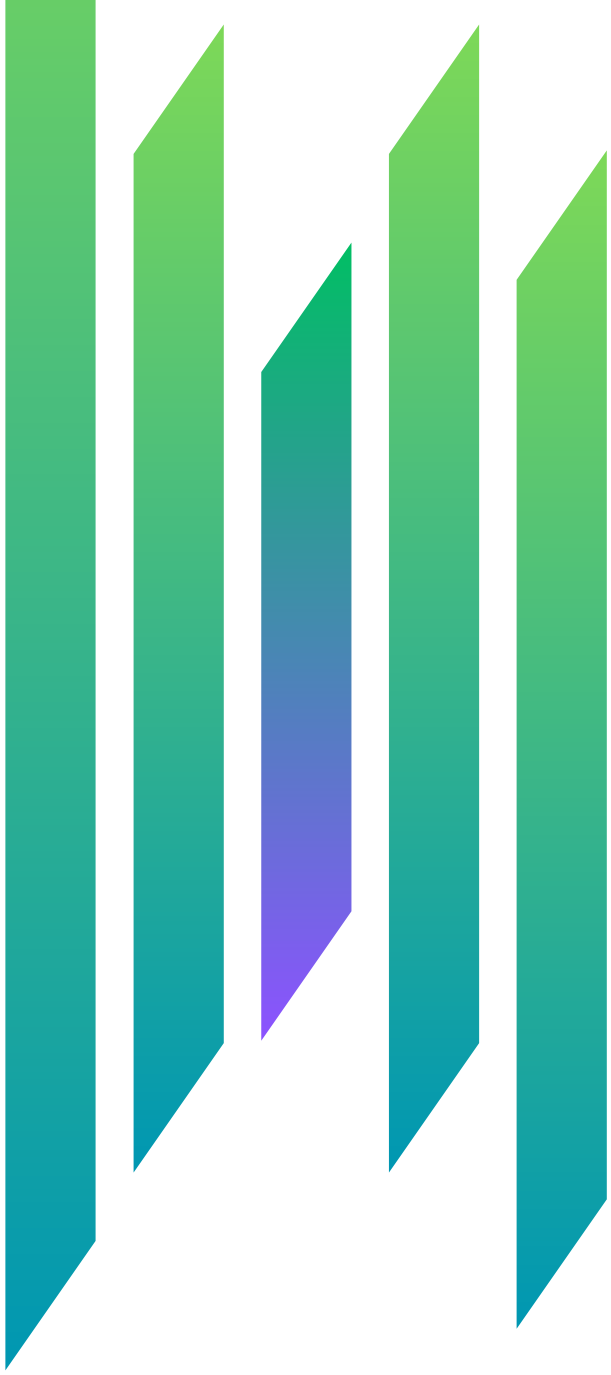


IHN-CCO SHARE INITIATIVE SPENDING PLAN

December 2024

IHN-CCO Government Programs:
governmentprograms@samhealth.org

2024 Annual SHARE Initiative Spending Plan Template

Due: December 31, 2024

Overview

The SHARE Initiative (Supporting Health for All through Reinvestment) was created through Oregon House Bill 4018 (2018). It requires coordinated care organizations (CCOs) to invest a portion of profits back into communities to address health inequities and the social determinants of health and equity (SDOH-E). For details, see OHA's SHARE Initiative guidance document. SHARE Initiative guidance is posted to the SHARE Initiative webpage.

Per the requirements stated in ORS 414.572(1)(b)(C) and OAR 410-141-3735, CCOs must designate a portion of annual net income or reserves that exceed the financial requirements for SHARE Initiative spending. CCOs are subject to a formula that determines their required minimum SHARE obligation. CCOs will follow the instructions in the Exhibit L6.7 financial reporting template to apply this formula to their 2023 financials and report their 2024 SHARE designation.

The CCO contract requires a CCO's annual SHARE Initiative designation to be spent down within three years of OHA's approval of the same year's SHARE Initiative spending plan; a one-year extension may be requested (four years total).

SHARE Initiative spending must meet the following four requirements:

1. Spending must fall within SDOH-E domains and include spending toward a statewide housing priority;
2. Spending priorities must align with community priorities from community health improvement plans;
3. A portion of funds must go to SDOH-E partners; and
4. CCOs must designate a decision-making role for the community advisory council(s) related to its SHARE Initiative funds.

(See OHA's SHARE Initiative guidance document for more details.)

It is important to note that SHARE Initiative reinvestments must go toward upstream, non-health care factors that impact health (for example, housing, food, transportation, educational attainment or civic engagement).

By December 31 of each contract year, the CCO shall submit a SHARE Initiative Spending Plan to OHA for review and approval. The spending plan will identify how the CCO intends to direct its SDOH-E spending based on net income or reserves from the prior year for the SHARE Initiative. This annual SHARE Initiative spending plan will capture from CCOs how they are meeting these contractual requirements.

SHARE Initiative Reporting

A. By June 30, each CCO must report its
   - **Annual SHARE Initiative Designation** in Exhibit L, Report L6.7 to identify its SHARE Initiative designation based on the *prior year's financials*.
   - **Annual SHARE Initiative Spend-Down** in Exhibit L, Report L6.71 to track year-over-year SHARE spending and to tie such spending to the appropriate year's SHARE Initiative Spending Plan.
   - **Annual SHARE Detailed Spending** in Exhibit L, Report 6.71 to track spend-down to each SDOH-E partner each year.

B. By December 31, each CCO must complete the **Annual SHARE Initiative Spending Plan** described in this document for the *prior year's financials*.

IHN-CCO 2024 SHARE Initiative Spending Plan

CCO name: **InterCommunity Health Network CCO**

CCO contact: Alicia Bublitz, abublitz@samhealth.org; Todd Jeter, tjeter@samhealth.org; IHN-CCO Government Programs, governmentprograms@samhealth.org

Instructions:

- Respond to items 1–9 below using this template.
- Be clear and concise.
- CCOs no longer need to submit partner agreements to OHA. CCOs still must have partner agreements in place that include all elements outlined in guidance prior to disbursing funds.
- Use clear file names (for example, CCOname-SHARE-Spending-Plan-2024).
- Submit your plan in the CCO Contract Deliverables Portal by December 31. (The submitter must have an OHA account to access the portal.)

Section 1: SHARE Initiative Designation

1. **What is the dollar amount of your CCO's SHARE Initiative designation represented in this spending plan? This amount must meet or exceed your CCO's designation amount recorded in cell G40 in Exhibit L – *Report L6.7.* If the amount does not match, please explain.**
   $2,695,048.24
   Corrected to reflect actual spending rather than amount recorded on exhibit L. Amount exceeds designation of $2,505,704.

Section 2: SHARE Initiative Spending Plan

Spending plan project summaries

2. **Provide a summary of the work your CCO is funding through this year's SHARE Initiative. Duplicate the row below and complete it for each funded project included in your spending plan.** Note: SHARE funds may not be used for any covered Medicaid benefits or delivery of covered Medicaid benefits, including health-related social needs (HRSN) covered services and substance use disorder (SUD) covered services.

