



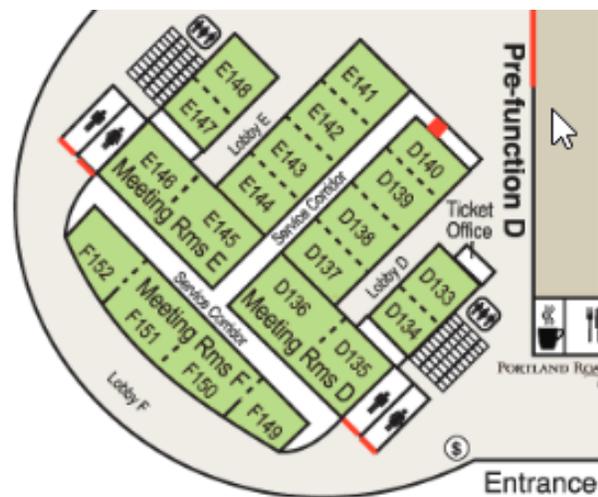
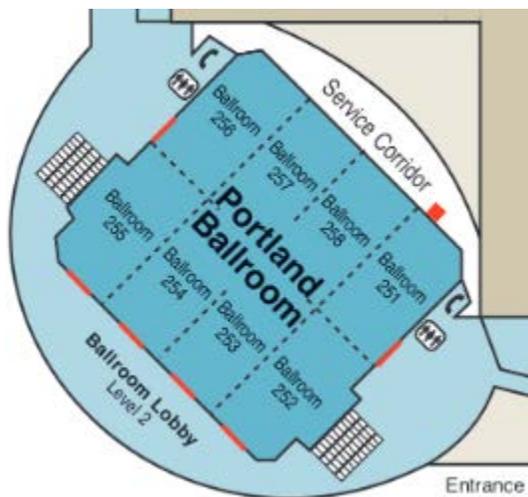
Innovation Café: Strategies for Addressing the Social Determinants of Health

June 5, 2019, Oregon Convention Center

7:30–8:30 a.m.	Registration and Breakfast (Portland Ballroom 251/258)
8:30–8:45 a.m.	Opening Remarks (Portland Ballroom 251/258) Chris DeMars, MPH, Director, OHA Transformation Center Dana Hargunani, MD, MPH, Chief Medical Officer, OHA
8:45–9:45 a.m.	Plenary: “Creating a Healthier World by Addressing Social Determinants of Health” (Portland Ballroom 251/258) Claire Pomeroy, MD, MBA, President, The Albert and Mary Lasker Foundation
9:45–10 a.m.	Café Instructions/Transition Time
10–11 a.m.	Café Session 1 (2 rounds, 25 minutes each)
11–11:15 a.m.	Break
11:15 a.m. –12:15 p.m.	Café Session 2 (2 rounds, 25 minutes each)
12:15–1 p.m.	Transition Time/Lunch Buffet
1–2 p.m.	Panel: “Oregon’s Community Health Centers: Key Partners Addressing Social Determinants and Social Needs” (Portland Ballroom 251/258) <ul style="list-style-type: none">• Danell Boggs, Licensed Clinical Social Worker, Tillamook County Community Health Center• Carly Hood-Ronick, MPA, MPH, Senior Manager of Health Equity, Oregon Primary Care Association (panel facilitator)• Christine Mosbaugh, MPH, Engagement and Communications Coordinator, Population Health Manager, Community Health Centers of Benton and Linn Counties• Brian Park, MD, MPH, Assistant Professor, OHSU• Charissa White, InterCommunity Health Network CCO
2–2:15 p.m.	Transition Time
2:15–3:15 p.m.	Café Session 3 (2 rounds, 25 minutes each)
3:15–4 p.m.	Optional Networking Time (Portland Ballroom 251/258)

Event Logistics

- **If you have a question about the event**, or need assistance, please reach out to Transformation Center staff, who will be wearing red lanyards and red ribbons on their name badges.
- **To access Wi-Fi**, select the “OCC WiFi” network. There is no password required to connect.
- **Join the conversation on Twitter!** Use the hashtag #2019InnovationCafe when tweeting.
- **All plenary sessions** will be in the Portland Ballroom 251/258.
- **Café sessions** will be in Portland Ballrooms 252, 253, 254, 255 and directly downstairs in D133, D134, D135 and D136.
- **A “Mamava” lactation pod** is outside of the D meeting rooms downstairs, down the hall to the left, and behind room E148. The passcode is 8008, and the door locks from the inside.
- See maps below for additional information:



Plenary Descriptions

Creating a Healthier World by Addressing Social Determinants of Health (Opening Plenary)

Claire Pomeroy, MD, MBA, President, The Albert and Mary Lasker Foundation

Despite consuming the majority of health dollars, research shows that clinical care delivery determines only about 10–15% of the health status of the U.S. population. Other factors, such as education, income, housing, job security, safe neighborhoods, and access to nutritious foods — the “social determinants” of health — are much more powerful drivers of health and quality of life. Addressing these “upstream” health factors can enhance wellness, prevent disease, and improve health more equitably and cost-effectively than our current approach of solely treating “downstream” disease manifestations. Policy changes, multi-sector program initiatives, and information technology solutions can all be utilized to reduce disparities and optimize health outcomes for all. In her opening keynote, Dr. Claire Pomeroy (Albert & Mary Lasker Foundation) will talk about the process of “Creating a Healthier World by Addressing Social Determinants of Health”. She will provide examples of social determinants of health best practices, and speak to the roles that government, the health delivery system and philanthropy should play in advancing this work.

Oregon’s Community Health Centers: Key Partners Addressing Social Determinants and Social Needs (Lunch Panel)

Danell Boggs, Licensed Clinical Social Worker, Tillamook County Community Health Center; Carly Hood-Ronick, MPA, MPH, Senior Manager of Health Equity, Oregon Primary Care Association (panel facilitator); Christine Mosbaugh, MPH, Engagement and Communications Coordinator, Population Health Manager, Community Health Centers of Benton & Linn Counties; Brian Park, MD, MPH, Assistant Professor, Oregon Health & Science University; Charissa White, MHA, Transformation Analyst, InterCommunity Health Network CCO

In recent years, the link between health and a person’s socioeconomic context and environment has become firmly established. Community health centers (CHCs) were built on this connection over 60 years ago, and they have been working steadily for decades to improve the health of families and communities experiencing poverty. In Oregon, CHCs serve over 430,000 patients, 1 in 4 of whom are on Medicaid. While the “social determinants of health” is a popular buzzword in our current dialogue, addressing both individual patient needs and the larger systems of inequity are foundational to the community health center movement. This plenary will highlight three CHCs in Oregon that have built strong relationships with community-based organizations and their coordinated care organizations to address social needs and advocate for broader systems change to address the root causes of poor health in Oregon.

Social Determinants Screening and Veggie Rx Pilot

We are in the second year of work linking Social Determinants of Health (SDOH) screening to an onsite Veggie Prescription (Rx) program in a primary care setting. We are connecting patients to the local food system through tokens which can be used at local Farmers' Markets or the clinic Farm Stand.

This project is successful through partnership between a Community Based Organization, Federally Qualified Health Center, local Farmers' Markets, and our Coordinated Care Organization.



Corvallis Farmers' Market - Albany Farmers' Market - Lebanon Farmers' Market - Sweet Home Farmers' Market

By the numbers:

Pilot phase: July 2017 to December 2018

Total pilot award: \$239,850 between the Community Health Centers and Corvallis Environmental Center

Total money spent: \$138,000 (remaining funds rolling over for scale and spread in 2019)

Number of SDOH screenings completed: 298 at two rural sites and one urban location

Tokens distributed: 1,000 (\$2,000 value)

Token redemption: Even split between the Farm Stand and Corvallis Farmers' Market, 402 tokens (\$840) total

Success to date-

- Testing the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) tool in three of our six clinic settings
- Providing a twice-weekly Farm Stand, from May to October, at one health center to increase access and opportunity to purchase or redeem tokens for local, organic fruits and vegetables
- Collaboration with the Oregon Community Food Systems Network (OCFSN) to discuss, plan, and position Veggie Rx program in the state to succeed in funding, sustainability, and evaluation methods



Lesson learned

1. PRAPARE implementation in clinical workflow is desired and understood. It is challenging to implement and find the right mix of team members (Medical Assistants, Health Navigators, Nurses, Providers, etc.) to standardize the work.
2. Integration of the PRAPARE tool in OCHIN, our Electronic Health Record, is useful in adoption. Changes to data collection, questions asked, and evolution of this space requires flexibility and impacts adoption rate/trends.
3. Sharing data back to the team is desired- it leads to improved care planning for patients, understanding of our clinical population, and allows for greater relationship building with Community Based Organizations.
4. Using local Community Health Assessments (CHA) and the Community Health Improvement Plans (CHIP) to align this work builds support and collaboration with primary care, public health, and the community.
5. Community Based Organizations' expertise is powerful as health care finds its way with SDOH work; we do not need to become a CBO, or do their work, to partner and harness the power of resources in our community!

2019 plan:

- Expansion of the Farm Stand in the primary care setting to include: Benton Health Center, Lincoln Health Center, and Monroe Health Center
- Tokens are now redeemable at the Corvallis, Albany, Lebanon, and Sweet Home Farmers' Markets
- All CHC sites will screen for at least food security (USDA questions about access, availability, and quality of food resources) from May to October, 2019; goal is to have full screening at all six CHC sites by December 2019
- In collaboration with the Oregon Primary Care Association (OPCA), we continue to learn about rollout and SDOH best practices through the Advancing Health Equity and Data Collection (AHEAD) collaborative
- Support and communication through OCFSN is helping us plan an evaluation of the project
- We hope to evaluate the model after this season to suggest ways to sustain and guide CCO 2.0 investments in SDOH work

Funding mechanism

InterCommunity Health Network- Coordinate Care Organization (IHN-CCO) funded this pilot from July 2017 to December 2018 through Delivery Systems Transformation (DST) pilot funding. Since 2014, DST funds have supported 65 pilots with an investment of over \$20 million dollars. Pilots focus on, and are awarded to, people and organizations in our community who can positively impact the lives of IHN members in our tri-county (Linn, Benton, Lincoln) region.

Resources

Community Health Centers of Benton and Linn Counties: bentonlinnhealthcenters.org

Corvallis Environmental Center: corvallisenvironmentalcenter.org

PRAPARE tool: nachc.org/research-and-data/prapare/

Veggie Rx work in the state of Oregon: ocfsn.net/veggie-rx/

InterCommunity Health Network Transformation: ihntogether.org/transforming-health-care

For more information, contact:

Christine Mosbaugh, CHC Project Manager: christine.mosbaugh@co.benton.or.us

Kyler Grandkoski, CEC Project Manager: kyler@corvallisenvironmentalcenter.org

Transformation at IHN-CCO: Transformation@samhealth.org



OREGON PRIMARY CARE ASSOCIATION

SUPPORT FOR OREGON'S COMMUNITY HEALTH CENTERS

WHO ARE WE

- ✓ The statewide association of the **32 community health centers** in Oregon.
- ✓ Community health centers are providers within the CCO networks, providing care to Oregon's underserved populations, **including one in four Oregon Health Plan members**.
- ✓ We provide technical assistance, training and policy support to health centers in an effort to advance the goals of health system transformation: **better health, better care, lower costs, and health equity**.

OREGON'S HEALTH CENTERS ARE UNIQUELY POSITIONED TO MOVE UPSTREAM

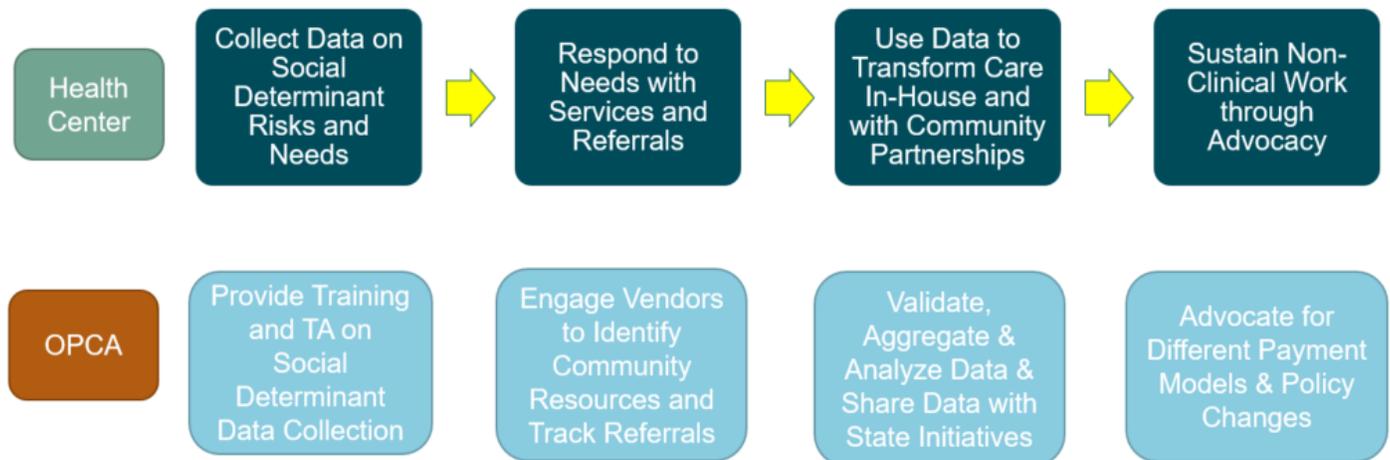
Health centers developing analytics and metrics around social needs screening = **10**

Over **80%** of health centers are documenting referrals to community partners

The average rating of health centers when asked how important it is to know a patient's social and environmental context was **9 out of 10**

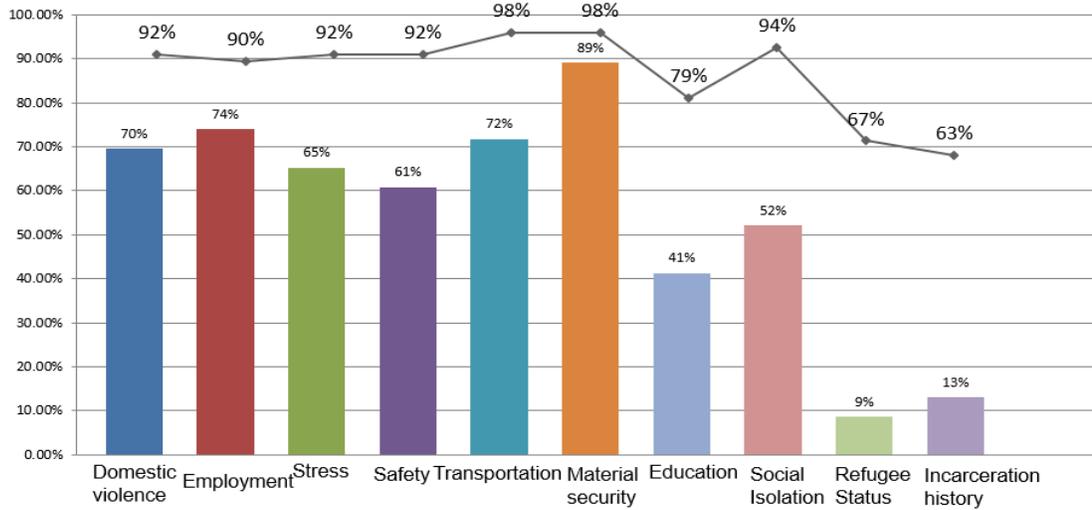
81% of CHC surveyed said they track social and economic circumstances beyond of federal reporting requirements

HOW WE PARTNER WITH HEALTH CENTERS ON SOCIAL NEEDS + SDH EFFORTS





WHAT HEALTH CENTERS ARE SCREENING FOR...



— What CHCs said are relevant to screen for to improve population health

HEALTH CENTERS ARE SAYING...

*“We want to think about **geo mapping patients** to build based on location and needs.”*

*“I want to speak with members of our clinic team to work on **developing a risk stratification model.**”*

*“We plan on **informing staff of the importance of SDH screening** at our All Staff Meeting tomorrow!”*

OUR FUTURE STATE – PARTNER WITH US!

Now

2019

2021



Clinic social needs screening rates



SDH needs statewide



■ Housing ■ Food ■ Employment ■ Education

Want to learn more?

Carly Hood-Ronick, MPA, MPH
Senior Manager, Health Equity

chood@orpc.org
503-228-8852, ext 223

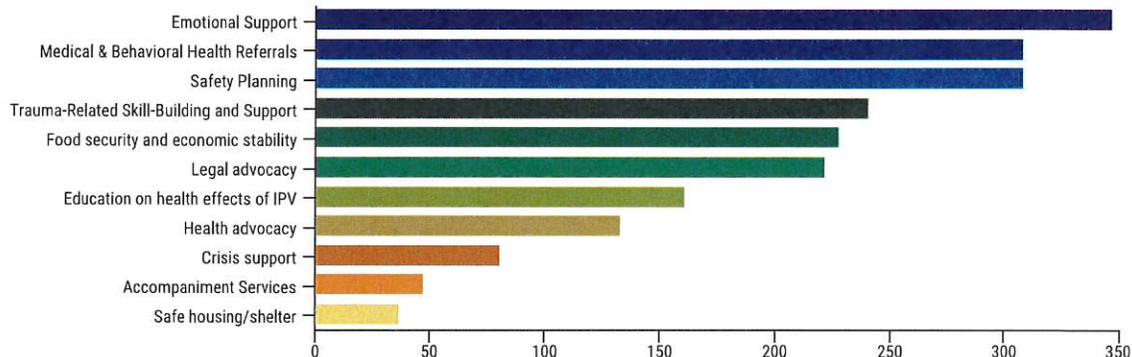
Safer Futures Evaluation

Model: Health care providers who are implementing a universal education based Intimate Partner Violence screening tool refer women experiencing IPV to a community-based IPV advocate.

Theory of Change



Advocacy Services Provided to Survivors Over 6 Months



"This has been a real game changer... (it is) not just another screening. (Safer Futures) has helped me see how IPV is significant... Visits aren't longer. We figured out how to do it in a rural federally qualified health center with pretty high risk patients." –Provider

Impact on Survivors

Survivors described many ways in which advocate services benefited their health and increased access to vital health-related services.

After the abuser was arrested, a survivor was traumatized and her **"brain wasn't working."** It would have been very difficult for her to remember all the things she had to do to qualify for assistance.

Another survivor said that because of the advocate **"my baby didn't die."** The advocate supported the survivor in reducing stress in order to gain weight during her pregnancy.

Advocates encourage women to advocate for themselves. A survivor credited the advocate with helping her **"to be able to do it myself"**

Impact on Providers

As a result of Safer Futures

- Discussing IPV is now part of visits to the clinics.
- Clinic staff have increased knowledge about how relationships impact health as well as what to do if there is a disclosure of IPV.
- Screening happens which facilitates improved understanding of the patient, trauma, and chronic health conditions.
- Conversations about IPV are normalized and this reinforces the idea that all staff care about IPV and the patient.
- Clinicians and patients have an additional resource for support as well as connections to community resources.



Relationship violence has well-documented direct health effects.ⁱ The impacts of IPV on survivor health are particularly significant for those who are pregnant and newly parenting. In Oregon more than 1 in 3 (37%) women and 1 in 3 men (34%) reported having experienced rape, physical violence and/or stalking by an intimate partner at some point in their lifetime.ⁱⁱ

The Oregon Safer Futures Project 2013-2017 (<https://www.doi.state.or.us/crime-victims/grant-funds-programs/safer-futures/>) was funded by the Office on Adolescent Health Pregnancy Assistance Fund to reach pregnant and newly parenting women experiencing intimate partner violence (IPV) at four project sites in Oregon. Safer Futures Project sites promoted the use of an evidence-based screening and assessment tool called the CUES intervention, developed by Futures Without Violence. The Tillamook County Safer Futures Project worked in partnership with Portland State University (PSU) to evaluate the model of co-located community-based advocates in healthcare settings. The evaluation was designed in collaboration with our health partners and Columbia Pacific CCO. It was a mixed methodology approach that included: a patient feedback survey conducted in the health clinic, provider interviews, survivor interviews, and the Advocate Tracking Tool. The latter was a tool designed by PSU to track services that advocates provided for survivors referred to them from healthcare providers. The infographic on the opposite page is a summary of those results.

From 2017 to present the Oregon Department of Justice Victims of Crime Act funding has designated a portion of funds to sustaining and enhancing advocacy and healthcare partnerships in Oregon. Tillamook County Women's Resource Center with the Tillamook County Community Health Centers and Rinehart Clinic is one of six program sites in the state. The current partnership has expanded the demographic to work with all patients who are experiencing IPV.

ⁱ Campell JC (2002). Health Consequences of Intimate Partner Violence. *Lancet*, 359, 1331-1346.

ⁱⁱ Black MC et al (2001). The National Intimate Partner and Sexual Violence Survey; 2010 Summary Report.

Presenter Bios

Liz Adams, Program Director, Rogue Retreat

Liz is the program director for Rogue Retreat. Liz began working in affordable housing in 1994 and came to Rogue Retreat in 2015 to help grow and enhance the programs. Liz believes everyone should have a voice and that the most important aspect of our work is the relationship that is developed between the case manager and participant.

Sherri L. Alderman, MD, MPH, IMHM-E Policy & Clinical, FAAP

Sherri is a developmental behavioral pediatrician, CDC Act Early Ambassador to Oregon, Oregon Help Me Grow Physician Champion, President of the Oregon Infant Mental Health Association, and AAP Executive Committee member of the Council on Early Childhood. She is endorsed as Infant Mental Health Mentor--Clinical and Policy and has a Master of Public Health. Her special interests include early childhood development, systems of care, and reflective supervision. She has made more than 100 presentations and serves on advisory committees, work groups, and boards.

Kate Allen, Housing Development Consultant, Community Development Services

Kate is the principal of Kate Allen Community Development Services, a Women Business Enterprise firm providing consulting in community development and affordable housing for nonprofits, government and community organizations, with an emphasis on eliminating racial disparities, serving people with special needs, and leveraging improved outcomes for residents of affordable housing by building linkages with jobs, education, transportation and civic engagement. Kate has worked in housing and community development in Portland and across Oregon, in a variety of roles, for more than 25 years. From 2008 until 2013 Kate worked for the City of Portland Housing Bureau on the Equity, Policy and Communications team. Kate currently serves as the board secretary of Our Ethiopian Home, working to transition youth from orphanage to independence in Addis Ababa, Ethiopia. Kate lives and works in Portland and Astoria.

Hannah Ancel, Community Health Manager, Jackson Care Connect

As the community health manager for Jackson Care Connect, Hannah works to engage community partners in implementing programs to address social determinants of health. During her three and a half years at Jackson Care Connect, Hannah has worked with her team to grow programs that incentivize preventive health and support stable families. Hannah applies her degree in anthropology to consider the systems and cultural appropriateness that impact access to services and ultimately health outcomes.

Rose Anderson, Recovery Ally/Peer Mentor, Clatsop Behavioral Healthcare

Rose is a certified recovery mentor (CRM) through the State of Oregon. Rose has been in recovery for over nine years and has worked in the recovery field for seven years. She is currently working as a CRM for Clatsop Behavioral Healthcare in Astoria, Oregon. Recovery can be a complex and dynamic process. Rose helps clients navigate this journey by helping clients

recognize and connect to the physical, social and emotional benefits of entering a life of recovery. Peer delivered services are a central component of the service model associated with The Agate House project. Rose offers support and encouragement to women and their children in this new sober living apartment. She meets with them weekly to help them on their personal recovery journey. This journey requires courage and commitment, it fosters healthy parenting relationships, enriched lives and promising futures.

Michael Anderson-Nathe, MPA, Chief Equity & Engagement Officer, Health Share of Oregon

Michael is the chief equity and engagement officer for Health Share of Oregon. Michael serves on the executive team of Health Share and is charged with enabling health care transformation by engaging Health Share's members, affiliates and community service providers to cultivate innovative approaches to addressing social determinants of health outcomes, upstream prevention, health equity and facilitating member engagement. Michael has a long history of working for social justice. Prior to joining Health Share in 2014, Michael worked for the Cascade AIDS Projects for almost 10 years in a variety of positions including as the director of prevention and education services, and an interim co-deputy executive director. Michael has over 20 years of experience working in partnership with marginalized communities on issues of sexual health, health equity and social justice. Michael holds a Master of Public Administration from Portland State University with a focus on organizational development, intercultural communication and leadership and a certificate in diversity and inclusion from Cornell University.

Jessica Arzate, MA, Senior Director of Impact, Greater Than

Jessica is the senior director of impact at Greater Than (formerly "I Have a Dream" Foundation of Oregon), an education nonprofit working in partnership with the Reynolds School District. As a member of the leadership team at Greater Than, she drives decisions and strategy for the organization's impact model. Jessica is also an elected school board member on the Multnomah ESD School Board for Zone 4 (East Portland) and brings over a decade experience as an educator and cross-sector and systems collaborator.

Cara Ashworth, MPH, Program Manager, ShelterCare

Cara is a native Oregonian who grew up in the Eugene/Springfield metro area. Cara graduated from Oregon State University with a Master of Public Health, specializing in health promotion. Cara has worked for nonprofits serving marginalized populations for 10 years, working primarily with the LGBTQ+ community, and individuals and families experiencing poverty and homelessness. Cara now works as a program manager for ShelterCare's short-term housing programs, which consist of a variety of emergency shelter and rapid rehousing services for Lane County residents.

Alysha Barraza, MBA, Systems Operations Manager, Douglas ESD

Alysha is the systems operations manager at the Douglas Education Service District in Roseburg, Oregon. She holds a Bachelor of Science from Oregon State University and a Master

of Business Administration in Executive Leadership from Northwest Christian University in Eugene, Oregon.

In her current work with the Douglas ESD, Alysha has developed software and systems to increase efficiency and streamline processes. These include work with the Early Learning Division and multiple early learning hubs to manage grant reporting, contract management, and data tracking. Other organizations using the software and systems have included a community based universal intake and referral system with time tracking and automation, public school districts student tracking, and donation/pledge systems.

Prior to her work with the Douglas ESD, Alysha worked in the community college field streamlining processes, writing procedures and protocols, advancing student retention, and managing grants. She served on many committees to improve student success, curriculum approval, equity and diversity, and process development.

Emily Barton, Grant Writer, Boys & Girls Club of Corvallis

Emily, a grant writer at the Boys & Girls Club of Corvallis, was an instrumental member of the fundraising team that made the Youth Med! project possible. A former voting member of the IHN-CCO Delivery Systems Transformation Committee, she is passionate about building equity, diversity and inclusion for youth and addressing upstream health disparities. Emily is a member of the Corvallis School District's DELTA (District Equity Leadership Team Advisory) group. Together the district and advisory group build support for families and students from racial, ethnic and religious minority groups. Emily holds a bachelor's degree in economics with a focus on law and policy.

Erin Bartsch, MS, P-3 Coordinator, Blue Mountain Early Learning Hub

Erin is the P-3 coordinator for the Blue Mountain Early Learning Hub, which is a partnership between Umatilla Morrow Head Start and InterMountain Education Service District. Trained in conscious discipline, Erin coordinates professional learning teams and other training opportunities in conscious discipline through the Hub's region. Erin has a MS in Child Development and Families Studies and has worked for Umatilla Morrow Head Start for 12 years.

Marilyn Berardinelli, Systems & Workforce Development Manager

Marilyn leads systems and workforce development efforts at the Oregon Center for Children and Youth with Special Health Needs. The center, located at Oregon Health & Science University, is Oregon's public health agency for this population.

Iris Bicksler, Traditional Health Worker Program Supervisor, Cornerstone Community Housing

Iris has 20 years of experience working in social service, health care access, policy change and advocacy of underserved populations. She is a certified community health worker, peer support specialist and doula. Currently, Iris is the traditional health worker program supervisor for Cornerstone Community Housing, an affordable housing nonprofit in Lane County.

