Coast to Cascades Community Wellness Network

May 15, 2024 - 10:00 am
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
10:00 am	Welcome/Introductions		Marty Cahill
10:05 am	Introduction- Coleman Tanner Alicia Casey		Marty Cahill
10:10 am	Meeting Summary 11/29/2023	Action	Marty Cahill
10:10 am	Consent Calendar Federal Grants Reports HRSA RC-SWAY HRSA Oral Health Co-Location HRSA HIWAY HRSA AVIROC	Action	Marty Cahill
10:15 am	Regional Health Assessment Update	Information	Sara Hartstein
10:30 am	Strategic Planning Process		Coleman Tanner Alicia Casey
12:00 pm	Lunch		
12:30 pm	Strategic Planning Process		Coleman Tanner Alicia Casey
1:45 pm	Finalize Strategic Planning Process		
2:00 pm	Announcements/Adjourn		

Microsoft Teams meeting

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Coast to Cascades Community Wellness Network (CCCWN)
Fall Meeting
Virtual Option – Microsoft Teams
10:00 a.m. – 2:00 p.m.
November 29, 2023
Meeting Summary

Attendance: Marty Cahill, Sara Andersen, Kayla Armstrong, Bruce Butler, Mica Contreras, Jeannie Davis, Ed.D., Emma Deane, Bryan Decker, Taylor Gilmour, Sara Hartstein, Wendy Hausotter, Laura Hennum, Daniel Keteri, Curtis Landers, Lincoln County Sheriff, Jennifer Meckley, Lacey Mollel, Ruby Moon, Todd Noble, Lesley Ogden, M.D., Jayne Romero, Toby Winn

Staff/Grant Representatives: Maisa Athamneh, Shelagh Baird, Jennifer Beckner, Todd Jeter, Molly Gelinas, Sommer McLeish, Jolynn Meza Wynkoop, JoAnn Miller, and Shelley Hazelton

Guests: Paulina Kaiser, PhD, Dusti Linnell, PhD, Extension Service, Family and Community Health, Sandi Phibbs, PhD, MPH, OSU Center for Health Innovation

Welcome:
Marty Cahill called the meeting to order at 10:00 a.m. and led introductions.

Meeting Summary:
The meeting summary of May 24, 2023, was reviewed and presented. **Wendy Hausotter made a motion and Bruce Butler seconded the motion to approve the May 24, 2023, meeting summary as presented. The motion was voted upon and unanimously approved.**

Consent Calendar:
Federal/State 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. A funding proposal for LifeSkills, Prevention, and Early Intervention/Treatment for the Implementation III RC-SWAY Grant – Year 3 was also noted.

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. This grant addresses violence in rural communities with a focus on child abuse, domestic violence, and human trafficking in Lincoln and east Linn Counties.

Lacey Mollel made a motion and Dr. Jeannie Davis seconded to approve the consent updates and reports for the HRSA RC-SWAY Grant and Funding Proposal, HRSA Rural Health Care Services Outreach Program Oral Health Grant, the HRSA RCORP-I HIWAY Project Grant, and the HRSA Addressing Violence in Rural Oregon Communities Grant. The motion was voted upon and unanimously approved.

Media Campaign/Website:
Jolynn Meza Wynkoop shared information on the grant's media campaign and CCCWN website.
Media Campaign:

- Media campaign background:
    a. The media campaign focuses on reducing stigma associated with accessing services for mental and behavioral health issues.
    b. Grant Funding: Behavioral Health Resource Network (BHRN) – Lincoln and Linn Counties, Helping Impact Women and Youth (HIWAY) – Lincoln County; and Rural Communities Supporting Women and Children (RC-SWAY) – East Linn County.
    c. The goal is to reach marginalized communities: Women, youth, individuals struggling with Mental Health/Substance Use Disorder (SUD)/Opioid Use Disorder (OUD), Black, Indigenous, People of Color (BIPOC), Latinx/o/a, and LGBTQIA2S+.
    d. The media kick off will be early to mid-December.
- A survey went out to partners asking for feedback on what they would like to see as part of the campaign. We wanted to make sure to include empowering language, education, prevention, and stigma reduction. Survey questions and responses were shared. Summary: Direct individuals to services (Behavioral Health Resource Network services), spread message of empowerment and hope, and reduce stigma surrounding mental and behavioral health issues.
- Initial steps:
    a. Began working with AHM Brands in early summer 2023.
    b. Available funds from RC-SWAY Grant, HIWAY Grant, and Linn and Lincoln County BHRNs.
    c. Set budget:
        - Youth Focused Campaign $61,006.00
        - Adult Focused Campaign $95,806.00
- Proposed media tactics:
    a. Streaming audio – social media.
    b. Streaming video – social media.
    c. YouTube.
    d. Digital display.

e. Billboards.
f. High profile TV.
g. Broadcast radio.

- We involved community partners and included Araceli Cuevas, ReConnections Counseling and family, and Carter Kachel, Family Tree Relief Nursery, and family in our billboards, radio ads, and TV ads. Jolynn Meza Wynkoop shared an example of what the billboards and social media ads might look like. They have our CCCWN logo and with the message of "Prevent, Treat, and Recover" – LinnBentonLincolnRecover.com followed by Behavioral Health Resource Network. Also with social media, there is a shared button that a person can click on that will take you to a mobile version.
- Videos – Will be displayed as TV commercials as well as on YouTube and social media platforms as ads. There isa a 30-second adult campaign video and a 30-second youth campaign video along with a 60-second adult campaign video and a 60-second youth campaign video. Jolynn Meza Wynkoop shared the 30-second video of Araceli Cuevas and family and the 30-second video of Carter Kachel and family.
- The radio ad will be broadcast across the tri-county region and will be shared in English and Spanish. There will be 30-second and 60-second adult and youth ads for Lincoln County and the Mid-Willamette Valley.
- Additional photography was shared of Carter Kachel/family and Araceli Cuerva/ family.
- We want to be able to direct individuals and families to our CCCWN webpage - LinnBentonLincolnRecover.com
- Our website is not yet live to the public.
- The videos will be available on the website under the Recover heading and information on the BHRN and brochure, outline of BHRN referral services, list of services provided, services based on location, regional partners contact information, BHRN county coordinators, prevent, treat, recover – toolkit, and regional partners.

Website:

- Is working with Miao Zhao, website developer, to revamp the CCCWN network.
- Jolynn Meza Wynkoop shared what the current website looks like.
  a. Home
     - Will talk about us, CCCWN events, supporting partners, in the news, Vision, events/trainings/conferences, different Oregon and federal update, resources, partners
  b. About Us
     - Organizational structure, Building Healthier Communities, partners, collaborative documents, and meeting minutes
  c. Programs
     - Healthy eating, oral health, substance use disorders
  d. Coalitions
     - Regional Mental Health/SUD
     - Oral Health
     - Partners for Health
  e. Recover
     (As listed above – About BHRN, referral categories, referral locations)
  f. 5210
     - 5210 (5 or more servings of fruits and vegetables; 2 or fewer hours of recreational screen time per day; 1 or more hours of physical activity per day; and 0 sweetened beverages) and shares information about the 5210 challenge

- **Jennifer Beckner** – How soon before it "goes live?"
    a. **Jolynn Meza Wynkoop** – Recover page will "go live" when we get the rest of the media materials with the hope of within a few weeks and looking at January for going live with additional pages being added after that.