   See Attachment 1 for simplified list of projects

Project #	Project name	Brief project description, including project goals, objectives and expected outcomes	Is this a housing project? If yes, indicate project type.[1]	SDOH-E domain	Populations served (list)[2]
1	Community Shelter and Resource Center	Onsite medical care to address the unique healthcare needs of our unhoused population. Meeting people where they are,	☐ Housing services and supports ☐ Permanent supportive housing	☒ Neighborhood and built environment ☐ Economic	Unhoused, medically complex

[1] For definitions of "housing services and supports" and "permanent supportive housing," see the SHARE guidance document.
[2] If applicable, please use standardized race, ethnicity, language and disability (REALD) categories (see REALD form).

	Medical Outreach Program	**on their terms, reduces barriers to access to care and builds trust. Other nonfinancial barriers to care include lack of knowledge regarding where to obtain care, lack of transportation, lack of childcare, chronic homelessness, long wait times, and feelings of discrimination from health professionals.** • **GOALS: More supported resource navigation around medical health options, traditional & non.** • **Augmented resources about medical health support impacts and destigmatizing care.** • **Increased access to medical health services that address CSRC guests needs.** • **Increase in CSRC guests using inhouse medical health services.**	☒ Other (write in; for example, transitional housing, emergency shelter, affordable housing): Emergency Shelter,	stability ☐ Education ☒ Social and community health	
2	**The Safe Space at 2nd CHANCE**	**Establishment of a space within 2nd CHANCE shelter to accommodate peers experiencing severe and persistent mental health, SUD, or other challenges that makes it difficult to offer them shelter in a traditional dorm setting.** **GOALS:** • **Provide a space for vulnerable individuals experiencing houselessness, SUD and/or mental health who are unable to shelter traditional dorms to be safe at night.** • **Reduce the strain on EMS and police, by providing a space that allows individuals to**	☐Housing services and supports ☐ Permanent supportive housing ☒ Other (write in; for example, transitional housing, emergency shelter, affordable housing): Emergency Shelter, BH Crisis	☒ Neighborhood and built environment ☐ Economic stability ☐ Education ☒ Social and community health	People experiencing houselessnes, severe and persistent mental health, substance use disorder (SUD), or other challenges

		stabilize, receive support, and have needs met. • **Offer a wraparound approach to care by having partners onsite, offering services.**			
3	**Crossroads Connections, Transitional Housing**	**A non-licensed transitional housing facility where renters can have their own private room. Renters will find safety, support, and case management to achieve *their* definition of post-treatment success.** **GOALS:** • **Provide service-connected medical recuperative beds in Linn County** • **Provide mixed-population, non-licensed transitional living for 5 residents at a time.** • **Provide urgent, supportive transitional housing for survivors of domestic violence.** • **Assess first year of operations and fine-tune the program for replication.** • **Prove the efficacy of the mixed-population, non-licensed transitional living model.**	☒Housing services and supports ☐ Permanent supportive housing ☐ Other (write in; for example, transitional housing, emergency shelter, affordable housing):	☒ Neighborhood and built environment ☒ Economic stability ☒ Education ☒ Social and community health	Those exiting facilities/ group homes for Substance Use Disorder (SUD), Severe and Persistent Mental Illness (SPMI), or Judicial Restraint; Survivors of Domestic Violence; and homeless/ unhoused populations needing to be discharged from Emergency Departments
4	**Housing Supports, Respite, and Life Stabilization**	**Provide social support services that stabilize people, support their discharge from various institutional settings, engage them in conversations and activities that springboard them towards housing, and directly help them secure stable, short- and long-term respite and living solutions that meet both their immediate and future housing needs.**	☒Housing services and supports ☐ Permanent supportive housing ☒ Other (write in; for example, transitional housing, emergency shelter, affordable housing): **Outreach and case management.**	☒ Neighborhood and built environment ☐ Economic stability ☒ Education ☒ Social and community health	Unhoused, housing instability, BH, medically complex

		GOALS: • **Minoritized community members use CDDC services to access housing and respite supports as they are ready and willing** • **Unhoused community members identify greatest barriers to their own housing and safety** • **Unhoused community members living in encampments receive services to access housing and respite supports as they are ready and willing**			
5	**Community Outreach Assistance Team Helping Unhoused Community Members (COAT)**	**Outreach support to get more unhoused clients insured and into permanent housing.** ***Note that HRSN Housing benefits do NOT apply to unhoused individuals so there is no overlap.*** **GOALS:** • **Increase number of persons in permanent housing** • **more clients signed up for health insurance through IHN** • **more clients accessing primary care doctors**	☒Housing services and supports ☒ Permanent supportive housing ☐ Other (write in; for example, transitional housing, emergency shelter, affordable housing):	☒ Neighborhood and built environment ☒ Economic stability ☐ Education ☒ Social and community health	Unhoused, housing instability, elderly, disabled, veterans
6	**Vivienda y Bienestar**	**Providing system navigation, wrap around services, educational support, and direct emergency financial assistance to improve housing security and reduce the barrier of the Latinx population in our community** **GOALS:** • **System navigation and wraparound support across the social determinants of health.** • **Educational Support** • **Non-HRSN or covered service financial assistance**	☒Housing services and supports ☐ Permanent supportive housing ☐ Other (write in; for example, transitional housing, emergency shelter, affordable housing):	☒ Neighborhood and built environment ☒ Economic stability ☒ Education ☒ Social and community health	Low-income, first generation immigrants from Latin America living in Linn, Benton, and Lincoln counties

7	**Collaborative Supportive Services Billing and Data Management**	**This proposal is to support the efforts of three organizations (Unity Shelter, Corvallis Housing First, The Corvallis Daytime Drop-In Center) involved in providing shelter, housing, and supportive services to people experiencing homelessness in accessing non-HRSN Medicaid funds to pay for services. An Eligibility and Data Coordinator will be hired by Unity Shelter to serve all three organizations in billing as well as in inputting and analyzing service data to better target services and to help ensure the sustainability of these programs.** **GOALS:** • **Have the ability to bill for supportive services through Medicaid for all three organizations** • **Develop efficient data input and sharing procedures to effectively communicate client needs** • **Integrate regular data input, analysis, and management into operations of each organization.**	☒Housing services and supports ☐ Permanent supportive housing ☒ Other (write in; for example, transitional housing, emergency shelter, affordable housing): Emergency Shelter	☒ Neighborhood and built environment ☐ Economic stability ☐ Education ☒ Social and community health	Unhoused individuals, housing instability
8	**Linn County Crisis Stabilization Center Re-model**	**24/7/365 Crisis Stabilization Center as the third and last State initiative in developing a comprehensive system of crisis care for our community. The Crisis Stabilization Center is "someplace to go" in a three-prong approach, along with "someone to talk to, someone to respond," for a comprehensive crisis system. A place where individuals in crisis will receive targeted support from**	☒Housing services and supports ☐ Permanent supportive housing ☒ Other (write in; for example, transitional housing, emergency shelter, affordable housing): Emergency case management	☒ Neighborhood and built environment ☐ Economic stability ☒ Education ☒ Social and community health	Unhoused, behavioral health

		trained, trauma informed mental health professionals including risk assessment, crisis recovery planning, treatment services, and community referrals/resources. Individuals needing enhanced support can access stabilization services, staying in a calm, stressfree environment for up to 23 hours while a collaborative aftercare crisis plan is developed. LCMH has purchased a building for this Crisis Stabilization Center, and it is ready to remodel with a goal to be open within a year. **GOALS:** • **Reduced Utilization and Length of Stay in Emergency Departments: Individuals experiencing a crisis diverted to a trauma informed, supportive environment that is conducive to individuals specific needs will increase the likelihood of stability and engagement.** • **Reduced Strain on Law Enforcement: Having a place to take individuals in real-time with a standard waiting time of 10 minutes will allow them to focus on their core responsibilities.** • **Improved Public Safety: Being proactive, the Crisis Stabilization Center contributes to a safer community by preventing potentially harmful incidents related to untreated mental health conditions.** • **Reduced Recidivism Rates: Crisis Stabilization Center comprehensive support connects individuals with**			