Danell Boggs, LCSW, Tillamook Community Health Centers

Danell is a native Oregonian, born and raised in Tillamook County, and believes it is vitally important that quality services are available to the people of her rural community. Danell graduated from Portland State University with a master's in social work and became a licensed clinical social worker. She is a certified drug and alcohol counselor I, certified gambling addiction counselor II, and certified grief recovery specialist. Danell has spent the past 18 years working with individuals in Tillamook County who experience developmental disabilities, and in the mental health and addiction field, including problem gambling services. She began working for Tillamook County Community Health Center in September 2018 as a behavioral health clinician and oversees the new medication assisted treatment program. Danell has a strong belief that integrated behavioral health is the way of the future; that all individuals should be able access the support and care they need to have a full and balanced life.

Erin Brochu, LCSW, EMS Social Worker, Tri-County 911 Service Coordination Program

Erin is a licensed clinical social worker and certified alcohol and drug counselor. Erin is an EMS social worker with the Tri-County 911 Service Coordination Program (TC911), a community based, short-term program serving residents of Washington, Clackamas and Multnomah counties having frequent interactions with ambulance and fire first responders. Erin has been with the TC911 team since its inception. Today, she is the program point of contact for referrals and provider consultations. Prior to working with TC911, Erin primarily provided substance use counseling and treatment, including medication assisted treatment.

Joseph Chick, MA, MBA, Program Administrator, ColumbiaCare Services

Joseph is a program administrator for ColumbiaCare Services. He manages all the veteran's programs as well as our rental assistance programs, housing and community-based projects for Southern Oregon. He has an MBA in Health Care Administration and an MA in Psychology to go with his 20 years of experience.

Tim Cling, Sr. Director of Business Operations, ShelterCare

Tim oversees the operations of ShelterCare. Included in his duties are the informatics measures of the quality, outcomes and financial impact of ShelterCare and its various programs.

Amanda Cobb, Executive Director of Medicaid, Trillium Community Health Plan

Amanda is the executive director of Medicaid for Trillium Community Health Plan and has nearly 20 years of experience working within the health care community. In past roles she worked for Health Policy Research Northwest, and as Trillium's manager of data analytics and reporting did extensive research on population health and community determinants of health and health equity. Currently Amanda is working to engage community partners and help promote policy alignment.

Tonya Coker, EI/ECSE Coordinator, Willamette ESD

Tonya has been an administrator in Early Intervention/Early Childhood Special Education for the last seven years. She specializes in autism spectrum disorder and other significant

disabilities. Tonya is a certified trainer in collaborative problem solving and is committed to trauma informed practice. She has dedicated the last several years to working closely with medical and mental health to connect the medical and educational worlds.

Kristi Collins, M.Ed., Director, Early Learning Hub of Linn, Benton and Lincoln Counties

Kristi's passion for early childhood education began as a young parent volunteer when her own son attended Head Start. She has devoted her career to the field earning a master's degree in early education and child care and a BA in multidisciplinary studies with an early care and education concentration from Cambridge College. Kristi's work experience includes work in private preschool programs, federal and state funded programs, and national nonprofits. She has worked in a range of roles from classroom assistant, teacher, center director, education specialist, community college adjunct faculty and program specialist. Her prior role before coming to the early learning hub coordinator position was as an early childhood program specialist in the Southern California region supervising and providing support, training and technical assistance to early childhood coordinators in the Early Steps to School Success program for Save the Children. The program focused on providing services to families with young children, increasing community awareness of the importance of early childhood education, and supporting home to school relationships in rural and remote areas.

Suzanne Cross, MPH, CHW, Senior Program Manager, Columbia Gorge Health Council & PacificSource Columbia Gorge CCO

Suzanne is the senior project manager for the Columbia Gorge Health Council (CGHC) which is a partner with PacificSource Community Solutions in the Columbia Gorge Coordinated Care Organization. As program manager for the Bridges to Health Pathways Community HUB Program, for which CGHC serves as the HUB, Suzanne has led the design, development and implementation of the program designed to provide cross-sector community care coordination for community members needing assistance.

Sankirtana Danner, MA, CCRP, Sr. Project Manager, Oregon Rural Practice-based Research Network

Sankirtana is a project manager at the Oregon Rural Practice-based Research Network (ORPRN) at OHSU. Through her work at ORPRN she administers the EOCCO Community Benefit Initiative Reinvestment Program. Sankirtana also works on the CMS-funded Accountable Health Communities project that screens Medicare and Medicaid beneficiaries for social determinants of health needs plus provision of resources and assistance to those most in need. Prior to her work with ORPRN, Sankirtana completed a master's degree in family therapy and worked with a research organization in Seattle, WA aimed to studying dissemination and implementation of evidence-based treatments for mental health issues.

Chris DeMars, MPH, Director, OHA Transformation Center

Chris is the director of the Oregon Health Authority Transformation Center, which is the hub of innovation and quality improvement for Oregon's health system reform efforts. In addition to managing the Transformation Center's supports and programs delivered at the health system,

provider and community levels, Chris plays a lead role in the agency's value-based payment and social determinants of health reform work. Before joining the Transformation Center in 2013, Chris spent eight years as a senior program officer at the Northwest Health Foundation, where she managed the foundation's health care reform grantmaking, including providing support for Oregon's delivery system reform initiatives and health reform advocacy organizations.

Prior to working for the foundation, Chris spent six years as a senior health policy analyst for the U.S. Government Accountability Office, where she authored numerous reports for Congress on Medicaid, Medicare and private health insurance payment policy. Chris has also held positions at Kaiser Permanente Northwest and health-policy consulting firms, including Health Management Associates, where she focused on public health, health system design and payment. Chris began her career as a policy analyst intern at Indiana's Office of Medicaid Policy and Planning. She currently sits on the National Academy for State Health Policy's Health System Performance & Public Health Steering Committee. Chris holds a Master of Public Health from the University of Michigan School of Public Health and a bachelor's degree in English literature from the University of Michigan.

Julia Doty, Director of Resident Services, Northwest Housing Alternatives

Julia is the director of resident services for Northwest Housing Alternatives. Her five years of experience providing resident services to NHA's senior population informed her understanding of the unique challenges faced by seniors living in affordable housing. She leads NHA's resident services program with a focus on helping residents age in place and access opportunities for growth with interventions based on demonstrable and measurable success.

Karen Edmonds, Programs & Services Director, FOOD for Lane County

Karen has been the programs and services director at FOOD for Lane County, the regional food bank serving Lane County, Oregon, for over ten years. The food bank has created health care partnerships to address the needs found at the intersection of hunger and health.

Sam Engel, Social Determinants of Health Manager, AllCare Health

With a background in food banking and food system work, Sam brings a lens of program operation to SDoH work. His work with AllCare Health focuses on food and housing and the interconnection of other SDoH on individual and community health. The aim is healthier, more livable and vibrant communities in southwest Oregon.

Angel Escobedo, MPA, Senior Program Development Specialist, Columbia Pacific CCO

Angel is the senior program development specialist at Columbia Pacific CCO (CPCCO). His role is to help CPCCO and community partners address childhood trauma and build resilience in children and families by supporting the development of Childhood Trauma-Informed Networks in Clatsop and Columbia counties. Angel has over 10 years of nonprofit leadership experience in the United States and abroad, most recently as executive director of Leadership Clark

County in Vancouver, WA, and formerly working in organizational capacity building for international non-government organizations in Guatemala and Pakistan.

Christopher Evans, Community Development Coordinator, Oregon Department of Human Services

Chris works as the community development coordinator with the Department of Human Services in Union, Baker and Wallowa counties, collaborating with local partners to further the vision of safety, health and independence for all Oregonians. He also previously managed emergency services and transitional housing programs at a Community Action Agency. Outside of this, Chris has also served as a volunteer with a shelter housing program in the Portland area, and now with the warming station in rural Union County.

Debi Farr, Manager of Community Relations, Trillium Community Health Plan

Debi is the manager of community relations at Trillium Community Health Plan. Farr's experience in community relations and public service spans more than two decades, including State Representative in the Oregon Legislature where she sponsored legislation that expanded the summer lunch program. She has been a member of both the Lane County Commission on Children and Families and the United Way Success by Six Leadership Team. Currently Farr represents Trillium on the Governance Consortium of the Lane County Early Learning Alliance and serves as chair of the Bethel School Board.

Melanie Fletcher, Rental Assistance Program Manager, Department of Housing Services, Washington County

Melanie is the rental assistance program manager for the Department of Housing Services, overseeing the Housing Choice Voucher program in Washington County. Melanie has been with the department for over 28 years and holds multiple housing industry certifications. Melanie is currently pursuing her Micro Master of Design Thinking from Rochester Institute of Technology, looking for innovative ways to successfully integrate affordable housing programs into neighborhoods and align housing programs with educational and economic empowerment programs.

Pamala Garrick, Grants Coordinator, Salem Housing Authority

Pamala has 30 years of experience in fields of addiction treatment, mental health, health care, juvenile and adult corrections, homeless outreach and housing. She is the coordinator of Emergency Housing Network, with 600 members statewide in Oregon. Pamala is also grants coordinator for Salem Housing Authority.

Alison Goldstein, Program Supervisor, Multnomah County Emergency Medical Services

Alison is the program supervisor for the Multnomah County Emergency Medical Services office and the Tri-County 911 Service Coordination Program (TC911). TC911 is a community based, short-term program serving residents of Washington, Clackamas and Multnomah counties having frequent interactions with ambulance and fire first responders. Under her leadership, TC911 has served over 1000 unique individuals and shown significant return on investment.

Alison is a licensed clinical social worker, with over 20 years of experience providing and supervising case management and behavioral health services for people with chronic health conditions, mental health and substance use disorders, involved in criminal justice systems, and those without stable housing.

Karen Hall, BS, Oral Health Integration Manager, Capitol Dental Care

Karen received her BS in dental hygiene from OHSU in 1985 and has practiced in family practices and community health settings. She has been involved in dental hygiene education for OHSU and Pacific University. She was employed by Virginia Garcia Memorial Health Center from 2007 to 2015 in clinics and school-based health centers. For six years, she worked for the Oregon Oral Health Coalition as an oral health educator creating and managing oral health initiatives. Currently Karen works as the oral health integration manager for the outreach team of Capitol Dental Care, placing expanded practice dental hygienists into non-traditional settings to meet the needs of Oregonians who have difficulty accessing dental services.

Claire Hambly, Education Program Manager, United Way of Lane County

Claire is the education program manager for the United Way of Lane County (UWLC). In this role she supports Lane County's Early Learning and Parenting Education hubs, as UWLC is the backbone support agency for both. Claire enjoys all aspects of her role, but especially appreciates the opportunity to work with other community members and agencies who are dedicated to ensuring that all children are cherished and raised in healthy, stable families.

Ashley Harding, Project Director, Native Connections Program, Yellowhawk Tribal Health Center

Ashley is the project director of the Native Connections program at Yellowhawk Tribal Health Center in Mission, Oregon. She works collaboratively across many disciplines to strengthen relationships, establish trauma-informed practices and enhance capacity for self-regulation. Ashley has worked in various capacities for tribal communities across the nation focusing on community mobilization, health equity, social justice, child development and child welfare. She received her bachelor's degree from Michigan State University.

Dana Hargunani, MD, MPH, Chief Medical Officer, Oregon Health Authority

Dana joined the Oregon Health Authority (OHA) as chief medical officer in January 2018. In this role she provides clinical leadership and integrated thinking to support implementation and spread of the coordinated care model and to transform Oregon's health care delivery system. She serves as the director of OHA's Office of Delivery Systems Innovation and provides guidance to initiatives across the agency focused on clinical policy, resources and quality improvement. From 2011 to 2015 Dana directed children's health policy for OHA in her role as child health director. In the interim she has served as the chief executive officer for the Oregon Public Health Institute and served as an independent health policy consultant focused on child and family health. In addition to her public health and policy focus, Dana continues to work part-time as a general pediatrician in a small, community-based clinic serving low-income families.

Lisa Harnisch, Executive Director Marion & Polk Early Learning Hub

Lisa is the executive director of the Marion & Polk Early Learning Hub. She effectively convenes community partners around a common agenda and the goals of kindergarten readiness, family stability, and services in a coordinated and aligned matter. She is very well connected to the broad scope of early childhood services in her region. Past experiences include transition director of the Early Learning Division, DHS and OHA Shared Services human resources administrator, DHS people and culture manager and core values initiative manager. Through her leadership, Act Early resources are present in many and varied early childhood agencies and clinics.

Amy Hendrix, Health and Nutrition Director, Umatilla-Morrow Head Start/WIC

Amy has spent 20 years working to improve the health of low-income families, serving a variety of roles in federal, state and locally funded programs and projects. She is passionate about ensuring that all children and their families have access to quality health services.

Terra Hernandez, Lead Education Specialist, Every Day Matters, Oregon Department of Education

Terra is the Every Day Matters, lead education specialist, with the Oregon Department of Education. She has been supporting the implementation and planning of the statewide attendance plan. Terra has spent the last 15 years in the education field in Nevada, Colorado and Wyoming as a classroom teacher, instructional coach, staff developer, and as an education consultant for the Wyoming Department of Education. Terra believes that education across Oregon is valued, and she will stand in the gap for students, caregivers and families. She advocates for all communities to wrap their arms around Oregon's youth, and believes anyone can follow their dreams if given the opportunity to seek their educational desires.

Schuyler Hibbard-Swanson, MA, MPH, Project Manager, Marion & Polk Early Learning Hub

Schuyler is the project manager for the Care Connect program with the Marion & Polk Early Learning Hub. She previously worked as the service integration coordinator for Salem Health and holds a master's degree in public health from Portland State University.

Helen Higgins, CEO, Boys & Girls Clubs of Corvallis

Helen joined the Boys & Girls Club in 2006 after an 18-year career with Hewlett Packard. Helen is actively engaged in the community including past service on the school board, Rotary International, and was just named the 2018 Corvallis Chamber's Business Person of the Year.

Amy Hoffert, MS, Operations Coordinator, Blue Mountain Early Learning Hub

Amy is the operations coordinator for the Blue Mountain Early Learning (BMEL) Hub, which is a partnership between the InterMountain Education Service District and Umatilla Morrow Head Start. Amy facilitates the day-to-day administrative and operational functions of the hub and collaborates with multiple committees in their work toward creation of a coordinated data informed system of early learning services. She has been trained in conscious discipline and works collaboratively with school districts and community partners to expand its

implementation throughout the region. Amy has an MS in Education, has taught K-12 for 15 years, and has been a coordinator for the BMEL Hub for three years.

Carly Hood-Ronick, MPA, MPH, Senior Manager of Health Equity, Oregon Primary Care Association

Carly oversees the social determinants of health and equity work at the Oregon Primary Care Association alongside community health centers around the state. She provides training and technical assistance, supports policy and metric development, and works with national partners on health care transformation efforts. With over a decade of experience in domestic and international work, she is called upon as a leader in systems-level equity efforts. She is co-chair of the Oregon Health Policy Board's Health Equity Committee, supports metric development in this innovative space, and is a proud board member of Project Access NOW. Carly has worked alongside communities in multiple states and countries to develop upstream programs and has published work on best practices in financing social care efforts. She received her Master of Public Affairs from the Robert M. La Follette School of Public Affairs and her Master of Public Health from the University of Wisconsin-Madison.

Meredith Howell, Resource Development Officer, NeighborWorks Umpqua

Meredith is a well-respected grant writer, grant coach, trainer and facilitator, and her work spans the fields of organizational, workforce and community development. Her background in scientific research, teaching and curriculum development at the university level helps her effectively communicate complicated and abstract concepts to audiences. Meredith joined NeighborWorks Umpqua in 2018 and serves as their resource development officer. She also continues to teach her popular Learn By Doing – Grant Writing Workshop in rural Oregon.

Jazmin Jackson, Community Health Worker, OHSU Family Medicine at Richmond

Jazmin is a state-certified community health worker at the OHSU Family Medicine at Richmond in southeast Portland. Based out of a family medicine clinic, she has the opportunity to support patients of all ages get connected with resources to lower any social barriers that can affect their overall health. Jazmin works on an SDoH team that thinks creatively about current service connections, gaps and ways to move social determinants of health work forward to best meet health needs and serve the community.

Rhonda Janecke, RN, CCM, Maternity Case Manager, Cascade Health Alliance

Rhonda joined Cascade Health Alliance in 2014. She works with high-risk maternity members, offering a Prenatal Incentive Program for pregnant members age 15–40 and works with members, providers and community partners to address social determinants for pregnant women and their children. She facilitates access to medical, dental and behavioral health care; transportation; housing; food bank; parenting classes; and other community resources.

Marnie Jewell, MA, Education Programs Specialist, Oregon Department of Education

Marnie serves on the Every Day Matters team at the Oregon Department of Education. Before joining the team in January 2019, she served on the secondary/post-secondary transitions

team working with CTE licensure and programs of study. Marnie spent most of her time in education in the school counseling realm. She has served as both a school counselor and counseling program associate in Salem-Keizer, a high school counselor at Chemawa Indian School, and as high school counselor in Woodburn.

Marnie completed her Bachelor of Arts with Corban in their adult studies program, and her Master of School Counseling from George Fox University. She has also completed the initial and continuing administrator programs at Portland State University. Marnie served as adjunct faculty in George Fox University's graduate school counseling program from 2011 to 2016.

Emily Johnson, Community Health Specialist, Yamhill Community Care

Emily serves as the community health specialist at Yamhill Community Care Organization. She is responsible for leading the community health assessment and improvement plan, as well as coordinating the community advisory council, which advises the YCCO board of directors. She also chairs the YCCO equity work group, which leads strategies around health and social equity, inclusivity and diversity, and building understanding of disparities. Emily graduated from Grinnell College in Iowa and lives in McMinnville.

Erin Jolly, MPHA, Senior Program Coordinator, Washington County Public Health

Erin is a senior program coordinator in the Health Equity, Planning and Policy Program at Washington County Public Health. She coordinates the community health improvement plan along with other community health initiatives. Erin has extensive training and experience in facilitation tools and methods, public health accreditation, community health assessment processes, and community engagement. She earned her bachelor's degree from Mills College in Oakland, California and her Master of Public Health from Portland State University. She participated in the 2014 National Leadership Academy for the Public's Health and the 2016 National Quality Improvement Leaders Academy Program.

Ed Junkins, MD, Pediatrician, Western University of Health Sciences

Ed is a board-certified pediatrician and emergency physician who has dedicated his career to the wellness and health of children. He's an experienced academician who has served as faculty educator, grant-funded researcher and administrator for more than two decades. During this time, he has delivered more than 100 professional communications, including peer-reviewed manuscript publications, abstracts and invited scholarly presentations.

Peg King, MPH, MA, Manager of Early Life Health Partnerships, Health Share of Oregon

Peg is the manager of early life health partnerships at Health Share of Oregon. Peg works closely with the tri-county early learning hubs and community-based organizations on a variety of initiatives. Peg has also worked in public health, higher education, research, philanthropy and freelance writing, all in pursuit of improving lives of women and children and addressing the social determinants of health and education. She spent four years overseas, first as a Peace Corps volunteer in Kenya, and later working in Tanzania and Taiwan.

Anne King, MBA, Director of Health Care Initiatives, Oregon Rural Practice-based Research Network, OHSU

Anne is the director of health care initiatives for the Oregon Rural Practice-based Research Network at OHSU. She has worked in health care research and administration for over 17 years and is the project director for the Accountable Health Communities project, which is working to implement social determinants screening and navigation for Medicaid and Medicare members in nine Oregon counties. She has partnered with the Eastern Oregon CCO since 2014 to implement the Eastern Oregon Community Benefits Initiative Reinvestment Fund. She also serves as principal investigator for several Oregon primary care transformation projects.

Cheryl Kirk, RDN, Instructor on Family and Community Health, OSU Extension

As a registered dietitian/nutritionist, Cheryl brings over 25 years of experience in community and clinical-based nutrition education to her work with Oregon State University Extension, communicating current information for food safety, nutrition education, and school and community garden efforts. She works to improve access to healthy food, physical activity and health care for people of all incomes and demographics.

Lynn Knox, State Health Care Liaison, Oregon Food Bank

Lynn has worked as the state health care liaison for the Oregon Food Bank since 2014. She has helped hundreds of health care organizations implement food insecurity or a broader social determinants screening and then connect patients to resources. Over 90 of these groups have worked with Lynn to establish deeper nutritional interventions such as cooking, gardening or smart shopping, medically tailored meals post discharge, diabetes support groups and clinic pantries or produce distributions. Lynn has worked with OHA staff on development of a social determinant screening and intervention metric and served on a CMS committee for the same purpose. Lynn's previous work included managing a network of 30 poverty reduction programs, working in Kaiser Permanente health education, and working with the Massachusetts Department of Public Health.

Kyle Lakatos, MS, Co-Founder & Executive Director, ECHO Initiative, Family & Community Medicine, University of California-San Francisco

Kyle is an aspiring physician and politician with ambitions to create a culture of health, emphasizing an expansion of health care systems to be more community-centric. In partnership with the San Francisco Health Network, he is currently working to bridge the gap between local communities and the clinics through collaborations based around early childhood development. He previously held a dual role as a professor of chemistry and as a vaccine researcher for the global health, nonprofit PATH. Kyle will be starting medical school this fall at the University of California, San Francisco.

Curtis Landers, Sheriff, Lincoln County

Sheriff Landers began his career with the Lincoln County Sheriff's Office in 1987 as a records/property clerk. In 1989, he was promoted to corrections officer and worked in the jail. In 1991, he was promoted to patrol deputy. In this position, he served as the contract deputy

for the City of Depoe Bay for two years and was on the Multi-Agency Crash Team. In 1997, he was promoted to the rank of patrol sergeant where he managed the field training program for new patrol deputies and was in charge of continued training for the patrol deputies.

In 2005, he was promoted to the rank of administrative lieutenant. In this position, he was responsible for obtaining and administering grants, policies and procedures, sheriff's office training, and risk management for the Sheriff's Office. He also oversaw the county's emergency management program. On June 1, 2016, the Lincoln County Board of Commissioners appointed Curtis to complete Sheriff Dotson's final year of his third term when he retired. In November 2016, he was elected as sheriff and is currently serving a 4-year term. Sheriff Landers has attended the FBI National Academy, Oregon State Sheriff's Association Command College, the DPSST Supervisory and Middle Management courses, and has over 3000 hours of training in corrections, law enforcement, leadership and supervision. He earned an executive certificate from DPSST.

Dominique Latimer, MBA, Department Administrator, Mary's Woods

Dominique has been with Mary's Woods since October of 2014 while earning her MBA in Healthcare Management at Marylhurst University, and she developed many roles for her department. Starting off as a temp, she developed systems and processes that promoted her to operations coordinator. In that position she worked closely with the director as well as the community outreach coordinator, who led and developed the NHA project with her support.

Lo Lewis, MBA, LPN, Community & Provider Outreach, Trillium Community Health Plan

Lo is responsible for provider and community outreach for Trillium Community Health Plan. She combines her MBA and LPN degrees to connect with health care and community service providers to improve the care of the Medicaid population.

Karen Long, Special Programs Manager, Mid-Columbia Housing Authority

Karen is the special programs manager for Mid-Columbia Housing Authority. She was a driving force behind initial grant funding for the Bridges to Health Pathways Program. She supervises the three community care coordinators who are working inside Bridges to Health Pathways.

Leah Lorincz, RN, BSN, Health Services Coordinator, Advanced Health

Leah has been with Advanced Health for about two years, serving as the health services coordinator. Through this role she was selected to be trained as an adverse childhood experiences (ACEs) master trainer through ACE Interface, and she received her certification in January 2019. She has been an RN for 10 years and has worked in diverse health care settings in her community of Coos Bay.

Sonia Luna, Community Health Worker, Mosaic Medical

Sonia began her career in health care as a receptionist at Mosaic Medical. With her strength at building trusting relationships with patients, she was recruited to join the community health worker (CHW) team. Sonia has been instrumental to the success of the Rx to Move program.

As the first CHW to support this program's development, implementation and expansion, her insight into the barriers families face has been essential in successfully navigating hundreds of families to access movement. Sonia's experience as a mother to an energetic 7-year old allows her to build connections with families as she helps them identify activities of interest, enroll and bust the barriers to participation.

Lindsey Manfrin, DNP, Deputy Director and Public Health Administrator, Yamhill County

Lindsey is the deputy director and public health administrator for Yamhill County. She has a Doctor of Nursing Practice Degree and a Master of Nursing in health systems and organizational leadership from Oregon Health and Science University. In 2016 she concluded a year-long clinical innovation fellowship with the Oregon Health Authority Transformation Center in which she focused on systems changes related to the psychosocial aspects of the perinatal period to improve outcomes for moms and babies. She is involved in many aspects of state and local work focused on the social determinants of health and health systems improvement.

Linda Mann, BS, RDH, EPDH, Director of Community Outreach, Capitol Dental Care

Linda is director of community outreach for Capitol Dental Care. Linda's responsibilities include implementing evidence-based practices in outreach programs to provide preventive services in community settings. Her work experience includes 18 years with the Confederated Tribes of Grand Ronde where she began her outreach work with the Head Start population. She has worked the last seven years with Capitol Dental. Linda was a 2015 fellow with the Oregon Council of Clinical Innovators. Linda has been instrumental in bringing teledentistry services to several sites in Oregon.

Rebeca Márquez, Abuela, Mamá y Yo Project Manager, Familias en Acción

Rebeca is the Abuela, Mamá y Yo project manager at Familias en Acción. She is an experienced educator in both Mexico and the United States and has background in nutrition. She most recently worked at the Immigrant and Refugee Community Organization as a community health worker and was recruited to Familias en Acción specifically to manage this project. She is a bilingual and bicultural Latina.

Chad McComas, Executive Director, Rogue Retreat

Chad is the founder and current executive director of Rogue Retreat serving Medford since 1998. Rogue Retreat is dedicated to helping the homeless develop life skills needed to become independent and self-sufficient.

Marci McMurphy, Business Development Director, Greater Oregon Behavioral Health, Inc.

Marci has been a project manager at GOBHI for the last one and a half years. During that time, Marci has developed and implemented two direct client service programs that have a significant impact on the social determinants of health for the individuals involved: 1) Money Management, which is a representative payee program; and 2) Frontier Veggie Rx, which is a fresh produce subscription program. The Frontier Veggie Rx program currently serves

Sherman, Gilliam, Wheeler and Harney counties. Marci has over 25 years of experience serving individuals and families through various social service programs, including senior services, juvenile probation, high-risk housing assistance, food assistance and other programs.

Cami Miller, Union County Warming Station Director, Eastern Oregon CCO Union LCAC Coordinator

Cami became the warming station director when her local community advisory council asked her to be responsible for the project supported by community benefit funds. She was honored to take on the project and has a passion for removing barriers and helping the housing challenged and anyone in need. She has worked with the station team from day one to make this a reality and has been dedicated to the future of the program. She is a mother/step mother of six, a wife, and a recovering addict, who spent most of her youth in rural eastern Oregon. She dreams of someday becoming an epidemiologist.

Phyusin Myint, PhD, Public Health Program Supervisor, Washington County

Phyusin holds a PhD in Public Affairs and Policy from Portland State University and a Master of Science in Public Policy. Phyusin has over twelve years of experience working in program management and strategic planning for complex human and health related issues in higher education, government and the nonprofit sector. Currently she is a public health program supervisor for the Health Equity Planning Program at Washington County. She supervises a team of program experts working specifically to promote and support policy, systems and environmental changes to improve the health of Washington County.

Tricia Mortell, MPH, RD, Public Health Division Manager, Washington County Public Health

Tricia has been the public health division manager for Washington County Public Health for the past five years. Tricia received a BS in Community Nutrition through Oregon State University, is a registered dietitian and holds a Master of Public Health from the University of Washington. Throughout over 30 years of public health practice, she served in leadership positions with Council of Local Health Officials, Washington Association of Local WIC Agencies and Oregon Public Health Association and was a project lead for a team appointed to the National Leadership Academy for the Public's Health.