Rural Communities' Responses to the Opioid and Fentanyl Crisis:
Dr. Dusti Linnell and Dr. Sandi Phibbs reported on rural communities' responses to the opioid and fentanyl crisis.

- In 2022, the OSU Center for Health Innovation conducted a needs assessment for the 16-county Oregon-Idaho High Intensity Drug Trafficking Area (HIDTA) with funding from the University of Baltimore Center for Drug Policy and Prevention. Funded by sub-award from University of Baltimore, through Combatting Overdose through Community-Level Intervention initiative supported by the CDC and the White House Office of National Drug Control Policy (Grant #G2099ONDCP06A).
- **The following evidence-based practices to reduce overdose were noted:**
    a. Communication or intelligence sharing between public health and public safety in communities.
    b. Data flow/data sharing between public health and public safety.
    c. Overdose reduction task force.
    d. Drug prevention education for youth.
    e. Academic detailing (education or training of healthcare providers on prescribing best practices).
    f. Hotlines or Text-lines (e.g., Lines for Life or Crisis Text Lines).
    g. Drug court (Treatment court, community court, or criminal deferment).
    h. Targeted Naloxone distribution.
    i. Rapid response teams for overdose or mental health (e.g., Cahoots, Portland Street Response).
    j. 911 Good Samaritan Law.
    k. Needle exchange or syringe services.
    l. Medication assisted treatment (MAT).
    m. Elimination prior-authorization requirements for Opioid Use Disorder treatment medications.
    n. Initiating Buprenorphine-based MAT in the Emergency Department (ED).
    o. Screening for Fentanyl or poly substance use in toxicology testing.
    p. Naloxone distribution in Emergency Departments, treatment centers, and criminal justice settings.
    q. MAT in criminal justice settings and upon release.
- Half or more of respondents said the following evidence-based practices/happenings ***are being implemented***:
    a. Hotlines/text lines (e.g., Lines for Life, 988, AgriStress Helpline).
    b. 911 Good Samaritan laws.
    c. Needle exchange and syringe services.
    d. Naloxone/Narcan distribution.
    e. Medication Assisted Treatment (MAT).
    f. Communication or intelligence sharing between public health and public safety in communities.
    g. Data sharing between public health and public safety.
- Half or more respondents noted these evidence-based practices ***were not being implemented or were unsure:***

a. Overdose reduction task force.
b. Naloxone distribution in Emergency Departments, treatment centers, and criminal justice settings.
c. Screening for Fentanyl or poly substance use in toxicology testing.
d. Eliminating prior authorization requirements for opioid use disorder treatment medications.
e. Medicated Assisted Treatment in criminal justice settings and upon release.
f. Initiating Buprenorphine-based MAT in emergency departments.
g. Education/training for healthcare providers on opioid prescribing best practices.
h. Drug court/treatment court.
i. Rapid response teams for overdose or mental health crisis.
j. Drug prevention education for youth.

- **Barriers and challenges to implementing evidence-based practices for overdose prevention included:**
  a. Capacity and data.
  b. Stigma.
  c. Complexities of collaborative partnerships.
  d. Treatment access.
- Learned from interviews that there is a lack of coordination within the system. Community partners need tangible support to create pathways. Policy landscape and policy and stigma are important. Some individuals felt Measure 110 created some bad feelings with partners.
- **Solutions identified from the HIDTA needs assessment:**
  a. Strong collaborations.
  b. Community education about dangers of substance use and importance of evidence-based practices.
  c. Funding and staffing.
  d. Access to housing and treatment.
  e. Leadership and accountability through local, state, and federal actions.
  f. Humanize the experience of addiction by involving people who have been affected by addiction and overdose.
  g. Two-way data sharing platforms (e.g., ODMAP-Overdose Detection Mapping Application Program), for multiple agencies to update access, and share real-time data.
- **Community Conversations about Behavioral Health in Rural Counties** – Received a collaborative grant - USDA National Institute of Food and Agriculture Rural Health and Safety Education (Grant #2019-46100-30280) and from SAMHSA Rural Opioid Technical Assistance Program (Grant # 6H79TI083266-01M001) and Combatting Overdose through Community-Level Intervention initiative (Grant #G2099ONDCP06A).
  a. Cross-sector participants include – Behavioral health providers, community members, Coordinated Care Organizations, County Commissioners, criminal justice system, healthcare providers, public health, public safety, school counselors, housing, and homeless services.
  b. Activities – Assess strengths and gaps and create priorities and action plans.
- **Community conversation process:**
  a. Establish planning committee to identify participants, logistics.
  b. Use data to understand behavioral health issues.
  c. Create an inventory existing programs, services, and activities.
  d. Identify successes, gaps, and needs.
  e. Create list of priorities and action plan.

- There are other layers of coordination happening. Shared Services available in Lincoln County that align with the Oregon Health Authority Opioid Settlement Framework – Continuum of Care in Lincoln County – Prevention, Naloxone (Narcan) distribution and education, syringe and other harm reduction programs, Medication Assisted Treatment, treatment and counseling, prenatal postpartum and neonatal services, treatment for incarcerated populations, warm handoff for recovery services.
- **Common themes from Community Conversations:**
    a. Behavioral health workforces are depleted.
    b. Housing shortages prevent hiring and retaining qualified professionals.
    c. Lack of communication and data sharing and between organizations.
    d. Gaps in eligibility for programs and lack of coordination means people are falling through the cracks of disjointed supports.
    e. Cross-sector coordination builds capacity and innovation.
- Shared spectrum of interventions – Prevention, harm reduction, crisis response, treatment, recovery.
- People are focused on treatment and recovery – Need to move to prevention.
- Dusti Linnell shared "Our Tillamook group," which is a notable example of highly coordinated efforts across the system. Brought in $3 million to Tillamook County.
    a. What is working – Cross-sector collaboration and implementing evidence-based practices in coordination using a system-wide approach.
- **Translating evidence-based practices to rural and frontier settings:**
    a. Challenges:
        - Cultural misalignment
        - Resource limitations
        - Lack of practitioner or partner commitment
        - Insufficient capacity
        - Adapting and tailoring programs to fit the local context

    b. What is needed:
        - Mentorship and guidance from evidence-based practice experts or model communities
        - Research to develop evidence-based for practices designed for rural communities
        - Establish metrics of success for rural communities
- **Actions needed to address the Fentanyl crisis in rural communities:**
    a. Rebuild the rural behavioral health workforce.
    b. Provide community education on the dangers of substance use and importance of evidence-based programs.
    c. Enhance cross-sector coordination and data sharing.
    d. Increase access to prevention, treatment, and recovery services.
    e. Provide support for translating evidence-based practices for rural contexts.
    f. Build the evidence for what works in rural communities through community-engaged research.
- **JoAnn Miller** – The hospitals are not listed for emergency crisis services for resources. Are hospitals involved?
    a. **Dr. Sandi Phibbs** – Would be happy to follow up on this.