		mental illness to ongoing mental health services, which helps reduce recidivism rates among those who may otherwise cycle through the criminal justice system. • **Improved Warm Handoff to Substance Use Services: Individuals in crisis that experience substance use disorders will be connected to appropriate services to address addiction.** • **Streamlined Referral Process: Will make it easier for community agencies, healthcare providers, and law enforcement to connect individuals with the appropriate mental health services.** • **24/7/365 Availability: Crisis Stabilization Center round-the-clock availability ensures those in crisis can access timely support and intervention when needed, reducing the likelihood of escalation.** • **Community Integration: Outreach programs and partnerships with community organizations, the Crisis Stabilization Center will foster a sense of community integration for individuals in need, promoting inclusivity and support.** • **Improved Social/Health Outcomes: Addressing mental health needs early and providing comprehensive support, the Crisis Stabilization Center should improve outcomes for individuals, leading to better**			

		long-term health, reduced involvement with the criminal justice system, increased employment opportunities, and enhanced community integration. These positive outcomes contribute to overall societal well-being and productivity.			
9	**Suicide Prevention Program Coordinator**	**Hiring of a Suicide Prevention Coordinator as part of the behavioral health team.** • **GOALS:** **Promotes learning and proactively develops information, resources, and expertise.** • **Build relationships with community partners to better foster participation in meeting prevention goals.** • **Lead Suicide Care Coalition.**	☐ Housing services and supports ☐ Permanent supportive housing ☒ Other (write in; for example, transitional housing, emergency shelter, affordable housing): Behavioral Health	☐ Neighborhood and built environment ☐ Economic stability ☒ Education ☒ Social and community health	Complex behavioral health, dual diagnosis, youth.
10	**Inter-Community Health Research Institute**	**A collaboration to build a robust community partnership that leverages shared resources to support SDoH/E programs and resources.** • **GOALS:** **Better utilize health system data specific to unhoused individuals and individuals with SUD.** • **Explore data sharing opportunities relating to housing data in the region per the CHIP goal improve data systems for efficacy and analysis.**	☒Housing services and supports ☐ Permanent supportive housing ☒ Other (write in; for example, transitional housing, emergency shelter, affordable housing): Behavioral Health	☒ Neighborhood and built environment ☒ Economic stability ☐ Education ☒ Social and community health	Unhoused, housing instability, SDoHE programming

11	**ABLE House**	**ABLE House will provide respite (a safe, nonjudgmental, and comfortable space) for guests experiencing mental health crisis or emotional distress to live their experience without judgment and WITH support from others who have been through similar situations.** **According to the National Empowerment Center (2024), ""a peer respite is a voluntary, short-term, overnight program that provides community-based, non-clinical crisis support to help people find new understanding and ways to move forward. It operates 24 hours per day in a homelike environment,"" para. 1.** • **GOALS:** **Obtain property and house, named ABLE House, in Lincoln County with 5 beds available. ABLE House will be a fully staffed, peer-run, hospital-alternative for mental health distress or crisis by July 2024.** • **Serve at least 15 individuals in distress or crisis by the end of 2024. This funding will allow us to provide this service for as long as state funding for the program continues.**	☒Housing services and supports ☐ Permanent supportive housing ☐ Other (write in; for example, transitional housing, emergency shelter, affordable housing):	☒ Neighborhood and built environment ☒ Economic stability ☐ Education ☒ Social and community health	Behavioral health, dual diagnosis, unhoused, housing instability, transitional housing
12	**CDDC HVAC Support**	**Funds are to support installing HVAC in our building at 530 SW 4th St. downtown. We currently have no AC or functional heat. HVAC heating and cooling will create an environmental respite space for unsheltered individuals.**	☒Housing services and supports ☐ Permanent supportive housing ☒ Other (write in; for example, transitional housing, emergency shelter, affordable housing): Climate Respite for unhoused individuals	☒ Neighborhood and built environment ☐ Economic stability ☐ Education ☒ Social and community health	Unhoused, behavioral health, dual diagnosis.

13	**Lincoln County Winter Shelter**	**The low-barrier shelter will operate from 10/1/23 to 3/1/24 in one or two locations in the county, comprising accommodations for 50-75 people. The program will serve adults in the shelter and offer hotel vouchers for families with children. The shelter will not discriminate based on race, gender identity, sexual orientation and/or religion.** • **GOALS:** **Make connections for case management and health referrals with individuals utilizing the shelter**	☒Housing services and supports ☐ Permanent supportive housing ☐ Other (write in; for example, transitional housing, emergency shelter, affordable housing):	☒ Neighborhood and built environment ☐ Economic stability ☒ Education ☒ Social and community health	Unhoused individuals, Behavioral health, dual diagnosis, medically complex
14	**Crossroads Rose Street Transitional Housing**	**Expand transitional housing options in Lebanon with the purchase of a 10 room home to use as an unlicensed transitional home with onsite peer support services.**	☒Housing services and supports ☐ Permanent supportive housing ☐ Other (write in; for example, transitional housing, emergency shelter, affordable housing):	☒ Neighborhood and built environment ☒ Economic stability ☒ Education ☒ Social and community health	Those exiting facilities/ group homes for Substance Use Disorder (SUD), Severe and Persistent Mental Illness (SPMI), or Judicial Restraint; Survivors of Domestic Violence; and homeless/ unhoused populations needing to be discharged from Emergency Departments

15	**Situation Table**	**Community members experiencing acutely elevated risk often require multiple resources to reduce their level of risk, and rapid intervention is needed to promote success. The Situation Table model of collaborative risk reduction has a demonstrated track record of positive community impacts in other communities in the US as well as Canada. The Albany Police Department (APD) has committed to utilizing existing staff to facilitate a Situation Table in Albany/Linn County. To successfully implement a Situation Table model of risk reduction, we must also secure funding to properly train the facilitators and community partners who will participate in the Situation Table. If funding is approved, we anticipate conducting this training in the fall/winter of 2024/2025 and beginning implementation of the Situation Table immediately thereafter.**	☒Housing services and supports ☐ Permanent supportive housing ☒ Other (write in; for example, transitional housing, emergency shelter, affordable housing): Behavioral health supports	☒ Neighborhood and built environment ☐ Economic stability ☐ Education ☒ Social and community health	Unhoused, housing insecure, SUD, behavioral health concerns, justice involved
16	**Lincoln County Transitional Housing**	**Transitional Housing for adults with complex trauma: including houseless, high BH needs, physical challenges exceeding shelter support capacity. Includes case management and connection to county services.**	☒Housing services and supports ☐ Permanent supportive housing ☐ Other (write in; for example, transitional housing, emergency shelter, affordable housing):	☒ Neighborhood and built environment ☒ Economic stability ☐ Education ☒ Social and community health	

CHP/statewide priorities

3. **Which specific priorities, topics or domains within your CCO's most recent shared community health improvement plan does this SHARE spending plan address? List single CHP topics in bullets and *briefly* describe how your SHARE spending plan aligns with your CCO's shared community health improvement plan.**