Christine Mosbaugh, MPH, Engagement and Communication Coordinator, Population Health Manager, Community Health Centers of Benton and Linn Counties

Christine is the engagement and communication coordinator and population health manager at the Community Health Centers of Benton and Linn Counties, a six-clinic federally qualified health center system serving a two-county region. Her work focuses on supporting primary care teams and organizational initiatives, as well as community engagement. A major focus for the organization in the past two years has been on social determinants of health (SDOH) screening and measurement, use of the PRAPARE tool, and connecting patients to local resources. Christine has led that effort through the pilot project she is sharing today, educating clinic staff about why and how we engage in SDOH work, as well as supporting recent reorganization of our care teams to more strategically focus on the characteristics and

management of our clinic population. Christine has a Master of Public Health from the University of Cincinnati and an undergraduate degree from the University of Oregon. She has worked in reproductive health care, academic medicine, adolescent health care research, and is now part of the Patient Centered Primary Care Home model in Oregon.

Heather Oberst, MS, Community Health Improvement Coordinator, Columbia Pacific CCO

Heather is a health communicator by training with a background spanning hospital to community to health plan, rural to urban, and academic to grassroots settings. She believes the most important and innovative work is made better by community partnerships. As a community health improvement coordinator for Columbia Pacific CCO, Heather works to find new ways to evaluate and act on community priorities at program and systems levels. Example areas of recent work areas include intimate partner violence and healthy relationships, diabetes prevention, Oregon Health Plan benefit education, and person-centered methods for assessing community need.

Brian Park, MD, MPH, Assistant Professor, Oregon Health & Science University

Brian is a family medicine physician at the OHSU Richmond Clinic, a community health center providing care for urban underserved communities in Southeast Portland. A passionate advocate for health equity, he is the director of Diversity-Equity-Inclusion at OHSU's Department of Family Medicine and co-founded the Health Equity And Leadership (HEAL) program, a clinic-based community organizing initiative building coalitions of patients, community organizations, and health care providers to advance patient-identified social policies. He also co-founded and directs the Relational Leadership Institute (RLI), an interprofessional leadership learning collaborative developing relational change-agents for advancing systems and social change in health care.

Maegan Pelatt, MSW, CSWA, Medical Social Worker, CareOregon

Maegan is a medical social worker currently managing maternal child youth programs for CareOregon; a health organization which supports three of Oregon's 15 CCOs. Maegan has been working to improve health outcomes among Oregon's Medicaid population for over a decade. She has a Master of Social Work and will receive a Graduate Certificate in Infant Toddler Mental Health this June. Maegan has worked across the lifespan and believes the most valuable investments are the ones focused on supporting early life health.

Vanessa Pingleton, Rural Home Visiting Systems Coordinator, Douglas ESD

Vanessa is the rural home visiting systems coordinator at Douglas ESD with the South Central Early Learning Hub. Vanessa joined Douglas ESD in 2016 to coordinate/facilitate early childhood providers and cross sector stakeholders in building an early childhood system that is aligned and coordinated. She and her colleagues plan and partner with local and state stakeholders increase the number of children and families receiving family support so they might enter kindergarten school-ready. Prior to her work at the South Central Early Learning Hub, she worked at a mental health organization on a wraparound project between mental health and DHS for children placed in foster care.

Claire Pomeroy, MD, MBA, President, Albert and Mary Lasker Foundation

Claire is president of the Albert and Mary Lasker Foundation. She serves as chief executive officer of the foundation and oversees the implementation of programs that advance the foundation's mission to "foster the prevention and treatment of disease and disability by honoring excellence in basic and clinical science, and through public education and research advocacy." An expert in infectious diseases, Claire is a long-time advocate for patients, especially those with HIV/AIDS, and public health. She continues to lead an active research team studying host responses to viral infections. She has a special interest in health care policy, with a focus on the importance of the social determinants of health. She has published more than 100 articles and book chapters and edited three books.

Claire is chair of the board of directors for the Association of Academic Health Centers, immediate past chair of the Council of Deans of the Association of American Medical Colleges, co-chair of the Blue Ridge Academic Health group, and a member of the board of governors for the Foundation for Biomedical Research. She was recently appointed to the board of trustees for Morehouse School of Medicine. She serves on the NIH's Advisory Committee on Research on Women's Health and on the VA National Academic Affiliations Council. She was elected in 2011 as member-at-large-representative for the AAAS medical sciences section. Claire was inducted into the Institute of Medicine in 2011.

Claire received bachelor's and medical degrees from the University of Michigan and completed her residency and fellowship training in internal medicine and infectious diseases at the University of Minnesota. She earned an MBA from the University of Kentucky. She has held faculty positions at the University of Minnesota, University of Kentucky and University of California (UC) Davis, where she is currently professor emerita. Claire was chief of infectious diseases and associate dean for research and informatics at the University of Kentucky. At UC Davis, she served as executive associate dean and in 2005 was appointed vice chancellor and dean. She became president of the Albert and Mary Lasker Foundation in June 2013.

Megan Post, Director of Integrated Services, Center for Family Development

Megan is the director of integrated services at the Center for Family Development. She has worked in partnership with the Center for Family Development and Springfield Family Physicians since 2014 and is supervising the ICCM team.

Shelly Regianni, Ed.D, Executive Director of Equity and Instructional Services, North Clackamas Schools

Shelly is the executive director of equity and instructional services at the North Clackamas Schools. Instructional Services is the advocacy arm of instruction for North Clackamas Schools. She and her team support English learners, Title 1 schools, migrant students, students with talented and gifted learning needs, bilingual parent outreach, dual language immersion programs, Title 9, social services, and the equity professional development needs for the school district. Supporting schools with the resources, coaching and services needed to close the opportunity and achievement gap for historically underserved students is their top priority.

Mandy Rigsby, BA, NCAC II, CADC II, CGAC, Coordinator of New Day Program, Behavioral Health Care Coordinator, Umpqua Health Alliance

Mandy is the coordinator of the New Day Program for Umpqua Health Alliance. She holds a BA in Addiction Treatment and Prevention from the University of Nevada, Reno. Mandy is nationally certified as a drug and alcohol counselor for co-occurring disorders through NAADAC and certified by the state of Oregon as an alcohol and drug counselor and problem gambling counselor. She has worked in the addiction field for over 10 years. Mandy has overseen multiple residential and outpatient substance use disorder (SUD) programs in Nevada and Oregon. Currently, as the coordinator of the New Day Program for Umpqua Health Alliance in Douglas County, Mandy coordinates care, serves as a liaison between the member and local prenatal providers, provides referral to SUD treatment/MAT services/mental health services, and provides ongoing behavioral support for pregnant OHP members engaged in the program. She works extensively with community partners throughout the county to ensure members are receiving safe and stable housing, transportation, medical, mental health, and SUD/MAT treatment as needed.

Riki Rosenthal, Starting Strong Program Specialist, Jackson Care Connect

Riki is the Starting Strong program specialist for Jackson Care Connect. As a certified lactation counselor, certified community health worker, and trained peer support specialist, Riki is in a unique position to work with, and offer support to, pregnant members and their families. Riki believes every expecting family deserves access to all available supportive services to optimize opportunities for good health outcomes and a happy family. This passion fuels her commitment to this work. As a single parent, Riki's experience navigating through local resources has equipped her with both the knowledge and understanding to support her clients as they work to navigate many of the same services.

Jamie Russell, Lieutenant, Lincoln County Sheriff's Office

Lieutenant Russel began her career with the sheriff's office in 1992. During her career, Lieutenant Russell has served as a corrections technician, corrections deputy, and corrections sergeant where she received the Oregon State Sheriff's Association (OSSA) "Supervisor of the Year" award. In 2003, she was promoted to her current rank of corrections lieutenant and assigned as the jail commander. In this position, she oversees the daily operations of the jail division. Lieutenant Russel received the Oregon State Sheriff's Association "Jail Commander of the Year" award in 2007. She also received the OSSA "Presidents' Special Recognition" award in 2010 and the "Meritorious Service" award in 2012. Lieutenant Russell is an FBI National Academy graduate.

Sandy Ryman, MBA, Health Integrations Team Strategic Initiatives Director, Greater Oregon Behavioral Health, Inc.

Sandy has been with GOBHI since 2010 and has an extensive work background in community health education and an MBA. GOBHI recruited her from the Northeast Oregon Area Health Education Center where she had served for 19 years as Oregon's first center director. She has

worked within public health, mental health and a hospital setting during her career. Sandy is GOBHI's Health Integrations Team strategic initiatives director and has focused on housing for the past two years. La Grande is home and the site of the first successful passage of a tiny cottage zoning code.

Mike Savara, LCSW, CADC III, Dual Diagnosis Program Manager, Central City Concern Old Town Recovery Center

Mike is passionate about serving people experiencing homelessness with high quality services that rely on evidence-based techniques. He is the dual diagnosis program manager of Central City Concern's Old Town Recovery Center. Mike is current chair of the Homeless Alcohol and Drug Intervention Network and recipient of the National Homeless Social Work Initiative Award for dedication to helping homeless persons through social work practice, research and advocacy. Mike is also a subject matter expert with the National Healthcare for the Homeless Council, consulting in the areas of permanent supportive housing, mental health and addictions. His experience in the field spans from street outreach, medical respite programs, assertive community treatment and permanent supportive housing. Mike is a licensed clinical social worker and also received his Master of Social Work from New York University.

Jennifer Schlobohm, MSW, LCSW, Behavioral Health Supervisor & Instructor, OHSU Family Medicine at Richmond

Jennifer is a licensed clinical social worker who has practiced in a wide variety of clinical settings in the Pacific Northwest over the past 15 years. She is currently behavioral health supervisor and instructor at OHSU Family Medicine at Richmond. Through direct patient care and program innovations, Jennifer has championed increased integration of behavioral health, social determinants, and trauma informed care into health care delivery.

Josh Sendejas, Resident Service Coordinator and Community Care Coordinator, Mid-Columbia Housing Authority

Josh is a community care coordinator for the Bridges to Health Pathways program. He has worked with many families to reach outcomes such as adequate housing and housing related supports, legal services, dental services, food, and negotiating through disability processes. Josh is very dedicated to his work and feels that his lived experiences help him relate to his clients and vice versa.

Brian Shelton-Kelley, Director of Acquisitions and Development, NeighborWorks Umpqua

Brian has over 15 years of experience in the fields of community development and real estate development. He joined NeighborWorks Umpqua in 2017, and oversees the organization's real estate development activities, including rental and for sale housing development, affordable housing preservation, commercial/community facility development, and manufactured housing initiatives. He has experience developing senior housing, permanent supportive housing, affordable family housing, market rate housing, and commercial development. Brian approaches real estate development holistically, paring community needs with market demands to deliver sustainable, viable, thriving communities.

Karen Shimada, MPH, Executive Director, Oregon Oral Health Coalition

Karen is the executive director of the Oregon Oral Health Coalition and brings more than 30 years of public health, gerontology, nonprofit and primary care clinic management experience. Karen previously served five years as the executive director of the Clackamas Volunteers in Medicine free clinic. Each day she saw evidence that oral health is one of the most significant gaps in the continuum of services patients need. She is the Oregon State Rep to the DentaQuest Partnership and is part of the OPEN Network Capacity Building Institute. Karen serves on various committees and task forces that advocate for the integration of oral health and primary care. Karen completed her BS from University of Wisconsin and her MPH from University of Hawaii under a US Public Health Service Traineeship and lived internationally for nearly 20 years.

Ben Solheim, LPC, Community-based Program Manager & Administrator, Columbia Care Services, Inc.

Ben has been a licensed professional counselor in Oregon since 2014, and completed graduate studies in mental health counseling from Seattle University in 2008. His over two decades of experience began working with inner city youth in California and has extensive working experience with at-risk and homeless youth, adults and families in various treatment settings. For the past 8 years, his main focus has been developing, implementing and managing programs that serve the most vulnerable and marginalized populations in the community, adults with severe and persistent mental illness with challenging and unique treatment needs.

Steve Sparks, Project Consultant, Stepping Up Initiative, Lincoln County

Steve's career spans five decades with both private and public sector executive management experience. Steve earned a BA in Management from St. Mary's College, in Moraga, CA. He retired from Nortel Networks in 2002, and relocated to Depoe Bay, Oregon in 2005. Since then he has been self employed as a business transformation consultant. Steve has served on numerous nonprofit boards over the last 25 years and in elected office as city councilor. His work the last three years has been as a project consultant with the Stepping Up Initiative, Lincoln County Oregon Board of Commissioners and Sheriff. Steve's passion is mental health advocacy for children and adults. His current role is helping county stakeholders and partners build a stronger community-based continuum of care for the most vulnerable populations, including the homeless and others who suffer from mental illness and addiction.

Lindsey Stailing, Patient Support Manager, Mosaic Medical

Lindsey has a passion for connecting people, resources and ideas to achieve more. Serving nonprofits faithfully since 2007, Lindsey has worked on issues such as indigenous rights, dropout prevention, youth incarceration; provided employment training to opportunity youth in traditional and nontraditional school settings; and served as a grant writer. Lindsey now oversees the community health worker and language access programs at Mosaic Medical. She also serves as board member and secretary for Central Oregon's Homeless Leadership Coalition and represents Mosaic on the region's Non-Emergent Medical Transportation Advisory Committee.

Jamie Stevens, NCMA, ICCM Medical Assistant, Springfield Family Physicians

Jamie is the ICCM medical assistant at Springfield Family Physicians, doing triage work and patient care for the past 6 years. Her past experience in the medical field includes ER and cardiac diagnostic work at McKenzie Willamette Hospital.

Lynne Swartz, Executive Director, Parenting Now!

Lynne is executive director at Parenting Now!, managing the provision of parenting education and support groups and home visiting programs throughout Lane County. Parenting Now! also provides training for parenting educators throughout Oregon and the United States. Lynne is also a research scientist, having created more than 20 technology-based health behavior interventions with NIH funding.

LeAnne Trask, Pollywog Coordinator, Linn-Benton Community College

LeAnne is an Oregon girl who graduated from Corvallis High School, and went on to receive her BA from Brigham Young University in communications, with an emphasis on advertising and accounting, and an AS in Home and Family Development. She went on to earn a certificate as a social media specialist and is currently working on an accounting degree. LeAnne came to work at Linn-Benton Community College in the Parenting Education Department in 2014, and she was hired as the early learning hub program assistant in January 2015. Her current assignment is as the Pollywog coordinator. Her previous work experience includes Evanite Fiber, Town & Country Realty, Money Tree Software, and Securitas Security (Hewlett Packard), giving LeAnne a wide range of business and technical experience.

Angie Treadwell, RD, LD, SNAP-ED Program Coordinator, OSU Extension

Angie has over 20 years of experience working in public health nutrition programs serving low income families. She is active on several local, state and regional boards and committees seeking to improve population health through community-based work related to policy, systems and environmental change.

Stacey Triplett, MPP, Community Programs Manager, Worksystems, Inc.

Stacey manages community programs at Worksystems, Inc. and oversees a broad set of local relationships including the Aligned Partner Network, a coalition of community-based organizations working together to support workforce development efforts. She also oversees the HealthCareers NW program. Stacey has management and program development experience from her previous employment at Metro and the UCLA-Labor Occupational Safety and Health Program. She holds a Master of Public Policy and enjoys the intersection of civic, social and political life. Ella habla espanol. Stacey was an exchange student in her youth and maintains that language immersion experiences change lives.

Cathy Wamsley, M.Ed, Project Coordinator, InterMountain ESD

Cathy holds a Bachelor of Arts from Washington State University in Education and a Master of Education from Eastern Oregon State College. She retired from Umatilla-Morrow Head Start

after 36 years and currently works part time as the coordinator of the OCF-funded School-Based Oral Health Program since its inception in 2015.

Gillian Wesenberg, MA, Director, South-Central Early Learning Hub

Gillian is the director of the South-Central Early Learning Hub. She holds a Bachelor of Science in Communications from the University of Utah and a Master of Arts in Management from the University of Phoenix. Gillian served on the Douglas County Commission on Children & Families from 1994 to 2014, and she was a director and department head for the commission.

Prior to her work in Oregon, Gillian was executive director of a nonprofit for pregnant teens, an adjunct professor at Mountain West College-Salt Lake City, performance analyst for Hercules Aerospace, and a manager with the Marriott hotel. Gillian previously served on the Sutherlin City Council, as chair of the local Public Safety Coordinating Council, on the Douglas Family Partnership on mental health issues, as the local commission liaison to the Association of Oregon Counties Human Services Steering Committee and on the Local Government Advisory Committee to the Oregon Department of Human Services.

Karen Wheeler, MA, Business Development Director, Greater Oregon Behavioral Health, Inc.

Karen has over 30 years of experience working in Oregon's behavioral health system. Karen worked for the State of Oregon, Department of Human Services and Oregon Health Authority during her 21 years in state service, which included compliance and quality assurance, program and policy development, administering statewide behavioral health and addiction services, administering contracts and business operations.

Several of her key career achievements include serving as project director for health systems transformation, a project leading to the implementation of coordinated care organizations in Oregon in 2012; leading efforts to implement medically monitored detoxification services statewide; leading the development of parent-specific substance use disorder treatment for families involved in the child welfare system; and directing the implementation of new mental health investments worth over \$80 million from 2013 through 2017.

Karen is now in a leadership role with GOBHI as the business development director where she focuses on improving the value of services for Oregon Health Plan members through strategic partnerships and business opportunities. Karen holds a Bachelor of Science in Community Health Education and a Master of Arts in Organizational Management.

Charissa White, MHA, Transformation Analyst, InterCommunity Health Network CCO

Charissa is a transformation analyst with InterCommunity Health Network Coordinated Care Organization. In this role, she supports and leads health equity efforts in the region, focuses on integration of health care through pilots, and oversees transformation contracts. She has a background in health management and policy and a master's degree in health care administration from Simmons College in Boston, MA.

Laura Williams, Director of Community Engagement, Advanced Health

Laura is the director of community engagement at Advanced Health. She oversees the community advisory councils in Coos and Curry counties and serves on the leadership teams for the community health assessments and improvement plans. Laura works collaboratively with cross-sector community partners to align community health initiatives with the CCO transformation plan, quality metrics and equity-focused work. She has a Bachelor of Science in Public Health and has worked in managed care for over 20 years, 15 of those spent in behavioral health.

Mary Ann Wren, BS, RDH, EPP, Manager, Community Care, Advantage Dental from Dental Quest

Mary Ann holds a Bachelor of Science from Oregon Institute of Technology in Dental Hygiene/Hygienist. She has worked for Advantage Dental since September 2008.

Phillip Wu, MD, Retired Pediatrician

Phil, a retired pediatrician, has served on the board of directors at the Oregon Oral Health Coalition (OrOHC) since 2016. While working part-time with Community Benefit at Kaiser Permanente NW, he also serves as the chair of both the Northwest Health Foundation and Outside-In's board of directors. Phil has been instrumental in reshaping OrOHC's strategic direction to focus on the social determinants of health and equity, community engagement and integration. He received his bachelor's degree from Stanford University and completed his residency at Madigan Army Medical Center in Tacoma, Washington.

Kiara Yoder, Screening and Care Systems Coordinator, Marion and Polk Early Learning Hub

Kiara is the screening and care systems coordinator for the Marion and Polk Early Learning Hub. She is focused on better connecting the medical, education and social service sectors. Kiara has also worked for Women, Infants and Children (WIC) and Woodburn Pediatric Clinic.

Lucy Zammarelli, MA, CADC3, Supervisor & Health Equity Officer, Trillium Community Health Plan

Lucy is a supervisor at Trillium Behavioral Health and is Trillium's health equity officer. She has extensive experience integrating behavioral health and physical health care and achieving reduced health disparities for those with greatest need.

Caroline Zeller, DDS, MPH, Dental Surgeon, OHSU

Caroline joined the Oregon Oral Health Coalition board in September of 2018. A graduate of the University of Missouri Dental School, Dr. Zeller relocated to Portland to pursue an internship in oral and maxillofacial surgery at OHSU. She is a student in the OHSU/PSU public health department, working toward a Master of Public Health in Health Policy and Management. Her clinical time is currently divided between two roles: at Smilekeepers, she works as an internal surgery referral for patients that qualify for Medicaid, and at OHSU she is a general practice residency hospital faculty member, where she works with patients with special needs on their dental surgeries and care.

Café Session 1: 10-11 a.m.

Portland Ballroom 252	Portland Ballroom 253	Portland Ballroom 254	Portland Ballroom 255
<p>The Role of Workforce Development for Oregon Health Plan Families (Housing)</p>	<p>Innovation in Cross-systems Care Coordination: Shared Care Planning (Early Learning)</p>	<p>Eastern Oregon CCO Community Benefit Initiative Reinvestment Program (Housing)</p>	<p>Every Day Matters: Focusing on Regular Attendance and Reducing Chronic Absenteeism (Cross-Cutting)</p>
<p>Senior Health & Housing (Housing)</p>	<p>Youth-Med! The Stealth Medical Home for Youth Who Need Us Most (Early Learning)</p>	<p>Act Early Oregon (Early Learning)</p>	<p>Trillium Resource Exchange (Cross-Cutting)</p>
<p>ShelterCare Medical Recuperation (Housing)</p>	<p>Community UPLiFT Coordinated Intake/Referral (Early Learning)</p>	<p>Comprehensive School-based Oral Health Program (Early Learning)</p>	
Room D133	Room D134	Room D135	Room D136
<p>Parks Model Supportive Housing (Housing)</p>	<p>Promoting Health and Education by Addressing Emotional and Behavior Health with Trauma Informed Practices (Trauma)</p>	<p>Strategies for Addressing Food Insecurity & Nutrition in CCO, Clinic and Hospital Settings (Food Insecurity)</p>	<p>Universal Social Determinants of Health Screening at a Community Health Center through Multi-Disciplinary Collaboration (Cross-Cutting)</p>

Café Session 1 Project Descriptions

Act Early Oregon (Early Learning)

Sherri Alderman, MD, MPH, IMHM-E Policy & Clinical, FAAP, CDC Act Early Ambassador to Oregon; Lisa Harnisch, Executive Director, Marion & Polk Early Learning Hub

Act Early Oregon is a statewide initiative promoting early detection of developmental delays by educating and empowering parents/caregivers to partner with professionals in monitoring and advocating for their child's optimal development. We present the FREE CDC developmental resources and the Marion Polk Early Learning Hub's experience embedding these in the medical and early learning community.

Community UPLiFT Coordinated Intake/Referral (Early Learning)

Alysha Barraza, MBA, Systems Operations Manager, Douglas ESD; Rhonda Janecke, RN, CCM, Nurse Case Manager, Cascade Health Alliance; Vanessa Pingleton, Rural Home Visiting Systems Coordinator, South Central Early Learning Hub/Douglas ESD; Mandy Rigsby, BA; NCAC II; CADC II; CGAC, Case Manager Coordinator, Umpqua Health Alliance; Gillian Wesenberg, MA, Director, South-Central Early Learning Hub

Community UPLiFT is a coordinated early childhood referral system in Douglas, Klamath and Lake counties. It connects expecting parents and families with children 0–5, including children with special needs up to age 21, to resources through a closed looped referral system.

Community UPLiFT is a collaborative that includes 28 partners, including two CCOs and DHS.

Comprehensive School-based Oral Health Program (Early Learning)

Cathy Wamsley, M.Ed, Project Coordinator, InterMountain ESD; Mary Ann Wren, BS, RDH, EPP, Manager, Community Care, Advantage Dental From Dental Quest

Presenters will describe oral health services delivered in house at early childhood education programs (PreK-3 grades). Comprehensive services include screenings, fluoride varnish, sealants if applicable, referrals, dental kits and oral health education. Mini dental health bags are distributed to classrooms or a dental health lab is available at schools.

Eastern Oregon CCO Community Benefit Initiative Reinvestment Program (Housing)

Sankirtana Danner, MA, CCRP, Sr. Project Manager, Oregon Rural Practice-based Research Network; Marci McMurphy, Business Development Manager, Greater Oregon Behavioral Health, Inc.

This discussion will focus on EOCCO's Community Benefit Initiative Reinvestment Program, which provides grants to Eastern Oregon organizations serving Medicaid members. The grant program is beginning its fifth year in 2019 and provides funding to local community advisory councils, health care systems, and other community-based organizations to support projects addressing topics such as social determinants of health, community health improvement plan goals, and CCO incentive measures. The discussion will provide an overview of the grant

program and requirements and examples of past and current funded projects, with a particular focus around projects addressing housing and food insecurity.

Every Day Matters: Focusing on Regular Attendance and Reducing Chronic Absenteeism (Cross-Cutting)

Terra Hernandez, Lead Every Day Matters Education Specialist, Oregon Department of Education; Marnie Jewell, MA, Education Programs Specialist, Oregon Department of Education

The Oregon Department of Education has launched an Every Day Matters campaign, which is building relationships with our families through the support of other community-based organizations, state entities and nonprofit organizations. Collective impact from the community is key to opening doors for our students to reach higher academic outcomes. Regular school attendance is linked to better health outcomes and has a great impact on Oregon's economy. We are striving to equitably impact students and their families by showing we are all in this together, and there are various barriers, aversions and other factors that contribute to students not attending school.

Innovation in Cross-systems Care Coordination: Shared Care Planning (Early Learning)

Marilyn Berardinelli, BS, Systems and Workforce Development Manager, Oregon Center for Children and Youth with Special Health Needs

OCCYSHN supports cross-systems care coordination for young children with special health needs through an innovative process of shared care planning. Public health nurses convene care planning teams that include medicine, education, behavioral health and other community-based providers. Everyone works together to help the family achieve their goals for their child. The process addresses gaps and barriers for families it serves.

Parks Model Supportive Housing (Housing)

Joseph Chick, MA, MBA, ColumbiaCare Services; Ben Solheim, LPC, Community-based Program Manager & Administrator, ColumbiaCare Services, Inc.

As the housing crisis and efforts for community integration continues, it is critical that we build a continuum of care that meets specific housing and treatment needs of people experiencing severe and persistent mental illness. We have built a highly cost-effective supportive housing model that targets the most vulnerable with unique and challenging treatment needs that work.

Promoting Health and Education by Addressing Emotional and Behavior Health with Trauma Informed Practices (Trauma)

Erin Bartsch, P-3 Coordinator, Blue Mountain Early Learning Hub; Ashley Harding, Project Director, Native Connections Project Director, Yellowhawk Tribal Health Center; Amy Hoffert, Operations Coordinator, Blue Mountain Early Learning Hub

Children and families in our communities are experiencing trauma that impacts their education and health, especially those who have experienced generational trauma. Through partnerships between Tribal health and early education agencies, trauma informed social emotional skills for children and adults are being taught through community book studies, parenting education, and school practices. These have changed how families are dealing with emotions and trauma.

Senior Health & Housing (Housing)

Julia Doty, Director of Resident Services, Northwest Housing Alternatives; Dominique Latimer, MBA, Home Services Administrator, Mary's Woods

Northwest Housing Alternatives (NSA) and Mary's Woods are partnering to help low-income seniors living in affordable housing age in place and improve their health by pairing individual- and community-level interventions. First, referrals are made by NHA's resident services team to Mary's Woods for reduced-cost home care services for residents who are struggling to complete their ADLs independently but cannot access help through OHP or OPI. Second, community events that offer basic health screenings and preventive care are coordinated and hosted regularly. The two-pronged intervention is improving residents' health and quality of life while reducing symptoms of isolation and depression.

ShelterCare Medical Recuperation (Housing)

Cara Ashworth, MPH, Program Manager, ShelterCare; Tim Cling, Sr. Director of Business Operations, ShelterCare

Our ShelterCare Medical Recuperation (SMR) program is in collaboration with PeaceHealth Hospital and Trillium Community Health Plan. SMR provides 30-day recuperative services at a fraction of the cost of a hospital stay. Most clients are covered by Trillium.