Regional Health Assessment:
Sara Hartstein presented an update on the Regional Health Assessment and Improvement Planning.
- Background:

a. County public health, IHN-CCO, and Samaritan Health Services (SHS) are all required to develop a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).
b. The CHA in 2014 was done together and then agencies broke off to do entity-specific CHIP's. The Regional Community Health Assessment was originally planned for 2020.
c. Late 2021 a Steering Committee convened and later adopted the name 'Partnership for Community Health.' Includes:
    - Linn, Benton, Lincoln Public Health Authorities; IHN-CCO; Samaritan Health Services; United Way of Linn, Benton, and Lincoln Counties; Confederated Tribes of Siletz Indians; and later Linn, Benton, Lincoln Health Equity Alliance
    - Plan to hire a project manager
    - IHN-CCO expanded contract – Consultant to help develop CHIP goals
d. 2022 – Work on Regional Community Health Assessment.
e. March 2023 – 2022-2026 Regional CHA finalized. There were 7 key themes identified.

- Themes from 2022-2026 Regional Community Health Assessment:
    a. **Access to Affordable Housing and Homelessness** – High prvalence of homelessness and fiancial burden due to housing costs.
    b. **Access to Quality Care** – Inadequate access to primary care physicians, behavioral health providers, and dentists.
    c. **Equity, Diversity, and Inclusion** – Minoritized racial and ethnic groups and people living with disabilities (and likely other vulnerable populations not adequately identified in available data) experiencee more challenges than able-bodied White individuals.
    d. **Food Insecurity and Access** – High rates of food insecurity and limited access to grocery stores.
    e. **Healthy Youth and Families** – Teen pregnancy, prenatal tobacco use, child abuse, and high number of children in foster care.
    f. **Mental Health** – High rates of depression and suicide; high rates of feeling sad or hopeless among high school students.
    g. **Substance use and Misuse** – Drug overdoses; teen use of e-cigarettes, alcohol, and prescription drugs.
- There were 4 priorities 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).

  Represents opportunities for reginal alignment and collective impact; These priority areas are not exhaustive, partners may work on other priorities in their jurisdiction.
- Current Phase: Regional Community Health Improvement Plan Development.
- Structure:
    a. Each of the 4 priority areas has:
        - Facilitators/Leads (1-2)
        - Planning team (5-15)
        - Workgroup (To be determined, approximately 20-30)
    b. Goal – Create a regional health improvement plan (focused on collective impact).
        - For each priority area – 2-4 goals

  - ➢ For each goal – 1-3 strategies
  - ➢ For each strategy – Associated measure/metric to track progress
- Shared the "Draft" Regional CHIP Development Timeline.
- **Timeline and Expectations:**
  a. End of February/March – Goals, strategies, and progress measures identified.
  b. March – Share "draft" of CHIP with IHN-CCO Community Advisory Council (CAC).
  c. April - Present final CHIP to Partnership for Community Health Steering Committee.
  d. May – Present final CHIP to IHN-CCO CAC for approval.
  e. June – Publish final CHIP.
- **JoAnn Miller** – Did you identify each planning group?
  a. **Sara Hartstein** – Each priority area has a co-lead and planning team members. We do not have the ability to open the groups to the larger community. Want representatives from each area in the region and those with lived experience and experts.
- **JoAnn Miller** – Bringing the three counties together to do work is not an easy task. Thanks for all you do, Sara Hartstein. You bring us together and keeps us on task. We have strong representatives from each county in the workgroup. We were inclusive. Mica Contreras is also on the committee as well.
- **Mica Contreras** – "Yes," would like to express her gratitude to Sara Hartstein.
- **Sara Hartstein** – All the partners are amazing and the different areas, resources, and cultural differences.

Where are the gaps in services? Priorities for 2024:

JoAnn Miller led discussions around gaps in services and priorities for 2024.

- **JoAnn Miller** – We know that substance use, and homelessness and housing is a huge need and there are gaps in these services. What other gaps and services are we missing?
- **Jennifer Beckner** – What about older and the aging population? Do we have representation? We are seeing a lot of individuals over the age of 55 accessing the shelters in Lincoln County.
- **Sara Hartstein** – There are representatives and services for seniors and people with disabilities. There is also work being done with affordable housing and the homeless. We are creating community plans and hope to look at developing goals and provide outreach, development, and identify areas that align and identify gaps.
- **JoAnn Miller** – Is early childhood in that – Childcare and childcare services?
  a. **Sara Hartstein** – This is not a priority area. The workgroup might identify, and it might fall under youth/families. That key issue was not identified in the CHIP, but it could weave through other areas.
- **JoAnn Miller** – Does not see juvenile justice identified and we are seeing an update in overdoses with youth. This is a gap.
  a. **Sara Hartstein** – They have someone from the juvenile department invited to the behavioral health workgroup.
- **JoAnn Miller** – We are starting to discuss and address domestic violence, child abuse, and human trafficking with our new AViROC Grant. We do want to look at things as a region and not just rural.
  a. As noted, housing is a big gap. Another area to look at would be people with disabilities.

Data-Driven Decision-Making Presentation:

Dr. Paulina Kaiser presented on data-driven decision-making.

- Discussed the goals for the presentation and shared information about herself.
- Define 'data-driven decision-making.'
    a. Data-driven decision-making – (Forbes) – "Data-driven decision-making entails using facts, metrics, and data to make strategic business decisions that align with your company's goals, objectives, and initiatives."
- Shared two books – "Be Data Driven" – How Organizations can Harness the Power of Data by Jordan Morrow and "Behind Every Good Decision" – How Anyone can use Business Analytics to Turn Data into Profitable Insight by Piyanka Jain and Puneet Sharma, edited by Lakshmi Jayaraman.
- CHDS-Center for Health decision Science, Harvard T.H. Chan School of Public Health – What is Decision Science?
    a. Decision Science is the collection of quantitative techniques used to inform decision-making at the individual and population levels. It includes decision analysis, risk analysis, cost-benefit and cost effectiveness analysis, constrained optimization, simulation modeling, and behavioral decision theory, as well as parts of operations research, microeconomics, statistical inference, management control, cognitive and social psychology, and computer science. By focusing on decisions as the unit of analysis, decision science provides a unique framework for understanding public health problems, and for improving policies to address those problems.
- Data-driven decision-making is:
    a. A process that uses data critically.
    b. Applied – Informs choices to increase likelihood of success.
    c. An iterative, ongoing process.
- How to make data-drive decisions:
    a. …does not start with the data!
    b. Start with the goal.
        - *Reduce opioid overdoses*
        - *Reduce no-show rate for primary care appointment*
        - *Improve colorectal cancer screening metric performance*
    c. Think about key drivers / causes / contributing factors.
        - Logic models and/or conceptual diagrams - Tell the story
- Shared logic models. Thinking of Logic Models as a Series of *If…Then* Statements *(Adopted from the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention).*
    a. Resources/Inputs – Certain resources are needed to operate your program.
    b. Activities – If you have access to them, then you can use them to accomplish your planned activities.
    c. Output – If you accomplish your planned activities, then you will hopefully deliver the services that you intended.
    d. Outcome – If you accomplish your planned activities to the extent you intended, then your participants will benefit in certain ways.

  Situation, Priorities – Inputs, Outputs, Outcomes/Impact – Assumptions, External factors.
- Shared conceptual diagrams.
- Making data-driven decisions, continued:
    a. Think about key drivers / causes / outputs.

