2024 CCO Annual Convening: Centering Member and Community Perspectives in HRS, SHARE and ILOS

Welcome to the 2024 annual convening on investing in social determinants of health and equity (SDOH-E) through Oregon Health Authority (OHA) Medicaid spending programs.

This convening is sponsored by OHA Transformation Center in partnership with Oregon Rural Practice-based Research Network (ORPRN) to support coordinated care organizations (CCOs) in implementing Supporting Health for All through REinvestment (SHARE), health-related services (HRS) and in lieu of services (ILOS).

Accessibility: Everyone has a right to know about and use OHA programs and services. Please visit the registration desk if you have any accessibility needs.

Program contents

Keynote speaker spotlight

We are thrilled to introduce and welcome our 2024 convening's keynote speaker:

Ivelyse Andino

Founder and CEO of Radical Health

Ivelyse Andino is a visionary health care abolitionist and health equity strategist building community at the intersection of health, equity and tech. She's using her platform to advocate for comprehensive health care fluency: an original concept created to bridge the gap between systemically marginalized communities and the medical system as we know it today. Ivelyse's mission is to engage, equip and empower all people to understand and advocate for their health. She plays an imperative role as the founder and CEO of Radical Health, the first Latina-owned-and-operated Benefit Corporation in NYC, that is building community at the intersection of health, equity and tech. Ivelyse is a former commissioner at the NYC Commission on Gender Equity and serves on the board of BX (Re)Birth Collective, an advocacy organization that builds alternate solutions to protect birthing people in the Bronx. Ivelyse is also an external advisor for the American Medical Association's Equity and Innovation Board. She was awarded the "My Brother's Keeper" Grant by the Obama Foundation to address social determinants of health in NYC community schools and was recognized by Rock Health's Top 50 in Digital Health Luminaries for 2021. She is a 2019 Roddenberry Foundation Fellow and a 2022 Aspen Institute Health Community Fellow. Ivelyse is always a passionate leader for her hometown of The Bronx and New York City. In 2022 she was named New York City's Top 25 Whole Health Heroes by Empire BlueCross BlueShield and Crain's New York. Her work has been featured in the Washington Post, Nasdaq, Crain's New York and Forbes, with bylines in Latina Magazine and Well + Good.

Agenda

Wednesday, October 9

- **7:30–8:30 a.m.** — Registration and breakfast *(West Gallery)*
- **8:30–9 a.m.** — Welcome: The role of HRS, SHARE and ILOS in achieving Oregon's 2030 health equity goal *(Santiam 4/5/6)*
- **9–9:45 a.m**. — Keynote: Reimagining health care: A call to action for equity, innovation and community-led change *(Santiam 4/5/6)*
- **9:45–10 a.m.** — Transition
- **10–10:45 a.m**. — Plenary: Community voice panel *(Santiam 4/5/6)*
- **11:00 a.m.–Noon** — Innovation Café session one *(Santiam 2, Santiam 3 & Santiam 4/5/6)*
    - 11:05–11:30 a.m. — Round one
    - 11:35 a.m.–Noon — Round two
- **Noon–1 p.m**. — Lunch *(Served in West Gallery; participants eat in Santiam 4/5/6)*
    - 12:30–1 p.m. — OHA tabling *(West Gallery)*
- **1–1:15 p.m.** — Transition
- **1:15–2:15 p.m.** — Innovation Café session two *(Santiam 2, Santiam 3 & Santiam 4/5/6)*
    - 1:20–1:45 p.m. — Round one
    - 1:50–2:15 p.m. — Round two
- **2:15 p.m.** — End

Session and speaker details

8:30–9 a.m. — Welcome: The role of HRS, SHARE and ILOS in achieving Oregon's 2030 health equity goal *(Santiam 4/5/6)*

Emma Sandoe, Oregon Health Authority

Emma Sandoe, Oregon Health Authority's new Medicaid director, will reintroduce Oregon's goal to eliminate health inequities by 2030, as well as share how Medicaid spending programs play a key role in the strategic plan to reach this goal. With a focus on transforming behavioral health, strengthening access to affordable care for all and fostering healthy families and environments, Sandoe will promote innovation in CCO investment and strategy in the next stage of addressing SDOH-E.

Emma Sandoe is the director of Oregon's Medicaid Division. She leads employees and programs that support Oregon Health Plan (OHP), the state's Medicaid program, which serves approximately 1.4 million members.

Before coming to OHA, Dr. Sandoe served as North Carolina's Deputy Director of Medicaid Policy, where she was the primary liaison to Tribal nations in the state and to the federal Centers for Medicare & Medicaid Services (CMS). She oversaw the state's Medicaid Plan and its Medicaid waivers and took a lead role in developing and implementing new policies to improve health equity.

As part of her work in North Carolina, Dr. Sandoe helped direct the passage and implementation of the state's Medicaid expansion, which brought health coverage to more than 550,000 people. She also led efforts to expand the health care workforce under North Carolina's home and community-based services program and assisted in developing and implementing the state's Healthy Opportunity Pilots program, leveraging Medicaid dollars to address food, transportation, and housing insecurity, as well as toxic stress.

9–9:45 a.m. — Keynote: Reimagining health care: A call to action for equity, innovation and community-led change *(Santiam 4/5/6)*

Ivelyse Andino, Radical Health

Ivelyse Andino, CEO of Radical Health, will explore how centering the voices of communities and Medicaid members — "nothing about us without us" — is essential for creating lasting change in health equity. Drawing from her extensive work advocating for underserved populations, Ivelyse will highlight the tension between policy, innovation and the real-world needs of communities.