Strategies for Addressing Food Insecurity & Nutrition in CCO, Clinic and Hospital Settings (Food Insecurity)

Lynn Knox, State Health Care Liaison, Oregon Food Bank

Oregon Food Bank has catalyzed and supports over 90 different projects with clinics, hospitals and CCOs to address food insecurity, nutrition and chronic disease across Oregon. Learn about best practices and see which models fit your patient population and resources. The goal of the session is to help participants understand the range of options and how to explore potential implementation.

The Role of Workforce Development for Oregon Health Plan Families (Housing)

Melanie Fletcher, Rental Assistance Program Manager, Department of Housing Services, Washington County; Stacey Triplett, MPP, Community Programs Manager, Worksystems, Inc.

Workforce development responds to needs for employment opportunity. Career coaching is one-on-one, individualized, strengths-based support that provides results. Locally, the A Home

For Everyone (AHFE) initiative has invested in employment outcomes for low-income populations. It is co-funded by the cities of Portland and Gresham, Home Forward and Multnomah County. Both the US Dept of Labor and the Office of Children & Families of US Health and Human Services have granted funds for customers receiving public benefits to receive career coaching and training scholarships to pursue careers in health care.

Trillium Resource Exchange (Cross-Cutting)

Amanda Cobb, Executive Director of Medicaid, Trillium Community Health Plan; Debi Farr, Community Relations Manager, Trillium Community Health Plan

Trillium's online community resource database (the Trillium Resource Exchange or T-REX) allows anyone to search for free and reduced cost services such as housing, food, goods, transit, money, care, education and more. Organizations can securely refer members to services and track engagement. There is also reporting of utilization by type of resource. The database is actively maintained by a third-party vendor, but anyone can suggest a resource or update their organization's profile.

Universal Social Determinants of Health Screening at a Community Health Center through Multi-Disciplinary Collaboration (Cross-Cutting)

Jazmin Jackson, Community Health Worker, OHSU Family Medicine at Richmond; Jennifer Schlobohm, MSW, LCSW, Behavioral Health Supervisor, OHSU Family Medicine at Richmond

Through multi-disciplinary collaboration, Richmond has developed and launched an SDoH screener to be used in all primary care visits. Drawing on established practices, a team of community health workers, social workers, and quality improvement staff established a tool, sustainable workflow, patient intervention, and data collection process with the goal of improving patient well-being.

Youth-Med! The Stealth Medical Home for Youth Who Need Us Most (Early Learning)

Emily Barton, Grant Writer, Boys & Girls Club of Corvallis; Helen Higgins, CEO, Boys & Girls Club of Corvallis; Dr. Edward Junkins, MD, Pediatrician, Western University of Health Sciences

We have partnered with Benton County Health Department and Samaritan Health Services to embed a medical home within the walls of our youth organization to provide out-of-school services to nearly 3,000 school-age youth. Through an innovative approach and partnerships, we're working to address upstream causes of generational poverty that lead to poor health outcomes by co-locating and integrating youth development practices, youth dental, medical and mental health services in a positive environment designed around a culture of trust.

Act Early Oregon

actearlyoregon.org

actearlyoregon@gmail.com

Act Early Oregon is a statewide initiative promoting early detection of developmental delays by implementing the FREE CDC developmental resources that are educational and empower parents/caregivers to partner with early childhood professionals in monitoring their child's development and advocate for their child's optimal development.

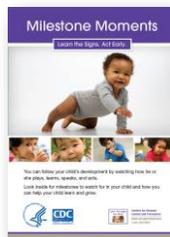
Marion Polk Early Learning Hub, Inc. has engaged with health and early learning partners to increase awareness of Act Early Oregon and use of the FREE resources.

Learn the Signs. Act Early.

Surveillance Resources for Parents

actearlyoregon.org

1. Educational
2. Parent vetted
3. Plain language, 5th grade reading level
4. Fun memento of child's developmental progress
5. Gives parents an active voice in surveillance
6. Functions as an objective tool for presenting parent's concerns
7. Promotes parent engagement and follow through with referral



Further Information or Technical Support:

Sherri Alderman
Act Early Oregon
actearlyoregon@gmail.com



FREE Parent Resources—English & Spanish, Birth to 5 years old

- CDC Milestone Tracker app
- Milestone Moment Booklet
- Milestone Brochure
- Children's books
- Milestone Video Library
- Milestone Checklists
- Talk-to-Doctor Parent Guide
- Talk-to-Parent Professional Guide
- Posters
- Much more!

To order:

actearlyoregon.org

Marion Polk Early Learning Hub Activities

- Training for community partners in the use of the materials. Will supply organizations information as requested.
- Childhood Health Associates of Salem uses the information with all Healthy Steps patients.
- Woodburn Pediatric and Salem Pediatric clinics use with patients.
- Community Action Agency includes Milestone Moments with registration in programs.
- Salem Keizer Public School Teen Parent Program utilizes the Milestone Moments in their program.
- Woodburn School District includes Milestone Moments Booklets in all kindergarten registration bags.
- Milestone Moments are handed out at appropriate community events.

Contact Information:

Sherri L. Alderman
CDC Act Early Ambassador to Oregon
actearlyoregon@gmail.com

Lisa Harnisch, Executive Director
Marion Polk Early Learning Hub, Inc.
lharnisch@earlylearninghub.org



Community UPLiFT is a coordinated early childhood referral system covering Douglas, Klamath and Lake Counties. It connects expecting parents and families with children 0-5, including children with special needs up to the age of 21 to resources in their community.

Community UpLiFT is a program of the South-Central Early Learning Hub and Douglas ESD. Douglas ESD received a two-year Home Visiting Coordination Systems Building grant from The Ford Family Foundation in 2016. Then, was awarded another two-year renewal grant in 2018.

Staffing Structure:

Regional Home Visiting Systems Coordinator
 Family Resource Facilitators (one per county)
 Klamath County - MIECHV Coordinator

- Douglas County
- Klamath County
- Lake County

Lessons Learned

- Go Slow to Go Fast
- Don't expect everyone to have immediate buy-in. It takes time to disseminate and get community buy-in.
- People need options. Some people burn bridges and will need continued options, some people have so much social chaos that they need more than one provider to help them.
- How much each of the twenty-seven community partners have learned about each other's services through this project. We thought we knew what other people provided; we thought we were doing all the work that was needed.

Intake and Referral Process

This process does not replace any current referral processes, but is an additional layer for families who have "fallen through the cracks" or who are at risk of such.



Community UpLiFT Family Resource Facilitator Receives Referral

Contact is attempted within forty-eight working hours

Once Family is contacted, a Family Support Questionnaire is completed

Voluntary programs are offered to family based on specified need(s)

Referrals for accepted services are submitted through a closed-looped referral system

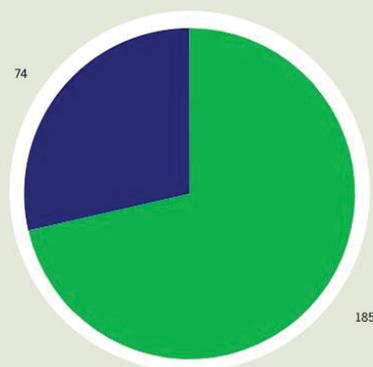
Impact and Outcomes

Since Community UPLiFT's soft roll-out in September 2017, we have received 259 referrals and out of those referrals, 185 have been connected to services.

Forty-two (42) stakeholders from the South Central Region participated in a System Survey for year two. Our data shows that stakeholders believed the following:

- There is effective communication between HV program leadership (e.g., HV supervisors, HV managers) within the county involved in the collaborative. 100% strongly agreed/agreed in 2018 compared to 2016 where 52% strongly agreed/agreed.
- There is effective communication between HV program leadership (e.g., HV supervisors, HV managers) within the region involved in the collaborative. 81% strongly agreed/agreed in 2018 compared to 2016 where only 32% strongly agreed/agreed that there was effective communication between HV program leadership within the region.
- HV program leaders are effective at working together to improve the overall HV system. 92% of stakeholder strongly agreed/agreed, compared to 52% in 2016.

259 Referrals Received



■ Connected to Services ■ Unable to Contact or Declined Services

Vanessa Pingleton

South Central Early Learning Hub
 Home Visiting Systems Coordinator
 Email: Vanessa.pingleton@douglasesd.k12.or.us
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Mandy Rigsby

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 Behavioral Health Care Coordinator/
 New Day Program
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 Phone: (541) 229-7049



Rhonda Janecke

Cascade Health Alliance
 Maternal Nurse Case Manager
 Rhonda.J@casadecom.com
 (541) 851-2058



Who's Involved?

Douglas ESD:
 South Central Early Learning Hub,
 Take Root Parenting Connection,
 Early Intervention/Early Childhood
 Special Education

Care Connections & Education

Lake ESD

Department of Human Services:
 Klamath/Lake- Douglas

Cascade Health Alliance

Umpqua Health Alliance

Douglas Public Health Network

Klamath County Public Health: WIC,
 Babies First & CaCoon

Lake County Public Health: Babies
 First-CaCoon-Maternity Nurse Case
 Management

Sky Lakes Hospital

Lake District Hospital

Klamath County Library

Klamath Basin Behavioral Health:
 Healthy Families

Family Development Center

Family Relief Nursery

UCAN: Healthy Start, Early Head
 Start/Head Start, Extended Babies
 First, CaCoon, Healthy Families

Klamath/Lake Early Head Start/Head
 Start

Oregon Child Development Coalition
 (OCDC) Head Start

Klamath Falls City Schools: Early
 Intervention/Early Childhood Special
 Education

Challenges

- Distance - Our region is 19,621 square miles of rural Central Oregon
- Three Counties
- Fear of programs losing referrals
- Cross-Sector partners not seeing the benefit or how it might tie into their objectives

Project Title:

Comprehensive School-Based Oral Health Program

Project Description:

Provide comprehensive school based dental health services to children/students in grades PreK – 12th grades in collaboration with Advantage Dental in all 18 schools districts in Union, Umatilla, and Morrow Counties. This includes dental screenings, fluoride application, sealants, referrals, dental health kits and oral health education. There is no cost for these services and are provided to all students, with parental permission, regardless of income.

Presenter Contact Information:

Cathy Wamsley, Project Coordinator
InterMountain ESD
cathywamsley@gmail.com
541 720 0142

Mary Ann Wren, Manager Community Care
Advantage Dental
maryw@advantagedental.com
541 504 3941

Impact, outcomes:

- Build partnerships with other funders to bring dental screening and preventive services into school settings
- Promote Oral Health literacy
- Develop infrastructure that provides all children in Oregon with timely access to age-appropriate dental care
- Children with untreated decay and urgent care needs are identified and receive care in a timely manner.

Challenges and how you overcame them:

The biggest challenge was getting parent release forms returned so children could be served - Incentives were offered to schools to give to children to return forms, mailing of release forms directly to parents, and utilizing passive consent forms.

Lessons learned – What would you recommend doing the same or differently if this project were replicated elsewhere in Oregon?

- Partner with your local Dental Care Organization
- Communicated this program widely in the communities through your local CCO Advisory Councils, Public Health, DHS, Behavioral Health, Schools, and community at large.

Organizations involved:

Public Health Departments, DHS, Schools, CCOs, DCO, Blue Mountain Early Learning Hub, Early Partnership Teams, LCACs, Hospitals, Preschools, Head Start, local Foundations, Behavioral Health, Home Visiting Programs, County Commissioners, and many others.



Eastern Oregon CCO Community Benefit Initiative Reinvestment Program

Program Overview

The Community Benefit Initiative Reinvestment Program provides funding to organizations in the EOCCO region to implement projects that improve the health of EOCCO members.

- **Local Community Advisory Council Grants:** Local Community Advisory Councils implement projects aimed at Community Health Improvement Plan goals, social determinants of health, and incentive measures.
- **Transformation Grants:** Projects aimed at specific incentive measures, including those such as Adolescent Well Care, Colorectal Cancer Screening, and Emergency Department Utilization
- **New Ideas:** Novel ideas focused on incentive measures, new collaborations, access to care and workforce issues, or behavioral health integration.

Program Highlights

5th year of CBIR Program underway	Approximately \$250,000 to Social Determinants of Health Projects in 2018	SDoHTopics: Housing, Food Insecurity, Transportation, Interpersonal Violence
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Project Highlight: Frontier Veggie Rx

Participating Communities: Wheeler, Sherman, Gilliam, and Harney counties

What is the Frontier Veggie Rx program?

- A fruit and vegetable prescription program designed to address food insecurity and increase the intake of healthy produce.
- The program empowers health care and social services providers to “prescribe” vouchers for healthy produce to qualifying community members.
- Vouchers can then be used to purchase healthy fruit and vegetables at participating stores.

How does it work?

- People are screened to determine eligibility for the Frontier Veggie Rx Program.
- If they qualify, they are given a booklet(s) of vouchers to redeem at a variety of local grocery stores, farm stands, or farmer’s markets.
- Providing direct access to healthy, local produce to those that need it most while strengthening the economy by keeping Local Community Advisory Council dollars local.

Who is eligible for the Frontier Veggie Rx program?

Anyone on the Oregon Health Plan that has screened positive for food insecurity by answering “Very Often” or “Often” to at least one of the two (2) screening questions.

- In the last 12 months, did you and the people you live with worry that you would run out of food before you were able to get more?
- In the last 12 months, did you and the people you live with run out of food before you were able to get more?

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Focusing on Regular Attendance and Reducing Chronic Absenteeism

Attendance matters for students at all grade levels. Students who attend school regularly are more likely to read at grade level, and to build a strong foundation as they move from preschool and kindergarten to high school. On the other hand, students who are chronically absent are at risk of falling behind.

What is Chronic Absenteeism?

Experts in the field define chronic absenteeism as missing 10 percent or more of school days and severe chronic absenteeism as missing 20 percent or more of school days, including excused, unexcused and discipline-related absences (Ehrlich, Gwynne, Pareja, Allensworth, Moore, Jagesic, & Sorice, 2014; Buehler, Tapogna & Chang, 2012; Connolly & Olson, 2004).

The 2015 Oregon Legislature enacted House Bill (HB) 4002 which directed the Oregon Department of Education (ODE) and the Chief Education Office (CEO) to develop a joint [statewide education plan](#) to address chronic absences of students.

How is Oregon promoting regular attendance?

The statewide plan outlines the structure for providing a proactive focus on building regular attendance among Oregon students. ODE has partnered with the P-20 Network to provide supports for school districts statewide. Regional Coordinators (based in their local Education Service District [ESD]) work to provide regional support to schools and districts. Schools with the highest levels of chronically absent students have had the opportunity to work with an ODE-funded coach to systemically address issues and barriers contributing to higher rates of absenteeism.

There are three main areas that both Regional Coordinators and ODE coaches have focused on this year:

1. **Data:** It is important that student information systems accurately capture student attendance information and that there is consistency across schools and districts.
2. **Teaming:** Attendance teams have proven to be effective in addressing student attendance, and schools and districts implementing these teams alongside local community partners to promote regular attendance.
3. **Communication:** Two-way communication tools have shown to be effective in improve student attendance. ODE has provided support to districts in developing strong communication tools.

Lessons learned:

1. School districts have needed supports to ensure that their student information systems are correctly “coding” student absences for monitoring and reporting purposes.
2. Districts report that the use of two-way communication tools has had a positive impact on student attendance and family engagement.
3. Teaming with community partners (such as health care providers and local businesses) has proven to be an effective support to improving student attendance.

Contact information:

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For more information, visit: <https://www.every-day-matters.org/>

Innovation in Cross-systems Care Coordination: Shared Care Planning

Presenter: Marilyn Berardinelli, BS, Systems & Workforce Manager, berardin@ohsu.edu

Co-author: Sheryl Gallarde-Kim, MSc, Assessment & Evaluation Research Associate

Summary Coordinating care across health and service systems is a promising strategy to address health, development, and social service needs of children and youth with special health care needs (CYSHCN).^{*} The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN)^{**} supports public health nurses to convene teams of professionals across organizations to develop **shared care plans** for individual CYSHCN (age 0-21). Teams include health, education, and community service providers, as well as the child's family.

The aim of shared care planning is to increase family knowledge, skills and confidence in ensuring care for their CYSHCN. Shared care plans address gaps and barriers in systems of care, and provide families with a roadmap to information, resources, and support. The plans specify who will do what, and when, creating shared accountability and integrating care. Care plans are monitored, updated and re-evaluated, as needed, or minimally at 6 months.

Of 109 shared care plans initiated or re-evaluated in local public health departments in 2018, 40% were for children aged 0-5. Aside from the public health nurse, team members included: Family Members (100%); EI/ECSE (86%); Primary Care Provider (66%); Occupational Therapist/Physical Therapist/Speech & Language Pathologist (66%); Specialty Provider (43%); and Insurer (41%).

Impact Families establish the principal goals of their child's shared care plan, which supports their investment in the plan. Public health nurses who convene shared care planning teams perceive increased communication among professionals and organizations. They also perceive closer relationships among professionals, and between professionals and families.

Funding OCCYSHN provides limited financial support to local public health authorities to implement shared care planning. Targeted case management dollars can also support the effort. Two local public health authorities secured additional funds for cross-organizational standing care coordination teams that meet regularly for shared care planning. One team gets funding from a Coordinated Care Organization innovation grant. The other is supported with pooled resources from five area school districts.

Challenges Challenges to implementing shared care plans for CYSHCN include: funding limitations, staff shortages and turnover, and identifying and engaging professional partners.

Takeaway Public health can support pediatric medical homes with cross-systems care coordination for CYSHCN. Shared care planning helps connect health care with education and community services. This collaboration addresses early childhood health and development, learning, and social service needs. [Shared care planning supports CCO 2.0's care coordination and integration objective, and aligns with Patient-Centered Primary Care Home \(PCPCH\) care coordination standards.](#)

^{*} CYSHCN are children "who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally." (McPherson, et al, 1998). This population includes children with complex medical conditions, and families facing socioeconomic challenges.

^{**} OCCYSHN is Oregon's Title V program for CYSHCN. OCCYSHN contracts with home-visiting public health nurses to provide care coordination for Oregon CYSHCN through the CaCoon Program. In FY18, CaCoon served 1,363 clients. Among those, 55% of clients served were age 0-5 and, of those, 86% were on Medicaid.

Parks Model SUPPORTIVE HOUSING

ColumbiaCare Services

As the housing crisis and efforts for community integration continues, it is critical that we build a continuum of care that meets specific housing and treatment needs of SPMI. We have built a highly cost-effective supportive housing model that targets the most vulnerable with unique and challenging treatment needs that work.

PARKS MODEL SUPPORTIVE HOUSING.

These programs are more intensively staffed supportive housing programs that provide tenants with access to on-site treatment and support services and programming that promotes recovery. An example of this type of program is Swing Lane that is located in Medford, OR, which is a combination of 5 units of intensive supportive housing (one 1-bedroom, four 2-bedroom units) and 2 units of transitional Board and Care (two 3-bedroom units). Swing Lane has an office with on-site staff 24 hours a day, 7 days a week. Supportive Housing programming includes mental health treatment services, structured rehabilitative services as needed, skills training, medication monitoring, assistance with activities of daily living, etc. The Supportive Housing Supervisor provides 5 hours per week of supervision, staff guidance, coordination with referring agencies, and treatment planning.

SUCCESS SNAPSHOT: BY THE NUMBERS

# of Clients	Average Age	Gender	Length of Stay	Pre-Housing Placement	Cost of Care (Intensive Supp. Housing)	Approx. Cost of Care (Hospital)	Housing Cost as % of Hospital Cost	Savings
30	44.6 years	66.6% F 33.3% M	254 months total 8.5 months average	67% from State Hospital 17% from Homelessness 7% from Licensed Residential 9% from Acute Care	\$1,854,000 Per Year	Over \$8,900,000 Per Year	Approx. 21%	Approx. 79%

Parks Model clients are successfully kept in the community. On average clients spend 93.6 percent of their days in the community, and they spend only .83 days in the acute care hospital for psychiatric reasons. Only one client returned to OSH within the timeframe above study was conducted.

Treatment avoids ED use, and when used reduces the frequency of ED use. Only two clients have had more than one use of the ED during the same timeframe. Treatment should affect outcomes. The more treatment the more improvement is expected.

Finding affordable, accessible housing is difficult for many of our community members. As a provider, we know it can be even more challenging for the vulnerable population we serve. We are appreciative of all the efforts and investments being made to provide an array of housing resources that provide shelter, but it is **critical** that we fund and offer housing programming that meet the sometimes-exceptional behavioral health needs of tenants. Treatment affects outcomes. The more treatment, the more improvement can be expected. We believe that having multiple “levels of care” available within the housing arena is a very proactive, person-centered way to improve population health and improve health care delivery while reducing costs by diverting and keeping people out of higher levels of care. ColumbiaCare has witnessed how this improves outcomes and it can even save lives.

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Joseph Chick, MA, MBA jchick@columbiacare.org

Promoting Health and Education by Addressing Emotional and Behavior Health with Trauma Informed Practices

Children and families in Eastern Oregon are experiencing trauma that impacts their educational and health outcomes. Through partnerships between Tribal Health and Early Education agencies, trauma-informed social emotional skills for children and adults are being taught through group coaching, community book studies, parenting education, and school practices.

Yellowhawk Tribal Health Center, in Mission Oregon, has been implementing Conscious Discipline since March 2017 under the Native Connections grant through Substance Abuse and Mental Health Services Administration (SAMHSA). Yellowhawk provides services to approximately 3,000 eligible patients which include tribal members enrolled in the

Confederated Tribes of the Umatilla Indian Reservation (CTUIR). This grant focuses on providing opportunities for community wide healing and wellness in partnership with stakeholders. The focus on healing stems from the impact of trauma experienced by tribal communities and families historically, inter-generationally and currently.

As part of this process, Conscious Discipline has served a primary role in shaping, coaching and modeling how to build healthy connections and relationships for children, adults, community members, and staff. The approach to implementation is unique as it is a community-based approach to using Conscious Discipline versus implementing in a school-based approach.

Outreach to Children and Youth- Pašáptawaxša kwiikwit ki (Raising Children in Truth)

Yellowhawk Native Connections and its partners provide outreach to children and youth of all ages to teach and discuss the emotional regulation, self-regulation, and cognitive development. At Cay-Uma-Wa Head Start, Yellowhawk staff and partners focus on assisting with coaching efforts with staff in role modeling Conscious Discipline.

Community and Stakeholder Outreach and Engagement

Yellowhawk Native Connections has ensured stakeholder engagement and created opportunities to enhance collaboration between community partners within Umatilla County and Morrow County to better serve children and families through a CD Leadership Team.



Larger Community and Outcomes

Yellowhawk and the Blue Mountain Early Learning Hub have brought several training opportunities to the region that focus on ACE's, Trauma and Social Emotional Learning (SEL) practices. These trainings have supported a shift in practice for the professionals who work with children, families, classrooms and communities.

The BMEL Hub has been partnering with the Pendleton School District (where children from CTUIR attend from K-8) to bring trauma informed

practices to every day learning. Through Professional Learning Teams, trainings and materials, teachers have learned how to incorporate Conscious Discipline in to their classroom structures and routines. Further, there has been a shift in understanding around trauma and behavior. Schools are shifting from punishment to connection, focusing more on social/emotional skills and improved learning opportunities.

Challenges

A main challenge experienced in implementing Conscious Discipline has been buy-in to change old beliefs. However, when the model is seen in action and the outcomes are noticed, this helps to diminish the lack of trust in the model.

The Future

The next steps for Yellowhawk Native Connections is to continue to increase the capacity of staff and community in the ability to deliver trainings, parent groups, coaching, parenting classes and weaving in to one-on-one services between children and families.

Through partnership with the Local Community Advisory Council, the Hub has been able to send 50 early childhood professionals to a 7-day Conscious Discipline training, this includes 4 employees from CTUIR and several from the local school districts. There will also be a 1-day follow up training on how to engage families in building their skills.

Funding Sources: Yellowhawk Native Connections, SAMHSA grant funds, Blue Mountain Early Learning Hub, Pendleton SD, Cay-Uma-Wa, CTUIR Education, OPEC, Umatilla LCAC

Websites:

- <https://yellowhawk.org/>
- <https://bluemountainearlylearninghub.org/>
- <https://consciousdiscipline.com/>



YELLOWHAWK
TRIBAL HEALTH CENTER



MORROW UMATILLA UNION COUNTIES

Blue Mountain
Early Learning HUB



Julia Doty
Director of Resident Services
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In-Home Services/Clinic Services Administrator
DLatimer@maryswoods.org

Senior Health & Housing

Enhanced health and wellness services are provided to senior (55+) residents of affordable housing in order to improve housing stability and reduce the financial burden on the health care system by promoting preventative health and keeping seniors living independently.

Problem Statement

- Older adults aging in place in affordable housing do not have the natural supports or income to access in-home care that keeps them living independently.
- A significant portion of this population does not qualify for Medicaid to pay for these services. They qualify by income, but are disqualified based on the number of Activities of Daily Living (ADLs) that they can complete.
- Oregon Project Independence (OPI) is designed to fill in this gap, but there is a long waiting list to receive these services, leaving seniors in need to deteriorate while they wait for access.

Project Summary

- Mary's Woods and Northwest Housing Alternatives formed a partnership in 2016 which provides home care services at a 50% reduced rate to NHA senior residents experiencing this service gap. Mileage fees and minimum caregiver hours are also waived. Additionally, Mary's Woods Home Care Services team hosts regular events at NHA's senior affordable housing properties in Multnomah and Clackamas County counties.

Project Activities

- Northwest Housing Alternatives' Resident Services Coordinators identify residents in need of in-home supports at NHA senior properties.
- A referral is submitted to Mary's Woods' In-Home Services & Clinic Services Administrator, and an in-person evaluation is conducted by an RN with the referred resident in.
- Services may be provided on an ongoing basis or for short-term recovery from illness or injury.

Expected Impact & Outcomes

- **94%** of residents who received home care services improved or maintained their housing stability.
- Since 2016, **53** events have been hosted at 14 NHA properties by Mary's Woods Home Care staff. Events range from direct health and wellness services to socialization and recreation opportunities.
- From NHA's annual survey of our affordable housing residents:
 - 55% report that they feel closer to their community as a result of participation in Resident Services activities
 - Social activities are consistently rated the most helpful activity offered to residents



ShelterCare Medical Recuperation

Emergency Shelter for Medically-Fragile Individuals

OUR MISSION

ShelterCare enriches lives through exceptional services that nurture hope, opportunity, and dignity.

OUR VISION

Inspiring all to create a home in our community.

CONTACT

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Cara Ashworth, MPH

cashworth@sheltercare.org

(541) 689-7156

Website
sheltercare.org

Facebook
@sheltercareorg

Twitter
@sheltercareorg

What is SMR?

ShelterCare Medical Recuperation is an 18-bed facility that provides unhoused individuals with a safe place to recuperate after an acute medical episode.

In cooperation with PeaceHealth (local hospital) and Trillium (Coordinated Care Organization, CCO), homeless patients usually stay at SMR for 30 days, most commonly due to complications from diabetes, wounds, cellulitis, heart disease, and COPD.

Each patient receives:

- Three meals per day
- Medication monitoring
- Help acquiring a primary care physician
- Transportation to and from appointments
- Front door housing assessment and registration for county waitlist.
- Help connecting to resources for housing, recovery, employment, etc.
- Assistance acquiring personal ID's, birth certificates, social security cards and SNAP funds among other individual services

What are the impacts?

A single night in the hospital costs the same as a month-long stay at SMR. Last year, SMR provided 101 unhoused individuals with a dignified way to heal from acute medical conditions, while saving the medical community well over \$2 million. With support from our Community Health Workers, individuals can focus on stabilizing their health and housing situations, while strengthening the community they live in.

What are the challenges?

High Needs Client - Many clients have mental health and/or developmental conditions that pose barriers to understanding their own health conditions. Many need more hands-on care than SMR is equipped or licensed to provide, such as help with checking insulin levels, going to the restroom, and doing laundry. A Lane County workgroup is currently investigating need and resources for obtaining additional medical respite beds, which was identified as a need by the Lane County Poverty and Homelessness Board. No plans are set at this time, but SMR is keeping track of these community trends and gathering internal data to support potential growth in this area.