- You may realize that you do not know important pieces of information (*This is a good thing)*

b. Then, identify opportunities to use data.
  - What is or can be measured
  - What can me be measured reliably and accurately

- Data is a tool – For example – Are opioid overdoses increasing or decreasing? What you want to know; What you can measure – Number of ED visits with a chief complaint of 'drug overdose.'
- "The Family Firm" – A Data-Driven guide to Better Decision Making in the Early School Years" by Emily Oster.

  The four F's:

  a. **Frame the Question (A or B)** – Establish two concrete choices.
  b. **Fact Find** – Gather evidence, including logistical information, data, and studies.
  c. **Final Decision** – Set time and date to hash out pros and cons and make a choice.
  d. **Follow-up** – Schedule time to follow up and check in and if the decision is working for everyone.

- **More about 'fact finding:'**

  a. Be clear about what you are trying to find out.
  b. Be open-minded in what 'data' looks like.
    - Large publicly available data sources
    - Published research, toolkits, etc.
    - Internal documentation
    - Conversations

- **More about 'fact finding:'**

  Survey data:

  a. How were participants recruited?
  b. When was the data collected?
  c. What was the wording of the question that was asked?
  d. Was the summary statistics adjusted for demographics?

  Research articles:

  a. Was the study design observational or randomized?
  b. Who participated in the study?
  c. How did they measure key variable?

- What do you do when you cannot make a data-driven decision?
- Not enough data:

  a. (You will never have enough data).
  b. Exercise: what data would you need to change the decision you make?
    - (What are the options)

- Not enough analytic resources:

  a. (You can learn).
    - Check out a library book or take a course (Coursera.org)

  b. (Invest in staff – Data is not going away…)
  c. Start somewhere.
    - Outline your logic
    - Learn more about the data you do have – Data dictionary

- Do not panic – Book – "The Tyranny of Metrics" by Jerry Z. Muller – "…accountability has come to mean demonstrating success through standardized measurement, ***as if only that which can be counted really counts."***
- The heart of data-driven decision-making.

a. Clear logic.
b. Transparency about data.
    - Where it comes from
    - What it means (…and what it does not mean)
c. It is never perfect – Do the best you can with what you have.

- **JoAnn Miller** – Appreciates the conversation. Are we making data-driven decisions?
- **Marty Cahill** – We need to be thoughtful in making decisions. We can look at data to help us. As we have more opportunities and there is a sense of urgency, we can make data-driven decisions.
- **Dr. Paulina Kaiser** – We have the tools, and we can get information quickly.
- **Mica Contreras** – When we have enough data to help change decisions and systems, can be better for everyone. That does not get to the heart of health equity. When we look at history, data was used against communities of color. We need more specific data on population.
- **Dr. Paulina Kaiser** – Tracking heath equity data is important. Still need to track outcomes. Deeper underlining goal is to recognize the nuisances in individuals and sources of vulnerability groups – interventions based.

IHN Community Benefit and Social Determinant of Health Funding – CCO 2.0 – 2024 Waiver:

Bruce Butler and Todd Jeter reported on IHN community benefit and social determinants of health and the CCO 2.0 2024 waiver.

- IHN Accountabilities from Oregon Health Authority (OHA). Shared IHN Accountability and Contractual or Statutory Basis. Accountabilities were established by Oregon Health Plan Services Contract, Exhibit K, "Social Determinant of Health and Equity," plus various OARs, plus Customer Expectations.

IHN Accountability:

a. Convene a Community Advisory Council (represented on CCO Board).
b. Convene a Collaborative Community Partnership (for CHA/CHP Oversight).
c. Support the development of a Community Health Assessment.
d. Support the development of a Community Health Improvement Plan.
e. Provide SHARE (Supporting Health for All through Reinvestment) Initiative Funding based on CHP Guidance.
f. Provide Health-Related Services Funding (Governor/OHA Guidance/Expectation: Total of 1.5-2.0% of CCO Revenue) for selected non-Oregon Health Plan (OHP)-reimbursable services comprised of:
    - Flexible Services Funding
    - Community Benefit Initiative Funding (aligned with CHP)

- Shared CCO 2.0 Community Funding Process Governance – Mechanisms established by Oregon Health Plan Service Contract, Exhibit K, "Social Determinants of Health," plus various OARs.
- The Recent IHN Community Investment Spending – Community Investment Funding Streams was noted – How funds are directed and distributed in the community. Oregon Governor, Tina Kotek, came out with guidance to the CCOs – Total of 1.5-2.0% of premium revenue that OHA pays to CCOs – Important opinion hovering at 1.5% mark.
- Post-Waiver Environment – Community Benefit Funding PLUS Reimbursable Health-Related Social Needs. Transitioning to 2024 Waiver.

a. CCO 2.0 – Supplemental Medicaid Funding:
    - Health Related Services

        - SHARE Initiative
    b. 2024 Waiver:
        - Housing
        - Climate Support
        - Nutrition
- Not seeing a replacement in mechanism, seeing supplemental and some shifting around.
- Delivery System Transformation (DST) projects funded short term may have more sustainable funding.
- CHA/CHIP Partnership for Community Health – Community Health Assessment and Community Health Improvement plan:
    a. Facilitating development of a combined regional CHIP that will align with IHN-CCO, Samaritan Health Services, and Linn, Benton, and Lincoln County Public Health.
    b. Focused on the four priority areas identified in the collaborative Regional Health Assessment – Diversity, Equity, and Inclusion, Access to Quality Care, Behavioral Health, and Housing.
    c. Providing technical writer and videographer to support community engagement and single voice.
- SHARE – Overview and Background:
    a. Investing a portion of IHN-CCO net income or reserves back into the community to support Community Health Improvement Plan priorities with a focus on economic stability, neighborhood and built environment, education, and social and community health; IHN-CCO Community Advisory Council provides input on priorities and participates in proposal evaluation.
    b. Legislative requirement defined by state law and Oregon Administrative Rules.
    c. Coordinated care organizations (CCOs) must invest some of their profits back into their communities by spending a portion of their net income or reserves.
    d. One way that CCOs respond to Social Determinants of Health, health inequities, and social needs of members.
        - IHN-CCO also does through the Delivery System Transformation Committee (DST) as well as flexible services
- The 2023 SHARE Request for Proposal process was noted.
- Shared the 2023 SHARE projects funded. The total SHARE Request for Proposal Awards totaled - $1,044,316.00.
- Delivery System Transformation:
    a. Annual Request for Proposal Process.
    b. Approved approximately $1.7 million in funding for new projects in 2023.
        - 8 large pilot projects (over $50,000)
        - 3 small pilot projects ($50,000 or less)
        - 14 capacity building projects ($15,000 or less)
    c. Strategic planning will begin in January 2024, but preparation will take much of December.
    d. Tracking of active pilot updates, closeouts, and extension requests.
    e. 3-part data justice training with the Indigenous Health Equity Institute.
- Provided a recap of 2023 DST Request for Proposal process and 2023 Funding Pathways. All proposals had to address the 2023 priority areas of Social Determinants of Health and Equity.
- The 2023 Request for Proposal Projects (by Social Determinants of Health Focus Area) was noted.