She will discuss how health care systems and community partners can better align by understanding each other's contexts, policies and opportunities. Attendees will learn practical tools for building meaningful relationships that share power, address social determinants of health and equity (SDOH-E) and bridge the gap between community needs and systemic change. Through this talk, Ivelyse will inspire a commitment to collective action and a reimagined future of health care where no one is left behind.

Ivelyse Andino is a visionary health care abolitionist and health equity strategist building community at the intersection of health, equity and tech. She's using her platform to advocate for comprehensive health care fluency: an original concept created to bridge the gap between systemically marginalized communities and the medical system as we know it today. Ivelyse's mission is to engage, equip and empower all people to understand and advocate for their health. She plays an imperative role as the founder and CEO of Radical Health, the first Latina-owned-and-operated Benefit Corporation in NYC, that is building community at the intersection of health, equity and tech. See her full biography on page 2.

10–10:45 a.m. — Community voice panel *(Santiam 4/5/6)*

Facilitator: Kristty Polanco, Oregon Health Authority
Panelist: Maria Park, Asian Health and Service Center; Dr. Sandra Hernandes, Doulas Latinas International

Leaders from local Oregon community organizations who partner with CCOs will share perspectives on member needs, what is working well, innovative ideas that could be replicated in other areas and ideas about improving services for better member-facing experience.

Before becoming an innovator agent, Kristty Polanco started in the field of public health as a community health worker in the Willamette Valley. Her passion for the work led her to pursue a master's degree in public health from Oregon State University. During her career, Kristty has also served as community health navigator supervisor for Kaiser Permanente in the Portland metro and Salem region, as well as a public health administrator, public health emergency coordinator and epidemiologist through the COVID-19 response for Polk County.

Maria Park is the senior program manager at Asian Health and Service Center (AHSC) since 2008, managing the Oregon Health Plan Healthier Oregon, Marketplace and Reproductive Health Programs. AHSC has been serving the tri-county area since 1983, with multicultural, bilingual certified community health workers who speak Cantonese, Mandarin, Vietnamese and Korean. AHSC is rooted in a holistic, integrated model of care — an innovative blend of language and culturally specific physical and mental health services, public health and wellness programs and community engagement opportunities for the Portland Metro region's growing Asian population. Our mission is to be the bridge between Asian and American cultures to build a harmonious community, and our vision is to reduce health inequity and improve health care quality for all Asians.

Sandra H. Hernandes is the executive director and founder of Doulas Latinas International, president of Oregon Community Doulas Association, and Alliance for Childbearing & Collective Health Equity for Maternal Child Health of Latino, Indigenous and Black partners. Doulas Latinas International is a nonprofit organization that was founded and has worked with Latino, people of color, immigrant, refugee and farmworker communities and partners since 2006. Doulas Latinas trains and certifies culturally and linguistically specific community doulas who were pregnant mothers and/or are from the communities they serve, focused on health prevention and health equity literacy for their families. Doulas Latinas operates across Oregon, including eastern and central Oregon, the Gorge and the Portland metro area, to support pregnant people, babies and families. Our programs support our mission and vision that every child deserves to be a healthy adult.

11 a.m.–Noon — Innovation Café session one *(Santiam 2, Santiam 3, Santiam 4/5/6)*

11:05–11:30 a.m. — Round one

11:35 a.m.–Noon — Round two

Speakers will give presentations in two rounds focusing on key topics:

- **Streamlining the experience of members receiving services and community partners providing services through Medicaid spending programs**

- **CCO and community organization partnerships that braid Medicaid funding, including HRS, SHARE, ILOS and other programs like health-related social needs (HRSN) covered services**

Transitional housing: bridging the gap *(Santiam 2)*

Samantha Watson, Jackson Care Connect; Melanie Doshier, ACCESS

The Transitional Bridge Bed program uses SHARE dollars to fill a crucial funding gap where other state and local resources fall short. Learn about Jackson Care Connect and ACCESS's adaptive partnership that uses their unique expertise to comprehensively meet the needs of community members while in transition and significantly improve their ability to obtain and maintain stable housing.

Streamlining HRS and HRSN services: enhancing member and provider experiences *(Santiam 2)*

Chanel Smith, Cascade Health Alliance

Cascade Health Alliance's streamlined "no wrong door" approach to HRS and HRSN services aims to create a seamless experience for both members and providers. Learn about their single HRS and HRSN intake form, pre-approved HRS flexible services pathways and other strategies to ensure timely and equitable access to essential services.

Improving health equity by creating streamlined pathways to HRS packages *(Santiam 3)*

Peg King, Maureen Seferovich and Tanya Nason, Health Share of Oregon

Health Share of Oregon's pilot, Safe Beginnings HRS packages, streamlines access to tangible supports for pregnant members with substance use disorders. Learn about their collaborative and strategic efforts to develop a standardized request form and a pre-approved menu of items to deliver timely supports to positively impact members.

Service Integration Teams (SIT) in the CCO toolbox *(Santiam 3)*

Laurel Schwinabart, InterCommunity Health Network

InterCommunity Health Network's (IHN) implementation of the SIT model, a collaborative framework for coordinated resource and service delivery, leverages a network of 54 community and clinical partners in East Linn County to meet community members' unmet needs. Learn how IHN coordinates HRS and other funding streams and collaborates across sectors in a coordinated effort to address community needs.