Local Hospital Bed Shortage - The Eugene/Springfield hospitals have reported to experience severe hospital bed shortage, which results in quick discharge/turnover rates for many unhoused patients without insurance. One local hospital stated that 65% of the patients who they would like to refer to SMR, end up being discharged with hotel vouchers because they cannot get clients into SMR quickly enough. SMR has made numerous improvements over the past year to better streamline our referral and acceptance process, but even with these changes we have not been fully able to meet the need this bed shortage creates.

What would make SMR better?

SMR is undergoing an internal review of how our operations compare against best practices for medical respite programs (as outlined by the National Health Care for the Homeless Council). The areas that we found SMR could improve upon is providing overnight support for participants and more participant access to direct medical assistance from program staff.

Strategies for Addressing Food Insecurity & Nutrition in CCO, Clinic and Hospital Settings



Lynn Knox | Statewide Health Care Liaison | OREGON FOOD BANK | 7900 NE 33rd Drive, Portland, OR 97211 | direct: 503.853.8732 | cell: 503-548-7508



There are numerous potential strategies to address food insecurity & poor nutrition in clinical settings. Two of the most commonly implemented are:

<i>Strategy</i>	<i>Impact/Outcomes</i>	<i>Challenges/Lessons</i>	<i>Partners</i>	<i>Funding</i>
On-site produce distributions	Reduction in patient no-shows, Increased consumption of produce resulting in prevention or management of chronic disease	May require clinic pick up of produce, Helps to have tastings/cooking demos to spur use of new foods. Requires a limited amount of staff support.	Regional Food Bank or local Pantry	\$0-\$20/wk./site (depends on local food bank/pantry capacity) Often provided if needed by CCO or Hospital Com. Benefit
Medically Tailored Meals	Reduction in Emergency Use & Hospital readmissions,(\$300 vs. \$14,000) Quicker, better patient recovery, Nutrition, wellness checks & socialization for high risk patients	Need to target meals to priority patients, back-up for volunteers doing delivery & wellness checks needed if there are red flags. Funding can be an issue.	Meals on Wheels or Regional Food Bank	\$300/mon./patient (usual total duration) Often provided by CCO or Hospital Com. Benefit

Every community, clinic & hospital is different; different populations, resources and interests. There is no one right approach to address food insecurity and poor nutrition, often multiple approaches work best. In many situations, food insecurity screening becomes the foundation for other interventions. Please contact me for support to identify the best approach for your organization and for help getting started.

There are nutritional strategies to address **18 of the 19**, 2019 CCO Incentive Measures so the investment in nutrition has exponential benefits!



THE ROLE OF WORKFORCE DEVELOPMENT FOR
OREGON HEALTH PLAN FAMILIES
HEALTH CAREERS NW 5 YEAR EXPERIENCE 2015-2020

A federal grant that funds residents of Housing Authority properties and other low-income populations to enter and advance in Nursing, Allied Health, Dental, Mental Health, Medical Office & Lab occupations

Worksystems and the Housing Authority of Washington County are aligning workforce training and employment services with services available to residents. This person-centered approach incorporates the supports necessary for households who are living in poverty to a) access (and complete) occupational training in health professions, b) attain middle-wage employment and c) increase self-sufficiency and health outcomes including food and housing security through higher incomes.

BACKGROUND

Employment is a Social Determinant of Health: Since the Great Recession, increases in low-income employment alongside decreases in middle-income employment have eroded the health-protective effects of employment. Being unemployed excludes people from social participation and the health benefits that employment generally furnishes. Low-income employment, resulting in poverty, has well-researched impacts on population health. In 2018, the median annual earning for skilled occupations in the Portland MSA was nearly \$23,000 more than the median annual earnings for unskilled occupations. Nearly a quarter of all people of color in the workforce were employed in unskilled jobs, compared to just 16% of whites. Closing skills-gaps will contribute to closing racial disparities related to workforce participation.

A Targeted Approach to Opportunity Creates Results: Health Careers NW (HCNW) is a collaboration that prepares low-income participants to enter training for healthcare career pathways, supports them through training completion, and places them in careers that offer family-sustaining employment. Participants receive assistance from a Career Coach, as well as academic preparation and post-secondary access from an Academic Navigator. Participants prepare for and enter occupational skills training. Throughout the program, coaches provide access to a variety of supportive services, some grant-funded and others leveraged, including child care, clothing for work, medical care for work, parking, transportation, personal care, professional licenses and certifications, tools, training-related costs and utilities. Worksystems, the Portland Metro Workforce Development Board, manages the grant, and maintains relationships with the state and local offices of the Department of Human Services, TANF JOBS contractors, a network of culturally-competent community-based organizations (Central City Concern, Community Action, Human Solutions, IRCO, SE Works) as well as Portland Community College and Mt. Hood Community College to implement this collaborative approach to workforce development.

Accomplishments to date: Around 800 occupational training credentials and courses have been supported by the Health Careers NW scholarship funds. The residents who have completed training are qualified to become:

- | | | |
|------------------------------------|-------------------------------------|-------------------------------|
| Certified Alcohol/Drug Counselor | Medical Billing & Coding Specialist | Peer Support Specialist |
| Certified Nursing Assistant I & II | Medical Equipment Repairer | Pharmacy Technician |
| Dental Assistant or Hygienist | Medical Insurance Biller | Phlebotomist |
| Licensed Practical Nurse | Medical Interpreter | Registered Nurse |
| Medical Assistant | Medical Receptionist | Sterile Processing Technician |

The Housing Authority has proactively offered this opportunity to residents in all of the housing programs it operates: families currently receiving housing subsidies (vouchers and public housing tenants), families on the waitlist to obtain subsidies, and families living in homes classified as Affordable Housing and which work in partnership with Washington County Housing.

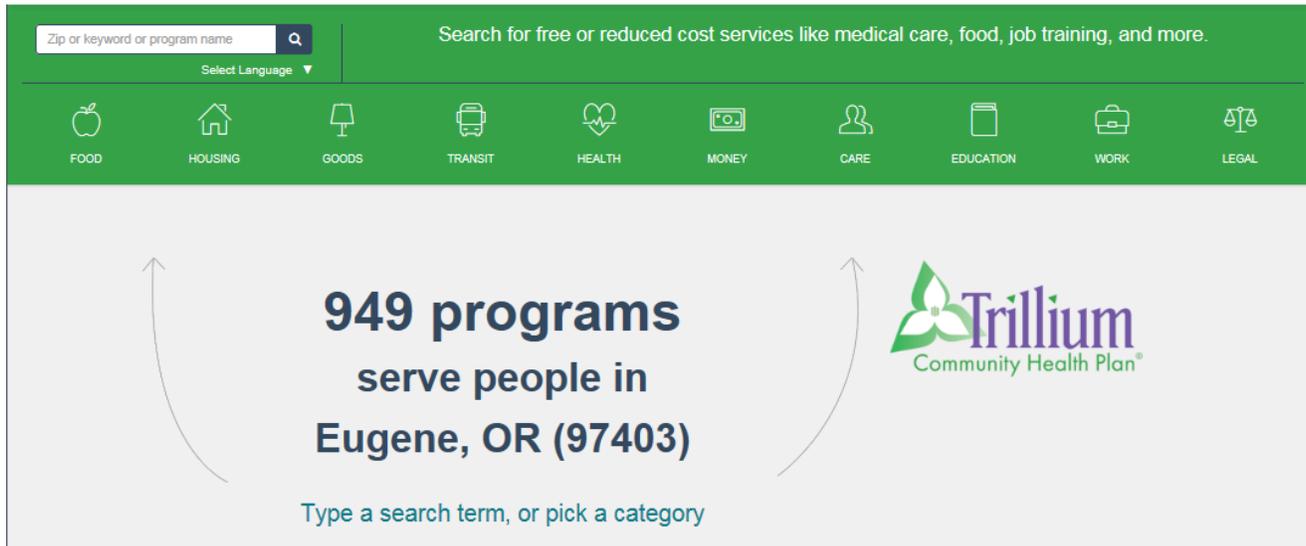
Resources:

Healthcare Labor Market Report 2018, The Columbia-Willamette Workforce Collaborative, www.worksystems.org
Health Careers NW, www.HealthCareersNW.org

Agency Contacts:

Worksystems: Stacey Triplett, (503) 478-7322, striplett@worksystems.org

Housing Authority of Washington County: Melanie Fletcher, (503) 846-4814, Melanie.Fletcher@co.washington.or.us



Top 10 Most-Visited Sites

No	Provider Name	Program Name
1	Head Start of Lane County	Head Start
2	Feeding Children Everywhere	Full Cart
3	First Place Family Center	Family Shelter
4	Food For Lane County	Produce Plus
5	White Bird Clinic	Dental Clinic
6	Burrito Brigade	Burrito Brigade
7	Bethesda Lutheran Church	Food Assistance
8	Homes for Good	Section 8 Housing Choice Vouchers
9	Katies Kause	Katies Kause
10	Autism Speaks	Autism Response Team ART

About T.REX

A tool for social workers, traditional health workers, care coordinators and others who help people in need. It's also software that allows people to help themselves.

Free or low cost programs addressing social and community determinants of health

Funded by Trillium, fueled by Aunt Bertha, Aunt Bertha is the largest search and referral network for social services in the United States, serving 1.8 million people

Program listings maintained by Aunt Bertha monthly



Trillium Resource **EX**change

Features

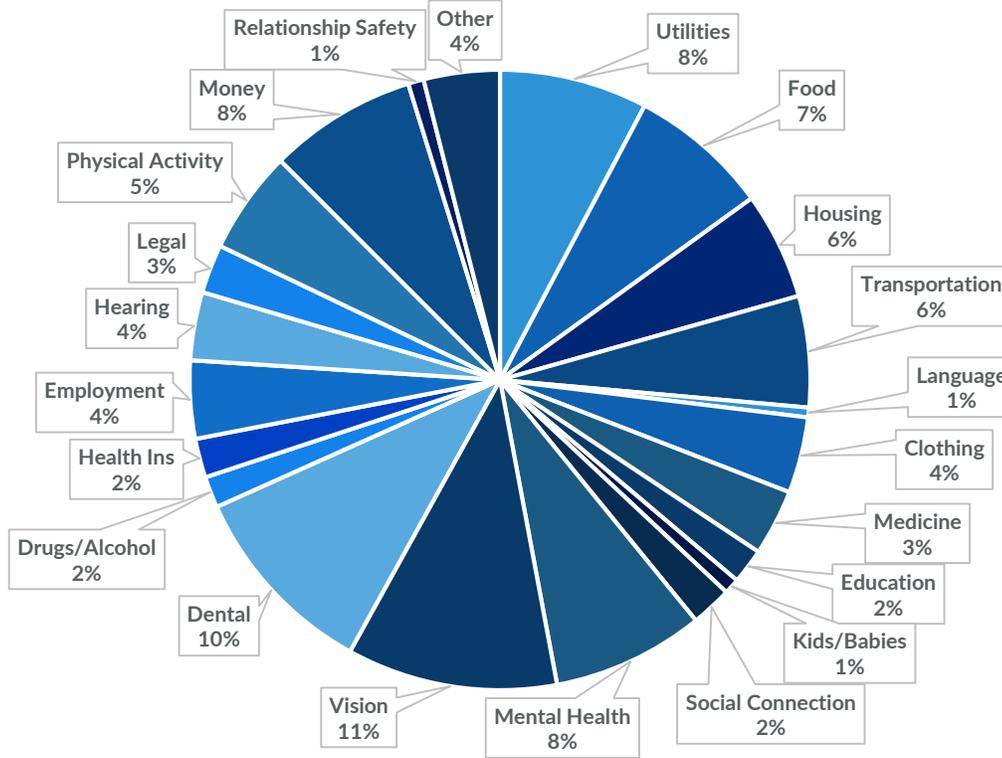
- **Search** for Resources
- **Refer** people to an organization
- **Screen** clients for eligibility
- **Schedule** appointments for clients

Contact:
 Amanda Cobb
acobb@trilliumchp.com



Universal Social Determinants of Health Screening at a Community Health Center through Multi-Disciplinary Collaboration

Needs Identified by SDH Screener: November 2018 - April 2019



Program Components:

- Dedicated Staffing
- Streamlined Tool
- Integrated Workflow
- Universal Screening
- Ongoing Data Collection

Data:

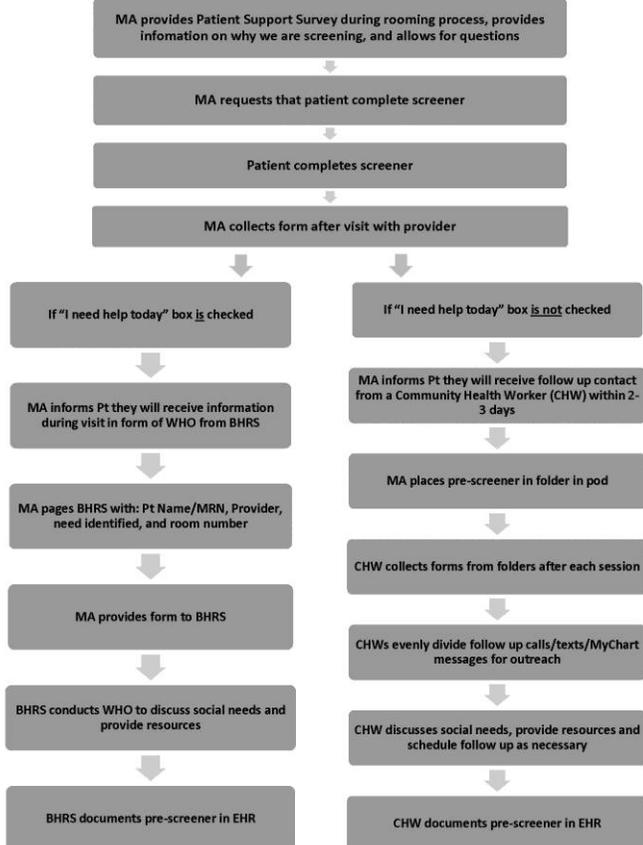
By gathering and reviewing real time data, we have been able to adapt the screening tool, provide responsive feedback to care teams, and analyze identified patient need.

Contact:

Jennifer Schlobohm, MSW, LCSW
Behavioral Health Supervisor
schloboh@ohsu.edu

Jazmin Jackson, BS, THW
Community Health Worker
jacksjaz@ohsu.edu

Workflow for Social Determinants of Health (SDH) Screening



Patient Support Survey

Patient label

There are many things that may affect your health. The more we know about you, the better care we can provide.

We cannot help with every need, but we can connect you with someone that can help.

How can we contact you?

- I would like to talk to someone about this today ← Indicates warm hand off to BHRS
- Phone _____ Call or Text MyChart ← Indicates follow up from CHW
- Do not contact me about this form ← No follow up

What concerns do you have?

<input type="checkbox"/> Utilities	<input type="checkbox"/> Mental health
<input type="checkbox"/> Food	<input type="checkbox"/> Vision (eye) care
<input type="checkbox"/> Housing needs	<input type="checkbox"/> Dental (tooth) care
<input type="checkbox"/> Transportation	<input type="checkbox"/> Hearing
<input type="checkbox"/> Language	<input type="checkbox"/> Drugs and alcohol
<input type="checkbox"/> Clothing	<input type="checkbox"/> Health insurance
<input type="checkbox"/> Medicine	<input type="checkbox"/> Employment / disability
<input type="checkbox"/> Education	<input type="checkbox"/> Legal
<input type="checkbox"/> Kids and babies	<input type="checkbox"/> Physical activity
<input type="checkbox"/> Social connection	<input type="checkbox"/> Money
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Relationship safety

I prefer not to do this survey today. ← No follow up

Youth-Med! The Stealth Medical home for youth who need us most!

Helen Higgins CEO, Boys & Girls Club of Corvallis. hhiggins@bgccorvallis.org
Dr. Ed Junkins Western University of Health Sciences ejunkins@westernu.edu

Project description: Through a unique public and private partnership between the Boys & Girls Club of Corvallis (BGCC), Samaritan Health Services (SHS), Benton County Health Department, and Western University of Health Sciences, a youth-centric medical home resides within the walls of our community youth organization that provides out of school services to nearly 3,000 youth, age 5-18.

Impact: Through an innovative approach and community partnerships, the project team is working to address up-stream causes of generational poverty which lead to poor health outcomes. To begin to address these causes, multiple services have been co-located and integrated into youth development practices in a positive environment designed around a culture of trust. These services include youth dental, medical and mental health services.

Challenges: With the planned addition of dedicated high school space to the Boys & Girls Club, an opportunity presented itself to bring additional health services “where the kids are”. Finding a healthcare provider to place a youth medical and mental health clinic in a non-traditional healthcare setting was challenging in-light of the organization’s cultural differences and the limited payment methodologies available for prevention services beyond a well-child check-up. An integrated youth and medical center for hard to reach populations was conceptually a “great idea”, but it took time to make the full vision for the Center for Youth Excellence a reality.

Lessons Learned – Since opening in September 2018 the learning curve has been steep. While the collaboration with multiple community health partners has been invigorating, much effort was required to intentionally align organizational missions. The Center’s strategic goals are to capitalize on the unique opportunities and potential to benefit youth that will most likely result in changes to the current healthcare culture and metrics. The team is driven by the mission to reduce the determinants that reinforce generational poverty and improve the long-term health and habits of our youth while exploring metric-centered outcomes as it relates to addressing social determinants of health.

Recommendations & Replication: Replication of the project model is enthusiastically recommended! Sustaining buildings and services is the #1 issue for nonprofit social service and healthcare businesses in rural and small communities around the state. The blending of skills and expertise creates efficiencies and extends the reach into the community. ***Impacting the health outcomes of a community requires a community.***

Collaborators: The governance committee currently consists of BGCC, SHS, and Western University of Health Sciences. We meet monthly to work toward shared goals.

Funding source: The capital construction was funded through private donations and grants from regional foundations. Today SHS leases the space from BGCC and those funds are used to pay for the high school programs and operations. SHS is funded through fee for services for medical and mental health. Funding for the research component is to be determined. We are exploring how to align the CCO’s priority funding for prevention to non-healthcare related services that educate and prevent. This is a paradigm shift in the healthcare industry that will require that non-medical prevention is valued for its positive outcomes for better health, especially for adolescents.

Café Session 2: 11:15 a.m.-12:15 p.m.

Portland Ballroom 252	Portland Ballroom 253	Portland Ballroom 254	Portland Ballroom 255
Using the Opportunity360 Framework to Inform Housing Investment Decisions (Housing)	Rx to Move: Increasing Physical Activity via Provider Prescription to Move and CHW Services (Early Learning)	Pretrial - Transition and Program Services (TAPS) (Housing)	Give the Mouth a Voice: Oral Health as a Social Justice & Equity Issue (Cross-Cutting)
Starting and Maintaining a Warming Station in Rural Areas (Housing)	Early Childhood Behavior Consultations to Promote Inclusion and Early Intervention: The Care Connect Pilot Program (Early Learning)	Where Oral Health and Housing Unite (Housing)	Fruits and Veggies for Families (FAVFF), (Food Insecurity)
Rogue Retreat Housing + Case Management = The Secret Sauce (Housing)	Getting Agency ASQs into the Hands of Medical Providers (Early Learning)	South Coast Together: A Self-Healing Community Initiative (Trauma)	
Room D133	Room D134	Room D135	Room D136
Permanent Supportive Housing and Food Insecurity: What's the Connection? (Housing)	Regional Kindergarten Readiness Network (Early Learning)	Building Community & Organizational Capacity for Trauma-informed and Equity Approaches in Washington County (Trauma)	Secret Sauce: ICCM Wraps Services around Chronically Ill Members (Cross-Cutting)

Café Session 2 Project Descriptions

Building Community & Organizational Capacity for Trauma-informed and Equity Approaches in Washington County (Trauma)

Michael Anderson-Nathe, MPA, Chief Equity & Engagement Officer, Health Share of Oregon; Erin Jolly, MPHA, Senior Program Coordinator, Washington County Public Health; Tricia Mortell, MPH, Public Health Division Manager, Washington County Public Health; PhyuSin Myint, PhD, Public Health Program Supervisor, Washington County

The Washington County community health improvement plan (CHIP) leadership team includes cross-sector partners from health systems, schools and community-based organizations.

Equity and trauma informed care (TIC) are guiding principles for the CHIP. Washington County Public Health and the CHIP leadership team provided grants to support ten organizations in building capacity in TIC and equity. These grants were provided to safety net clinics who serve Medicaid populations, school partners, and culturally specific community organizations.

Early Childhood Behavior Consultations to Promote Inclusion and Early Intervention: The Care Connect Pilot Program (Early Learning)

Schuyler Hibbard-Swanson, MA, MPH, Project Manager, Marion & Polk Early Learning Hub

Care Connect is a prevention and intervention program that addresses challenging and concerning behaviors in early learning settings (childcare and preschool), primarily among OHP-eligible children. It builds the capacity of caregivers and educators to respond to trauma and special needs and provides access to mental health specialists for children needing more intensive support. Come hear about lessons learned and partnerships developed as well as discuss ways to improve referrals and decrease stigma.

Fruits and Veggies for Families (FAVFF) (Food Insecurity)

Amy Hendrix, Health and Nutrition Director, Umatilla-Morrow Health Start/WIC; Angie Treadwell, RD, LD, SNAP-Ed Coordinator, Umatilla and Morrow Counties, Oregon State University Extension

WIC participants who screen positive for targeted health and food security risk factors are enrolled in the FAVFF, receiving a monthly produce distribution paired with cooking classes, all at the WIC clinic site. In 2018, FAVFF used Eastern Oregon CCO funding and Oregon Food Bank produce. Over 90% of participants were EOCCO members.

Getting Agency ASQs into the Hands of Medical Providers (Early Learning)

Kristi Collins, M.Ed., Director, Early Learning Hub of Linn, Benton and Lincoln Counties; LeAnne Trask, Pollywog Coordinator, Early Learning Hub of Linn, Benton and Lincoln Counties

Many social service agencies and early learning providers are mandated to create Ages & Stages Questionnaires for their young clients; however, what happens to those completed assessments? Pollywog has partnered with our CCO and the Regional Health Information

Collaborative (RHIC) to get those ASQs into the hands of medical providers so that our youngest Oregon Health Plan clients get recognized and treated as soon as possible. Early Learning and social service agencies have a large role to play in providing their expertise with these early assessments.

Give the Mouth a Voice: Oral Health as a Social Justice & Equity Issue (Cross-Cutting)

Karen Shimada, MPH, Executive Director, Oregon Oral Health Coalition; Dr. Phillip Wu, MD, Retired Pediatrician; Dr. Caroline Zeller, DDS, SmileKeepers, OHSU

Oregon Oral Health Coalition has been strategically pivoting to a health equity informed approach for supporting communities in meeting their self-identified oral health needs and creating solutions that address their unique oral health challenges. We will offer prompts for our attendees to explore how housing, trauma, early childhood education and food insecurity impact oral health and how collaborations with organizations working in each of these areas can make a difference in improving not only access to care, but overall health at all ages. In this interactive session we will prompt exploration of how the social determinants impact oral health disparities and provide some innovative ideas for addressing these disparities.

Permanent Supportive Housing and Food Insecurity: What's the Connection? (Housing)

Mike Savara, LCSW, CADC III, Dual Diagnosis Program Manager, Central City Concern Old Town Recovery Center

The need for high levels of food resource support while residents are in permanent supportive housing (PSH) is an important consideration for any program wishing to serve people with histories of homelessness. Partnerships with food resources are key, as well as developing these relationships and mending them when needed. As behavioral health providers who have deep connections to housing and PSH programs, CCC has learned to foster these relationships and ensure residents have both the resources and information to address food insecurity. We have identified several barriers including stigma from accessing food resources, transportation, disabilities and knowledge of food preparation skills. We will facilitate a conversation about how to address some of these deficits systemically and clinically.

Pretrial: Transition and Program Services (TAPS) (Housing)

Curtis Landers, Sheriff, Lincoln County; Lt. Jamie Russell, Lincoln County Jail Commander, Lincoln County Sheriff's Office; Steve Sparks, Project Consultant, Stepping Up Initiative, Lincoln County

The 'pretrial transitional housing model' was developed as a result of the availability of a property purchased by Lincoln County Health & Human Resources in 2017. In a partnership with the sheriff, community justice and corrections, and CHANCE Recovery Reconnections Counseling, the property was repurposed and funded to provide structured supportive

housing for homeless individuals awaiting trial. This is a major step toward meeting the goals and priority actions of the Stepping Up Initiative.

Regional Kindergarten Readiness Network (Early Learning)

Jessica Arzate, MA, Senior Director of Impact, Greater Than; Peg King, MPH, MA, Manager of Early Life Health Partnerships, Health Share of Oregon; Shelly Regianni, Ed.D, Executive Director of Equity and Instructional Services, North Clackamas Schools

Fifty organizations in the Portland Metro area, representing health, early learning, housing, K–12, social services and community-based organizations, are working together to ensure that race, class and disability are no longer predictors of kindergarten readiness. Our siloed “business as usual” approach is not working for many children in our region, and our network recognizes we all need to redesign our systems with kids and families at the center, addressing the social determinants of health and education.

Rogue Retreat Housing + Case Management = The Secret Sauce (Housing)

Liz Adams, Program Director, Rogue Retreat; Hannah Ancel, Community Health Manager, Jackson Care Connect; Chad McComas, Executive Director, Rogue Retreat

Jackson Care Connect and Rogue Retreat partner to provide housing and case management for Medicaid members in recovery from addiction or homelessness in Jackson County. This partnership is supported by a case rate contract. Rogue Retreat supports members in moving along a continuum of housing and stability with their successful model for case management. Evaluation is in process to measure health outcomes and impact on cost and utilization. This partnership has recently expanded to pilot housing for members undergoing medication assisted treatment.

Rx to Move: Increasing Physical Activity via Provider Prescription to Move and CHW Services (Early Learning)

Sonia Luna, Community Health Worker, Mosaic Medical; Lindsey Stailing, Patient Support Program Manager, Mosaic Medical

Rx to Move is a prescription physical activity program designed to increase physical activity of youth ages 6–18 who would benefit from increased movement in their lives. Patients are referred to this program regardless of income, insurance status or family size, and there is no required diagnosis for eligibility. This PCP based referral program leads to community health worker navigation that matches the youth with available community resources and financial support, with the goal to get the youth engaged in the movement activity of their choice.

Secret Sauce: ICCM Wraps Services around Chronically Ill Members (Cross-Cutting)

Lo Lewis, MBA, LPN, Community & Provider Outreach, Trillium Community Health Plan; Megan Post, Director of Integrated Services, Center for Family Development; Jamie Stevens, NCMA,

ICCM Medical Assistant, Springfield Family Physicians; Lucy Zammarelli, MA, CADC3, Supervisor & Health Equity Officer, Trillium Community Health Plan

Intensive community care management (ICCM) is a high-intensity value-based care model designed for the highest risk patient populations. Clinics meet CCO metrics and have an improved clinical experience for both patient and professional. The model fully integrates physical, behavioral and oral health wraparound care at a single PCPMH with a care team focused on improving social determinants of health through social work in the community and behavioral health interventions. ICCM is the culmination of years of integration work at Trillium, is guided by consultant expertise and clinical practice, and is proving to be a recipe for success.

South Coast Together: A Self-Healing Community Initiative (Trauma)

Leah Lorincz, RN, BSN, Health Services Coordinator, Advanced Health; Laura Williams, Director of Community Engagement, Advanced Health

South Coast Together is a community collaborative focused on fostering resilience in Coos and Curry counties. Its goals are to engage community members as agents of change in preventing the accumulation of adverse childhood experiences and building resilience in children, adolescents and families.