- A list of those 2023 Request for Proposal Funded Pilots was shared.
- Health Related Service (HRS) and Community Benefit Initiative (CBI):
    a. **Health-Related Services Dollars:** Non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being. Health-related services include:
        - Flexible services, which are cost-effective services offered to an individual member to supplement covered benefits; and
        - Community benefit initiatives, which are community-level interventions focused on improving population health and health care quality (not exclusive of non-members); includes Delivery System Transformation.

    b. Invested over 2.5 million dollars into the region in 2023.
    c. Priority areas included:
        - Social Determinants of Health
        - Equity
        - Behavioral Health
        - Traditional Health Workers
        - Social Care Network Development
- Collective Impact – CBI/HRS/SHARE/DST:
    a. Total investment of over $6.7 million into the region in 2023.
    b. Directly informed by the:
        - Community Health Assessment
        - Community Health Improvement Plan
        - Health Equity Plan
        - Comprehensive Behavioral Health Plan
        - Delivery System Transformation Committee
        - Community Advisory Council
- Social Determinant of Health Spending over the last ten years – Over $19 million.
- Health Related Social Needs (HRSN) and Development of the Social Care Network – Now will be reimbursed as a benefit.
    a. The term "Health-Related Social Needs" is sometimes used interchangeably with the Social Determinants of Health (SDOH), but an important distinction can be made.
    b. HRSN refers to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They include things such as housing instability, housing quality, food insecurity, employment, personal safety, lack of transportation and affordable utilities, and more.
    c. SDOH, on the other hand, refers to the conditions in which people are born, grow, work, live, and age that are shaped by the distribution of money, power and resources and impacted by factors such as institutional bias, discrimination, racism, and more.
- Oregon Health Plan 1115 Demonstration Waiver: (runs for a 5-year period):
    a. Waivers specify ways that the state Medicaid program will operate differently than what is outlined in the Code of Federal Regulations (CFR).
    b. Oregon renews/revises the OHP waiver every 5 years.
    c. The latest waiver application was approved in September of 2022 and backdated, serving as the waiver for the 2022-2027 demonstration period.

d. Oregon received authority for $268 million in federal buy out for the five years of the demonstration. The buy-out allows federal matching funds for a state-funded Designated State Health Program (DHSP) that "free up" state funding to support Youth with Special Health Care Needs (YSHCN) coverage and HRSN services and related infrastructure investments.
e. The "freed up" state funding will result in $1.2 billion across the demonstration, which includes a state contribution of $88 million during the last year of the demonstration. The total federal funds are $1.1 billion for the demonstration.

- Waiver components – Overall goal is to advance health equity, broken down into four-sub goals:
  a. Ensuring people can maintain their health coverage.
  b. Improving health outcomes by addressing health related social needs.
  c. Ensuring smart, flexible spending for health-related social needs and health equity.
  d. Creating a more equitable, culturally and linguistically responsive health care system.
- HRSN benefit categories/components – Housing, Food, and Climate. OHA is developing a fee schedule.
- HRSN and Development of the Social Care Network:
  a. SDOH-E/T is leading the development of the IHN Regional Social Care network via:
     - Heat mapping and gap analysis of current state
     - Building new and leveraging existing community partner and CBO relationships to ensure an adequate network
     - Incentivizing the uptake of UniteUs and the UniteUs social care payments module
     - Incentivizing the active screening and referral of members
     - Focusing on targeted applications to achieve equitable outcomes
     - Upskilling CBO's and providing technical and financial assistance
- UniteUs Expansion – Platform selected by Oregon Health Authority. Addressing Social Determinants of Health and community infrastructure by connecting providers and community support services. Will have unlimited number of licenses to support IHN-CCO's providers/community partners; Social Care Payments Module to bring case management functionality to partners; Technical assistance and targeted outreach to community-based organizations; and full adoption by Samaritan Health Services (clinics and case managers).
- Housing Initiative – Working on access to affordable, culturally adequate, safe, and stable housing.
  a. **Coalition for Housing Equity:** To share information and develop a regional approach to housing that leverages and aligns with current policy, resources, and funding while ensuring gaps are being addressed and met.
  b. **FUSE (Frequent Users System Engagement):** To focus on high utilizers of the emergency department and justice system.
  c. **Data Harmonization:** Project funded by IHN-CCO to determine ways to collect, standardize, and evaluate housing –related data (IHN-CCO, SHS, OHSU, Community Partners).
  d. **Respite Care Support:** Funding from IHN-CCO to SHS Care Hub and others for post-hospital respite care.
- Food and Climate – Working on initiatives to support community food insecurities and purchase, delivery, and installation of climate devices for HRSN eligible populations.

a. **Foodsmart:** Nutritional app that tailors food preferences and dietary needs for health meal and grocery planning; food boxes and dietician support for high-risk populations (hypertension, diabetes, high-risk pregnancy).
b. **Mobile Van Drives:** Exploring opportunities to leverage mobile van health care and health education services (SHS, OHSU, and dental) with the addition of food distribution; county and community organization collaboration.
c. **Community Events:** Leveraging planned community events to coordinate various food distribution opportunities.
d. **Furniture Share:** Purchasing, storing, and delivering/installing climate devices.

- Shared Integrated Community System – Collective Impact.
- **Jennifer Beckner** – Lincoln County Health and Human Services is interested in using UniteUs. It could be a significant cost to get their Electronic Medical Record to talk with UniteUs.
    a. **Todd Jeter** Alicia Bublitz with Samaritan Health Services Health Plans – abublitz@samhealth.org is the primary resource person for this. The current work group with UniteUs is looking at the fiscal impact.
- **JoAnn Miller** – Will there be an opportunity for training with UniteUs?
    a. **Todd Jeter** – Will provide trainings in 2024 and technical assistance is available.
- **Jayne Romero** – Lincoln County Health and Human Services primary care/behavioral health/maternal care/primary care all have a time demand on providers.
    a. **Todd Jeter** – We want to make it as low barrier as possible.
- **JoAnn Miller** – Will there be community awareness around the 1115 Waiver?
    a. **Todd Jeter** – Some know, and some will wait for additional information. Taking a broad approach. Some people have been informed through them, partners, social media, etc. Will see a lot more information in 2024.
- **Bruce Butler** – Would like to recognize Todd Jeter with all his work around all of this.

Memorandum of Agreement and Charter Review:
Marty Cahill led discussions presented the Memorandum of Agreement for the CCCWN for 2024-2027 and the CCCWN Charter – 2024.

- The Memorandum of Agreement can be sent out via DocuSign.
- The CCCWN meets twice a year and the CCCWN Steering Committee meets every other month.
- With our CCCWN, we have been successful in securing round $11 million in grants since 2011.
- Our Project Officers and Technical Assistants for our federal HRSA grants will be here for our May CCCWN meeting. They are interested in seeing all the great work we are doing with our network and through our grants.
- Marty Cahill noted that both he and JoAnn Miller have been invited nationally to talk about the CCCWN.
- When you look at the membership on our Network, it makes us a high candidate for receiving grants.
- **JoAnn Miller** – Through letters of support and the Memorandum of Agreement it is available to help other organizations with grants and funding.

