Grant reports and Work Plan Highlights, HRSA RCORP-I HIWAY Project Grant reports and Work Plan Highlights, and the HRSA Rural Health Network Development Grant Addressing Violence in Rural Oregon Communities report and Work Plan Highlights as presented. The motion was voted upon and unanimously approved.

Community Health Improvement Plan Process Update:

Sara Hartstein provided a Community Health Improvement Plan (CHIP) update.

- It is a Partnership for Community Health (PCH) for Linn, Benton, and Lincoln Counties.
- Hired a Project Manager and Epidemiologist.
 - a. Amy Young, Project Manager.
 - b. Kate Marsi, Epidemiologist (0.5 FTE)
- High-priority initiatives include:
 - a. Development of operating budget and cost-sharing agreements.
 - b. Community Health Assessment (CHA)/CHIP cycle timeline incorporating all partners' milestones.
 - c. Coordination of agencies working on common strategies.
 - d. Establishing progress measures and goals for community change.
- Samaritan Health Services (SHS) is on a three-year cycle for the Community Health Needs Assessments and CHIP. Local health departments are on a five-year cycle.
- The project is a coordination of agencies working on common strategies.
- PCH website:
 - a. Website planned to host CHA/CHIP reports, data dashboards, and community impact narratives.
 - b. Development on pause until CHIP was drafted.
 - c. Preliminary design and user interface has been designed.
 - d. Content from CHIP report will be adapted as website content.
 - e. Phase 1 of site launch planned for Fall 2024.
 - f. Phase 2 of website launch will include dashboards.
- CHIP components – Making sure health equity is integrated throughout. The Project Manager is fine tuning everything.
- CHIP Strategy Areas:
 - a. **Housing:**
 - Expand housing units.
 - Expand supportive services.
 - Improve housing data.

- b. **Access to Quality Care:**
 - Grow and sustain workforce.
 - Increase Oregon Health Plan (OHP) access and use.
 - Timely, local, and empowering care.
 - c. **Behavioral Health:**
 - Build community resilience.
 - Grow a healthy workforce.
 - Improve care coordination.
 - d. **Inclusion, Diversity, Anti-Racism, and Equity (IDARE):**
 - Improve equity and well-being.
 - Increase education and accountability.
 - Improve data quality.
- Shared Access to Affordable Housing, Access to Quality Care, Behavioral Health, and IDARE – Showing inputs, goals, strategies, progress measures, targeted long-term impact for each.
- Community partners developed goals and strategies.
- Implementation: Action Planning Next Steps:
 - a. Already done:
 - Prioritize issues for the CHIP.
 - Develop a logic model for each goal.
 - b. In progress:
 - Develop shared goals and measures.
 - Write the CHIP.
 - Assign roles and responsibilities for implementation.
 - c. Next steps:
 - Develop an action plan.
 - Develop Strategic, Measurable, Ambitious, Realistic, Time-bound, Inclusive, and Equitable (SMARTIE) objectives.
 - Monitor and evaluate the CHIP.
- **Shelagh Baird** – Community impact narrative – How are you collecting and what are you envisioning?
 - a. **Sara Hartstein** – No plan yet. This is part of where we go next. As partnership, discussing progress measures. Data does not always tell the full story. Need reference to data improvement at community level – Community storytelling to fill in data holes.
- **Taylor Gilmour** – This process is exciting. Starting to capture things and how to tell the story and how this will tie into the CCCWN plan.

CCCWN Name/Logo Standardization:

Jolynn Meza Wynkoop led discussions around the CCCWN name and logo standardization.

- We have noticed in a few different places that our CCCWN title is written differently and the logo as well. We have seen the CCCWN name written as follows:
 - a. Coast to the Cascades Community Wellness Network.
 - b. The Coast to the Cascades Community Wellness Network.
 - c. Coast to Cascades Community Wellness Network.
- Shared different logos. We could look at doing a redesign of the original logo. Noted Rectangle logs with CCCWN in the logo and COAST TO CASCADES COMMUNITY WELLNESS listed underneath or THE COAST TO CASCADES COMMUNITY WELLNESS listed below.

There was one with a black background and white lettering or a white background and black lettering. Also, showed the rectangle logo with waves before the rectangle and mountains after and this was mostly used for marketing purposes.