Starting and Maintaining a Warming Station in Rural Areas (Housing)

Christopher Evans, Community Development Coordinator, Oregon Department of Human Services; Cami Miller, Union County Warming Station Director, LCAC Coordinator

The Union County Warming Station was created because homeless folks have nowhere to go at night and are sleeping in cars, tents and campers with little to no support. We became a 501-c3 in 2018 and are about to wrap up the second year of our station. There have been many hurdles and we are working hard to keep finding solutions.

Using the Opportunity360 Framework to Inform Housing Investment Decisions (Housing)

Meredith Howell, Resource Development Officer, NeighborWorks Umpqua; Brian Shelton-Kelley, Director of Acquisitions and Development, NeighborWorks Umpqua

NeighborWorks Umpqua is using the new Opportunity360 framework from Enterprise Community Partners to inform our housing and community development investments and program design and development. This framework uses a comprehensive set of criteria, including health and well-being, and other social determinants of health, to guide decision-making. This approach looks at more than just cost, including how more equitable decisions can be made to promote opportunity for all.

Where Oral Health and Housing Unite (Housing)

Karen Hall, BS, Oral Health Integration Manager; Linda Mann, BS, RDH, EPDH, Director of Community Outreach, Capitol Dental Care

By partnering with low-income housing partners in two regions, Capitol Dental Care has been using teledentistry and an expanded practice dental hygienist to provide dental care and navigation. This session will share how the relationships were forged, and roles of partners and specific workflows and documents will be shared.

Building Community & Organizational Capacity for Trauma Informed and Equity Approaches in Washington County

Project Description & Background

Washington County Community Health Improvement Plan (CHIP) Leadership Team is comprised of cross-sector partners including health systems, schools, and community-based organizations. Equity and Trauma Informed Care (TIC) are guiding principles for the collaborative health improvement work. With guidance from the CHIP Leadership Team and funded by Washington County Public Health, we provided grants to support ten organizations in building organizational capacity in TIC and Equity and advance the work of the CHIP. On average grantees received \$15,000. These grants were provided to safety net clinics who serve Medicaid populations, school partners, and culturally specific community organizations. In addition, the CHIP Leadership Team guided development of an Equity and TIC Toolkit to support the Washington County CHIP committees and community partners. The toolkit includes TIC meeting guidelines, operationalizing equity examples, decision-making tools, work plan and charter templates and adopted TIC principles.

2018-2019 Grant Projects

Sexual Assault Resource Center: Moving Towards Equity: SARC's Three-Tiered Approach

Adelante Mujeres: Nourish the Community: Creating a Healthier, More Equitable Community

Tigard Turns the Tide: Raising Resilient Children and Families

Virginia Garcia Memorial Health Center: Trauma Informed Health Care Symposium

Boys and Girls Club (Inukai): Trauma Informed Clubs: Our Model to Support the Future

Lutheran Community Services NW: Trauma-Informed Continuing Education for Refugee Mental Health

Sequoia Mental Health: Increasing Access to EMDR Treatment/Helping Teens Heal from Trauma

LifeWorks NW: Cultural Diversity/Trauma Informed Training

Beaverton High School: Trauma Sensitivity and Equity Movement

Mountain View Middle School: Wellness Support

Highlighted Impact and Outcomes

- TIC training for over 50 teachers and administrators and over 500 clinicians and clinic staff
- 13 new family resiliency & TIC community trainers
- Eye Movement Desensitization and Reprocessing (EMDR) training for 8 clinicians
- Equity strategies incorporated into 6 organizational policies and procedures
- Meals provided for over 150 families to reduce barriers for engagement in family resiliency events

Successes & Lessons Learned

- Increased ability for grantees to prioritize equity & TIC work and integrate into organizational policies.
- Supported school-based social emotional learning goals and strategies
- Increased community capacity for culturally responsive & TI mental health services
- Organizations are seeking funding to support capacity building in Equity and TIC
- Initial funding to advance equity and TIC can catalyze future investments in this work

Contact Information and Website

CHIP Leadership Team:

Alfonso Ramirez, Tigard High School
Anissa Rogers, University of Portland
Kristine Rabii, Tuality Healthcare
Linda Nilsen, Project Access NOW
Maria Loreda, Virginia Garcia Memorial Health
Maureen Quinn, OSU Extension Service
Michael Anderson-Nathe, Health Share of OR
Rachel Schutz, Boys and Girls Club
Zach Raschke, Dept. of Human Services

Find out More:

HealthierTogetherWashingtonCounty.com
www.co.washington.or.us/HHS/chip.cfm

Contact:

Erin_Jolly@co.washington.or.us
(503) 846-4965



Funding source

Grant from the Mid-Valley Behavioral Care Network, which currently manages the mental health and alcohol and drug treatment benefits for OHP members with Willamette Valley Community Health (the regional CCO)

Program description

Care Connect builds the capacity of the Marion and Polk region to meet the social-emotional needs of young children. It connects early learning providers and families with professional development, parenting education, social-emotional curricula, and access to early childhood mental health specialists. The purpose is to identify supports that can address the root causes of behavior and build positive relationships with caregivers, thereby preventing suspension/expulsion and mental health challenges later in life.

Impact and outcomes

Delivered 9 trainings to 294 providers to build a foundation of more skillful and inclusive care. Increased knowledge of trauma-sensitive practices, the impact of stress on challenging behavior, healthy sexual development in early childhood, and supports for children with fetal alcohol spectrum disorders and autism.

Launched social-emotional instruction as a universal support at 42 sites to build the self-regulation and relationship skills of 695 additional children.

Provided 46 consultations regarding 58 children to 30 early learning programs or agencies as well as parents and made referrals to more than 20 family support programs. Contracted early childhood mental health specialists, some bilingual, conducted 21 observations onsite in childcares or classrooms. 14 children were referred to counseling or crisis services.

Surveyed providers and learned that 89% gained increased capacity to meet complex social-emotional needs, 74% felt more capable referring families to services, and 90% felt the program was valuable and needed.



Challenges and advice

Allow extra time for hiring and contracting process

Develop consent and intake forms and use a secure file sharing system

Respect parental/guardianship rights and identify as a fellow parent

Consult practitioners on protocols and training needs

Set clear expectations for consultants, providers, parents, and children

Focus on a few key strategies or referrals

Think creatively to try to overcome stigma

Work collaboratively with your EI/ECSE contractor and other partners

Strive to represent all parties—parent, provider, and above all, the child

Contact info

Schuyler L. Hibbard-Swanson, project manager
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971-701-0438

Fruits and Veggies for Families (FAVFF)

Need

- Low income households are more likely to experience obesity, chronic disease and have lower fruit and vegetable (FV) intake.
- Barriers to F/V intake include cost, knowledge, quality, variety, limited cooking skills and transportation.

Program

- SNAP-Ed partnered with the Women, Infants and Children (WIC) program in Umatilla County
 - WIC participants who screened positive for targeted health and food security risk factors enrolled.
 - Screened at WIC appointment by certifier
 - Oregon Food Bank food insecurity questions
 - BMI classified as overweight or obese (CDC)
 - Self-reported health care provider diagnosis:
 - Hypertension, Type II diabetes, Gestational diabetes

"This has really helped add the veggies to our food"

Produce Distribution

- 40-50 pounds of produce provided to participants each month at the WIC clinic
 - Oregon Food Bank produce delivered by local partner (CAPECO)
 - Additional purchases from local farms
 - 8 months of distribution (June 2018-January 2019)

Cooking Classes

- Paired with produce distribution at the WIC clinic
- Participants and their families prepared 3 to 5 OSU Food Hero recipes each month and shared a meal

2018 Impact

- Served 137 families with 597 contacts at Food Hero cooking classes
- >90% of participants were EOCCO members
- Cooking classes rated as most valuable aspect of program
- Pre/Post increases in:
 - Ability to afford fruits and vegetables
 - Child vegetable consumption
 - Use of Food Hero recipes and resources

Lessons Learned

- Managing large volumes of fresh produce is labor intensive
- Adequate and appropriate produce storage is key
 - Minimize time between delivery and distribution
- Dedicated program FTE essential
- Provide child care for classes
- Be flexible

Funding

- Eastern Oregon Coordinated Care Organization's (EOCCO) Umatilla County Community Benefit Reinvestment funds

Future

- EOCCO funding for continuation and expansion in 2019
- Integration of EOCCO metrics and FAVFF program coordination
- Participating in the 2019 Veggie Rx Evaluation Collaboration



Contacts:

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LD
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Health and Nutrition
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UMCHS, Inc. WIC
Program
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Video Link: <https://www.foodhero.org/fruits-and-vegetables-families>

GETTING AGENCY ASQs INTO THE HANDS OF MEDICAL PROVIDERS

Project Goals:

- Put social service agency ASQs in front of medical providers
- Assist InterCommunity Health Network CCO with their Regional Health Information Collaborative (RHIC) Project
- Assist Samaritan Health Services with their ASQ metrics
- Assist Early Intervention with access to screenings
- Get ASQs into Pollywog as a permanent child record
- Help social service agencies get a stipend for each ASQ entered (\$25-\$50)

Project Parameters:

- Begin Pilot Project with agencies doing large numbers of ASQs
- Set criteria for ASQs: 0-3 year olds only, OHP clients only, at least 1 area in the black
- Get feedback from social service agencies



Project Outcomes:

- Currently have 88 completed ASQs in ASQonline software, in RHIC, and in Pollywog
- Currently have 9 social service agencies participating
- Responses from social service agencies
- Lessons learned
- Next steps

Project Title: Giving the Mouth a Voice: Oral Health as a Social Justice & Equity Issue

Project Description: In this session, we will share three actual case studies of patients who needed and accessed dental care and explore how the social determinants of health and equity impacted their journey towards health. Each presenter will lead an exploratory conversation with café participants regarding the various influences that affected each patient's ability to have their oral health and dental needs met, barriers they encountered, potential solutions to each situation, and the various perspectives from which each patient's care could be interpreted. We will be highlighting the role that trauma plays in the delivery of culturally sensitive care and those factors that influence access to care from a trauma-informed lens. We will examine these from the personal, dentist, social services, community and policy perspectives and specifically discuss the intersection of oral health with the various social determinants of health in terms of building community collaboration.

Presenter Contact Info:

Karen Shimada, MPH Karen.shimada@ocdc.net 971-263-5054 Oregon Oral Health Coalition, Exec Dir

Phil Wu, MD philwupdx@mac.com 503-705-5940 Oregon Oral Health Coalition, NWHF, Outside-In Board Member

Caroline Zeller, DDS caroline.e.zeller@gmail.com 785-221-6294 Oregon Oral Health Coalition Board, Smilekeepers, OHSU

Impact/Challenges: In each scenario, a holistic view of the individual patients within their family, work, social and medical systems calls for a deeper understanding of the impact of trauma on their ability to access care and our systems ability to deliver care. These are intertwined in the social determinants of health, and are often overlooked in our current understanding (or lack thereof) that oral health plays in determining an individual's ability to achieve and maintain health and well-being.

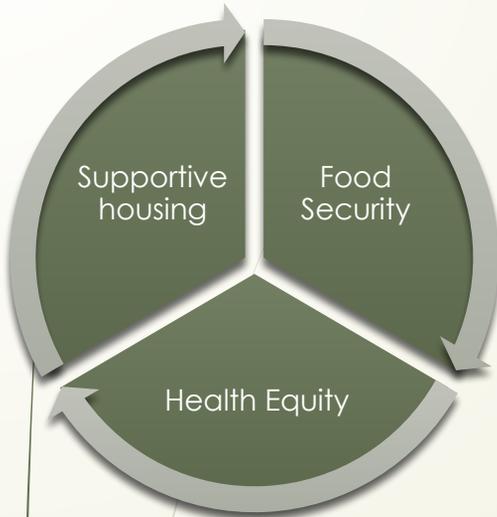
Lessons Learned: We will be engaging our attendees to help identify the lessons they perceived in each of the scenarios, and recommendations for addressing oral health from a holistic framework, with consideration for the wide range of social determinants of health that impacted each patient in each scenario. Key to this will be the deeper acknowledgement that an individual cannot achieve overall health unless their oral health needs are addressed and an integral and integrated part of their overall life. Key lessons are that we cannot manage chronic disease unless we all support the patient in receiving the oral/dental care they need, and that this is profoundly impacted by the social determinants of health and our willingness to engage this from a systems perspective.

Funding Source: 501c3: Oregon Oral Health Coalition and The DentaQuest Partnership

Website: www.orohc.org

Permanent Supportive Housing and Food Insecurity

What's the connection?



Project Background:

A recent study of participants in PSH found that two thirds reported very low or low food security. (Bowen et al., 2019) The connection between supportive housing, food security and health outcomes is not well understood at this time. From on-the-ground experience at the Bud Clark Commons, we have learned several key lessons regarding the use of targeted food resources and the importance of providing food assistance alongside any Supportive Housing intervention. Funding for BCC services are provided through the Joint Office of Homeless Services – a collaboration between the City of Portland and Multnomah County.

Challenges:

- Bringing food to the site rather than sending people to go and retrieve food boxes
- Storage and distribution – equity considerations
- Seeing access to healthy food as a right, not a privilege
- Supporting self-sufficiency while limiting dependency
- Healthy nutrition and dental health
- Lack of desire to go to hot food distribution sites after ending homelessness

Lessons Learned:

- Partnerships are essential
- Skill building is key
- Stigma needs to be addressed
- Outreach and Engagement is critical
- Accessing food is a learned survival skill, not manipulation
- Supportive Housing without access to food doesn't work



Bud Clark Commons



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Spenser.Canada@homeforward.org



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Sheriff Curtis L. Landers
PRETRIAL TAPS
35 NW Cottage Street
Newport, Oregon 97365
541-265-0700

Pretrial Transition and Program Services

- Stepping up Initiative – Signed proclamation in Lincoln County - October 5, 2016
 - SUI 2.0 – October 3, 2018 (4 hours)
- Sequential Intercept Mapping – August 29 – 30, 2017

Project Description: The pretrial transitional housing model, referred to as Pretrial Transition and Program Services (TAPS), is a collaborative community-based model designed, developed, and implemented by the Lincoln County Sheriff's Office and select community partners. The primary target population represents individuals waiting for trial, these individuals would otherwise have been housed in the Lincoln County Jail awaiting trial. Without adequate housing, wrap around services, and a positive community-based continuum of care structure, these individuals all too often do not make it to their court appearances unless they are incarcerated. Many pretrial cases are released from jail with no support and little or no housing or supervision to help guide them while waiting for future court appearances.

Partnerships: Lincoln County Board of Commissioners; Lincoln County Sheriff's Office; Lincoln County Community Corrections; Lincoln County Judicial Department; Lincoln County Health and Human Services (Behavioral Health); CHANCE; and many other collaborative partners.

Sustainability: A diversified funding strategy, including Medicaid VBP capitation for wrap around services, and peer support. Sheriff pretrial budget and other support.

Challenges/Lessons learned: Build community collaborations (still a work in progress) and funding strategies. Sequential Intercept Mapping (SIM) was essential to identifying gaps within our community and gaps within our process. Law enforcement participation from the start is essential. Utilize all available resources and partnerships. Peer delivered services are a valuable addition to utilization of necessary services.

Impact/outcomes: Increased collaboration with local resources/partnerships.

Presenter contact information:

- Curtis Landers – Sheriff (clanders@co.lincoln.or.us)
- Jamie Russell – Jail Commander (jrussell@co.lincoln.or.us)
- Steve Sparks – Project Consultant (stevesparks.nfk@gmail.com)

Regional Kindergarten Readiness Network

Working together to change systems so that race, class and disability are no longer predictors of school readiness.

Description

In our community, we know that poverty, racism and ableism create barriers & gaps in kindergarten readiness. All families want the best for their children—to see them healthy and thrive. It's our job as system leaders to work together, across sectors, to close those gaps & make it easy for families to meet their goals.

OUR GOAL: By 2028, we as a regional network, will redesign how we work together so that race, class, and disability no longer predict families' access to and use of quality early childhood supports and services that ensure readiness for Kindergarten and beyond.

OUR APPROACH:

- Bridge expertise in early childhood education, social services, healthcare, and communities
- Tackle structural inequity by shifting power across and within organizations and systems
- Elevate and strengthen existing initiatives
- Create a shared communications and advocacy agenda
- Align goals and funding for bigger impact

Partner Organizations: 50+ cross sector organizations in the Portland Metro area

Seed Funders: Health Share of Oregon, Providence Children's Health, Tri-County Early Learning Hubs, Oregon Community Foundation, Social Venture Partners, United Way of Columbia-Willamette

Impacts & Outcomes

We have 5 cross-sector workgroups meeting monthly to meet milestones on the following:

- Mapping the Money and Power
- Anti-racist/Trauma-informed Organizational Change
- Systems Alignment
- Data and Metrics
- Design Team (stewarding the Network overall)

Impacts & Outcomes

- Strengthening cross sector relationships & alignment – people are actively working together outside their organizational silos
- Working from a bigger, shared strategic picture of what is and is not working to advance our shared goal
- Aligning people across many organizations around the most critical intervention points
- Collectively advancing the need to focus on racism and oppression to meet our goal
- Focusing on removing institutional barriers - not individual level interventions – to drive better outcomes for kids and families

Lessons Learned

- It takes a huge amount of time and energy to coordinate a network and it needs to be someone's job
- Dedicate people and \$\$ to this kind of collaborative, system-building work
- Networks are necessary for complex systems change – don't do it if you can solve the problem in simpler way
- You can never have "all the right people" in the room
- Don't let 'perfect' be the enemy of 'good enough for now' – be iterative and bold
- Pay attention to power dynamics early and often if you want to be truly transformational
- Start with root causes
- Question your assumptions – be open and honest

READY + RESILIENT | This work is part of Health Share of Oregon's *Ready + Resilient* strategic investment plan, a long-term roadmap to support the wellbeing of children, families, and communities through prevention, support for recovery, and focused investment in health equity.

Peg King, MPH, MA, Early Life Health Initiatives, Manager - peg@healthshareoregon.org
www.healthshareoregon.org



Housing + Case Management = The Secret Sauce

To learn more:

www.rogueretreat.org

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Hannah Ancel

Community Health Manager
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ancelh@careoregon.org

Challenges and Lessons Learned:

Evaluation:

Challenging to have claims data spanning large enough period to properly evaluate impact on utilization. Plan is to focus on continuity of coverage and hopeful this will help provide needed data. RR is tracking waitlist to have a comparison group.

Data Sharing:

Data sharing between organizations has been a challenge. Currently done via an excel spreadsheet. Learned that Case Managers can be very effective in addressing gaps in care and that it is best to focus on a few targeted outcomes. A web based portal is planned and will be a method for sharing this information.

Program Description:

Jackson Care Connect (JCC) and Rogue Retreat (RR) partner to provide housing and case management for Medicaid members in recovery from addiction and/ or homelessness in Jackson County. This partnership is supported by a case rate contract between JCC and RR out of JCC's community reinvestment funds. RR supports members in moving along a continuum of housing and stability with their successful model for case management. Evaluation is in process to measure health outcomes and impact on cost and utilization. This partnership has recently expanded to pilot housing for members undergoing Medication Assisted Treatment.

Impacts & Outcomes:

- ◆ **159 JCC members** were provided housing and case management in 2018.
- ◆ **Average length** of engagement in RR programs for JCC members is **7 months**
- ◆ JCC members who are engaged at RR have **greater continuity of OHP enrollment** (328 days enrolled vs. 285 days enrolled for all JCC members) and therefore **greater access to care**. This is a result of the case management and stability provided.
- ◆ RR housing programs include **case management services** to assist participants through several levels and degrees of self-sufficiency. The progress of housed participants is evaluated and recorded by level. There was an average **increase by more than one level** (1.2 on average) among all JCC members participating.
- ◆ Of members who were housed and had continuous coverage through JCC for at least 9 months in 2018 (total of 43 members), there was an **84% decrease in the number of emergency room visits**.
- ◆ RR is **addressing gaps in preventative care** identified by JCC such as PCP visits, effective contraceptive use, immunizations, and colorectal cancer screening through their case management.

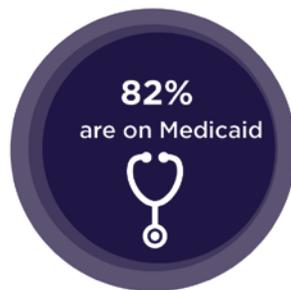


Mosaic Medical - Rx to Move

Increasing physical activity via provider prescription to move and CHW services

About Rx to Move: A medical or behavioral health provider writes a prescription (Rx) to increase physical activity. This Rx connects a patient to a Community Health Worker with the goal to increase physical activity via engagement in an activity of the youth's choice and assistance with barrier removal.

Conditions in order of Prevalence: Obesity, Anxiety, Asthma, Depression, PTSD, Developmental Delay



CHW Role in Rx to Move

- Connect youth to available community resources
- Remove barriers to participation by assisting with activity research, sign up paperwork, transportation needs and activity and equipment purchase
- Encourage youth to identify an activity to try

Lessons Learned

- Provider adoption of *Rx to Move* program was swift due to open eligibility and an easy referral process
- Partner meetings are critical to successfully and efficiently connecting youth
- Financial support and CHW encouragement are the key ingredients identified by families in post participation surveys
- We note trends in difficulty to engage teenagers over the age of 15 & additional attention must be paid to rural participants to ensure access
- Given duration of youth program participation we have not yet seen statistically significant impacts on biometric or behavioral health outcomes

Presenter Contacts:

Lindsey Stailing, Patient Support Program Manager,
Lindsey.stailing@mosaicmedical.org
Sonia Luna, Community Health Worker,
Sonia.Luna@mosaicmedical.org
Website: www.mosaicmedical.org

Population Served

Pediatric patients, ages 6-18, from Crook, Deschutes, and Jefferson Counties

Project Funding

COHC Regional Health Improvement Plan Workgroup for Heart Disease and Diabetes Prevention

The Trailblazers Foundation

Oregon Community Foundation

This program leverages available scholarships

Qualifying participants benefit from access to Health Related Services

Funds paid for:

.25 FTE CHW

Bus passes & gas cards

Activity fees like fitness memberships, martial arts classes, Parks & Recreation programs, school sport fees, swimming lessons...

Equipment like bikes, helmets, sneakers, uniforms, hiking shoes, basketballs, soccer balls, shin guards, baseball gloves, yoga mats and much more!

Secret Sauce: ICCM Wraps Services Around Chronically Ill Members

Intensive/Integrated Complex Care Management (ICCM): Whole health care that is cost effective; results in improved health & wellness; ensures an integrated experience of care that includes physical, behavioral and oral health; and addresses social determinants of health.

Presenters and contact emails:

Lucy Zammarelli, Supervisor (Trillium Behavioral Health)—Lzammarelli@Trilliumchp.com

Lo Lewis, Practice Coach (Trillium Medical Management)—Llewis@Trilliumchp.com

Megan Post, Project Director (Center for Family Development) – Mpost@c-f-d.org

Jamie Stevens, Medical Assistant (Springfield Family Physicians)—Jstevens@c-f-d.org

Population: Patients with at least 5 chronic medical conditions and at least 1 BH condition.

Funding: A collaborative funding model is used. Trillium provided a Value Based Payment with risk, with additional incentives based on meeting OHA CCO metrics and some additional outcome targets including reduced total cost of care. Start-up funding was provided by Lane County/Trillium Behavioral Health (TBH) for 3 month lead-in. Consultants are funded by TBH.

History: In 2014, Trillium and Lane County collaborated on 8 Trillium Integration Projects; 2 of those projects collaborated and provided a foundation for ICCM. Consultants were utilized to create and implement the project (5 separate consultants were used; 2 continue to be helpful as ICCM moves through its first full year.)

Challenges: Full ICCM integration in a primary care clinic including BH and Oral health requires a lot of coordination; adding social work to the mix to address Social Determinants of Health (SDOH) increases the difficulty considerably. Registry builds are time intensive; and Systematic Caseload Reviews are needed to keep the team focused on the populations needing the most primary care—and helps to keep patients out of the ER or inpatient care. Supporting the care team is another ongoing need for the project to be successful.

Solutions: Continued use of consultants has helped provide targeted assistance when and where most needed. Trillium's full-time medical Practice Coach works in the clinic with the ICCM team; TBH's part-time behavioral health Practice Coach assists as needed with care management and a part-time oral health Practice Coach helps solve those issues. Monthly meetings include all the organizations and help keep the focus on the ICCM model and answer system questions that arise. Senior leaders act as champions within each organization to help support the new model. Success stories are celebrated and there is recognition of the hard work needed to make the model succeed!



South Coast Together

a self-healing community initiative

www.southcoasttogether.org

South Coast Together is a community collaborative focused on fostering resilience in Coos and Curry counties. Its goals are to engage community members as agents of change in preventing the accumulation of Adverse Childhood Experiences and to build resilience in children, adolescents, and families.

How We Began: Project stemmed from the desire to get to the root cause of poor population health outcomes. Trainings about the ACE Study & Trauma-informed care in the Rogue Valley & Curry County spurred requests from Advanced Health members, providers, local clinics, early learning partners, and schools.

Current Partners: Our partners are from multiple sectors including: Healthcare, Education, Early Learning, Juvenile Justice, Public Health, and Community Service organizations.

Funding Sources: Nine (9) initial partners each paid \$5,000.00 to send someone to become an ACE Interface Master Trainer. We joined with Rogue Community College and Southern Oregon University to meet the minimum number of participant requirements for ACE Interface. Other funding sources include In-kind and Grants.

Timeline (Impacts & Outcomes)

Year 1 (2017): Community Interest & Readiness * Cross sector partnership established with Advanced Health as fiscal agent * First cohort through the ACE Interface Master Training Program * Steering Committee seated

Year 2 (2018): Metrics and Communications Committees established * Trainings provided to interested groups, approximately 1,000 people trained in Coos & Curry Counties * Regular support and guidance from ACE Interface * Regular monthly Steering, Metrics, and Trainers' Meetings * 1st public showing of the film, Resilience * Key Informant Interviews Report & Metrics Report * Named group collaborative, South Coast Together

Year 3 (2019): Expanded training options to include tailored workshops * Trained Presenters * Opportunity to add to Master Trainer cohort * Family Café Training * Regular showing of films, Resilience & Paper Tigers * Launched website * Developed Core Team for strategic planning * Planning for 1st Community Summit

Challenges

- Meeting the needs of 2-county region
- Planning future for Structure of the Initiative (backbone agency, paid staff, funding)
- Keeping momentum for trainings
- Engaging the community versus professionals

Lessons Learned

- Realizing initiative of this size takes designated coordinator and in-kind support from multiple organizations
- Entering paper evaluations become an administrative burden
- Consider grants and funding opportunities as a factor when selecting a backbone organization

Presenters

Leah Lorincz, RN, ACES Master Trainer, Health Services Coordinator, Advanced Health
leah.lorincz@advancedhealth.com;

Laura Williams, Director of Community Engagement, Advanced Health
laura.williams@advancedhealth.com



“The Union County Warming Station provides a welcoming, safe and compassionate place where all people can stay the night and are offered resources and pathways toward housing stability.”

www.ucwarmingstation.com



Background: Winter of 2017 was particularly harsh and dangerous for unhoused individuals and families in Eastern Oregon. To address safety and health needs, the **Union County Local Community Advisory Council (LCAC)** to the **Eastern Oregon Coordinated Care Organization (EOCCO)** allocated \$8,000 to conduct a **warming station**. A pilot operated during 2018, with service expansion for the 2018-2019 winter.

Outcomes include:

- Creation of operations manual, procedures, volunteer trainings.
- Shelter provided for 112 guests during 18-19 season, equating to 1,415 nights of shelter.
- Connection points: referrals were made to various social service agencies for necessities and to help remove barriers such as transportation, laundry services, a mailing address and medical care.
- Volunteers provided 4,605 hours of service to operate the warming station in 2018-2019.
- \$3,523 in cash donations, and thousands more of in-kind do such as food and operating supplies.
- Creation of new not-for-profit agency to sustain operations and electing a board of directors.
- Numerous instances of preventing ED utilization, unnecessary jail services (for potential trespass), and of guests arriving immediately after hospital discharge.