HRSA Rural Health Network Development Grant:
JoAnn Miller shared information on the HRSA Rural Health Network Development Grant.

- We have an opportunity to apply for a one-year rural planning grant. This is for healthcare and health systems, not to be used for direct services; to improve health access in rural communities.
- The target population is the underserved. We will be including the LGBTQIA2S+ population in Lincoln County. In the last year, there has also been an increase in the number of Native American, Latino(x) and LGBTQIA2S+ community members diagnosed and overdosing on various illegal substances.
- We would conduct a Needs Assessment, identify critical gaps, and develop a Strategic Plan.
- The grant is due on January 26, 2024.
- We would submit the application under the CCCWN and create a subcommittee that reports up to the CCCWN.
- We are seeking approval to submit the application with one of our coastal facilities as the fiscal agent for the grant.

Bruce Butler made a motion and Bryan Decker seconded the motion to approve the submission of an application for the HRSA Rural Health Network Development Grant. The motion was voted upon and was unanimously approved.

Spring Meeting:
The Spring CCCWN meeting is scheduled for May 15, 2024, and will include HRSA Project Officers and Technical Advisors as well as site visits to our grant funded projects.

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

Respectfully Submitted,
Shelley Hazelton
Community Health Promotion

CCCWN
May 2024

Rural Communities Supporting Women & Youth (RC-SWAY)

September 1st, 2021 –August 31st, 2024

Project Director and Project Specialist

Michelle Means

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).

PIMS Report – Final

- PIMS Y3R1 for reporting period September 1st, 2023-February 29th, 2024 was submitted to HRSA via Salesforce March 29th, 2024.

Biannual Progress Report – Final

- Y3R1 Biannual Progress Report for reporting period September 1st, 2023-February 29th, 2024 was submitted to HRSA April 2nd, 2024.

Sustainability Plan – Final

- Sustainability Plan Report 3 is due September 30th, 2024.
- RCSWAY PD will partner with Brandan Kearney to develop a user-friendly Sustainability Plan for our partners and community. Luis Acosta will provide translation services.

Progress Report – Final

- The Final Progress Report is due to HRSA November 2024.

Year 3 Budget

- RCSWAY applied for a six-month extension to continue SUD initiatives in rural East Linn County. RCSWAY would provide additional funding to The Boys & Girls Club of the Greater Santiam if approved.
- RCSWAY, HIWAY, and the Oral Health Grant are coming together to raise awareness about substance use disorder and promote it as a disease. This campaign will aim to eliminate stigmas related to substance use disorders within communities and organizations. The three grants will use their funding to support marketing initiatives through AHM Brands to present the message in a new and effective way.
- The Family Tree Relief Nursery and The Hope Center are actively using funds from RCSWAY to address a range of needs, including emergency beds, sustainability for current clients and tenants, regaining life skills, rental application fees, recovery house fees, storage unit and transportation fees, as well as infant and children's items.
- Acosta Services is working to identify regional dialects and translation options and provide a comprehensive report on the works to assess and improve Spanish translation services. RCSWAY will fund the assessments.

Prevention, Treatment, & Recovery Activities	Responsible Persons	Timeline	Progress
1d. Work with AHM Brands to develop the culturally specific messaging for the media campaign around SUD/OUD in multiple languages.	~~STARS PSS~~ PD-DC	Q3, Q7, Q11	May PD-DC Updates RCSWAY, HIWAY, and the Oral Health Grant are joining forces to raise awareness about substance use disorder as a disease and eliminate stigmas related to it. They will fund marketing initiatives through AHM Brands to present the message effectively. April PD-DC Updates: RCSWAY PD met with AHM Brands in March to prepare for an additional media campaign extending behavioral health marketing materials promoting pregnant women and youth. The campaign aims to present substance use disorder as a disease and decrease associated stigmas within our communities and organizations. March PD-DC Updates: A meeting is scheduled with the new RCSWAY PD-DC and AHM to discuss the continuation of marketing materials for pregnant women and youth. February PD-DC Updates: FTRN PSS Youth Outreach Specialist and FTRN PSS Carter is the face of our media campaign in rural Linn County; Radio spots, billboards, & media launched December 11th, 2023.
1i. LCAD Program will continue to provide and expand evidenced-based LifeSkills Training in elementary and middle school classrooms.	LCAD	Q2, Q3, Q5, Q6, Q7, Q9, Q10, Q11	March LCAD Updates: **LifeSkills Training Program Lancomb School:** Thirty students, grade six, attended one alcohol classroom lesson lasting two hours. Thirty students, grade six, attended one marijuana classroom lesson lasting two hours. **LifeSkills Training Program Cascades Elementary School:** Forty students, grade fourth, attended two tobacco classroom lessons lasting three hours. February LCAD Updates: LCAD is in the process of purchasing incentive items for youth LifeSkills and curriculum materials for early intervention/prevention. January LCAD Updates LCAD was awarded $12,166.50 for curriculum materials and incentive items for youth LifeSkills (Incentive Items for youth LifeSkills $8560.00 / curriculum materials for early intervention/prevention $3,606.50 = $12166.50)
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.	SLCH and clinics FTRN STARS CHCBLC	Q1-Q12	May STARS Updates: STARS met with a young woman who began using substances at the age of 14 and has been living on the streets of Lebanon since the age of 16. STARS PSS supported the patients' decision to enter detox and began receiving services at STARS. The patient has an appointment at the STARS MAT Clinic and is utilizing temporary housing with family. She is actively working with Jackson Street Youth Authority. After two months of relationship building and earning trust, STARS PSS supported a 23-year-old woman who initially came into contact at St. Martin's Soup Kitchen. The woman was engaging in trading sexual favors for a place to stay before entering STARS Residential Treatment. She is currently 31 weeks pregnant and receiving prenatal care for the first time. STARS PSS is collaborating with Crossroads Community to help the patient with living arrangements after completing the

			STARS program. The patient's ultimate goal is to break the cycle of drug addiction that her mother experienced and not to lose her baby to drugs. <u>April STARS Updates:</u> STARS PSS successfully connected a 19-year-old woman to detox and STARS services. She is scheduled to receive STARS MAT services and has found temporary housing. In addition, she is scheduled to meet with Jackson Street Youth Authority during the second week of April. STARS PSS connected with a 23-year-old mother-to-be at St. Martin's Kitchen and established services at STARS residential treatment. STARS PSS is working with Crossroads Community to secure her suitable living accommodations after her treatment is complete and will also assist with prenatal care. <u>March STARS Updates:</u> STARS PSS placed two pregnant women into housing of which one client was placed into youth services and one client into STARS. STARS PSS assisted one pregnant woman with OHP and SNAP benefit assistance. STARS PSS reported one female opioid overdose at SLCH. <u>February STARS Updates:</u> STARS PSS referred a mother and father to a parenting program with Obria Medical Clinic, Pregnancy Resource Center, Lamaze and Birthing Classes. <u>January STARS Updates</u> STARS PSS referred one male into the Milestones program and provided care coordination for MAT services. STARS PSS placed four clients into housing (one Offord house, two in the Sweet Home Huts, and one in the Hope center). STARS PSS referred a mother, two-year-old child and her S/O to ideal options and is helping them with housing resources. STARS PSS referred one male to detox and residential tx. PSS reported five female OD's at SLCH in Nov. <u>March FTRN Updates:</u> FTRN attended an outside training therefore was unavailable to provide workplan updates. <u>FTRN February Updates:</u> FTRN PSS provides support to five women, with a combined total of thirteen children, who are engaged in services. FTRN is implementing an SUD screening process to assist individuals on levels of care for residential treatment where needed.
1h. FTRN will continue to provide Nurturing Parents evidenced-based parent education workshops and classes for parents and caregivers impacted by SUD/OUD.	FTRN	Q1-Q12	<u>May FTRN Updates:</u> The weekly Parent Café continues, and it is open to the public as well as patients at the STARS facility <u>FTRN March Updates:</u> FTRN attended an outside training therefore was unavailable to provide workplan updates. <u>FTRN February Updates:</u> FTRN PSS will begin a new series of Parent Café in Lebanon on 1/9/2023. FTRN received “evidence-based curriculum Parent