IHN-CCO's CHIP strategy are includes:

Priority Area:

Access to Affordable Housing

Strategies:

- Expand housing units
- Expand supportive services
- Improve housing data

Priority Area:

Behavioral Health

Strategies (included in SHARE spending):

- Build community resilience

IHN-CCO's share spending plan, developed with the Community Advisory Council, prioritized housing as the priority area, with the inclusion of Behavioral Health as an essential part of developing sustainable housing programs. All projects were selected to further the stated CHIP long term impact goal to: *Ensure that all Linn-Benton-Lincoln residents have safe, stable, affordable housing with a focus on priority populations that have been historically marginalized.* Recognizing the clear and substantial link between unmet behavioral health needs and housing stability, some projects are working towards both the CHIP housing goal and the behavioral health goal to: *Ensure that all Linn-Benton-Lincoln residents have access to behavioral health support and treatment.*

4. **Briefly describe how your SHARE Initiative spending plan addresses the statewide priority of housing-related services and supports, including supported housing, and helps people find and maintain stable housing.** In the description, please reference the specific housing projects using the project numbers from the table above (question 2).

IHN-CCO SHARE spending priorities focusing on housing were developed with extensive community input and align exactly with the statewide priorities of housing services and supports, including supported housing. The secondary focus of Behavioral Health programs, prioritizing those including case management and SDoH referrals as a pathway to housing supports addresses a need recognized among high acuity individuals with SUD and complex behavioral health diagnosis.

Housing specific projects focusing on shelter and the CAC defined priority of 'increased capacity' in the IHN-CCO region include:

2. Safe space at 2nd CHANCE
7. Unity Shelter Collaborative Support Services
13. Lincon County Winter Shelter

Projects aiming to increase case management and access to housing for unhouse or individuals with

housing instability include:

1. Community Shelter and Resource Center Medical Outreach Program
4. Housing Supports, respite, and Life Stabilization
5. Community Outreach Assistance Team Helping Unhoused Community Members
8. Linn County Crisis Stabilization Center Remodel
12. CDDC HVAC Support
15. Albany Situation Table Implementation

Projects supporting Transitional or Supported Housing:

1. Crossroads Connections Transitional Housing
6. Vivienda y Bienestar
11. ABLE House
14. Crossroads Rose Street Transitional Housing
16. Lincoln County Transitional Housing

Projects Supporting other CHIP Goals (Behavioral Health, improving data communications)

9. Suicide Prevention Program Coordinator
10. InterCommunity Health Research Institute

SDOH-E partners and agreements

5. Complete the table below for each funded SDOH-E partner. Duplicate the row below for each partner included in your spending plan.

A) Identify each SDOH-E partner that will receive a portion of SHARE Initiative funding.
B) Identify the total SHARE budget (dollar amount) being allocated to the partner.
C) Briefly describe how the partner will be using the SHARE funds.

Note: For each partner, your CCO must have a partner agreement in place that meets requirements in guidance. You don't need to submit the agreements to OHA.

Project # (match above)	Partner name	SHARE budget to partner ($)	Partner agreement	Describe the specific items, activities or services being funded with SHARE
1	Lincoln County Health and Human Services	$174,830	☒ Yes ☐ No	• **Train shelter staff, work with college nursing program.** • **Train doctor on referrals to HHS medical clinic toward stabilization** • **Identify, advise, and communicate to guests about medical services available where they are at.** • **Increase access to medical care for the individuals served in the shelter.** • **Have basic care provided in both winter shelters and add Veterans services to assist with guests needs**
2	CHANCE	$109,120	☒ Yes ☐ No	• **Utilizing an existing space at 2nd CHANCE that is unused at night, we will hire 2 PSS to staff the space, opening it overnight. Along with a safe, therapeutic milieu, the space will have**

				calming activities aimed to assist peers experiencing crisis in stabilization. • Work with partners to transport peers to the Safe Space if they are unnecessarily utilizing law enforcement or EMS. Offer the space to peers who are unable to shelter in traditional dorms due to behavior as an alternative to being outside at night. • Invite service providers to have regular hours onsite to meet with peers.
3	Crossroads Communities	$120,288	☒ Yes ☐ No	• Set aside 2-3 two-occupant rooms to provide a safe and supportive healing environment for homeless from which they may exit local emergency depts. • Set aside 5, single occupancy rooms to provide a safe and supportive pro-social environment for those exiting program-specific treatments. • Set aside 1-2 rooms in which a twin bed and a bunkbed may be set up to provide supportive transitional housing for a parent and up to two children escaping domestic violence. • Intake surveys and exit surveys must be completed to verify the success (or failures) in the project, which will be assessed at year end. • Complete first year assessment, compile and analyze data, and prepare an After Action Report.
4	Corvallis Daytime Drop-in Center	$100,000	☒ Yes ☐ No	• Amplified outreach and education around CDDC housing and stabilization supports; better communication in street outreach; peer to peer support around housing/respite at CDDC initial intake • Minoritized and underserved guests (BIPOC individuals; people with mental health disabilities; individuals with substance use disorders) are more intentionally supported; interested individuals receive targeted outreach via Basic Needs Navigators and SORT; at-risk populations are priority for services tailored toward their needs • Increased community engagement; more listening sessions; survey distribution, and data gathering and collection; compensation for guests' time and expertise • hiring another Needs Navigator; continued

				outreach to as many diverse encampments as possible twice per week; increased engagement with collaborative partners on SORT in the field; augment data collection around pipeline from encampment to CDDC use
5	Creating Housing Coalition	$115,000	☒ Yes ☐ No	• **4-day-a -week outreach, offering services, intensive case management to assist in navigating agency and system requirements.** • **Case management following referral** • **Intake assessments to determine need and then case management to assist with process**
6	Casa Latinos Unidos	$179,975	☒ Yes ☐ No	• **In-person and telephone one-on-one intake and follow up with clients.** • **Referrals to specialized agencies** • **Distributing information on resources and services through social media and outreach at health/resource fairs and other community events** • **English languages classes in Corvallis, Albany and Lebanon.** • **Financial education classes in Corvallis, Albany, Monroe and Lebanon. Emphasis on budgeting and using banking resources.** • **Financial coaching: One-on-one guidance on financial literacy in areas of need.** • **Workshops on tenant rights.** • **Digital literacy classes.** • **In-person or phone interviews with applicants using eligibility protocol to ensure HRSN eligible services are not included.**
7	Unity Shelter	$76,230	☒ Yes ☐ No	• **Recruit, hire, and onboard an Eligibility and Data Coordinator to create policies and procedures for medical billing for all three organizations.** • **Train staff to input notes in a timely manner in necessary databases (Shelterware, UniteUs, HMIS). Develop ROI for data management across three organizations.** • **Effectively train staff to input data that is consistent with the requirements of billing for supportive services. Integrate regular input of HMIS, UniteUS, and Shelterware into the daily tasks of direct support staff.**