- Brandan Kearney had redesigned the circular logo with yellow lettering.
- **Sommer McLeish** – Finds that the yellow or red fonts make it difficult to read for those with visual impairments.
- **Sara Hartstein** – Always thought it was Coast to Cascades Community Wellness. Likes this best and all caps underneath can be hard to read. Would use a font that is clear or white.
- **Brandan Kearney** – Why would you need two logos? If you go with the rectangle one, then you could use the same one.
- **Jolynn Meza Wynkoop** – The idea with the rectangle logo originally was for use with pens/marketing. It works better than the round logo.
- **Brandan Kearney** – Do you need the circular logo? With the CCCWN rectangle one, you could tweak the lettering a bit.
- **Taylor Gilmour** – We want to provide consistency and make sure it is consistent with our grant documents.
- The Memorandum of Understanding has the name listed as The Coast to the Cascades Community Wellness Network. Will we need to update since it takes a while to get signatures? *Maisa Athamneh indicated she would follow up with Mary Landis.*
- Committee members present felt like “Coast to Cascades Community Wellness Network” was the best name and we might need to add “The” at the beginning in some situations.

Wendy Hausotter made a motion and Dr. Jeannie Davis seconded to accept the change in name to “Coast to Cascades Community Wellness Network” and that sometimes “The” might need to be added at the beginning in some situations. The motion was voted upon and unanimously approved.

Further discussion followed on the CCCWN logo.

- **Wendy Hausotter** – We may want to stick with one logo.
- **Sara Hartstein** – Agrees with one logo.
- **Brandan Kearney** – The C is close to the W on CCCWN.
 - a. It was noted that is how the font works.
 - b. **Jolynn Meza Wynkoop** – Can look at other font options.
- Examples of the rectangle logo were reviewed further.
- Members present felt like the main logo should be the rectangle logo black/white or white/black and we can use the version with waves and mountains for other marketing type items, etc. This would eliminate the circular logo. An example was listed below.



Wendy Hausotter made a motion and Dr. Jeannie Davis seconded the motion to approve the rectangle CCCWN logo with COAST TO CASCADES COMMUNITY WELLNESS NETWORK listed below as the main logo, black/white or white/black, with the option of using the waves and mountains version for marketing, and other purposes. The motion unanimously passed.

Strategic Planning Debrief/Further Discussion:

Shelagh Baird led discussions around strategic planning.

- At our site visit with our Technical Assistants (TA's) with our grants we worked on developing strategic goals.
- Presented the meeting notes from the May 15, 2024, strategic planning process session.
- Brandan Kearney has put together a “draft” Strategic Plan. *Shelagh will send out and solicit feedback.*
- **Brandan Kearney** – We wanted to make sure and align with the Regional Community Health Assessment and align with Community Health Improvement Plan moving forward.

Coalition Updates:

Linn, Benton, Lincoln Partners for Health (Partners for Health) Update:

Dr. Jeannie Davis provided a Partners for Health update.

- The annual Community Health Summit is scheduled for August 23, 2024, at Linn-Benton Community College (LBCC) Chinook Hall, Corvallis.
- It is a free event that will start at 8:30 a.m. and go until 3:00 p.m.
- Dr. Mandilin Hudson will be the keynote speaker.
- Our theme is “Communities Supporting Youth Together.”
- There is a good variety of workshops looking at the youth population.
- We have 120 open spots and have 100 people registered to date.
- LBCC is a great partner, and we want to recognize them for their contribution to the summit. They are not charging us for rental of the space and just charging for AV/Tech support and housekeeping/cleaning/staff.
- **Thien Nguyen** – Contact him if you would like help with getting registered for the summit - thnguyen@samhealth.org
- Dr. Jeannie Davis noted that medical students do 30 hours of community outreach as part of their graduation requirement. She took issues identified in SHS' Community Health Needs Assessments and let the students choose areas of focus such as homelessness, poverty, etc. Hoping to make an impact in the community through volunteering and impacting those areas of needs identified in the Community Health Needs Assessments.
 - a. **Shelagh Baird** – Could this align with the community impact narratives Sarah Hartstein talked about?
 - b. **Dr. Jeannie Davis** – The medical students do capstone projects on community impact – Can connect moving forward.

Benton, Lincoln, Linn Regional Oral Health Coalition of Oregon (Regional Oral Health Coalition-ROHC) Update:

Shelagh Baird provided a Regional Oral Health Coalition update.

- The Coalition continues to meet quarterly.
- This Coalition meets and oversees the Oral Health Co-Location project. We are in Year 4 of the co-location grant and currently working on the Sustainability Plan. The grant ends April 30, 2025.
 - a. People love the program and having the Expanded Practice Dental Hygienist (EPDH) in the coastal hospitals.
 - b. As mentioned, we are working on the Sustainability Plan and in the early stages. There are some changes coming in Medicare fee schedules and they will start to reimburse for oral health.
 - c. Leah Hitz is the EPDH at the coastal hospitals and is working with Lincoln County OSU Extension Services on events and providing outreach in the communities.