Stepping up to be better funding partners: adventures in a single-entry request for proposals and braiding funds *(Santiam 4/5/6)*

Shannon Buckmaster and Emily Johnson, Yamhill Community Care Organization

Yamhill CCO created an innovative, single-entry funding model for investments in SDOH-E to ensure equitable access to resources for community partners. Learn how Yamhill CCO aligns investments with community needs, braids five funding streams and provides comprehensive support to community partners to demonstrate tangible impacts in their communities.

A collective approach to maximize impact: regional housing impact fund *(Santiam 4/5/6)*

Nancy Knopf, Columbia Pacific Coordinated Care Organization

Columbia Pacific CCO established the Regional Housing Impact Fund, a collective approach and funding pool, to address housing needs in Clatsop, Columbia and Tillamook counties. Learn about their prioritization of region-identified needs, engagement of cross-sector partners in a coordinated approach and significant advancements in housing stock, services and supports.

12:30–1 p.m. — OHA tabling *(West Gallery)*

- **Behavioral health housing**
  - Blanca Barocio and Alondra Orozco (Behavioral Health Investments Team)
- **Community engagement and state health improvement plan**
  - Tosha Bock and Cintia Vimieiro (Office of the State Public Health Director)
- **Finances of HRS, SHARE and ILOS**
  - Rebecca Level (Office of Actuarial and Financial Analytics)
- **Health-related services (HRS)**
  - Anona Gund (Transformation Center) and Tom Wunderbro (Health Systems Division)
- **Health-related social needs (HRSN)**
  - Charissa Young-White (1115 Medicaid Waiver Strategic Operations), Staci DeLeon-Davis and Tania Curiel (Transformation Center)
- **In-lieu of services (ILOS)**
  - David Inbody (CCO Operations)

- **Supporting Health for All through REinvestment (SHARE)**
    - Rachel Burdon and Laura Kreger (Transformation Center)
- **Traditional health workers**
    - Lily Sintim (Traditional Health Worker Program)

1:15–2:15 p.m. — Innovation Café session two *(Santiam 2, Santiam 3, Santiam 4/5/6)*

1:20–1:45 p.m. — Round one

1:50–2:15 p.m. — Round two

Speakers will give presentations in two rounds focusing on key topics:

- **CCO approaches to addressing member housing and food needs through HRS, SHARE and ILOS**
- **Advancing access to behavioral health and traditional health worker services**

SHARE investment: CASA and cooperative housing models (*Santiam 2)*

Skylar Fate, AllCare Health; Rose Ojeda, CASA of Oregon

AllCare Health's partnership with Community and Shelter Assistance (CASA) of Oregon supported two manufactured housing projects through SHARE. Learn about AllCare Health's ongoing and robust engagement efforts and CASA's cooperative housing model that resulted in intergenerational land ownership, community resiliency and housing stability for community members.

Addressing member food needs through community collaboration (*Santiam 2)*

Amanda McCarthy, Advanced Health

Advanced Health's approach to addressing immediate food access needs and long-term solutions to food insecurity centers community voice and collaboration. Learn about their strategic investments through SHARE, HRS and HRSN to advance equity along the continuum of food access.

Impacts of SHARE kitchen remodels (*Santiam 3)*

Jennifer Gustafson, AllCare Health; Amber Ferguson, Rogue Food Unites; Stephanie Mendenhall, Reclaiming Lives

AllCare Health offers a creative approach to increase food access in their community. Learn about three of AllCare Health's partnerships and investments through SHARE that bridge food access and social connection, supporting kitchen remodels and renovations in various settings to meet unique needs of community members.

SHARE-ing is caring: supporting doulas in Oregon (*Santiam 3)*

Mariam Ukbazghi, Ophelia Vidal, Health Share of Oregon; Iris Bicksler and Martha Rivera, Oregon Doula Association

Health Share of Oregon partnered with the Oregon Doula Association through SHARE to improve access to trained, certified, culturally and linguistically diverse doulas and improve birthing outcomes among communities experiencing health inequities. Learn about their multi-faceted approach to supporting doulas across the state through education, technical assistance and advocacy leading to an increased workforce, policy and systemic changes and a ripple effect impacting health equity.

Bridges to Health: a network of community health workers in the Columbia Gorge (*Santiam 4/5/6)*

Jenny Anglin, Gorge Health Council; Jasmin Huila Flores, Adventist Columbia Gorge

The Columbia Gorge Health Council and PacificSource govern the Bridges to Health program, a cross-sector community health worker (CHW) hub that aims to address barriers to health and well-being; improve health quality, access and equity; and grow a skilled network of CHWs. Learn how Bridges to Health coordinates multiple funding streams, reduces administrative burden for CHWs and significantly improves client health outcomes while reducing health care costs.

HRS investment: Grants Pass Sobering Center *(Santiam 4/5/6)*

Lana McGregor, AllCare Health

AllCare Health and Grants Pass Sobering Center have partnered for ten years to improve access to and capacity of sobering services in their community. Learn about this vital piece of the behavioral health continuum of care and how coordination across sectors is positively impacting community members while reducing emergency department and carceral setting use.