8	Linn County Health Services	$500,000	☒ Yes ☐ No	**Remodel of county purchased building for use as a 23 hour crisis center**
9	Samaritan Health Services	$284,604.84 *Corrected transposed numbers*	☒ Yes ☐ No	**3 year contract for the support of a BH Program Coordinator supporting suicide prevention programs.** • **Design and coordinate suicide prevention strategies, planning and implementation of solutions to advance capabilities across organizations. Partner with key leaders on education strategy.** • **Develop/recommend policies, procedures, and standard work supporting programs** • **Lead project/programs focused on developing system changes to improve health outcomes.**
10	Samaritan Health Services	$126,000	☒ Yes ☐ No	**Develop processes for the effective use of health system data and CCO utilization data to indicate gaps or areas of opportunity to increase community health for individuals understood to be homeless or with a diagnosis of Substance Use Disorder.**
11	Project Able	$175,000	☒ Yes ☐ No	• **Project ABLE has ongoing funding from the state of Oregon to operate a Peer Run Respite for hospitalization/crisis alternative for people in mental health crisis. This funding will allow us to secure property to provide this service in a long term sustainable manner. Closing our financing gap through this funding will allow the guests' to receive the highest quality care from the ABLE House Peer Respite.** • **ABLE staff will support the guests based on what the guests have shared. Activities, such as Yoga, exercise, art, painting, crafts, gardening, E-bikes, walking, and relaxation will be available.**
12	Corvallis Daytime Drop-In Center	$12,000	☒ Yes ☐ No	**Installation of necessary HVAC (mini split or other) to ensure climate control in CDDC building**
13	Lincoln County Health and Human Services	$150,000	☒ Yes ☐ No	**Operation of the Lincoln County Winter Shelter from 10/1-3/1 or as needed.**
14	Crossroads Communities	$440,000	☒ Yes ☐ No	**Purchase home with funds provided by IHN, and apply for funds from SHARE committee to handle renovation and initial onboarding.**
15	City of Albany/Albany Police Department	$32,000	☒ Yes ☐ No	• **Contract for and receive Situation Table Training** • **Implement the Situation Table model**

16	Lincoln County Health and Human Services	$100,000	☒ Yes ☐ No	**Develop transitional housing model in existing county owned 5 bedroom facility**

6. **Are any of your partner agreements a subcontract as defined in CCO contract?** ☐ Yes X No
   If yes, which ones?

Partner selection and community advisory council (CAC role)

7. **Describe the process for identifying and selecting the SDOH-E partners for SHARE Initiative projects.**
   A. **Below are some examples of CAC roles in SHARE. Check all boxes that apply.**
   ☒ CAC determined SHARE priority areas.
   ☒ CAC created or approved the overall SHARE decision-making process.
   ☒ CAC developed a scoring rubric for reviewing SHARE proposals.
   ☒ CAC members recommended organizations to fund using SHARE dollars.
   ☒ CAC members reviewed SHARE proposals and made recommendations to CCO leadership.
   ☒ CAC made final SHARE project funding decisions.
   ☒ CAC will have a role in ongoing monitoring of SHARE projects.

   B. **Briefly describe what steps were taken to identify and select partners and who was involved (for example, CCO leadership, CCO staff, committee, advisory group, CAC). Be sure to include your CAC's designated role in SHARE Initiative spending decisions.** (If applicable, also describe the ongoing engagement and feedback loop with the CAC as it relates to SDOH-E spending.)

IHN-CCO's CHIP process utilizes a unique partnership of counties, providers, tribal governments, health systems, and community members—including the CAC—to set goals and review progress. The CHIP goals are then considered by the CAC to set priority areas for the year's SHARE spending which is managed by the Social Determinants and Transformation and Behavioral Health teams. Existing SHARE requests were reviewed by the IHN-CCO team and a portion of share dollars held for a CAC led competitive request for proposals. This allows IHN-CCO to adhere to CAC priorities while still being able to move quickly to support projects on a short timeline (e.g. purchase of property). The 2024 timeline was as follows:

Jan 2024: Community Advisory Council sets 'Housing' as the priority area with an added emphasis on increasing the housing and shelter capacity in our region

March 2024: CAC approves priority area and establishment of a SHARE Funding committee for the solicitation and review of proposals (attachment 2).

May 2024: CAC Funding committee is established with 6 CAC members

June-August 2024: Priority Areas defined, RFP released (attachment 3)

September 2024: Scoring priorities defined and scoring rubric developed (attachment 4)

October 2024: RFP Proposals and Scoring

November 2024: SHARE Funding recommendations approved by CAC

December 2024: SHARE Funding recommendations approved by IHN-CCO Board of Directors (attachment 5)

Contracting

The SHARE funding committee set 2 priority areas based on the full CAC recommendations:

- Collective impact housing models focusing on comprehensive and complete solutions to housing
- Projects to increase the housing/shelter capacity of the IHN-CCO Region

Scoring priorities were defined as projects having:

- Relevant and measurable goals that relate to the priority areas
- Innovative or community led solutions for housing equity in underserved communities
- Demonstrating a comprehensive understanding of need and has established partnerships necessary to build complete solutions
- Supports the engagement of individuals in health and SDoH services
- Has an understanding of health equity and an intentional health equity strategy
- Meets the priorities

Feedback from the process was positive and CAC members were particularly happy to have time to build a score card that reflected their priorities. Twelve applications were received for the competitive RFP with 7 selected for funding.

Section 3: Additional details

8. **If the project or initiative requires data sharing, attach a proposed or final data-sharing agreement that details the obligation for the SDOH-E partner to comply with HIPAA, HITECH and other applicable laws regarding privacy and security of personally identifiable information and electronic health records and hard copies thereof. Does the project require data sharing?**
   ☐ Yes ☒ No

9. **(*Optional*) CCOs may choose to include an evaluation plan. If so, describe or attach the evaluation plan for the SHARE spending plan portfolio or for each project, including expected outcomes; the projected number of your CCO's members, OHP members, and other community members served; and how the impact will be measured.**
   n/a

Attachment 1

IHN-CCO 2024 SHARE Spending Plan

1	Lincoln County Health and Human Services	*Community Shelter and Resource Center (CSRC) Medical Outreach Program*	$174,830.40
2	CHANCE	*The Safe Space at 2nd CHANCE*	$109,120.00
3	Crossroads Communities	*Crossroads Connections, Transitional Housing*	$120,288.00
4	Corvallis Daytime Drop-in Center	*Housing Supports, Respite, and Life Stabilization*	$100,000.00
5	Creating Housing Coalition	*Community Outreach Assistance Team Helping Unhoused Community Members (COAT)*	$115,000.00
6	Casa Latinos Unidos	*Vivienda y Bienestar*	$179,975.00
7	Unity Shelter	*Collaborative Supportive Services Billing and Data Management*	$76,230.00
8	Linn County Health Department	*Linn County Crisis Stabilization Center Remodel*	$500,000.00
9	Samaritan Health Services	*Suicide Prevention Program Coordinator*	$284,604.84
10	Samaritan Health Services	*InterCommunity Health Research Institue*	$126,000.00
11	Project ABLE	*ABLE House*	$175,000.00
12	Corvallis Daytime Drop-in Center	*CDDC HVAC Support*	$12,000.00
13	Lincoln County Health and Human Services	*Lincoln County Winter Shelter*	$150,000.00
14	Crossroads Communities	*Crossroads Rose Street Transitional Housing*	$440,000.00
15	City of Albany, Albany Police Dpartment	*Situation Table Implementation*	$32,000.00
16	Lincoln County Health and Human Services	*Lincoln County Transitional Housing*	$100,000.00
		TOTAL	**$2,695,048.24**