			Café" materials on 11/7/23.
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.	SLCH and Clinics FTRN STARS CHCBLC	Q1-Q12	May FTRN Updates: FTRN did not conduct screenings due to staff departures and unqualified staff. However, FTRN PSS provided 15 referrals, out of which 9 individuals actively accessed the services they were referred to. As of February 28th, 2024, 6 active individuals were accessing services out of 15 referrals made by FTRN PSS.
2e. Peer Support Specialists will conduct outreach efforts to Maternity Care Coordinators to assist pregnant women in navigating the treatment and recovery system.	SLCH, STARS, FTRN	Q2-Q12	April STARS Updates: STARS PSS connected with a 23-year-old mother-to-be at St. Martin's Kitchen and established services at STARS residential treatment. STARS PSS is working with Crossroads Community to secure her suitable living accommodations after her treatment is complete and will also assist with prenatal care. March STARS Updates: STARS PSS met with RCSWAY PD-DC to help facilitate funding resources for Pregnant and Parenting Women. STARS PSS did not report outreach efforts with the Maternity Care Coordinator for the month of February. Maternity Care Coordinator left position 02/22/2024. February STARS Updates: STARS PSS is collaborating with FTRN to assist three parents who are attending parenting support classes regularly. One mother established care with Obria Medical Center – Lebanon and two pregnant mothers are established with Sweet Home Pregnancy Resource Center. STARS PSS is providing support to two pregnant mothers, three postpartum and four women with children over the age of two. January STARS Updates: STARS PSS began working with an additional two pregnant women and one postpartum mother. STARS PSS referred two new mothers into the parenting program with Obria Medical Center. STARS PSS sees thirteen (four pregnant & three postpartum mothers) clients regularly. PD/DC connected with Nurse Family Partnerships, a home visiting program for teen moms with first-time pregnancies. There is currently one pregnant teen and two postpartum mothers in East Linn County STARS PSS would like to support. March FTRN Updates: FTRN attended an outside training therefore was unavailable to provide workplan updates. February FTRN Updates FTRN Supervisor and outreach services successfully contacted and provided educational presentations to Obria Medical Center – Lebanon. FTRN hopes to visit the new Obria Medical Center – Urgent Care in February to present available FTRN services.

2f. Peer Support Specialists will conduct outreach efforts to schools and youth serving agencies to assist youth in navigating the treatment and recovery system.	FTRN	Q2-Q12	March FTRN Updates: FTRN maintains relationships with schools concurrently youth PSS Carter continues to provide presentations.
2g. Mental Health/SUD Clinicians will facilitate entry of local middle and high school youth into early intervention and treatment services to reduce stigma.	LCAD	Q3-Q12	March LCAD Updates: LCAD had five assessments attended in East Linn County for the month of February, five of the five assessments were informed/referred to peer support services of which three of the five were women. February LCAD Updates: LCAD was awarded $12,166.50 for curriculum materials and incentive items for youth (LifeSkills $8560.00 and early intervention/prevention $3,606.50 = $12166.50)
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.	STARS FTRN CHCBLC	Q1-Q12	May FTRN Updates: # of referrals from FTRN PSS:5 # of connections from FTRN PSS (people connecting to those services you refer them to): 5 5 mothers are currently receiving services from FTRN. April STARS Updates: STARS PSS connected with a 23-year-old mother-to-be at St. Martin's Kitchen and established services at STARS residential treatment. STARS PSS is working with Crossroads Community to secure her suitable living accommodations after her treatment is complete and will also assist with prenatal care. March STARS Updates: STARS PSS assisted one pregnant woman with OHP and SNAP benefit assistance. February STARS Updates: STARS PSS referred one mother to God Gear and will continue supporting DHS efforts. STARS PSS referred one mother to Gleaners Group and delivered one food box, one baby basinet and one play pen to a mother in need. STARS PSS referred one male into the STEP Program. STARS PSS recorded overdoses for the month of January, PSS will provide data. January STARS Updates: STARS PSS connected three women to the ACP program who will receive free cell phones. PSS is in collaboration with the President of Auxiliary at Albany Post 10 Legion who will provide holiday gifts for youth and gift cards for clothing to families including clients with children, (all clients in STARS residential program with children will receive these items). PSS provided holiday resources such as meals, food boxes, and presents to multiple families. March FTRN Updates: FTRN attended an outside training and, therefore, was unavailable to provide work updates.

			February FTRN Updates: FTRN presented available services for youth to the Oregon Health Authority including the benefits when transitioning youth into adulthood after leaving FTRN. FTRN launched a parenting support group available every Tuesday at 1:00 PM, which is successful; STARS participants also attend. January FTRN Updates: With extra funding from the last reporting quarter, FTRN is exploring housing support that includes rent, application fees, hygiene products, storage unit costs, and move-out process sustainability for women housed at the HOPE Center. FTRN PSS is working with five mothers and eight children on a consistent basis and has referred some children to the early therapeutic childhood classroom located there in Sweet Home.

CCCWN Oral Health Co-Location Project

CCCWN Update – May 2024

Reporting Updates

- Grant Year 3 ended on April 30, 2024
    - 943 patients seen at SNLH and SPCH in Year 3 (May 1, 2023 – April 30, 2024)
- PIMS Report will be due to HRSA by May 31, 2024
- Sustainability Report will be due to HRSA by Nov. 15, 2024

Other Updates

- New EPDH, Leah Hitz, began working at SPCH and SNLH on May 6, 2024
    - She had 24 patient encounters during her first week
    - Working with hospital leadership and admin to ensure she participates in staff and department meetings, conducts outreach with SHS providers
- Capitol Dental Care team presented about this project and related efforts at the National Oral Health Conference in April
- AHM Brands will continue developing a Spanish-language oral health video for Lincoln County
- Year 4 community outreach and education efforts will include expanded presence at community events, educational summit for oral health and primary care providers
- HRSA Technical Advisor visiting May 14-17 for Reverse Site visit, CCCWN meeting, and strategic planning support

Helping Impact Women & Youth (HIWAY)

CCCWN Full Network Meeting Update - May 2024

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:

- The next HIWAY partners meeting will take place on Friday, June 21, 2024.
- Partners continue to submit their monthly work plan updates.
- The PD/DC met with the new Executive Director at the Olalla Center to provide project details on the HIWAY grant.