Addressing Member Food Needs through Community Collaboration

Advanced Health CCO

Advanced Health's approach to addressing immediate food access needs and long-term solutions to food insecurity involves community collaboration and strategic investments along the continuum of food and nutrition through **SHARE, HRS and HRSN**, including:

- **$86,400:** 2023 SHARE investment in **Coos Head Food Co-Op** to build and strengthen a collaborative open to all community members, focused on removing barriers to accessing healthy foods. Investments include:
  - **Double Up Food Bucks Program**
    - Average of 179 participants per month
    - $1312 of produce redeemed each month per household
    - 74 percent of produce is locally grown, supporting community's economic health
  - **Expansion of the Oregon Farm-to-School Network** to three schools, three gardens, 59 students and 11 volunteers.
- **$1,777,930:** 2023 HRS community benefit initiative (CBI) investments related to **supporting the food access continuum**, such as:
  - Emergency food for rural communities
  - Food pantry services in primary care

Process details

- **Community-identified needs:** Food insecurity and access to healthy foods were identified in the community health assessment; through collaboration with community and consumer members, access to healthy foods became a focus of the community health improvement plan (CHP).
- **Strategic coordination:** Addresses identified community needs through funding, program design and facilitation of community partners; reviews multiple funding streams (SHARE, HRS, HRSN) to identify appropriate source to support interventions.
- **Community-led action:** Connects consumer members with action teams to lead this work, such as Coos Head Food Co-Op, The Beet and Health Equity Coalition.

Outcome: equity across the continuum of food access

Addressing identified needs along the continuum allows these programs to be equitable:

- Funding HRS CBI supports inclusion for all members of the community; funding HRS flexible services supports unique needs of members.
- Understanding how SHARE, ILOS and HRS will interact with HRSN is key to maintaining a well-rounded strategy to address access to healthy food and food insecurity, including:
  - Funding organizations with existing programs while establishing mechanisms to ensure HRSN covered services are considered first.
  - Augmenting community-based organizations (CBOs) with HRS, SHARE and ILOS as they transition to the Medicaid model.

Funded projects across the continuum:

Emergency food: four projects
- Homeless shelter meals
- Food pantry in primary care
- Sack lunches

Healthy Food: one project
- Veggie RX

Sustainable, affordable food: two projects
- Meals for older adults

Challenges

- Understanding HRSN and its interactions with nutrition-focused programs.
- Guiding CBOs through HRSN billing and reimbursement when they are accustomed to receiving grant funding as a lump sum.
- Identifying reliable data sources and determining how to measure health outcomes to fuel key program metrics and evaluations.

Keys to success

- **Identify and invite community champions to the table early:** Partners who do the work know the most about potential barriers and challenges. Consumer members have insights into navigating processes; these perspectives will help build an inclusive process from the beginning.
- **Start with the end in mind:** What is your overall goal, and how do you measure it?

Next steps

- Assess current nutrition provider network in preparation for HRSN covered services.
- Navigate and identify benefits of covered services versus grant-funded programs.
- Continue to align with 2024 CHP, which identified similar community needs.

Contact

- **Amanda McCarthy**, Advanced Health, amanda.mccarthy@advancedhealth.com

Impacts of SHARE Kitchen Remodels

AllCare Health; Rogue Food Unites

AllCare provided **three SHARE grants** in 2024 supporting kitchen remodels and renovations to improve access to ready-to-go and onsite meals for key populations.

- **Kitchen hood replacement** at the **Grants Pass American Legion Post 28 ($20,000)** that serves at least three dinners per month and opportunity for social connections to veterans, active military personnel and families.
- **Commercial kitchen build-out** for **Rogue Food Unites ($50,000)** to provide about 60,000 fresh, regional, organic and ready-to-eat meals annually to older adults, people experiencing houselessness and people with economic insecurity, including those with underlying health issues, with particular care for culturally specific food needs.
- **Kitchen and center redesign ($80,202)** at **Recovery Café/El Camino Seguro** to meet the nutritional, social and recovery needs for individuals with substance use disorders in Jackson County.

Process details

- **Identifying community needs:** Being active in the community has allowed AllCare to have strong working relationships with partners across the area. Various community needs have been identified when attending listening sessions, cross-collaborative work groups, one-on-one meetings, community advisory council meetings, city council meetings and more.
- **Connecting food access and social supports:** Throughout southern Oregon, there is a drastic need for nutritional supports. Nutritional needs increased over the last several years following the pandemic, wildfires that gravely impacted local communities, a shift in SNAP benefits and unmanageable cost of living increases. Supporting communal eating provides people with a place to make connections and increases happiness following several years of social isolation from the pandemic.

Outcomes and impacts

These projects demonstrate the unique connections of community members' social needs in various settings and how food provides a safe way to bridge people together.

- **Increased nutritional resources:** 200+ individuals are provided hot meals, at least four times weekly, in Josephine and Jackson County for two SHARE projects.
- **Increased cultural connections:** Meals are shared with families that have common language and culture.
- **Improved access to substance use recovery:** Providing meals in a safe, warm environment builds trust and fosters connections that improve recovery outcomes.
- **Improved access to trauma-informed supports:** Having a place to gather while eating a meal allows skilled peers and advocates to offer supportive services.
- **Improved nutritional disaster responsiveness:** Supporting a community partner that can provide organic meals during a natural disaster can address climate injustice across multiple counties.