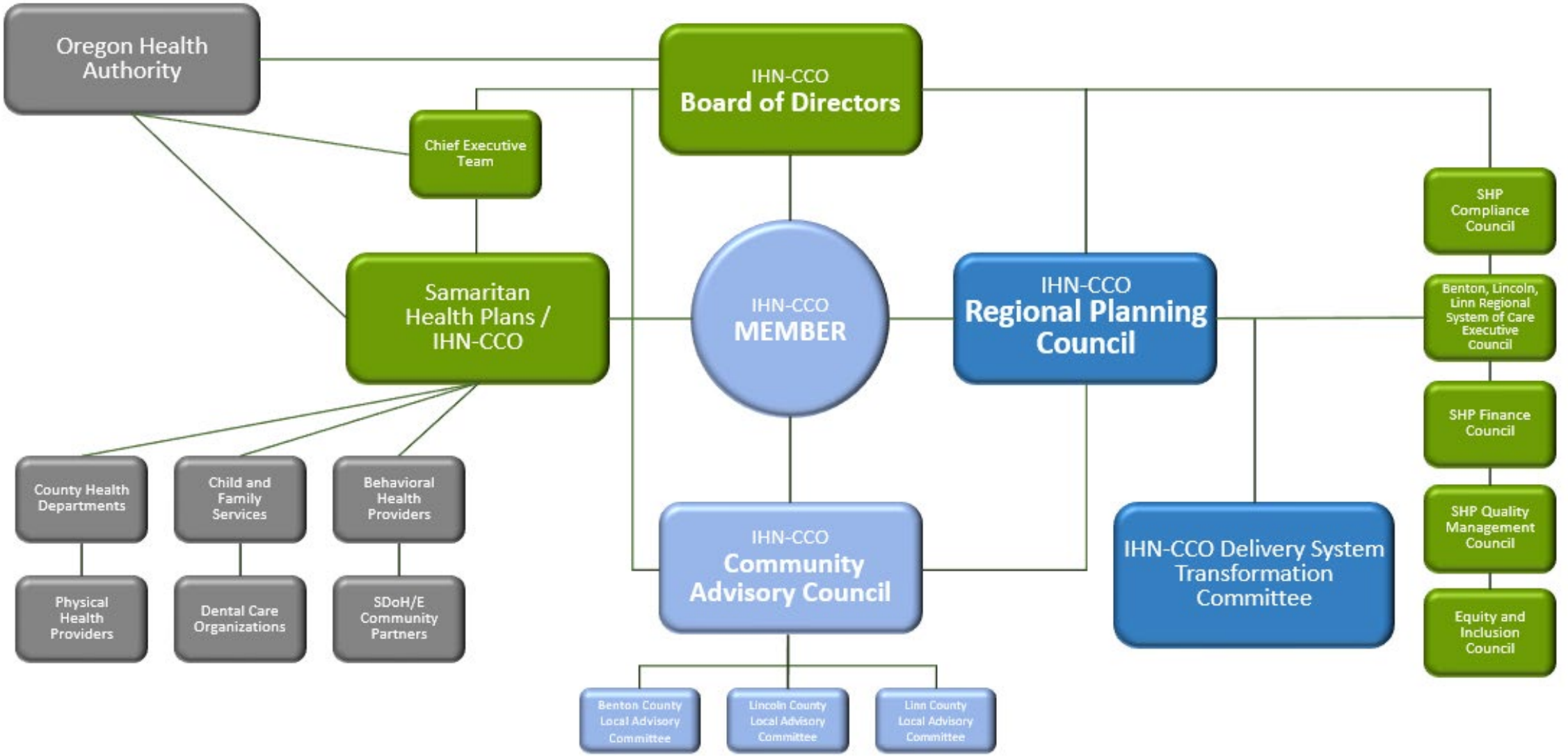
Attachment 2

IHN-CCO Community Advisory Council & the SHARE Initiative

March 11, 2023
Community Advisory Council

InterCommunity Health Network CCO

IHN-CCO Committee & Council Structure or the "Member in the Middle Chart"



2023 Funded Projects

Project Name	Champion Organization	Amount	County (s)	Rank
Lincoln City Hope Center	Helping Hands Reentry Outreach Centers	$133,429	Lincoln	**1**
Outreach Housing Case Management	Corvallis Housing First	$148,554	Benton	**2**
Vivienda y Bienestar	Casa Latinos Unidos	$145,234	Benton, Linn	**3**
Young Adult Dorm	Community Outreach, Inc.	$100,000	Benton	**4**
Hub City Village	Creating Housing Coalition	$39,500	Linn	**5**
Young Roots Housing Stabilization	Young Roots Oregon	$119,500	Benton, Linn	**6**
Housing Supports, Respite, and Life Stabilization	Corvallis Daytime Drop-In Center	$100,000	Benton, Lincoln, Linn	**7**
Street Hope	Faith, Hope and Charity Inc.	$138,529	Benton	**8**
Microgrant Program Sustainability and Queer Financial Education	Mid Willamette Trans Support Network	$119,570	Benton, Lincoln, Linn	**9**
Community Sustainability and Support Program	The United Way of Linn, Benton, & Lincoln Counties	$149,960	Benton, Lincoln, Linn	**12**

TOTAL SHARE RFP AWARD(S) $1,194,276.00

InterCommunity Health Network CCO

Priorities

Housing

- Changes to the priority areas?
  - New sources of actual housing—navigation programs are less effective when there isn't a bed
- Clarifications or a narrowing of scope? Overarching goals?
- Based on what wasn't funded are there things we can do to better communicate your goals to our community partners?
  - Review requirements from OHA
  - 'encouraging applications from organizations working to…' language to keep the priority area broad but clarify?
    - Weighting factors in scoring
    - Don't lose the new and innovative ideas
    - Multiple year funding
    - Does the budget serve the overall priorities (ie one big vs. 3 small ones)—scoring?