- **Wendy Hausotter** – For the future can we list on the agenda when each grant ends.
 - a. Shelagh Baird – “Yes,” we will note this on future agendas.

Behavioral Health Resource Networks Update:

Committee members reported on the Behavioral Health Resource Networks (BHRNs).

- **Thien Nguyen – Linn County:**
 - a. Things are going well. All partners are familiar with the process and are collaborating.
 - b. September 1, 2024, Michelle Means will step in as the Linn County Coordinator along with her duties on the RC-SWAY Grant. He will then be going to the Lincoln County BHRN only.
 - c. Community Services Consortium will host an All-Staff event in collaboration with other BHRN partners.
 - d. Faith, Hope and Charity sponsored Oregon’s 18th Annual African American Youth Leadership Conference.
 - e. Family Tree Relief Nursery continues to run Peer Support trainings, with 15 trainees having graduated the program on August 9, 2024.
 - f. Representatives from Faith, Hope and Charity and Family Tree Relief Nursery will be hosting workshops at the annual Community Health Summit.
- **Sara Hartstein – Benton County:**
 - a. The request for grant applications for the next round of funding are now open. All existing BHRN providers and others are encouraged to apply. The due date for the applications is early in October and funding is for a 4-year period. No scoring criteria if already funded.
 - b. It looks like there might be more funding allocation for Benton County with the new funding.
 - c. Jennifer Beckner has requested confirmation on the amount because it looked like a decrease for Lincoln County.
 - d. Benton County has begun deflection planning as required by legislation.
- **Shelagh Baird** – Tomorrow there is another pre-proposal webinar at 5 pm.
 - a. August 15, 2024 - 5:00- 6:00 PM
<https://www.zoomgov.com/j/1618428991?pwd=gR2as9QYmYHTvanfv60D1CBQkafEmM.1>
 Meeting ID: 161 842 8991
 Passcode: 611644

Additional Business/Upcoming Event:

Additional business and upcoming events were shared.

- **Jolynn Meza Wynkoop:**
 - a. As part of Recovery Month - SHS will be hosting four screenings of the documentary, “Inheritance,” which is a documentary filmed over 11 years that follows a young boy in poverty-stricken Appalachia. The screenings are for September 10-13, 2024, and will be in Albany, Lebanon, Lincoln City, and Newport. It is an 82-minute film, and we will have community conversation after. The film maker and the main character (boy now age 19) will be here and be part of the community conversation. The documentary will be shown each night from 7:00 p.m. – 9:30 p.m. with the community conversation following the film.
 - b. Also, as part of Recovery Month we will be having tabling events at each of our SHS hospitals and will share materials with staff such as stigma reduction books, swag, stickers, and hopefully will have cookies as well.

These events are as follows:

- September 3, 2024 – Samaritan Albany General Hospital – 11:00 a.m. – 2:00 p.m.
- September 4, 2024 – Samaritan North Lincoln Hospital – 11:00 a.m. – 2:00 p.m.
- September 5, 2024 – Samaritan Pacific Communities Hospital – 11:00 a.m. – 2:00 p.m.
- September 6, 2024 – Samaritan Lebanon Community Hospital – 11:00 a.m. – 2:00 p.m.

Gratitude Moment:

Members were asked if they had a gratitude moment they would like to share.

- Grateful to all who attended the meeting and for those making motions for approval.

Next Meeting:

The next meeting of the CCCWN Steering Committee is scheduled for October 9, 2024, at 2:00 p.m.

Adjourn:

With no further business to discuss, the meeting was adjourned at 3:00 p.m.

Respectfully Submitted,

Shelley Hazelton

Community Health Promotion

The Coast to the Cascades Community Wellness Network
Charter
2015

Article I. Name

Section 1. The name of this group shall be the Coast to the Cascades Community Wellness Network (CCCWN).

Article II. Mission/Vision

Section 1. Mission: To provide leadership to enhance the health of communities through development and support for collaborative regional partnerships and community health programs in Benton, Lincoln and Linn Counties.

Section 2. Vision: The Coast to the Cascades Community Wellness Network leads and sustains a system of partnerships of agencies and organizations working together to provide integrated services and programs to promote individual and community health.

Article III. Organization

Section 1. The CCCWN will consist of a general body of members and a Steering Committee. Committees may be organized to develop and support community health projects.