Challenges

- Increasing costs of renovation projects caused unexpected delays of two projects.
- Immediate needs don't always align with SHARE or other funding timelines.
- Requests exceed SHARE budget. Last year, AllCare received over $5 million in SHARE grant requests.

Keys to success

- Success can be seen by the positive relations community members make and maintain through these communal locations.
- It takes strong community partnerships to learn where community needs are being addressed and ways we can impactfully help.

Next steps

- Expand nutritional relationships at local community centers and other settings where individuals gather to have meals.

Contact

- **Jennifer Gustafson**, AllCare Health, Jennifer.Gustafson@allcarehealth.com
- **Amber Ferguson**, Rogue Food Unites, amber@roguefoodunites.org

SHARE Investment: CASA & Cooperative Housing Models

AllCare Health; Community and Shelter Assistance (CASA) of Oregon

In 2023, AllCare Health partnered with CASA of Oregon through **SHARE grants** to support two housing projects:

- **$150,000** to redevelop a manufactured home park destroyed in 2020 by the Almeda fires. This funding contributed to bringing back 77 new manufactured homes to the residents of Talent Mobile Estates. Leveraged to $22 million (affordable housing loans and grants).
- **$200,000** to purchase a 110-space manufactured dwelling park as a non-profit cooperative in Grants Pass. Leveraged to $15 million.

CASA of Oregon uses a cooperative model of governance to give residents greater control over the operation and management of their park, promoting:

- Social inclusion
- Community engagement
- Housing stabilization
- Overall well-being

Process details

- AllCare CCO actively identifies community needs through **ongoing and robust engagement efforts**. Because CCO staff live and work within the communities we serve, we gain a firsthand, in-depth understanding of the unique and evolving challenges faced by residents. This proximity allows us to develop responsive, tailored solutions that reflect the specific nuances of each community's needs.
- **Cooperative Housing Model:** Resident ownership happens when manufactured homeowners form a non-profit cooperative to buy their community when it's up for sale. Without this option, they risk displacement or higher land rents if a new owner changes the property use. Resident control is a unique, affordable housing option that directly supports resident empowerment and increased community resilience.

Outcomes and impacts

Both projects resulted in **intergenerational land ownership, community resiliency and housing stability:**

- Talent Mobile Estates will have residents moving in September. Redwood Family Park is owned by the residents and in full operation, including immediate repairs.

- **Improved housing stability and rental rates** for hundreds of households.
- The rents proposed for both projects will be below market rental rates and stay stabilized. For example, one previous cooperative supported by CASA did not raise rental rates from 2009 to 2023, and in 2024, the rent only increased by $20. These savings on rent allow for intergenerational wealth-building in other parts of life — home repairs, cost of health care, recreational activities and more.
- Being connected to a nonprofit like CASA also brings other resources and benefits. This model of keeping people housed is beneficial not only for residents, but for the state and community.

Residents who decide to purchase their park have seen lower lot rents, higher average home sale prices and greater housing stability when compared to residents in investor-owned parks.

Challenges

- The inability to fully fund these projects can feel limiting for CCOs.
- The time required to make decisions regarding projects, financing and grant application periods can cause delays.

Keys to success

Let the community partner take the lead on their grant project, supporting them with resources and guidance as needed. Stay actively engaged with the community, listening to their needs and maintaining a presence throughout the project to ensure the work aligns with their priorities and fosters collaboration.

Next steps

AllCare aims to strengthen its partnership with CASA of Oregon through more **cooperative housing projects** and will assess future locations for potential support. We also plan to further support families at these locations by **exploring additional services**, such as mobile health clinics, expanded social services and home repairs or modifications that enable residents to remain comfortably in their homes.

Contact

- **Skylar Fate**, AllCare Health, skylar.fate@allcarehealth.com
- **Rose Ojeda**, CASA of Oregon, roseo@casaoforegon.org

Bridges to Health: A Network of Community Health Workers in the Columbia Gorge Region

Columbia Gorge Health Council; Adventist Health Columbia Gorge

The Columbia Gorge Health Council (CGHC) partners with PacificSource Community Solutions to govern the Columbia Gorge Coordinated Care Organization (PS-CG CCO). The council runs the **Bridges to Health program (B2H)**, **a cross-sector community health worker (CHW) hub** that aims to address barriers to health and well-being, improve health quality, access and equity and grow a skilled network of CHWs.