SCORECARD

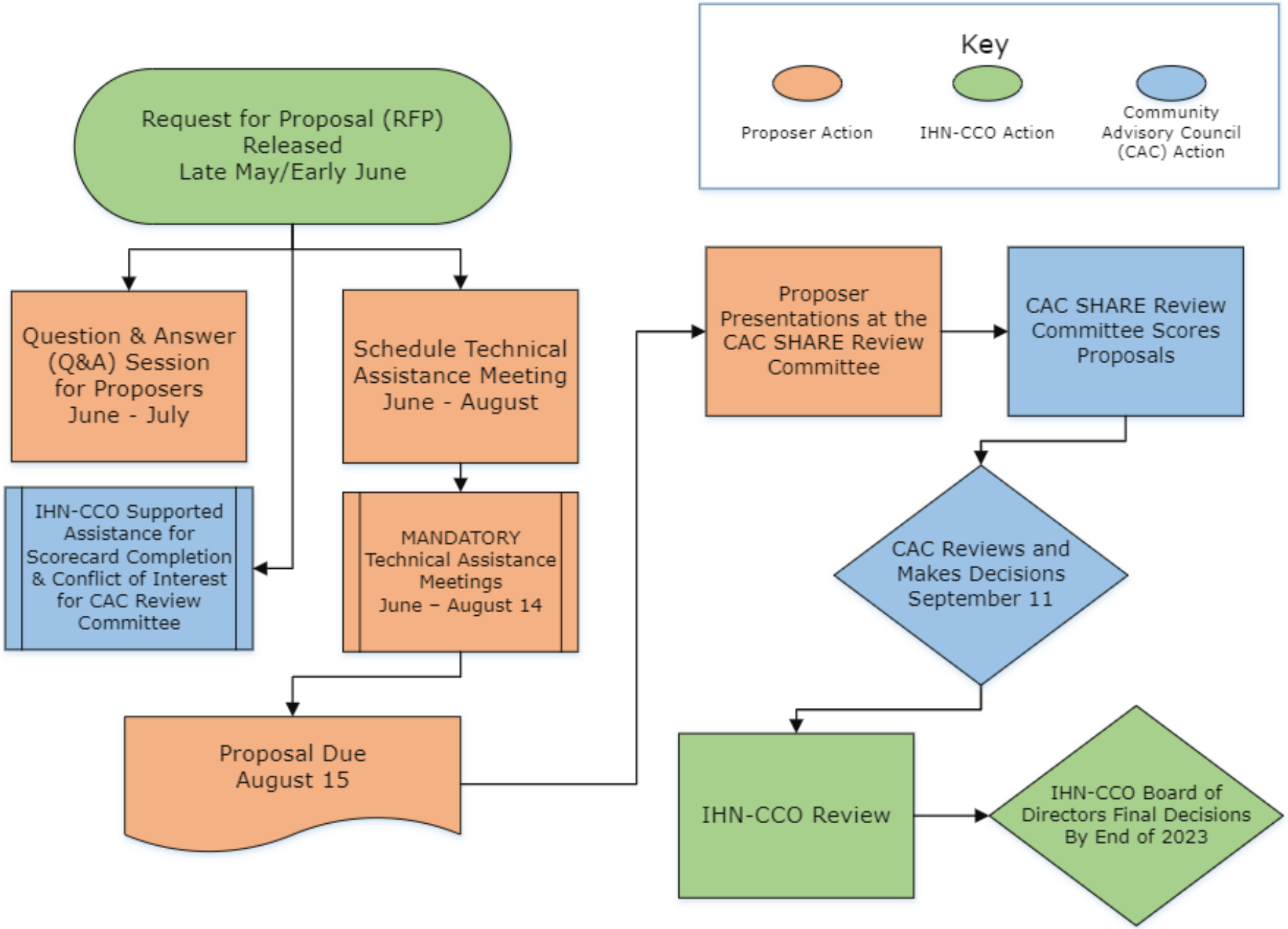
12 components scored on a scale of 0-10

- 0 is disagree
- 5 is agree
- 10 is strongly agree

Results are presented in a heatmap style with standard deviation reported as well; this shows areas of disagreement for discussion purposes

Criteria	Score
Health Equity: The project has a defined approach for fair opportunities for members to be as healthy as possible.	
Health Improvement: The project holds promise for making a significant improvement in the health or health care of IHN-CCO members.	
Improved Access: The project activities will result in improved access of healthcare; availability of services, culturally considerate care, and quality and appropriate care to IHN-CCO members.	
Need: The proposer has established that there is a substantial need for this project and has indicated the demographics of the Medicaid population impacted.	
Total Cost of Care: The project will likely result in improvement in the total cost of care for IHN-CCO Members. The project targets areas of health care associated with rising costs or provides upstream healthcare that will reduce costs long-term.	
Resource Investment: The budget is reasonable and appropriate to the work proposed. It is well justified and directly tied to the project goals. The project has exhibited consideration for other funding sources.	
Priority Area: The addresses housing, specifically medical respite or navigation in the housing sector.	
Financial Sustainability: The project has a sustainability plan including continued funding and new reimbursement models. The project will likely continue after SHARE funding ends.	
Replicability: The project has a clearly defined plan to spread lessons learned to new organizations or regions such as rural or urban or a new county in the IHN-CCO community.	
Depth of Support: The proposer showed clear and strong depth of sponsoring organization support as well as community backing.	
Partnerships & Collaboration: The project brings together organizations and/or resources and describes how team members, providers, and partner organizations will work together effectively.	
Outcomes & Evaluation: Proposal outcomes and measures are aligned to project goals and will be sufficient to evaluate project success. The project outcomes are aligned with the Community Health Improvement Plan's Outcomes and Indicator Concepts.	
TOTAL PROPOSAL SCORE	

IHN-CCO SHARE Process



InterCommunity Health Network CCO

IHN-CCO Social Determinants & Transformation

transformation@samhealth.org

InterCommunity Health Network CCO

IHN-CCO Community Advisory Council

SHARE Initiative

Priorities Areas

IHN-CCO Funding Streams- InterCommunity Health Network CCO (ihntogether.org)

Collective impact housing models focusing on **comprehensive and complete** solutions to housing

- Collaborations between care (ED, treatment, CMHP, local governments, etc.) and housing providers

Projects to increase the housing/shelter capacity of the IHN-CCO Region

- Inclement weather shelters
- Low barrier shelters, shelter spaces for hard to shelter folks (SPMI, SO, etc.)
- Crisis spaces
- Partnerships with city leadership to address barriers to building (permits, zoning, etc., community outreach)
- Safe and Sober housing options

InterCommunity Health Network CCO

SCORECARD

Adapt, develop weighed measures, other?

Criteria	Score
Health Equity: The project has a defined approach for fair opportunities for members to be as healthy as possible.	
Health Improvement: The project holds promise for making a significant improvement in the health or health care of IHN-CCO members.	
Improved Access: The project activities will result in improved access of healthcare; availability of services, culturally considerate care, and quality and appropriate care to IHN-CCO members.	
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Outcomes & Evaluation: Proposal outcomes and measures are aligned to project goals and will be sufficient to evaluate project success. The project outcomes are aligned with the Community Health Improvement Plan's Outcomes and Indicator Concepts.	
TOTAL PROPOSAL SCORE	

Scoring Priorities

Simplification

Measurable and relevant measures and outcomes

Innovation in housing equity for the under-served.

Long-term sustainability

Collaborative with other resources/services includes Navigation Supports/mobile health/Improved Access/Capture/engagement—breadth and depth, potential for improved experience
Comprehensive/Collaborative Bring together unique elements of environment, facility and services to enable optimized care for these special needs individuals

Model for subsequent projects

Improve physical 'capture', engagement/retention (including enrollment of qualified but not yet covered target individuals)

Health Equity

Health Improvement

Total Cost of Care

Better Definition of Need—subdivide 2 categories? Number (reach?) and acuity (impact?) gaps

Meeting the priorities

InterCommunity Health Network CCO

Scoring Priorities

- Relevant and Measurable Outcomes that relate to the priority areas
- Innovative or community led solutions for housing equity in underserved communities
- Demonstrates a comprehensive understanding of need and has (established?) partnerships necessary to build complete solutions
- Supports the engagement of individuals in health and SDoH services
- Has an understanding of health equity and an intentional HE strategy
- Meets the priorities

InterCommunity Health Network CCO

Timeline

- June/July: RFP Language
- July/August: Scorecard review and development
- August: RFP Released
- September 15: RFP Closes
- ***Presentations***
- Late October: Scoring meeting
- November 18: Full CAC Approval
- December: IHP Board Approval

IHN-CCO Social Determinants & Transformation

transformation@samhealth.org

2024 SHARE Scoring Priorities

- Relevant and measurable goals that relate to the priority areas
- Innovative or community led solutions for housing equity in underserved communities
- Demonstrates a comprehensive understanding of need and has (established?) partnerships necessary to build complete solutions
- Supports the engagement of individuals in health and SDoH services
- Has an understanding of health equity and an intentional HE strategy
- Meets the priorities

Relevant and measurable goals that relate to the priority areas

SMARTIE Goals Sheet

Activities and goals including the definition of success & timeline.