Article IV. Membership

Section 1. Member partners shall include key leaders and executives that have an interest in issues of the overall health needs for children and adults in Benton, Lincoln and Linn County areas.

Section 2. Membership contributions of the CCCWN are voluntary. Contributions are used to cover meeting materials, meals, room rentals, related activities and grant matching funds. Contributions are not used for staff or administration.

Article V. Steering Committee

Section 1. The Steering Committee will be developed from the body of the CCCWN and have representation of one person from each county.

Section 2. The Steering Committee is responsible for the overall direction of the CCCWN.

Section 3. The Steering Committee will meet to develop agenda and review activities of the CCCWN.

Section 4. Members shall actively participate in CCCWN meetings each year.

Article VI. Officers

Section 1. The CCCWN shall have a Chairperson.

Section 2. The Chairperson shall be nominated and elected by the CCCWN.

- Section 3. The Chairperson shall preside over all CCCWN meetings and serve on the CCCWN Steering Committee.
- Section 4. In the event the Chairperson is unable to attend the CCCWN meeting, the chairperson will contact staff or a Steering Committee member within 24 hours to preside over the meeting.
- Section 5. Terms of office shall be reviewed annually.

Article VII. Meetings

- Section 1. The CCCWN shall meet two times a year. Official business will include but not limited to: reports, discussion of projects and goals, funding and grant opportunities and any additional activities surrounding overall health in the region. The meetings will rotate between each of the counties to include Benton, Lincoln and Linn.
- Section 2. The Steering Committee will meet every other month. The Steering Committee will set the agenda, review programs and activities, and identify projects for the CCCWN. The Steering Committee can meet via email or other electronic options.

Article VIII. Staffing

- Section 1. Staffing of the CCCWN will be provided by Samaritan Health Services Community Health Promotion.
- Section 2. Staff shall work with the chair to develop and distribute the agenda, meeting summaries, and other information that is of interest to the CCCWN. Staff will also schedule meeting locations that will include conference calling capabilities.

Article IX. Roles & Responsibilities

- Section 1. The CCCWN Steering Committee will review and approve all items to be forwarded to the full CCCWN.
- Section 2. The CCCWN Steering Committee will review and approve grant and foundation applications that will be forwarded to the full CCCWN.
- Section 3. The CCCWN will review and approve all reports, assessments and plans that are required by local organizations and agencies.
- Section 4. The CCCWN will review and approve all grant and foundation applications that are requested by local organizations, agencies, and members.
- Section 5. The CCCWN Chair will endorse requested letters of support that align with the vision and mission of the CCCWN.

Adopted: July 31, 2013

Revised: May 27, 2015



CCCWN Meeting
 Measure 110 Behavioral Health Resource Network (M110 BHRN)
 Linn County
 November 2024

Seven community-based and governmental organizations are working together to support individuals actively using substances or diagnosed with substance use disorder in Linn County. Organizations are providing services to individuals in the areas of Peer Support Services, Screenings and Behavioral Health Needs, Low Barrier Substance Use Treatment, Housing Services, Harm Reduction Services and Supported Employment Services. While the target populations are individuals who identify as Black, Latinx, Native American, LGBTQIA2S+, Asian, Pacific Islander, houseless, incarcerated, veterans, and anyone qualifies who has lived with the experience of SUD/OD.

Partners on the project include Albany Comprehensive Treatment Center (Albany CTC), CHANCE Recovery, Community Services Consortium (CSC), Emergence Addiction Counseling and Education Services of Albany, Faith Hope and Charity (FHC), Family Tree Relief Nursery (FTRN) and Samaritan Treatment and Recovery Services (STARS).

Reporting Updates:

- Q3, Report 7 (data: 01/01/2023-03/31/2023) was submitted to OHA on Jul 8th, 2024.
- Q4, Report 8 (data: 04/01/2023-06/30/2023) was submitted to OHA October 15th, 2024
- Q5, Report 9 (data: 07/01/2023-09/30/2023) will be submitted to OHA by January 15th 2024.

BHRN Media Campaign

- BHRN continues collaborative outreach efforts with the HI-WAY and RC-SWAY grants.

Partner Updates:

CHANCE:

- CHANCE opened five respite beds at their shelter, funded by RCSWAY and IHN, to support individuals experiencing homelessness and in rehabilitation. A ribbon cutting ceremony took place on Tuesday, and the beds will be operational this week.

STARS

- PSS Kandyce Stirman is no longer a peer at STARS as of 09/27/2024.