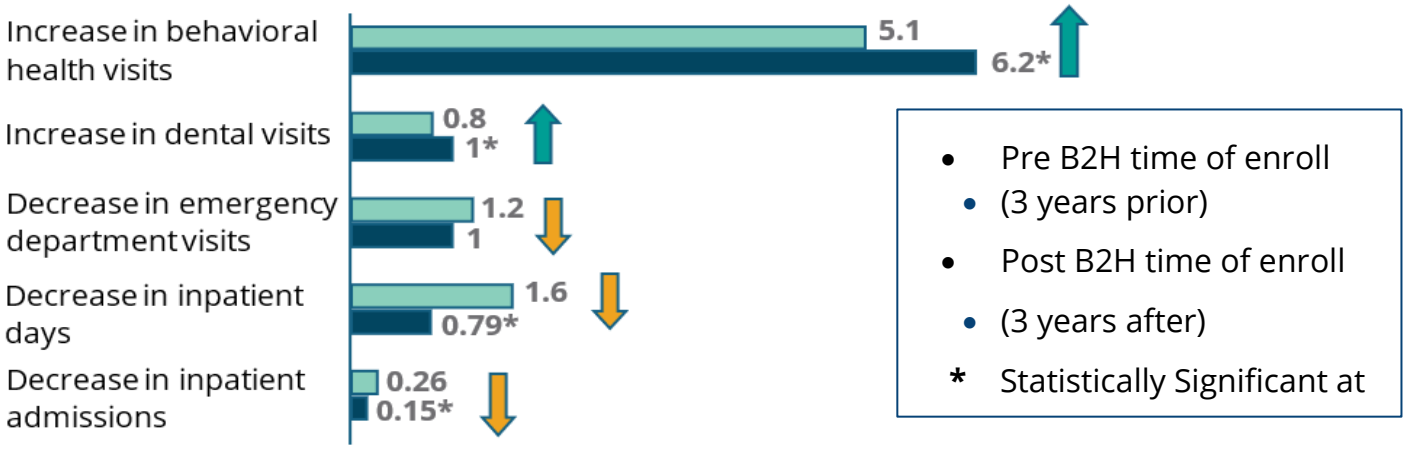
B2H hub details

- Embeds CHWs in regional health care and community-based organizations (CBOs) and oversees CHW training, certification and support.
- **Invests through a variety of Pacific Source-Columbia Gorge CCO funding mechanisms:** HRS, Shared Savings and now HRSN. Since 2018, over $3 million of HRS funds and $2 million of Shared Savings have been invested.
- Coordinates funding streams, applies for grants and issues payments to organizations.
- Handles data, reporting and quality assurance and hosts the shared data platform, Activate Care.

Outcomes and impacts

- **Increased support to clients in getting and staying housed** through connections to local housing resources.
- **Increased flexibility for CHWs to pay for clients' needed items** to overcome barriers to health and well-being through Client Incidental funds.
- **Strengthened support and shared learnings** across CHWs in the network.
- **Improved health outcomes and reduced health care costs:** B2H clients more likely to use health care appropriately after participating in B2H:

Difference in health care utilization rates per member per year



Source: PacificSource CCO/Medicaid members enrolled 36 months before and up to 36 months after enrollment in the Bridges to Health Program as recorded on claims paid by November 2022 (N=1,052).

Challenges

- **Lack of sustainable funding**, including low reimbursement rates for CHWs, makes it challenging to support our staff and community members with the resources needed.
- **Lack of resources** puts a heavy burden on CBOs to support key populations (older adults with limited support systems, clients with severe and persistent mental illness, refugee and asylum-seeking families) and leave CHWs at risk of compassion fatigue.

Keys to success

- Building **trusted relationships and collaboration** with community partners.
- **Pay equity and family-centered values** leading to a well-established workforce.
- **Workforce that mirrors the language and culture of clients** we serve.
- **Program alignment** with community priorities and initiatives.

Next steps

- Increase coordination and collaboration at our new office location, The Gloria Center, a supportive services multi-agency navigation center.
- Expand opportunities for sustainable funding.

Contact

- **Jenny Anglin**, Executive Director, Columbia Gorge Health Council, Jenny@gorgehealthcouncil.org
- **Jasmin Huila**, Program Manager, DEI, Case Management, Adventist Health Columbia Gorge, huilafj@ah.org

HRS Investment: Grants Pass Sobering Center

AllCare Health and Grants Pass Sobering Center

AllCare Health and Grants Pass Sobering Center have partnered for 10 years to **improve access to and capacity of sobering services** in our community.

- In 2023, AllCare invested **$100,000** in the sobering center through **HRS Community Benefit Initiatives** to provide non-medical, non-covered direct care and navigation services to support individuals through the sobering process and safely re-enter the community.
- Grants Pass Sobering Center staff connect AllCare members discharged from sobering to various social services and resources using **HRS flex dollars**, including services like non-covered transportation and temporary lodging for short waits to residential treatment.

Process details

- Grants Pass Sobering Center opened in 2016 after four years of **community collaboration, mobilizing and planning**. AllCare was an early partner with the sobering center, city police, emergency department, jail and behavioral health providers. AllCare gave start-up funding in 2015 and have continued some sort of funding every year. AllCare and Grants Pass Sobering Center's **relationship goes beyond funding**. In addition to early and continued community partner collaboration, AllCare has a role in the sobering center's governance, and we work closely in various operational capacities, including care coordination and language access technical assistance.
- Key community partners have enabled the sobering center's success. The City of Grants Pass, particularly **Grants Pass Police**, has been a critical partner in the development, community collaboration, ongoing funding and success of the Grants Pass Sobering Center. **Local behavioral health treatment providers**, including a new community resource center called The Hub, have been key partners and contribute to the ongoing success of the sobering center through their continuous engagement and care coordination. Finally, **other engaged justice-related, health care and nonprofit partners** make and receive referrals, participate in governance, provide funding and champion the work of Grants Pass Sobering Center.