0. Has no defined goals
1. Goals are unclear
3. Goals are defined but include no plan to measure
5. Goals are clear and measurable, activities seem appropriate to meet them

InterCommunity Health Network CCO

Innovative or community led solutions for housing equity in underserved communities

0. Project is not innovative, community led, and in an underserved community

1. Project does not meet goals to be innovative or community led.

3. Project meets 1 or 2 (e.g. innovative and in an underserved community but not community led) but not all 3.

5. Project proposes innovative and community led solutions in underserved communities

InterCommunity Health Network CCO

Demonstrates a comprehensive understanding of need and has explored partnerships necessary to build complete solutions

0. Has no defined partners

1. Partnerships are undefined

3. Defines a clear understanding of partner organizations and a plan to utilize them

5. Defines partnerships and has a demonstrated ability to build coalitions and partnerships to support program goals

InterCommunity Health Network CCO

Supports the engagement of individuals in health and/or SDoH services

0. Does not address engaging individuals in health or SDoH services
1. Connection to health/SDoH services referenced but not defined
3. Project utilizes referrals only for health/SDoH services
5. Project integrates engagement in health or SDoH services (transportation, on site services, etc.)

InterCommunity Health Network CCO

Has an understanding of health equity and an intentional HE strategy

0. Does not define a health equity strategy

1. Does not have a demonstrated understanding of health equity (we serve everyone!)

3. Incomplete or only addresses one aspect of health equity (we asked people what they wanted and did it ourselves)

5. Project includes health equity principles such as: intentional outreach strategies, community feedback in design, alignment with community goals, individuals served are part of project analysis.

InterCommunity Health Network CCO

Meets the priorities

Comprehensive and complete solutions; increase capacity

0. Does not address the priorities at all
1. Minimally addresses/actions do not demonstrate alignment with priorities
3. Project outlines priorities but all activities do not align
5. Project demonstrates the ability to completely meet one or more priorities

InterCommunity Health Network CCO

InterCommunity Health Network CCO

IHN-CCO Community Advisory Council
SHARE Initiative

SHARE

Supporting Health for All through REinvestment

Legislative Requirement to invest CCO profits into communities for SDoH-E priorities

SHARE spending MUST

- Align with community priorities and the current CHIP
- Include the statewide priority (housing)
- Include a role for the CAC
- Involve community SDoH-E Partnerships
- Address one of the SDoH-E domains:
  - Economic Stability
  - Neighborhood and Built Environment
  - Education
  - Social and Community Health

InterCommunity Health Network CCO

Timeline

- March 2024: CAC Priority Areas Approved
- June/July: RFP Language, refine priorities
- August/September: Scorecard review and development
- August: RFP Released
- September 15: RFP Closes
- ***Presentations***
- November 1: Scoring and recommendation meeting
- November 18: Full CAC Approval
- December 4: IHP Board Approval
- January 1 2025: Projects Begin

Priorities Areas

IHN-CCO Funding Streams- InterCommunity Health Network CCO (ihntogether.org)

Collective impact housing models focusing on **comprehensive and complete** solutions to housing

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- Safe and Sober housing options

InterCommunity Health Network CCO

Scoring Priorities

- Relevant and measurable goals that relate to the priority areas
- Innovative or community led solutions for housing equity in underserved communities
- Demonstrates a comprehensive understanding of need and has (established?) partnerships necessary to build complete solutions
- Supports the engagement of individuals in health and SDoH services
- Has an understanding of health equity and an intentional HE strategy
- Meets the priorities

InterCommunity Health Network CCO

Recommendations

Lincoln County Health and Human Services	*Community Shelter and Resource Center (CSRC) Medical Outreach Program*	$174,830.40
CHANCE	*The Safe Space at 2nd CHANCE*	$109,120.00
Crossroads Communities	*Crossroads Connections, Transitional Housing*	$120,288.00
Corvallis Daytime Drop-in Center	*Housing Supports, Respite, and Life Stabilization*	$100,000.00
Creating Housing Coalition	*Community Outreach Assistance Team Helping Unhoused Community Members (COAT)*	$115,000.00
Casa Latinos Unidos	*Vivienda y Bienestar*	$179,975.00

total $799, 213.40

request to IHN-CCO to consider funding:

Unity Shelter *Collaborative Supportive Services Billing and Data Management* $84,915.00

InterCommunity Health Network CCO

Lincoln County Winter Shelter

January 1, 2025 – December 31, 2025

$174,830.40

Having onsite medical care addresses the unique healthcare needs of our unhoused population. Meeting people where they are, on their terms, reduces barriers to access to care and builds trust. Other nonfinancial barriers to care include lack of knowledge regarding where to obtain care, lack of transportation, lack of childcare, chronic homelessness, long wait times, and feelings of discrimination from health professionals.

Unhoused individuals in Lincoln County utilizing the shelter sites in Newport and Lincoln City

2nd CHANCE Shelter

January-December 2025

$109,120.00

Establishment of a space within 2nd CHANCE shelter to accommodate peers experiencing severe and persistent mental health, SUD, or other challenges that makes it difficult to offer them shelter in a traditional dorm setting.

People experiencing houselessness, severe and persistent mental health, substance use disorder (SUD), or other challenges.

Crossroads Communities

Start/End Date: As soon as possible through December 2025

$590,688, of which $120,288 is requested from SHARE

A non-licensed transitional housing facility where renters can have their own private room. Renters will find safety, support, and case management to achieve *their* definition of post-treatment success.

Those exiting facilities/group hopes for Substance Use Disorder (SUD), Severe and Persistent Mental Illness (SPMI), or Judicial Restraint; Survivors of Domestic Violence; and homeless/unhoused populations needing to be discharged from Emergency Departments

Corvallis Daytime Drop-In Center

1//1/2025-12/31/2025

$100,000

Provide social support services that stabilize people, support their discharge from various institutional settings, engage them in conversations and activities that springboard them towards housing, and directly help them secure stable, short- and long-term respite and living solutions that meet both their immediate and future housing needs.

People experiencing extreme poverty in Benton County, and beyond

Creating Housing Coalition

October 2024 – December 2025

$115,000

Outreach support to get more unhoused clients insured and into permanent housing

Unhoused elderly, disabled, veterans, minority groups

Casa Latinos Unidos

January 1, 2025 – December 31St, 2025

Budget: 179,975.00

Providing system navigation, wrap around services, educational support, and direct emergency financial assistance to improve housing security and reduce the barrier of the Latinx population in our community

Population: Low-income, first generation immigrants from Latin America living in Linn, Benton, and Lincoln counties.

Unity Shelter

March 1, 2025-February 28, 2026

Requesting $84,915

This proposal is to support the efforts of three organizations (Unity Shelter, Corvallis Housing First, The Corvallis Daytime Drop-In Center) involved in providing shelter, housing, and supportive services to people experiencing homelessness in accessing Medicaid funds to pay for services. An Eligibility and Data Coordinator will be hired by Unity Shelter to serve all three organizations in billing as well as in inputting and analyzing service data to better target services and to help ensure the sustainability of these programs.

Individuals experiencing homeless in Corvallis/Benton County

IHN-CCO Social Determinants & Transformation

transformation@samhealth.org