Challenges, lessons learned: Overcoming stigma and fear in the community. We learned to provide information, work with the city and law enforcement and create policies to help emphasize safety. Positive publicity and strict adherence to the warming station policies were essential. Currently, an operating location is the biggest challenge for the next year. Volunteer support and retention is also a critical aspect to success.

Partnerships: Opening lines of communication with existing structures was critical. Site visits were conducted with nearby warming stations in Hood River and Hermiston. Local social service agencies participated in the initial advisory committee. Law enforcement, emergency departments, adult and juvenile probation offices each supported the creation of the warming station, collaborating on policies and safety procedures. Social work students and student athletes from the local university completed volunteer hours. Faith based groups provided essential volunteers, supplies, food and financial donations.

Sustainability: Ultimately, a non-profit agency was formed to continue operating the Union County Warming Station. UCWS can apply for grant funding, and currently has some Oregon philanthropic funding through partnership with a local housing collaborative. The Community Benefit (CBIR?) funds from the EOCCO continue to provide some operational funds.

Cami Miller, Director, Union County Warming Station, cmiller@neonoregon.org;
Chris Evans, Community Development Coordinator, DHS, Child Welfare, Self Sufficiency,
Christopher.m.evans@dhosoha.state.or.us

NeighborWorks Umpqua is using the new Opportunity360 framework from Enterprise Community Partners to inform our housing and community development investments and program design and development.

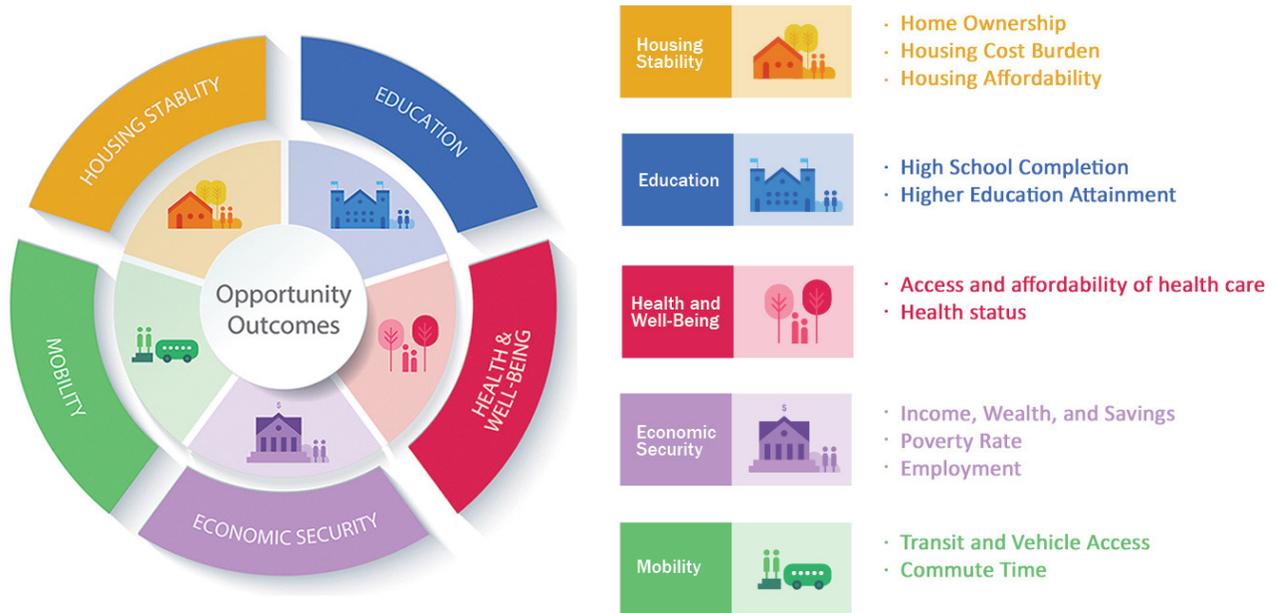
This framework uses a comprehensive set of criteria, including health and well-being, and other social determinants of health, to guide decision making. This approach provides additional factors, other than just cost, and looks at how more equitable decisions can be made to promote opportunity for all.



POWERED BY ENTERPRISE COMMUNITY PARTNERS

Social Determinants of Health

A variety of conditions in our communities affect a number of significant health risks and outcomes; these conditions are known as social determinants of health (SDOH). Within the Enterprise Opportunity360 framework, these determinants of health are referred to as 'essential foundations of opportunity' and include the following pictured below:



Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to quality education, adequate public safety, availability of healthy foods, local emergency/health services, and access to jobs, and access to transportation. By applying what we know about SDOH, we can not only improve individual and population health but also advance health equity.

As Enterprise Community Partners notes: “When people have access to the essential foundations of opportunity, including affordable housing, jobs, good schools and transit, then everyone has a chance to succeed - no matter where they’re starting from.”

Where Oral Health and Housing Unite



The Need- Lane county, Cornerstone Housing focusing on social determinants of health using Community Health Workers to support families to meet basic needs and support strong families.

The Partnership- Through Trillium CHIP workgroup, CDC and Cornerstone forged partnership and determined need for dental services at several apartments in specific areas. Using questionnaires given to residents (CDC provided free toothbrushes to those who filled them out) the project was started. An MSW intern schedules residents for the hygienist and provides onsite support.

Advantages- Residents know the intern, dedicated staff make appointments, administrative support, Trillium support, schedule is full for CDC team, CDC supplies toothcare kits and advertising

Challenges- Not able to provide teledentistry yet

The Need- Clients experiencing stages of drug rehabilitation, mental health treatment, adults and children. Outpatient and residential treatment.

The Partnership- Jonnie McBride, CDC EPDH works 3 days/week in outpatient medical clinic and one day per week in residential sites providing teledentistry and full dental hygiene services.

Advantages- Clients utilize CHW as support, case management with medical provider, lower ER usage for dental.

Challenges- Can we clone our provider?



The Need- Central Oregon, smaller # of members spread across several communities, want to bring services to our members who reside a distance from our clinic.

The Partnership- Leased MTI van once a week, staffed with EPDH. Karen met with administrators at HousingWorks which owns low-income housing apartments in Madras, Prineville, LaPine and Redmond. We are able to park the MTI van at each of these sites once a month. The site managers advertise with posters that the dental van is onsite, to provide a local access point for teledentistry and dental hygiene services for members making services readily available in our members' neighborhoods.

Advantages- Call center able to use gap lists and target CDC members

Challenges- Slow start



Contact Us:

Linda Mann, EPDH
Director of Community Outreach
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Karen Hall, EPDH
Oral Health Integration Manager
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Café Session 3: 2:15-3:15 p.m.

Portland Ballroom 252	Portland Ballroom 253	Portland Ballroom 254	Portland Ballroom 255
Salem Housing Authority Homeless Rental Assistance Program: Housing First Model (Housing)	Integrating Triple P in Lane County: A Community Approach to Parent Education (Early Learning)	"Abuela, Mamá y Yo": Strengthening the Health of Three Generations (Food Insecurity)	Tri-County 911 Service Coordination Program (Trauma)
Oregon Accountable Health Communities (Housing)	Community Prevention & Wellness Fund (Early Learning)	Double Up Food Bucks: Food Security Meets Economic Development (Food Insecurity)	Building a Trauma-informed Community to Address Childhood Trauma and Build Resilience in Children & Families in Clatsop and Columbia Counties (Trauma)
Changing Zoning Codes for Housing Flexibility (Housing)	Developmental Screening Pathways: Establishing and Improving Processes for Young Children Identified at Risk (Early Learning)	Clatsop Women's SUD Supportive Housing (Housing)	
D133	D134	D135	D136
Bridges to Health Pathways Program: Providing Culturally Appropriate Community Care Coordination Linking Health and Housing (Housing)	Engaging Communities in Health Outcomes (Early Learning)	Partnership for Better Health (Food Insecurity)	Starting Strong: Supporting Maternal Child Health through Resource Connections (Cross-Cutting)

Café Session 3 Project Descriptions

“Abuela, Mamá y Yo”: Strengthening the Health of Three Generations (Food Insecurity)

Rebeca Márquez, Abuela, Mamá y Yo Project Manager, Familias en Acción

Abuela, Mamá y Yo is our food equity and nutrition program. It was designed in partnership with Latino families, Latino organizations and the OHSU Moore Institute. It includes epigenetic research on the developmental origins of health and disease that shows the impact of food and toxic stress upon generations. It examines decolonizing food and encourages eating traditional foods to build a healthier lifestyle to lower the risk of chronic diseases.

Bridges to Health Pathways Program: Providing Culturally Appropriate Community Care Coordination Linking Health and Housing (Housing)

Suzanne Cross, MPH, CHW, Senior Program Manager, Columbia Gorge Health Council & PacificSource Columbia Gorge CCO; Karen Long, Special Programs Manager, Mid-Columbia Housing Authority; Josh Sendejas, Resident Service Coordinator and Community Care Coordinator, Mid-Columbia Housing Authority

The Bridges to Health Pathways program helps community members connect to needed services including health care, housing, transportation, food, social services and others. “Pathways” refer to these categories of needs. The “bridges” are community health workers (CHWs) who, through cultural and linguistically appropriate services, connect households to services and provide support and education. The program is a cross-sector partnership of PacificSource Columbia Gorge CCO, two hospital systems, two public health departments, Head Start, The Next Door and the Mid-Columbia Housing Authority. Clients served by the housing authority and meet the criteria for the B2H program work with a community care coordinator (CHW) and together they prioritize needs and work toward pathway outcomes. We will describe the system processes, workflow successes and lessons learned in providing community care coordination services, funded with Medicaid dollars, through a local housing authority.

Building a Trauma-informed Community to Address Childhood Trauma and Build Resilience in Children & Families in Clatsop and Columbia Counties (Trauma)

Angel Escobedo, Senior Program Development Specialist, Columbia Pacific CCO; Heather Oberst, MS, Community Health Improvement Coordinator, Columbia Pacific CCO

In Clatsop and Columbia Counties, Childhood Trauma Informed Networks (CTINs) bring together health care, education, child welfare, economic, community and criminal justice sectors to support an integrated effort toward trauma informed care. The CTINs will work to sustain awareness, shared understanding, integration and improvement of trauma-informed strategies through engaged, resilient communities and a robust community investment plan.

Changing Zoning Codes for Housing Flexibility (Housing)

Sandy Ryman, MBA, Strategic Initiatives Director, Greater Oregon Behavioral Health, Inc. with Eastern Oregon CCO

To facilitate additional housing stock, GOBHI obtained a Meyer Memorial Trust grant to create zoning codes for accessory dwellings, cottage developments and tiny cottages on infill lots. Challenges and learnings with planning commissions and city councils will be shared along with a link to a zoning code.

Clatsop Women's SUD Supportive Housing (Housing)

Kate Allen, Housing Development Consultant, Community Development Services; Rose Anderson, Recovery Ally/Peer Mentor, Clatsop Behavioral Healthcare; Karen Wheeler, MA, Business Development Director, Greater Oregon Behavioral Health, Inc.

Through close collaboration with community partners, this rural supportive housing project serving single, pregnant and parenting women in early SUD recovery was launched in a rural, coastal town in Northwest Oregon. The project was funded by OHCS and GOBHI, and property was donated by Clatsop County. This project is a multi-generational model supporting recovery goals for moms as well as parenting, healthy attachments, and early childhood development.

Community Prevention & Wellness Fund (Early Learning)

Emily Johnson, Community Health Specialist, Yamhill Community Care; Lindsey Manfrin, DNP, Deputy Director and Public Health Administrator, Yamhill County

Yamhill Community Care has convened a multi-sector Community Prevention and Wellness Committee to guide investment in prevention-based, population health programs. The committee develops innovative financing strategies, including building community reinvestment into contracts with partners and identifying unique grant-seeking opportunities. The committee's first major investment was in PAX Good Behavior Game, an intervention shown to improve short- and long-term academic and behavioral outcomes. The presenters will lead a discussion around developing sustainable funding models to support programs addressing the social determinants of health.

Developmental Screening Pathways: Establishing and Improving Processes for Young Children Identified at Risk (Early Learning)

Tonya Coker, EI/ECSE Coordinator, Willamette ESD; Kiara Yoder, Screening and Care Systems Coordinator, Marion & Polk Early Learning Hub

Marion and Polk Early Learning Hub has continued a project that Oregon Pediatric Improvement Partnership began in 2016 with Willamette ESD and two pediatric clinics and has also expanded the focus to include early learning providers. The project has been exploring

and improving the referral process between clinics, Willamette ESD and other referral options for children identified at risk to ensure that all children are ready for kindergarten.

Double Up Food Bucks: Food Security Meets Economic Development (Food Insecurity)

Sam Engel, Social Determinants of Health Manager, AllCare Health; Cheryl Kirk, Instructor on Family and Community Health, OSU Extension

A partnership-based approach to reducing hunger and increasing nutrition through existing community networks, Double Up Food Bucks can increase low-income family purchasing power at local markets, reduce hunger, offer more choices for consumers, improve nutrition, and boost local economy. Through local partnerships, matching funds and technical assistance grants, DUFEB can offer a lot to producers and consumers in rural and urban environments.

Engaging Communities in Health Outcomes (Early Learning)

Kyle Lakatos, MS, Co-Founder & Executive Director, ECHO Initiative, Family & Community Medicine, University of California-San Francisco

Our clinic partners with city-funded family resource centers to provide a more concerted support system for low-income families living in San Francisco. We are developing interventions designed by the community systems most intimately connected to families in need.

Integrating Triple P in Lane County: A Community Approach to Parent Education (Early Learning)

Iris Bicksler, Traditional Health Worker Program Supervisor, Cornerstone Community Housing; Claire Hambly, Education Program Manager, United Way of Lane County & Lane Early Learning Alliance; Lynne Swartz, Executive Director, Parenting Now!

The Lane County implementation of Triple P, the Positive Parenting Program, is a cross-sector approach to parenting education, engaging partners from the health, early learning, and social and human service sectors. Specifically, this partnership includes the CCO, the public health department, a low-income housing community, and two nonprofit organizations.

Oregon Accountable Health Communities (Housing)

Anne King, MBA, Director of Healthcare Initiatives & Project Director, Accountable Health Communities, Oregon Rural Practice-based Research Network, OHSU

We are working with six CCOs and over 50 clinical sites (primary care, dental, behavioral health, public health) to implement screening and navigation for social determinants of health needs. We'll share learnings about the housing, safety and food insecurity needs identified, different roles and workflows being used by partners, and how we are reducing the burden of Medicaid patients when trying to access resources for their health-related social needs.

Partnership for Better Health (Food Insecurity)

Karen Edmonds, Programs and Services Director, FOOD for Lane County; Debi Farr, Manager, Community Relations, Trillium Community Health Plan

FOOD for Lane County and Trillium Community Health Plan connect Medicaid recipients to food programs including Produce Plus: high-quality fresh fruits and vegetables available in health clinics; Screen and Intervene: food insecure members are referred to Produce Plus sites; and Veggie Rx: Diabetes Prevention Program participants receive vouchers to farm stands. The program is assessing impact through usage data and health monitoring.

Salem Housing Authority Homeless Rental Assistance Program: Housing First Model (Housing)

Pamala Garrick, Grants Coordinator, Salem Housing Authority

HRAP is the largest Housing First initiative in Oregon. Currently, 165+ chronically homeless persons are housed with a 95% housing retention rate. An intensive case management model provides support in achieving and sustaining housing stability. Individualized housing stability plans assist clients in addressing issues that impact housing stability, including: physical health, mental health and addiction disorders, trauma, lack of employment, positive peer supports, food security, economic development, literacy and more.

Starting Strong: Supporting Maternal Child Health through Resource Connections (Cross-Cutting)

Riki Rosenthal, Starting Strong Program Specialist, Jackson Care Connect; Maegan Pelatt, MSW, CSWA, Medical Social Worker, CareOregon

Starting Strong is a community-based program focused on improving the health outcomes and experiences of Jackson Care Connect's maternal-child population. Through this program, members receive in-person support in accessing local resources like WIC, SNAP, Head Start, clinical partners, and internal care teams. Members and their families are incentivized to engage in care and have opportunities to receive essential items like diapers and car seats.

Tri-County 911 Service Coordination Program (Trauma)

Erin Brochu, EMS Social Worker, Tri-County 911 Service Coordination Program; Alison Goldstein, Program Supervisor, Multnomah County Emergency Medical Services

The Tri-County 911 Service Coordination Program (TC911) serves Clackamas, Multnomah and Washington county residents who frequently use emergency medical services when other services are more appropriate. Most TC911 clients have physical and behavioral health issues, experience housing instability, and have a history of trauma. Community-based social workers help people connect to services and facilitate multi-system care coordination. Evaluations consistently show the program reduces ED visits and health care costs among Medicaid clients served (~\$10,644 per person annually). TC911 is largely funded by Health Share of Oregon as a

community utility. TC911's collaboration with first responders; Aging, Disability and Veteran Services; medical clinics, mental health and addictions providers; housing agencies; and regional hospitals across three counties have been instrumental to its success.



What is Abuela, Mamá y Yo?

Abuela, Mamá y Yo (AMY) is our Latino nutritional program to build family knowledge about nutrition and social determinants. This research-based program is offered by our community, in our community to increase knowledge about healthy practices and to build advocacy skills around the link between food justice, social determinants of health and health equity for families.

These issues are addressed on 2 levels:

- Culturally and linguistically specific education around personal and family health and nutrition
- Encouragement to become advocates for their child and other within their community



The ultimate goal is to reduce the impact of food and health inequities and to build communities that raise strong children who become healthy adults.

The goals of Abuela, Mamá y Yo are to:

- Reduce the impact of health due to food inequities, social determinants, and poverty
- Increase parental knowledge of positive health and behavior practices from conception, during pregnancy, and through early childhood
- Increase participant practice of new healthy behaviors around nutrition and exercise
- Build advocacy skills useful in their own families and their communities

Format of Abuela, Mamá y Yo

Group sessions welcome:

- Women who are pregnant- or planning on become pregnant
- Parents of infants and young children
- Grandparents and other relatives
- Children's caregivers and family friends

Sessions are warm and non-judgmental, provided in English and Spanish, encouraging participants with videos and active learning, offering practical solutions that fit busy families and encouraging peer networking for lasting connections and community involvement.

Each of 4 sessions in the series is about 2 hours long:

- Session 1: Sembrando resiliencia/ Sowing resilience
- Session 2: Los primeros mil dias/ Nutrition for the first thousand days
- Session 3: Volver al Maiz/ Returning to corn
- Session 4: Familia que esta unida, se fortalece unida/ Strong families building healthy communities



ABUELA
MAMA
YO

FORTALECIENDO LA SALUD
DE TRES GENERACIONES



Presenters:

Josh Sendejas- Community Care Coordinator, Mid-Columbia Housing Authority- josh@mid-columbiahousingauthority.org,
Karen Long- Special Programs Manager, Mid-Columbia Housing Authority,- karenl@mid-columbiahousingauthority.org,
Suzanne Cross, MPH, CHW- Snr Program Manager, Columbia Gorge Health Council- suzanne@gorgehealthcouncil.org

Bridges to Health Program Background:

The Bridges to Health Pathway Program Goals:

- 1) Empowering community members most in need to improve their overall health and well-being
- 2) Assisting clients with access to services and resources by addressing disparities
- 3) Improve integration of services in and out of healthcare

Bridges to Health Program Strengths:

- Ability to address the needs of the **HOUSEHOLD**
- Engaging clients where they are, “no wrong door” approach
- Limit duplication of services
- Build on community strengths and collaboration
- Standard process regardless of agency (CLARA software)
- Data-driven decision making

Community Care Coordinators (CCCs) employed by Community Care Agencies (clinics, health departments, social service agencies) help coordinate needed services for clients & their households. Agencies contract with the HUB to get paid when evidence- based outcomes are met.

CORE PATHWAYS (Needs)	
Behavioral Health	Employment
Developmental Screening	Health Insurance
Developmental Referral	Housing
Education	Medical Home
Family Planning	Medical Referral
Food	Medication
Immunization	Tobacco Cessation
Pregnancy	Postpartum
Social Service Referral (transportation, clothing, legal, etc.)	



Bridges to Health Project Description:

The Columbia Gorge CCO has taken its collaborative energy and systems thinking approach to utilize its local implementation of the Pathways Model, “Bridges to Health (B2H) Pathways” in an effort to help meet the needs of our Housing Challenged Population.

This program is a partnership supported by PacificSource Columbia Gorge CCO, and the model is a cross-sector collaborative approach to providing community care coordination. Clients who are served by the housing authority and other agencies work with a Community Care Coordinator (CHW) and together they prioritize needs and work towards pathway outcomes. “Pathways” refer to the categories of needs. The “bridges” are community health workers (CHWs) who, through cultural and linguistically appropriate services, connect households to services and provide support and education. Currently the program is primarily funded through CCO Medicaid Global Budget dollars (for CCO members) and CCO Shared Savings funds (for others).

Outcomes:

500 individuals have been enrolled in the program since inception, on average 65% are CCO members

After having been in the program for 4 months consecutively, clients have noted:

- Feel better connected to services: 84%
- Quality of life has improved: 74%
- Feel more confident in managing health and health needs: 50%

Steps towards Implementation of a HUB:

1. Identify a Core Team of champions (5-10 diverse stakeholders).
2. Identify funding possibilities. Need to cover startup costs prior to being able to measure and achieve outcomes (1 yr. min).
3. Work with the Core Team to: develop population focus, determine if you have any additional community goals
4. Identify an organization to serve as the HUB and which organizations they will contract with to be Care Coordination Agencies.

PROGRAM WEBSITE: <https://cghealthcouncil.org/programs/bridges-to-health-pathways-program/>



Columbia Pacific Coordinated Care Organization
**Building a Trauma-Informed Community (TIC) to address childhood trauma
 and build resilience in children and their families in Clatsop and Columbia counties**

Project Description:

Community partners, together with Columbia Pacific CCO, are working to change the community context around childhood trauma and build resilience in Clatsop and Columbia counties.

In recent years, we've learned a lot more about the tremendous impact of unaddressed Adverse Childhood Experiences (ACEs) on future health and wellbeing. Specifically, individuals who experience high levels of childhood trauma including abuse, neglect, bullying and community violence are at increased risk for social, behavioral, cognitive and academic problems, impaired physical health and early death.

In both Clatsop and Columbia counties, community discussions of childhood trauma, ACEs and the challenges that children and their parents face inspired the creation of Trauma-Informed Networks to provide dedicated focus on creating a coordinated and trauma-informed response to build resilience and provide tools to respond to and prevent childhood trauma across sectors and systems. The overarching goal of this effort is to prevent and heal trauma across systems and build resilience in children, families and communities.

Timeline/Next Steps for Each County:

June 2019	Review/revisit vision and or develop mission statement
July 2019	Develop 1 st draft of charter
August 2019	Adopt TIC principles
September 2019	Provide TIC training for steering committee and sector work group
October 2019	Identify priorities and focus for trauma-informed network
November 2019	Draft strategic plan for networks
December 2019	Approve strategic plans

Contact:

Angel Escobedo, Senior Program Development Specialist:
escobedo@CareOregon.org, 503-416-3688.

Changing Zoning Codes for Housing Flexibility



Development of an organizational housing plan led Greater Oregon Behavioral Health, Inc. (GOBHI) to consider ways to increase housing stock in thirteen rural counties of eastern Oregon. As part owner of the Eastern Oregon Coordinated Care Organization (EOCCO), GOBHI clearly recognized how hard it was to find affordable housing for their Members. The GOBHI CEO, Kevin Campbell, the board of directors and staff strongly believe all people have a right to a home — and to a home similar to anyone’s home.

In thinking about how to create more affordable housing, GOBHI decided to expand potential housing options in order to encourage development of additional home building, such as fully equipped tiny cottages. GOBHI envisioned these cottages as accessory dwelling units added to existing lots, used to expand a neighborhood’s density on in-fill lots (those empty lots which exist in some neighborhoods due to an odd size or due to loss of a structure), or allow for creation of an affordable neighborhood (as a new development).

Our key learnings are that this success was possible due to:

- ▶ Treating the city Planner with respect and as a friend. They are all overworked and need support.
- ▶ Hiring a professional architect to assure appropriate code wording, reduce the workload of the Planning Manager and answer questions at the Planning Commission level. When requested, his firm was able to show scenes of what multiple cottages might look like on actual in-fill lots in La Grande (see the scenario at the right).



- ▶ GOBHI staff pulling together key community contacts who were educated on the code and testified at City Council meetings as interested citizens in support of the codes. Showing the City Council photos of a cottage development in Washington. The response by elected officials: “Oh, that is what you are talking about! Yes, we would like that.” Photo shared with council is shown at the left.

Upon passage, the Union County Veteran’s Affairs Officer found a developer and they jointly planned a ten (10) unit cottage development for veterans. This is exactly what GOBHI hoped would happen: that the idea would spark the process and inspire others to begin building.

The La Grande code is available for anyone who wants to carry it further. See Article 3.22 at: <http://www.cityoflagrande.org/muraProjects/muraLAG/lagcity/index.cfm/city-offices/community-development/planning-division/ordinances/land-development-code-zoning-code/>

For additional information, contact Sandy Ryman at sdryman@gobhi.org.

Project Title: Clatsop Women’s SUD Supportive Housing

Project Description: Clatsop Women’s SUD Supportive Housing project is designed to provide housing with gender-specific recovery support services and access to other resources. This is a supportive housing project for single, pregnant and parenting women who are in early stage recovery from Substance Use Disorders (SUD).

Presenter Contact Information:

Rose Anderson, Peer Recovery Mentor, Clatsop Behavioral Healthcare: rosea@clatsopbh.org

Karen Wheeler, Business Development Director, Greater Oregon Behavioral Health, Inc. (GOBHI): kwheeler@gobhi.org

Kate Allen, Community Development Services, Housing Development Consultant: kmadev76@gmail.com

Intended Impact/Outcomes:

This presentation will focus on the project development milestones and how our partners came together to make this resource a reality. Client specific outcomes will also be tracked as the project matures over time.

Key Milestones:

- Secured commitment from GOBHI Board of Directors for \$140,000 investment
- Identified and developed agreement with developer
- Secured funding commitment from Oregon Housing and Community Services (\$200,000)
- Property acquisition due to generous donation from Clatsop County Commissioners
- Identified and developed agreement with general contractor
- Structural components of project developed by Key Partners: Clatsop Behavioral Healthcare, Department of Human Services District One, Northwest Oregon Housing Authority, GOBHI

Challenges:

- Locating a suitable property
- Working through house guidelines and tenant selection and prioritization process
- Complexities and details associated with housing development

Lessons Learned:

- It is OK to challenge assumptions about the service model, guidelines and rules have been used in other models.
- Construction rehab takes time, particularly when using local sub-contractors who are busy on other projects.
- The time period before “go live” can be stressful as all the pieces come together. People are identified and waiting for housing so project delays can be stressful and have a real impact on lives.