Outcomes and impacts

Grants Pass Sobering Center is a vital piece of the behavioral health continuum of care that increases community partner collaborations and timely connections for individuals impacted by substances:

- **Community members served:** The sobering center served about 1300 community members in 2023 (1200–1700 annually). About 80 percent of clients are CCO members.
- **Community members can self-refer** for services: Individuals who are intoxicated or impaired by substances and need a safe, low barrier and welcoming place can self-refer to sobering services. Self-referrals make up about 50 percent of annual referrals. This allows a community member to avoid law enforcement, jail and/or emergency department involvement.
- **Reduced frequency of emergency department and carceral setting use:** Law enforcement is the second largest referral source after self-referrals, connecting around 50 individuals per month directly to sobering and diverting from jail. In 2023, most Grants Pass Sobering Center clients safely used sobering services without needing emergency services, and only 124 clients had emergency department referrals.

Challenges

- Balancing non-clinical and non-covered services while the program is also adding in peers and navigation supports.
- Exploring the sustainable ways to support Grants Pass Sobering Center in the future.

Keys to success

- Several community partners working together.
- Grants Pass Sobering Center functioning as a standalone facility, and not attached to a substance use disorder treatment agency, has allowed Grants Pass Sobering Center flexibility, autonomy and to be seen more as a community service rather than a treatment service.

Contact

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SHARE-ing is Caring: Supporting Doulas in Oregon

Oregon Doula Association; Health Share of Oregon

Health Share of Oregon partnered with Oregon Doula Association (ODA) in 2022, investing **$500,000 through SHARE** over three years to improve access to trained, certified, culturally and linguistically diverse doulas and improve birthing outcomes among communities of color, both those with and without access to Oregon Health Plan. Through SHARE funding, ODA:

Supporting doulas is supporting communities

- Strengthened ODA's foundation, redesigning the organizational structure and hiring staff for operations and traditional health worker (THW) projects.
- Supports workforce development and infrastructure for individuals to become state-certified, community-based doulas for culturally and linguistically diverse communities.
- Launched a Doula Awareness Campaign and created toolkits for doula integration and utilization to improve access to doula services in the tri-county region.
- Advocates to address challenges and barriers to enter and sustain the workforce.

Process details

- **Prioritization of THWs:** Health Share named THWs as a key focus area in their community health plan. Collaboration with and recommendations from Health Share's THW Advisory Committee were leveraged through their governance structure, including the community advisory council and board of directors, to align and invest in community-based doulas through SHARE funding for ODA.
- **Ripple effect of impacting health equity:** ODA advocates and ensures integration of the workforce that mirrors communities affected by health inequities, fidelity of the role, livable reimbursement rates and reduced and/or alleviated challenges and barriers to enter the workforce.
- **Ongoing collaboration:** Aside from funding, Health Share includes ODA in conversations to ensure implementation of services, messaging and billing practices across Health Share partners are in alignment with best practices for doulas.

Outcomes and impacts since 2023

- **Increased the THW doula workforce** by 88 new doulas on the THW doula registry. Collaborated with Oregon Health Authority (OHA) to improve THW registry search options, specifically searching for bicultural doulas.
- **Increased awareness of best practices for doulas:** billing guide and technical assistance; annual Oregon Doula conference; and peer review of best and promising practices through OHA THW Commission's Systems Integration subcommittee.
- **Expanded doula Medicaid-covered visits** (to be implemented in 2025) from the current "Doula Global Package" (two prenatal visits, labor support, two postpartum visits) to include four additional visits to be used as the family wishes.

Challenges

- **Systemic changes can be slow to be implemented:** THW doulas were integrated in 2013. It wasn't until 2017 that a billing pathway was created, and it took three more years for doulas to be able to bill Medicaid.
- **Recent, various systemic changes:** Only state-approved doula trainings are accepted; adding a legacy pathway for doulas; and changing billing codes.

Keys to success

- ODA's diverse representation of Oregon's regions and extensive experience and expertise as doulas within CCOs, hospitals and community-based organizations brings diverse perspectives to ensure equitable practices are implemented.
- ODA being the bridge between systems and doulas enables a multifaceted approach to systemic changes, supporting the workforce and expanding access to families.
- THWs are meant to reflect the communities they serve. Including and empowering members of the workforce to participate in decision-making improves understanding of systems and consistency in standardization of processes.

Next steps

- Co-develop communications strategy for emerging doula guidance on policy and billing changes through OHA and dissemination strategy for the 2024 Doula Billing Guide.
- Continue partnering for ongoing doula strategy and technical assistance to doulas in Health Share's network.

Contact

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Innovation Café Roundtable Discussion Topic: Streamlining the member and community partner experience engaging with spending programs

Improving Health Equity by Creating Streamlined Pathways to HRS Packages

Health Share of Oregon

Health Share of Oregon piloted a **Safe Beginnings HRS package** in 2022 to provide a streamlined path for pregnant members with substance use disorders (SUD) to access tangible supports surrounding their pregnancy:

- Created in response to recommendations from the Children's Health Advisory Council, Clinical Advisory Panel, clinicians and members.
- Convened five health plan partners and six initial clinical teams working with this population to develop a **standardized request form, menu of pre-approved items** and member-facing promotional materials.
- **Piloted to 324 members** at Project Nurture clinics and home visiting programs in each of the three counties.

