Coast to Cascades Community Wellness Network
STEERING COMMITTEE
October 9, 2024
2:00 pm
Virtual - Microsoft Teams Meeting
Agenda

Topic	Disposition	Lead
Welcome		Shelagh Baird
Safety/Reliability Moment		
Meeting Summary	Approve	Shelagh Baird
August 14, 2024		
Federal/State Grants Reports (Consent)	Approve	
Oral Health Co-Location - (Ends April 30, 2025)		Linda Mann/Shelagh Baird
Supporting Women & Youth - (Ends February 28, 2025)		Michelle Means
Helping Impact Women & Youth - (Ends August 31, 2025)		Jolynn Meza Wynkoop
Addressing Violence In Rural Oregon - (June 30, 2027) Communities		Sommer McLeish
Language Assessment Project	Information	Luis Acosta
Community Health Improvement Plan Process Update	Information	Sara Hartstein Taylor Gilmour
Strategic Planning Further Discussion	Information	All
Coalition Updates	Information	
Partners For Health		Dr. Jeannie Davis
Mental Health/SUD		Jennifer Beckner
Regional Oral Health		Shelagh Baird
Behavioral Health Resource Networks	Information	
Lincoln County - (Ends June 30, 2025)		Jennifer Beckner
Linn County - (Ends June 30, 2025)		Michelle Means
Benton County - (Ends June 30, 2025)		Sara Hartstein
Next Meeting – December 11, 2024-CCCWN Steering Comm	Information	
CCCWN Meeting – November 6, 2024 – SLCH		All
2025 Meetings – Do we want to keep 2nd Wednesday of every other month – 2 pm (2/12/25, 4/9/25, 6/11/25, 8/13/25, 10/8/25, 12/10/25)	Information	All
Gratitude Moment/Adjourn:	Information	All

Microsoft Teams meeting

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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:
Witten 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 contact.
    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

CCCWN Oral Health Co-Location Project

CCCWN Update – October 2024

Reporting Updates

- Grant Year 4 began May 1, 2024
    - EPDH has seen 464 patients at SPCH, SNLH in Yr 4 to date (May 1 – October 4, 2024)
    - EPDH has participated in 6 outreach events:
        - 3 Medical Team International dental van events
        - Provided education and outreach at 3 Spanish-speaking “walking group” events coordinated by OSU-EXT
- Carryover request for $78,577 of unspent Year 3 funds was approved by HRSA
- Sustainability Report due to HRSA by Nov. 15, 2024

Other Updates

- EPDH Leah Hitz continues to see patients 0.5 FTE at each SPCH and SNLH
    - EPDH will be on maternity leave for 12 weeks starting mid-November 2024
- EPDH continues to conduct outreach and education with community partners throughout Lincoln County
- AHM Brands has developed a script for a Spanish-language video for the Yr 4 media campaign
- Project Director attended the Oregon Rural Health Conference in Bend, OR October 2-4

CCCWN Steering Committee Update
Rural Communities Supporting Women & Youth (RCSWAY)

October 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/OUD 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:

- Due to HRSA June 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.
- RCSWAY funds allocated to purchase bus passes for women served at Samaritan Lebanon Community Hospital, Labor and Delivery, and STARS were successfully utilized to support women.
- Ralston Academy, an alternative high school program a part of the Lebanon School District, received RCSWAY funding to offer evidence-based LifeSkills Training for high school-aged youth. Treatment and recovery resources will be available to students, families, and caregivers.

RC-SWAY Work Plan

Overarching Goal: Reduce morbidity and mortality of substance use disorder (SUD), including opioid use disorder (OUD), in rural Linn County.								
Goal 1: Strengthen and expand SUD/OUD prevention services in rural Linn County.								
Objective	**Activity Number**	**Activities**	**Improvement to health care delivery**	**Deliverable**	**Responsible persons**	**Timeline**	**Progress**	**Details**
Develop and implement all five core prevention activities by February 28th, 2025.	1c	FTRN, STARS, LCAD, CHCLBC, will develop and distribute culturally and linguistically appropriate education material for family members and caregivers on SUD/OUD prevention, treatment and recovery.	Improve knowledge of family members and caregivers around SUD/OUD, reduce stigma and increase ability to access care	# of education materials developed and distributed	FTRN STARS LCAD CHCLBC	Q1-Q12	In Progress	STARS 07/2024-08/2024 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. FTRN 7/01/2024-08/01/2024 7 children and 10 women were provided with EDU materials from an evidenced-based Nurturing Parenting curriculum. Parent Café support groups are still being held weekly in Lebanon.