Work Plan Highlights ______ *= updates*

SUD/OUD Activities	Responsible Persons	Timeline	Progress
1d. Hire or assign Staff to implement HIWAY activities.	SNLH, RCC, FHC, OC, SH, PAADA, NWCH	Q1-Q8	**In Progress:** RCC – hired, FHC – hired, OC – hired, SH – hired, PAADA – hired, NWCH – hired, a new Peer Support Specialist will take over this role in April/May.
1g. Provide copies of all federal required reports and documents to the CCCWN Steering Committee and full CCCWN.	PD/DC, Network Director	Q1-Q12	**In Progress:** All federal required reports and documents are now available for the consortiums to view on the CCCWN website. After a report has been reviewed by the committee and then submitted to HRSA, it is put on the website for the general public to have access to. The PD/DC is currently working with consultant, Brandan Kearney, to have all the HIWAY reports put into a professional report format. These reports will also be translated into Spanish by Acosta Services.
1h. Partners will work with consultant to develop the culturally specific messaging for the media campaign around SUD/OUD in multiple languages.	PD/DC, SNLH, CTSI, RCC, FHC, OC, PAADA	Q3, Q7, Q11	**In Progress:** The stigma reduction media campaign went live on December 11, 2023. The campaign ran for 3 months. TV, radio, digital and social media ads were finalized in early December and have been actively engaged with by the general public. Billboard locations were selected and were placed in January 2024.The CCCWN.org/recover webpage (LinnBentonLincolnRecover.com) is now active and contains partner contact information for organizations that serve Benton, Linn and Lincoln counties in the areas of substance use disorder prevention, treatment and recovery. Webpage views: November 2023: 15 December 2023: 2,431 January 2024: 1,759 February 2024: 1,462 Adult Focused Campaign – Lincoln County – January 2024 Targeted Display Impressions: 117,837, clicks: 231 Streaming Audio Impressions: 19,676, clicks: 7 Connected TV Impressions: 19,370, clicks: 3 Youth Focused Campaign – Lincoln County – January 2024 Streaming Audio Impressions: 18,687, completes: 18,366 Connected TV Impressions: 19,241, completes: 16,583 Adult Focused Campaign – Lincoln County – February 2024 Targeted Display Impressions: 103,428, clicks: 104 Streaming Audio Impressions: 18,675, clicks: 4 Connected TV Impressions: 18,674, clicks: 3 Youth Focused Campaign – Lincoln County – February 2024 Streaming Audio Impressions: 15,585, clicks: 8 Connected TV Impressions: 15,395, clicks: 37 Adult Focused Campaign – Lincoln County – March 2024 Targeted Display Impressions: 115,501, clicks: 102 Streaming Audio Impressions: 18,969, LTR: 98.1% Connected TV Impressions: 19,676, VCR: 97.7% Youth Focused Campaign – Lincoln County – March 2024 Streaming Audio Impressions: 12,628, LTR: 99.2% Connected TV Impressions: 13,081, VCR: 90.5% Adult Focused Campaign Explained: In March 2024, 19,676 TV commercials were aired. The Video completion rate was 97.7%. This means 19,100+ ads were watched to completion. Our ads were delivered at a frequency of 5x per unique household and reached 4,100+ unique households. For audio commercials, we aired 18,969 total ads. The average listen through rate was 98.1% which means that 18,600+ of the people who heard the ad listened to the entire commercial. The ads delivered at a frequency of 2x per unique individual and reached 10,500+ unique individuals. For display ads, we saw 115,501 impressions served. This ad group drove 102 clicks to the site, giving us a click-through-rate of 0.09% against the platform average of 0.10%. Youth Focused Campaign Explained: In March 2024, 13,081 TV commercials were aired. The video completion rate was 90.5%. This means 11,700+ ads were watched to completion. Our ads were delivered at a frequency of 4x per unique household and reached 3,500+ unique households. For audio commercials, we aired 12,628 total ads. The average listen through rate was 99.2% which means that 12,500+ of the people who heard the ad listened to the entire commercial. The ads delivered at a frequency of 7x per unique individual and reached 1,800+ unique individuals.

Addressing Violence in Rural Oregon Communities (AVIROC)

CCCWN Steering Committee Meeting Update – April 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* provides therapy services weekly in-person at the new Sweet Home clinic.
- *Center Against Rape and Domestic Violence (CARDV)* spend 2 days a week facilitating resources for survivors; providing Healthy Relationship curriculum presentations for students in east Linn Co.
- *Acosta Services* has completed 4 focus groups in Lincoln County so far; the final focus group will be in Newport on May 23rd focus on Mam speakers.
- Strangulation Prevention Training completed on 5/3/24 in Lebanon with 73 attendees.
- *Partners for Health*'s Violence Prevention Summit will be on May 17, 2024 in Lebanon with support from the Linn-Benton Anti-trafficking Coalition.
- Upcoming reports that are due: Evaluation Plan, Dashboard, and PIMS.

Work Plan Highlights:
Quarter 4 (April 1- June 30, 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 and ongoing)
- ☑ Provide copies of all required federal reports and documents to the CCCWN Steering Committee and full CCCWN (ongoing)
- ☐ Convene and facilitate focus groups, community forums and events with Latinx, Mam-speaking, and other marginalized community members in Lincoln Co to increase awareness of child abuse, domestic violence, and human trafficking (Q1-Q4) Community partner Acosta Services will facilitate focus groups and community forums scheduled for 11/22, 2/19, 3/21, and 4/24, 5/23
- ☐ 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).
- ☐ Provide resource navigation services 2 days per week to residents in rural east Linn Co (ongoing) Community partner CARDV resumed outreach, navigation, and DV support groups in December when staff returned from leave.
- ☐ Plan and host annual Violence Prevention Summit in Linn County 5/17/24 at SLCH
- ☑ Host in-person Strangulation Institute training for medical professionals working at Emergency Dept and Medical Facilities in the region 5/3/24- 73 attended
- ☐ 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.
- ☐ Develop Evaluation Plan (Q2) Due June 28, 2024- in progress

Measure 110 Behavioral Health Resource Network (M110 BHRN)

Linn County

CCCWN Update – May 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), Community Helping Addicts Negotiate Chance Effectively (C.H.A.N.C.E), 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 Update

- Phase 3 – Report 6 aggregated data for services provided October 1, 2023-December 23, 2023 were submitted to the OHA by Thien Nguyen on April 5th, 2024.
- Phase 3 – Report 7 aggregated data for services provided January 1, 2024-March 31, 2024 will be submitted to the OHA by July 15th, 2024.

Conferences/events

- Linn County BHRN partners continue to meet monthly to discuss relevant events and coordinate efforts. The next meeting is on June 7.

BHRN Media Campaign

- Drafts started for a Linn County BHRN newsletter and other resources, to be hosted on the CCCWN website.

Partner Updates:

- FTRN plans to offer year-round Peer Support training, pending OHA approval.
- STARS welcomes its new program director, Melissa Lawson.
- STARS and FHC staff met in late April, discussing referral processes, and have begun closer collaboration on Peer Support services.
- Emergence reports a high percentage of graduation from their self-referred Intensive Outpatient program, many clients successfully transitioning into SUD treatment, and continued growth of their Reflections program.