Partner Organizations:

GOBHI – Project Sponsor and Property Owner

Clatsop Behavioral Healthcare – Service Provider and Gatekeeper

DHS – Reunification support and Tenant Selection Committee Member

Northwest Oregon Housing Authority – Property Manager and Administrator of Project-Based Subsidies

Funding Sources: GOBHI (\$140,000), OHCS (\$200,000), Local Fundraising

TIMELINE

FALL 2018

- YCCO Board of Directors update governance & charter
- Review suite of evidence-based prevention programs
- Establish funding parameters for partner participation

2019

- Expand CPW Membership via community outreach
- Leverage initial investments
- Monitor investments for impact
- Continued quality improvement
- Stabilize ongoing funding structures

2020

- Identify additional innovation for cross sector funding models
- Continue to build relationships and conduct outreach

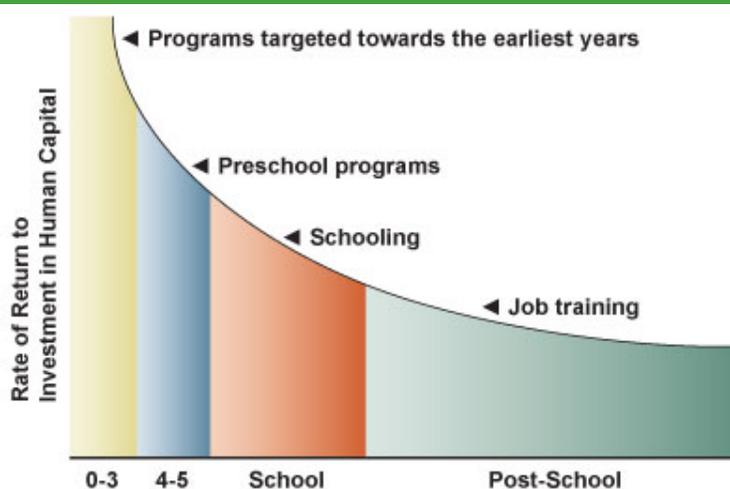
Yamhill CCO and Yamhill County Public Health have begun a Community Prevention & Wellness Fund to support initiatives that will improve the long-term health of all residents in Yamhill County and reduce the rising costs of healthcare, social services and special education.

PROGRAMS

- ❖ Investment in **evidence-based interventions** and promising practices that have shown to have long-term impacts on population health
- ❖ **School-based prevention** to address classroom problems, such as Good Behavior Game, which has shown success in Yamhill County
- ❖ **Early childhood prevention** to address the trauma and toxic stress that poverty and other factors can impose, such as home visiting and relief nursery programs
- ❖ **Prenatal prevention** to support positive maternal child health outcomes health, such as public health education, outreach and social emotional supports
- ❖ **Social and academic supports** to get our youngest off to the right start, such as universal preschool, proven to have long-term impacts on the trajectory of participants' lives

FUNDING SOURCES

- ❖ Business relationships and contracts
- ❖ Cost savings in other areas redirected to prevention funds
- ❖ Grant and foundation funding
- ❖ Investment models that may take on risk for the success of the program
- ❖ Publicly-funded partners
- ❖ County prevention funds



Questions?

Contact Lindsey Manfrin – manfrinl@co.yamhill.or.us

Emily Johnson - ejohnson@yamhillcco.org

Developmental Screening Pathways

Establishing and Improving Processes for Young Children Identified At Risk

Marion & Polk Early Learning Hub Willamette Education Service District

Marion & Polk Early Learning Hub (MPELH) has continued a project that Oregon Pediatric Improvement Partnership began in 2016 with Willamette ESD and two pediatric clinics and has also expanded the focus to include early learning providers. The project has been exploring and improving the referral process between clinics, Willamette ESD and other referral options for children identified at risk to ensure that all children are ready for kindergarten.

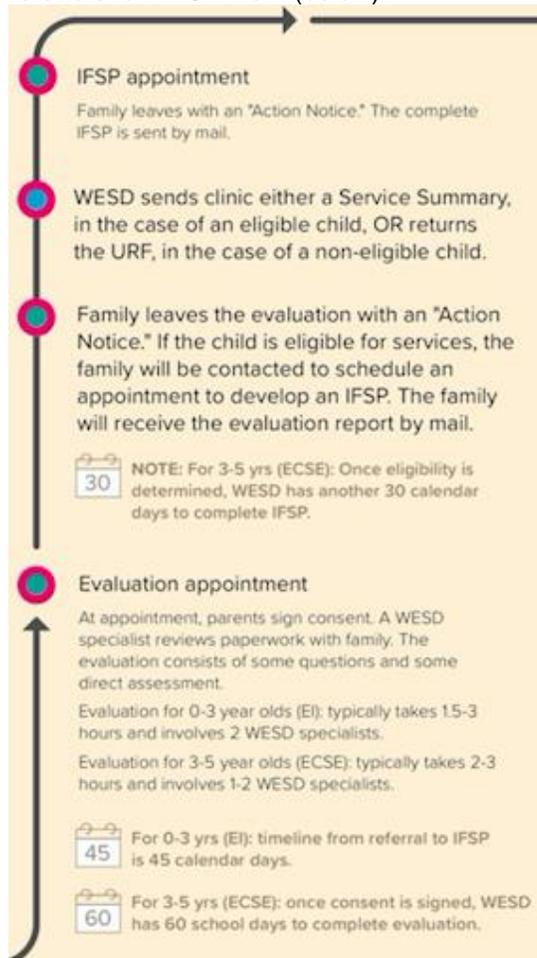
Partners:

- Childhood Health Associates of Salem
- Marion & Polk Early Learning Hub
- Willamette Education Service District
- Woodburn Pediatric Clinic

Impact:

- Better communication and understanding between medical providers and WESD
- Improved rates of referral loop being closed
- New communication tool implemented statewide

Part of a flow chart developed to explain how referrals to WESD work (below).



Lessons Learned:

- Long-term change takes a long time!
- Data is important
- You can't always get all the data you want
- Clinic/organization champions are important

Funding Source:

- Initial funding: EI/ECSE budget
- Current funding Local CCO, WVCH, grant
- Future: Unknown

Challenges:

- Getting into more medical clinics
- Uncertainty around CCOs

Contact:

Kiara Yoder: kyoder@earlylearninghub.org
Tonya Coker: tonya.coker@wesd.org

Project title: Double Up Food Bucks – Food Security Meets Economic Development

Project description: Double Up Food Bucks isn't unique to our communities but we have embraced DUFB as a model that supports CCO members, local agricultural economy, encourages healthy nutritional habits, and reduces barriers to healthy eating.

Presenter contact information:

- Cheryl Kirk RDN, Family and Community Health, OSU Extension, Cheryl.kirk@oregonstate.edu
- Sam Engel, SDoH Manager, AllCare Health, sam.engel@allcarehealth.com

Impact, outcomes:

- There was a 26% increase in Grants Pass Growers Market SNAP debit disbursed during 13 weeks of the pilot program as compared to the same weeks in 2017. (>\$ 2,320 increase in SNAP dollars)
- 241 individual SNAP customers accessed the program (462 transactions)
- \$13,921 (SNAP + DUFB) was spent at the Grants Pass Growers market during the project.
- These dollars directly support local farmers' effort and allow families and individuals to purchase more fresh produce at the market – Doubles the money for both.
- 78% of survey respondents indicated household chronic health conditions.

Challenges and how you overcame them (if relevant): DUFB was not without challenges! One important challenge to keep in mind is that DUFB vouchers are a second currency that the market manager and vendors have to handle. This incurs a cost for printing and circulating as well as a cost in time for the manager or bookkeeper. Addressing these (and other) challenges requires trust, championship, and support from inside and outside the market.

Lessons learned – What would you recommend doing the same or differently if this project were replicated elsewhere in Oregon? In the first year, the funding was limited to only the cost to print the DUFB vouchers and the reimbursement value of the vouchers. In year two, the funding is being expanded, with broader community support, to include sustainability components such as: reimbursement for the market manager's time spent on DUFB and advertising. It is worth noting that there may also be funding available through the Farmers Market Fund to support equipment and technical assistance such as a SNAP/EBT reader and information on participating in SNAP.

Which organizations were involved:

AllCare CAC	OSU Extension	Blue Zones
Rogue Valley Food System Network	Primary Health CCO	AllCare CCO
Grants Pass Growers Market	WIC / Public Health	

Funding source – How is this project being sustained? (actual budget not required): The funding for this project varies from market to market, based on several factors. Using our newest participating market as a case study:

- Year one: CAC awarded grant from AllCare CCO's Josephine County CAC
- Year two: AllCare CAC award, Market funding, funding from a second CCO CAC

Website address for more information: <http://www.growersmarket.org/> *"Living on food*

Engaging Communities in Health Outcomes

To promote the wellbeing of children and their families through a holistic model, drawing on the strengths of a child's entire community including family, educators, and medical and mental health providers.

Kyle Lakatos, MS Co-Founder & Executive Director, ECHO Initiative
Family & Community Medicine, UCSF | Family Health Center, ZSFG
Email: Kyle.Lakatos@ucsf.edu | Phone: 650.735.1320



Designed to address the social determinants of health, the ECHO Initiative is a cross-sectoral collaboration formed to bridge the gap between the clinic and community. Our vision is a world where the wellness of each individual is woven into the fabric of our society.

What we mean when we say “community-designed”

Putting families' needs first

Community Centers were a commonly suggested point of contact for parents based on our stakeholder interviews. Our additional research helped to identify and prioritize working in neighborhoods that have disproportionately high rates families living in low-income conditions in San Francisco. In building this community-designed health intervention, it was important to keep our end-users (the parents and communities) at the front-end of our planning process. We have worked to develop relationships with local community organizations that support families within our city. We have been diligent to seek feedback and incorporate input from our community partners at every step as we progress in the planning process.

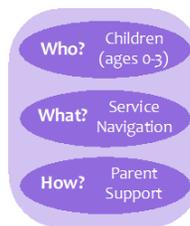
Our intent is to move the needle closer to an integrated system between healthcare and organizations that focus on addressing the socioeconomic determinants of health.

Stakeholders were interviewed (n=34)*
A shortlist is provided below

Department of Children, Youth, and their Families
San Francisco Office of Early Care and Education
San Francisco Department of Public Health
University of California, San Francisco
Children's Council of San Francisco
Zuckerberg San Francisco General
San Francisco State University
Wu Yee Children's Services
Our Children, Our Families
First 5 San Francisco
Support for Families
Help Me Grow



Identification of gaps and needs



A collaborative model was developed for maximizing sustainability and support



Being culturally responsive, and focusing our outcome through a cultural lens

A persistent point shared by our community partners was to ensure that any intervention introduced retained a strong level of cultural relevance to the community. In every step of the design process, it was clear an effective form of community engagement would require us actively taking a community-first and (*more importantly*) a community-driven approach for gaining short-term adoptability and ensuring the long-term sustainability.

The three pillars to our early childhood health platform

I. Community Health Programs

Provider-facilitated, and community center-housed, these group classes focus on health topics as chosen by the community center staff and are hosted on-site at the center. The group didactic sessions are designed to promote bidirectional learning for families and also UCSF 2nd and 3rd year family medicine resident physicians.

II. Talking is Teaching

A consistent messaging platform used to remind families of the importance of and the many ways to engage in talk or play with their child. Includes high quality materials and supplies for families to take with them and use as an at-home reminder. Currently used in clinics, community centers, and libraries.

III. Kid's Resource Menu

A non-digital, paper-based pamphlet provided to families at various touch points (i.e., the clinic, libraries, or a community center). With appeal to children and content geared towards caretakers, it showcases a map of the most commonly referred to resources (e.g., libraries, museums, parks, etc...) in a given neighborhood.

Key take-aways

- Always consider the end-user in the design of a product / intervention / etc.
- Engage stakeholders early and communicate with them often on outcomes.
- Listen to what your constituents want, be willing to adapt and change.
- Community engagement is not an exact science, learn the evaluation methodology and don't be afraid to ask for help from others, some data is always better than no data.

*Stakeholders were interviewed with a questionnaire developed to identify the following: the current concerns for low-income families and children living in San Francisco; locations where an early childhood development initiative would be most appropriate to house; the components of an ideal intervention; and the metrics and evaluations most appropriate to track the intervention effectiveness.



This work was supported by the Milton and Rosalind Chang Career Exploration Prize from The California Institute of Technology.

Integrating Triple P in Lane County:

A Community Approach to Parent Education

History and Overview:

As part of their commitment to health transformation, Trillium Community Health Plan identified parenting education and support as a priority for primary prevention. Triple P- Positive Parenting Program, with its unique and varied service delivery model, was selected to fit Lane County's needs.

Triple P – Positive Parenting Program is a community based system of parenting supports with multiple levels of intensity and delivery modalities. Triple P draws on social, emotional, cognitive, behavioral, and developmental theory to help parents build skills to address parenting and family struggles in a positive and consistent manner. Extensive and rigorous research supports its effectiveness.

Lane County's implementation is led by a cross-sector of key partners from health, early learning, social and human services, behavioral health, and housing.

Implementation Team Members

- Trillium Community Health Plan
- Lane County Public Health (LCPH)
- United Way of Lane County (UWLC)
- Parenting Now!
- ORI Community and Evaluation Services
- Cornerstone Community Housing (CCH)

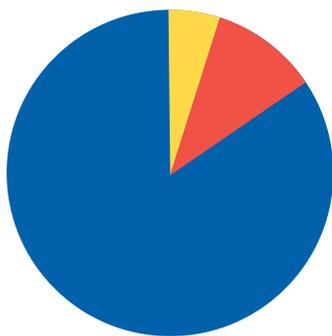
Many other community partners are involved and either provide Triple P services, or refer families.

Funding

Funding for the project comes from Trillium's investment in primary prevention that is contracted to Lane County Public Health. LCPH grants funds to UWLC, who subcontracts with the other implementation partners.

Impact and Outcomes

- 425 total families reached



- Triple P Online (TPOL): 361
- Discussion Groups: 52
- Individual Consultations: 12

88%

Felt that their child's behavior had improved at least some.

95%

Were "somewhat" or "very" positive about what they had learned, and would participate in Triple P in the future.

Lessons Learned by the Implementation Team

- Focusing on the organizational readiness/careful selection of trainees improves the success
- Agencies and trained providers need tools and resources to be successful
- Triple P is most successful as a systematic approach, not just a one-off

Project Goals

- Normalize and de-stigmatize parenting education
- Familiarize parents with Triple P principles
- Provide parenting education through unique models and in community settings
- Develop a strong, cross-county implementation in both English and Spanish

Current Triple P services in Lane County

- Community-wide marketing approach using a variety of media channels
- In-person consultations with trained providers in community locations
- Discussion groups for parents with children 12 and under
- Comprehensive online intervention with Triple P Online (TPOL)

Contact the Presenters for more Information!

- **Claire Hambly, United Way of Lane County:**
chambly@unitedwaylane.org
- **Lynne Swartz, Parenting Now!:**
lswartz@parentingnow.org
- **Iris Bicksler, Cornerstone Community Housing:**
ibicksler@cornerstonecommunityhousing.org
- **Jacqueline Moreno, Lane County Public Health:**
jacqueline.moreno@co.lane.or.us

LaneTripleP.org



United Way of Lane County





Oregon Accountable Health Communities (OAHC)

Project Description

The OAHC is a CMS-funded project that is helping communities understand and address social needs by:

- Identifying health-related social needs of 75,000 Medicaid and Medicare beneficiaries annually, specifically focusing on housing, food, utilities, transportation and violence
- Providing a tailored summary of community resources for those with identified needs
- Providing personalized navigation to services for 2,925 high risk (high ED utilizer) patients annually
- Facilitating sharing of data across clinics, payers and social service agencies for patient care, population health, and identifying where resources are not available to meet a social need

Participants

CCOs- AllCare, Jackson Care Connect, Primary Health of Josephine County, PacificSource Central Oregon CCO, PacificSource Columbia River Gorge CCO **Clinics-** 45 primary care, public health, hospital, dental clinics in 9 counties in Southern and Central Oregon, Columbia River Gorge and Yamhill County

Outcomes to Date

- Project started in December 2018, active in 17 clinical sites & working toward getting everyone going by summer.
- Initial data shows high need in Medicaid members: food (51%), utilities (24%), housing (19%), transportation (13%), verbal abuse-screaming/cursing (20%).
- Not many patients disclosing physical harm (3%).

Challenges & Early Lessons Learned

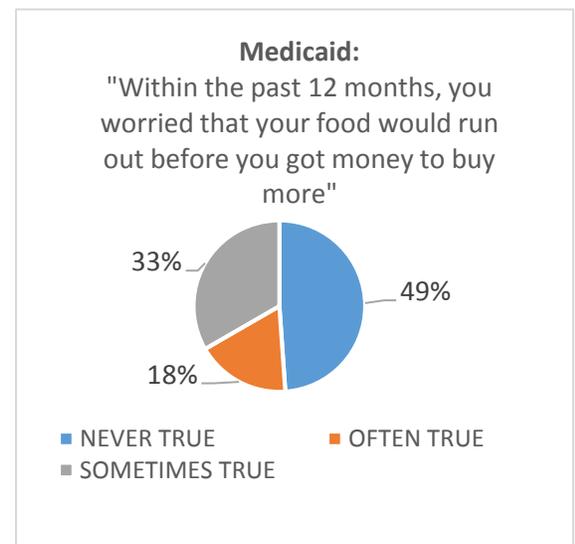
- Getting sites started has been slower than anticipated.
- There is no “one size fits all” approach to doing social needs screening and navigation. It’s best to tailor the approach to the needs of the clinical site.
- It appears that patients appreciate being asked by their health care providers about their health-related social needs.
- Patients report that they appreciate being offered help from a navigator, even if they do not accept that help.
- Everyone involved really wants to make a difference. The challenges lie in figuring how to do that given operational and resource constraints.

Next Steps

The project is currently recruiting in the Portland-metro area and continues through Spring 2022.

Contact

Anne King, MBA
Project Director
503-459-1414
kinga@ohsu.edu



Partnership for Better Health

In June 2018, Trillium Community Health Plan (Trillium) and FOOD for Lane County (FFLC) launched a partnership to run three key programs that specifically address social determinants of health to increase access to healthy food for local families who need it:

- Trillium Produce Plus, bringing free fresh produce to convenient community locations, including medical clinics
- Trillium Veggie Rx, providing vouchers for free fresh fruits and veggies to a pilot group of Diabetes Prevention Program members
- Trillium Screen and Intervene, identifying food-insecure individuals during healthcare visits and referring qualifying patients to a Produce Plus site

Our partnership through these programs helps prevent chronic conditions such as obesity, diabetes, and high blood pressure, as well as makes healthy eating more affordable.

Trillium has committed to funding this project through 2019, with an option to renew in 2020.

Comparison of weight loss: used vs. unused vouchers	Total	Avg spend	Avg weight loss (lbs)
Used vouchers	23	\$148.44	11.3
Did not use vouchers	11	NA	6.2

Making an Impact

This partnership has allowed us to serve more community members by adding new Produce Plus sites, as well as improve the health of prediabetes patients by increasing their weight loss through access to fresh produce with Veggie Rx vouchers.

- Produce Plus continues to serve community members at its current locations and has expanded to six additional medical clinics in rural Lane County. Two of the clinic sites are open to anyone in the community who is income eligible, not just patients of the clinic.
- Members of Trillium’s Diabetes Prevention Program (DPP) received Veggie Rx vouchers redeemable at one of two FFLC produce stands. DPP members who redeemed their vouchers lost almost twice as much weight on average compared to members who did not redeem their vouchers. The sample size is small, but early results are promising.

Community Contacts

Debi Farr
 Community Relations Manager, Trillium Community Health Plan
dfarr@trilliumchp.com
www.trilliumohp.com

Karen Edmonds
 Programs and Service Director, FOOD for Lane County
kedmonds@foodforlanecounty.org
www.foodforlanecounty.org





**Salem
Housing
Authority**

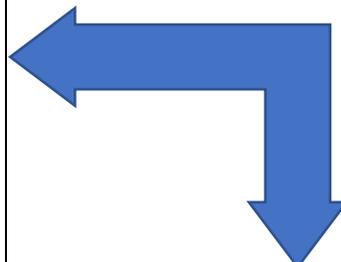
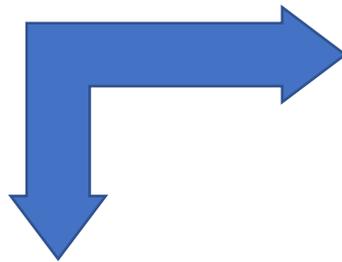
**Salem Housing Authority
Homeless Rental Assistance
Program (HRAP)
Housing First Model
Launched July 2017**



**Salem
Housing
Authority**



- Move directly into housing with no preconditions on treatment engagement
- Continued tenancy not determined by service engagement
- Targets the most vulnerable chronically homeless
- Harm reduction / recovery focused
- Clients are lease holders with tenant protections
- Project based or scattered site

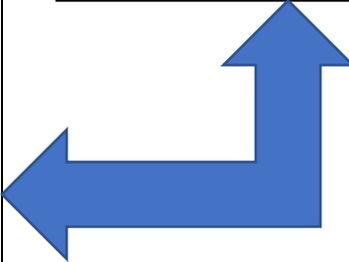
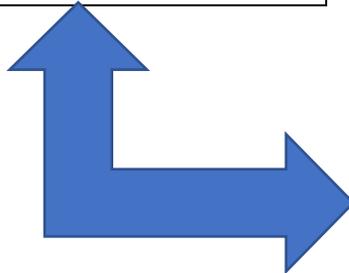


- Social Determinants of Health Addressed by HRAP**
- Housing
 - Basic Needs
 - Education
 - Employment
 - Economic development
 - Reduction of barriers to housing
 - Access to mainstream benefit
 - Access to primary health care and insurance
 - Transportation
 - Trauma informed care
 - Housing stability
 - Community reintegration

- HRAP Model**
- VI-SPDAT & VAT through Coordinated Entry
 - Intake & Enrollment
 - Group Orientation
 - Pre-tenancy
 - Barrier Removal
 - Housing Search
 - Move In
 - Housing Stability – Intensive Case Management (ICM) approach
 - Transition to Voucher
 - GOAL – Long-term housing stability



- HRAP Program Elements**
- 12 months rental assistance payments
 - Barrier Removal Funds
 - Intensive Case Management
 - Wraparound Supportive Service
 - Eviction prevention, mediation and resolutions
 - Community Life Group
 - Peer Supportive Services – Housing Buddies
 - Restoration and access to primary medical care, addiction treatment & mental health services
 - Access to employability assessment, employment preparation, job search



PRESENTED BY: Ms Pamala Garrick
Grants & Emergency Housing Network
Coordinator for Salem Housing
Authority
503-373-3807
pgarrick@cityofsalem.net

STARTING STRONG

Supporting Maternal Child Health through Resource Connections

Presenters:

Riki Rosenthal
Starting Strong
Program Specialist
rosenthalr@careoregon.org
503-416-3397

Maegan Pelatt
Maternal Child Youth
Programs Manager
pelattm@careoregon.org
503-416-7591

Most popular items available in Starting Strong store:
(as % of total items redeemed)

Diapers : 36%
(size newborn to 6)

Wipes: 23%

Car Seats: 3%
(infant & convertible)

35 items make up the remaining 38%

Program Description:

Starting Strong is a perinatal incentive program supporting Jackson Care Connect members through pregnancy up until their child's 4th birthday. Members can earn vouchers for taking part in over 25 activities which they can then redeem for items in our Starting Strong store. Car seats, diapers, health and safety items, and cooking supplies are just some of the items available to Starting Strong participants.

The Starting Strong Program Specialist is a certified community health worker, certified lactation counselor, and formally trained peer support specialist. Along with lived experience, these pieces allow Starting Strong participants access to additional supports and formal resource navigation.

Program Evaluation Highlights for 2018:

The proportion of members who had at least one visit with their assigned PCP was significantly higher among the Starting Strong participants (94.5%), as compared to JCC overall (62.5%). This proportion was higher still among the Starting Strong participants who disclosed that they were pregnant (98.4%).

Metrics:

Higher rates of ASQ screenings, effective contraceptive use, and childhood immunizations have been shown among JCC members engaged with the Starting Strong program when compared to the same JCC metric results overall.



Tri-County 911 Service Coordination Program (TC911)

ABOUT US

TC911 serves Clackamas, Multnomah and Washington county residents who use emergency medical services (EMS) frequently. Staffed by seven licensed clinical social workers and a peer wellness specialist, we aim to connect people to services, facilitate communication, and improve coordination across systems and providers.



CLIENT PROFILE

Compared to the average adult Medicaid member, TC911 clients had:

- 40 x higher rates of ED and inpatient visits;
- 13 x greater costs than the average Medicaid member per year (\$57,672);
- 10 x the outpatient mental health care visits per member per month;
- 3 x the use of primary care.

2018 SNAPSHOT

574 referred, 521 served

- 1 in 2 have a mental health diagnosis
- 1 in 2 have a physical health diagnosis
- 1 in 5 use alcohol or other drugs
- 1 in 5 are homeless or unstably housed
- 1 in 5 had a Mult. Co. jail intake in last year
- Average age: 53
- Gender: 49% male, 50% female, 1% trans/other
- Race: 70% White, 11% Black, 11% Unknown, 6% Other
- Ethnicity: 2% Hispanic
- County: 64% Multnomah, 21% Washington, 15% Clackamas
- Medicaid: 87%

INTERVENTION/PROGRAM HIGHLIGHTS

Bridge to/from EMS and Other Systems

- Referrals from ambulance utilization reports and first response agencies
- Share and coordinate information across systems and disciplines
- Implement EMS system-level care plans as needed (e.g. single hospital destination)

Tri-County Reach and Partnerships

- Work doesn't end at the county line
- Coordination across public safety, medical, behavioral health, hospitals, payors, long term care, housing and other systems in three counties

Community-based, client-centered approach

- Staff time largely in the field (e.g. homes, shelters, jail, EDs, at appointments)
- Short-term care coordination, case management, and provider consultation (30 days-6 mos.)
- Small caseloads allow for meaningful coordination of complex issues

Demonstrated Impact on Cost and Care

- Reductions in EMS and ED utilization
- Reduction in emergency care costs

LESSONS LEARNED

- Pre-hospital providers (e.g. EMS) are a critical, untapped part of the health care system.
- Care managers need the right information, at the right time to be successful (e.g. real time ED notifications).
- Community-based and flexible approaches improve patient care and program outcomes.
- Flex funds are a critical tool for engagement and care management.
- Long-term case management is needed for those with complex physical and behavioral health needs.

IMPACT OUTCOMES

- Evaluations showed statistically significant declines in EMS responses (-40%), ED visits (-41%), and inpatient admissions (-24%) after Medicaid members enrollment with TC911.
- Cost savings of \$887 per member per month, or \$10,644 per member per year.
- Return on investment calculated at \$2.8M annually to serve roughly 350 Medicaid members.



FUNDING

- Began 2012 with CMMI grant
- Annual budget ~\$1.2M
 - Mostly personnel costs
 - 87% CCO/Medicaid funds
 - 13% county general funds

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WEBSITE

<https://multco.us/health/providers/emergency-medical-services>

VIDEO

<https://vimeo.com/125402751>

My Action Plan: 2019 Innovation Cafe

Topic or strategy I learned about today	My questions or next steps for follow-up

2019 Innovation Café Planning Committee Members

- Michael Anderson-Nathe, MPA, Chief Equity & Engagement Officer, Health Share of Oregon
- Heidi Beaubriand, Program Manager, Health and Wellness Services, Oregon Department of Human Services
- Bevin Hansell, Innovator Agent, Oregon Health Authority External Relations Division
- Carly Hood-Ronick, MPA, MPH, Senior Manager of Health Equity, Oregon Primary Care Association
- Christy Hudson, MSW, Policy Analyst, Oregon Health Authority Public Health Division
- Connor McDonnell, MPA, Community Engagement Integrator, Oregon Housing & Community Services
- Dawn Myers, SNAP Program Manager, Oregon Department of Human Services
- Angel Parmeter, Senior Transformation Analyst, InterCommunity Health Network CCO
- Sue Parrish, MA, Early Learning Hub Partnerships Manager, Oregon Early Learning Division
- Lee Ann Phillips, MSW, Center Manager, Trauma Informed Oregon
- Amit Shah, MD, Chief Medical Officer, CareOregon
- Shali Rajput, MD, Physician, Kaiser Permanente
- Samantha Shepherd, MA, Executive Director, CCO Oregon
- Emily York, MPH, Climate & Health Program Lead, Oregon Health Authority Public Health Division

OHA Transformation Center Staff: Tom Cogswell (Project Coordinator), Liz Stuart (Child Systems Collaboration Coordinator), Alissa Robbins (Systems Innovation Manager)