								LCAD 06/2024-08/2024 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.
	1h	FTRN will continue to provide Nurturing Parents, evidenced-based parent education workshops, and classes for parents and caregivers impacted by SUD/OUD.	Reduce child abuse rates and incidents of emergency department visits	# of classes and workshops offered # of participants attend classes and workshops	FTRN	Q1-Q12	In Progress	FTRN 07/01/2024-08/2024 FTRN launched a 17-week SUD Nurturing Parenting curriculum, beginning on August 27th and 6 people were in attendance. FTRN continues to host weekly Parent Cafes.
	1j	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	Increase the number of individuals with or at risk of SUD/OUD who are referred to treatment programs	# of screenings conducted	SLCH and clinics CHCBLC LCAD	Q1-Q12	In Progress	SLCH & Clinics 06/2024-08/2024: # of screenings conducted: 996

		middle and high school youth using the SBIRT.						
	1k	Clinicians, Peer Support Specialist, and primary care providers will identify and screen individuals at risk of SUD/OUD and connect them to prevention, harm reduction, early intervention services, referral to treatment and other support services.	Increase number of individuals with or at- risk of SUD/OUD who are referred to treatment programs	# of screenings conducted # of referrals # of connections	SLCH and clinics FTRN STARS CHCBLC	Q1-Q12	In Progress	SLCH & Clinics 06/2024-08/2024 (including STARS) # of screenings conducted: 996 # of referrals: 152 FTRN 07/01/2024-08/2024 FTRN completed 1 screening during the reporting period; there were 4 women who were connected to outside agencies for A&D services.
Goal 2: Strengthen and expand SUD/OUD treatment services in rural Linn County.								
Develop and implement all seven core treatment activities by August 31,	2a	Individuals at risk of infectious complication, including HIV, viral hepatitis, and endocarditis, will be screened, tracked, and	Increase number of individuals with or at risk of infectious complications who are referred to treatment	# of screenings # of referrals	SLCH and clinics CHCBLC	Q1-Q12	In Progress	STARS 06/2024-08/2024: # Patients with a diagnosis of SUD who were screened for HIV/AIDS: 99 # Patients screened for HCV: 104

2024.		referred to treatment.						
	2d	RC-SWAY will continue to strengthen the service integration model between physicians, mental health providers, dentists, local law enforcement and service providers to reduce barriers to treatment and recovery.	Improve coordination of services for women and youth with SUD/OUD	Service integration model implemented in the community	PD-DC SLCH STARS FTRN LCAD CHCBLC	Q1-Q4	Complete	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. STARS 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 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. LCAD August 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/OUD to available services.
	2e	Peer Support Specialists will conduct outreach efforts to Maternity Care Coordinators to assist pregnant women in navigating the treatment and recovery system.	Improve access to treatment and recovery programs for pregnant women	# of pregnant women provided assistance	SLCH STARS FTRN	Q2-Q12	In Progress	FTRN 06/2024-08/2024 FTRN continues providing educational handouts to multiple agencies, supporting women in treatment services, offering transportation, and assisting with appointments. STARS 07/2024-08/2024 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.

	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.	Improve access to services and community support for women, families, caregivers, and youth with SUD/OUD	# of people who are referred to services # of people connected to services	STARS FTRN LCAD CHCBLC	Q1-Q12	In Progress	FTRN (receiving referrals) 08/2024 # of connections:5 # of people referred to direct services: 5 LCAD (referring out) 03/2024-08/2024 Employment Services: 69 Recovery Housing: 27 Transportation: 19 Mental Health Treatment: 22 Self-Help Groups: 227 STARS 03/2024-08/2024 # 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 # of referrals to CARDV: 5 # of referrals to Mental Health Treatment: 3 # of referrals to Community Recovery: 23 # of people who are referred to services: 41 # of people connected to services: 152

Goal 3: Strengthen and expand SUD/OUD recovery services in rural Linn County.								
Develop and implement all three core recovery activities by August 31, 2024.	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.	Improve access to services and support for individuals within the justice system and residential treatment facilities	# of people connected to services	STARS FTRN	Q2-Q12	In Progress	FTRN 07/01/2024-08/01/2024 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. STARS 03/01/2024-08/2024 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/OUD 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 # of referrals to Prenatal/Postpartum services: 5 # of referrals to Recovery Housing: 37 # of referrals to Transportations to treatment: 31 # of referrals to CARDV: 5

								# of referrals to Mental Health Treatment: 3 # of referrals to Community Recovery: 23 # of people who are referred to services: 41 # of people connected to services: 152
	3b	Peer Support Specialists will be assigned to the SLCH /emergency department, jails, residential treatment facilities and schools.	Peer support services available on-site to facilitate entry into treatment, increase number of people entering SUD / OUD treatment	# of contacts # of referrals # of connections	STARS FTRN	Q2-Q12	In Progress	STARS 03/01/2024-08/2024 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/OUD. 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 # of referrals to CARDV: 5 # of referrals to Mental Health Treatment: 3 # of referrals to Community Recovery: 23 # of people who are referred to services: 4 1# of people connected to services: 152 FTRN 07/01/2024-08/01/2024 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

	3c	Outreach and train individuals and agency staff to increase the supply of Peer Recovery Coaches and Peer Support Specialists.	Increase in peer support workforce, increase support for people with SUD/OUD	# of people trained	FTRN	Q3, Q7, Q11	In Progress	FTRN 07/2024-08/2024 FTRN Peer Wellness classes were held in July and August, 17 participants graduated as THWs and CRM.

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/OUD 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/OUD Activities	Responsible Persons	Timeline	Progress
1i. Partners will develop and distribute culturally and linguistically appropriate education material for family members and caregivers on SUD/OUD prevention, treatment and recovery.	PD/DC, SNLH, CTSI, RCC, FHC, OC, PAADA	Q3, Q7, Q11	**In Progress:** Educational resource brochures were purchased this year as a way to educate the community on various SUD/OUD topics. The brochures purchased covered the following topics: 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 opioids 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	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). 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.
2c. Provide evidenced-based prevention training to coalition youth.	CTSI, OC, PAADA	Q2, Q3, Q5, Q6, Q7, Q9, Q10, Q11	**In Progress:** 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. 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.
2g. LCHHS will coordinate and monitor the purchase and distribution of Narcan.	LCHHS	Q1-Q12	**In Progress:** 36 boxes of Narcan were distributed to SNLH & SPCH hospital staff/community members during September 2024 Recovery Month tabling. 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	**In Progress:** Angell Job Corps Quarterly Resource Fair | 8/23/2024 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 Steering Committee Meeting Update – August/ September 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 new Sweet Home Family clinic and have increased hours for year 2.
- *Center Against Rape and Domestic Violence (CARDV)* will focus on networking and sharing information in rural Linn Co to increase awareness of services.
- *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 CCCWN on 10/9
- Media Campaign committee finalizing details for Partner Toolkit for CCCWN.org website
- Upcoming reports that have been completed and submitted: Evaluation Plan, Dashboard, and PIMS.

Work Plan Highlights:

Quarter 5 (July 1- September 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 (Q3) Ongoing facilitating Origins of Violence and Sexual Violence presentations in Middle and High Schools in rural Linn County continues.
- ☐ 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.	• 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, CADC, and others.	• 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.	• 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.	• 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

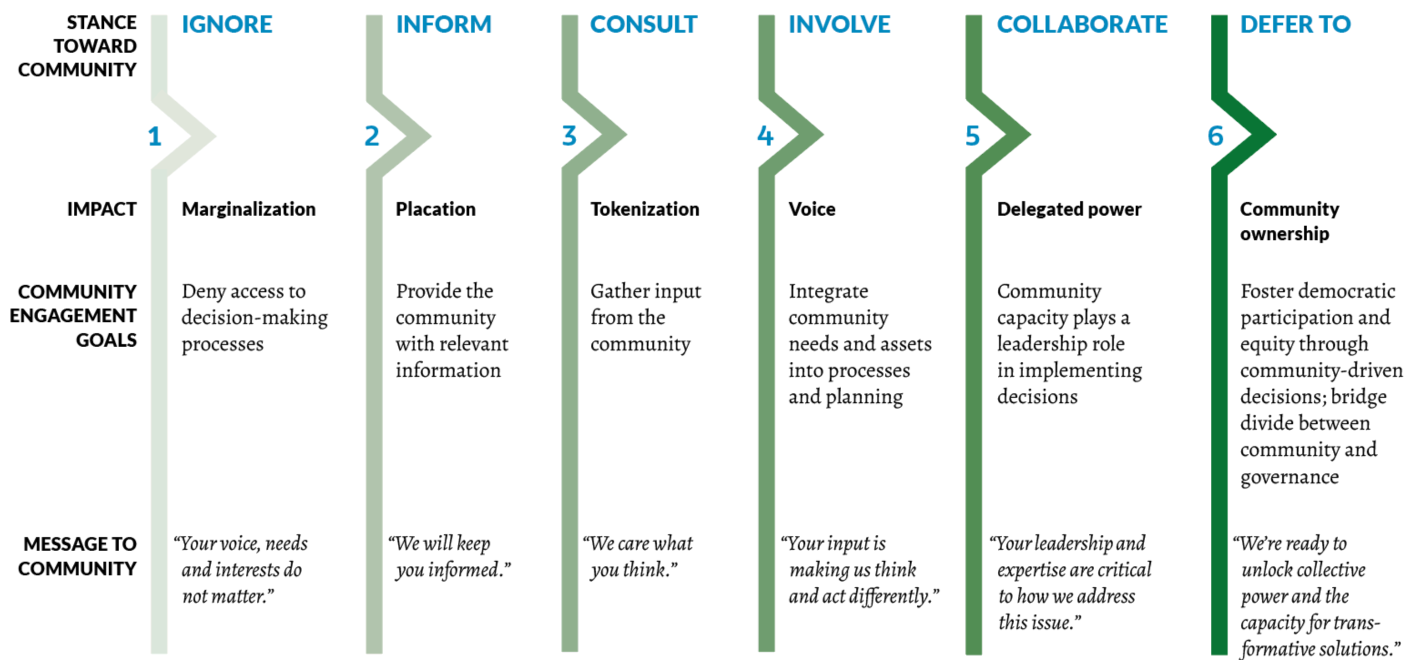

Chart adapted from Community Commons: https://www.communitycommons.org/entities/3aec405c-6908-4bae-9230-f33bef9f40e1

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	RELATED CHIP STRATEGIES
Incorporate achievable and accountable EDI goals into the Network's mission and value statements.	IDARE 2.2. Build accountability measures for providers and community members. IDARE 1.1. Develop community-driven practices which embed equity principles in the removal of institutional barriers.
Create a request for proposal/memorandum of understanding specifying a percentage of Network funding to be allocated to DEI efforts.	IDARE 2.3. Provide resources (e.g., funding) and supports to community members around participation in decision-making bodies and advocacy.
Marketing should communicate DEI values.	IDARE 2.3. Provide resources (e.g., funding) and supports to community members around participation in decision-making bodies and advocacy.
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.)	• 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.
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.)	• 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	RELATED CHIP STRATEGIES
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.)	• 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.
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.)	• 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	RELATED CHIP STRATEGIES
Increase trauma-informed, linguistically and culturally appropriate training.	• 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.
Create workforce retention strategies, especially in rural areas.	• 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.
Define pathways along the continuum of care to educate providers and community members on where to get appropriate mental/behavioral health services.	• 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	RELATED CHIP STRATEGIES
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.	• 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.
Improve pathways for people who connect with recovery services to becomes peer support specialists or other types of providers or communtiy-based advocates (cf. ReConnections Counseling program in Lincoln County).	• 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.

CCCWN Steering Committee Update

Measure 110 Behavioral Health Resource Network (M110 BHRN)

Linn County

October 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/OUD.

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:

- BHRN Report 7 was submitted to the OHA on Jul 8, 2024.
- BHRN Report 8 will be submitted to the OHA Oct 15, 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 Jubal Johnson met with CHANCE and Helping Hands to continue outreach and coordination of care efforts. PSS referred clients to the Buckley Detox Center and the Pacific Crest Detox Center (located in Milwaukee).
- PSS Kandyce Stirman is no longer a peer at STARS as of 09/27/2024.