Safe Beginnings menu of pre-approved items:

- Body-to-body baby carrier
- Safe sleep crib set
- Diapers and wipes
- Lactation supplies
- Home safety items
- Books for bonding with baby

Process details

- **Collaboration in development:** Solicited feedback from Project Nurture clinics and OHSU Doernbecher's safety program on postpartum health items. Convened a work group to discuss items, processes and HRS requirements and to create a simple aligned workflow.
- **Streamlining requests:** Designed a low-barrier process for both members and/or clinical staff to submit requests, including a mostly pre-filled form with the diagnosis code (pregnancy), minimal input of information required and a checkbox feature to reduce administrative burden. Provided technical assistance to clinics to implement.
- **Culturally tailored services:** In the Safe Beginnings menu, we included books to increase bonding that were in both English and Spanish and contained images that reflected many cultures. We then expanded access to county home visiting programs including Healthy Birth Initiative, which serves African and African American members.

Outcomes and impacts

- Safe Beginning's focus on serving pregnant members with SUD aims to strategically, positively impact two generations. During the pilot from July 2022 to August 2024:
  - **324** Safe Beginnings pregnancy packages were delivered to members.
  - **$178,200** were invested through HRS flex funding on Safe Beginnings.
- Qualitative program evaluations conducted six months into the pilot found **overwhelmingly positive impacts** on member care and morale of clinical staff:
  - "Increases dignity and relieves mom's anxiety. Allows for focus on learning that the nurses offer about pregnancy, childbirth, breastfeeding and care of newborn."
  - "It enhances safety and valid resources, not just another promise."
  - "It is an easy process for both families and providers."

Challenges

- Facilitating agreement across multiple partners on one universal form, the package items and ensuring package items met HRS requirements.
- Navigating package deliveries for clients experiencing houselessness or housing insecurity; some packages were delivered to the clinic itself or sent to a participant's friend's house to ensure access to items.

Keys to success

- **Centering the member in all conversations**! When the group got stuck in the "how" we would recenter on the "why" this is important.
- **Incorporating the input of key partners and experts** in our region. Clear and consistent communication with key partners made this program successful.
- **Don't let perfection get in the way of "good enough for now."** After lengthy discussions about potential menu items, we decided to scale back, try it for six months, then refine and evaluate along the way.

Next steps

- Potential expansion of program and additional package concepts, including a Gender Affirming Care package and package to support youth in foster care.
- Identifying metrics for potentially measuring longer term health outcomes in the future.

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Streamlining HRS and HRSN Services: Enhancing Member and Provider Experiences

Cascade Health Alliance (CHA)

CHA's **streamlined approach** to **HRS and health-related social needs (HRSN) services** creates a seamless experience for members and providers, ensuring timely and equitable access to essential services. This approach includes:

- Creation of **pre-approved flexible services pathways** that are accessible when and where members need them.
- Implementation of a **"no wrong door" approach** to reduce the burden on members and providers navigating eligibility criteria.

Process details

We've worked on simplifying how members and providers navigate services. Here's what's worked for us:

- The **"no wrong door" approach** means members can access services through any community partner or provider without worrying about finding the "right" way in. This has taken a lot of the stress off both members and providers.
- We've created **pre-approved flexible services**, so members don't have to jump through as many hoops to get the help they need. For example, during extreme weather events, members can get climate control devices like air conditioning units without the lengthy approval process.
- To make the process even smoother, we removed barriers like **reducing paperwork** and **standardizing request forms** across HRS and HRSN programs.
- Behind the scenes, we're using **digital request forms** and **automated systems** to cut down on administrative hassle and make it easier for providers to get things done quickly.

Outcomes and Impacts

- **Efficiency improvements:** Processing times for requests have been reduced from **two weeks to three days**, and we've **completely eliminated incorrect form submissions**, which used to occur 30 percent of the time.
- Members have shared **positive feedback** with staff, noting how much smoother and more supportive the coordination process feels to them.

Challenges

Initially, providers were resistant. They found it tough to connect **clinical needs** with social determinants of health (SDOH) needs. There were two main struggles: 1) figuring out how to use the new forms and submission process, and 2) providing enough documentation to back up requests or explain the social need for services.

Keys to Success

Our success has come from **close collaboration** with community partners, clear and **ongoing communication** and offering **technical support** as needed. Getting **provider buy-in early on** made a huge difference and we've also focused on making sure members' experiences are as easy as possible, even though there's a lot going on behind the scenes.

Next Steps

We're planning to improve access by taking **tablets** to outreach events in rural and isolated rural communities. This will allow members to complete **SDOH screenings** on the spot and connect to services, ensuring people in even the most remote areas can get the help they need.

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Transitional Housing: Bridging the Gap

Jackson Care Connect (JCC); ACCESS

This **SHARE Transitional Bridge Bed program** is a partnership between JCC and ACCESS. It supports individuals and families who have identified housing or shelter and need a safe, stable place to stay while waiting for their plans to be finalized. During this transition, participants receive comprehensive case management to help navigate this critical time and ensure a smooth transition to obtaining and maintaining stable housing.

Why this program matters

- **Unique funding stream:** SHARE funding is a crucial financial resource that fills a gap where other resources fall short. This type of transitional housing programming hasn't been prioritized for funding opportunities through Oregon Housing & Community Services and the Governor's emergency order.
- **Immediate impact:** By providing transitional housing, we ensure individuals and families have an opportunity to succeed in reaching the next step in their housing journey.

Process details

- **Leveraging expertise:** The program's success relies on strong partnership between JCC and ACCESS. Each brings unique expertise to the table — JCC offers essential financial support, while ACCESS provides direct services and case management.
- **A year in the making:** This collaboration took a year of careful planning and relationship building. Together, we've created a program that addresses urgent housing needs and sets participants up for long-term success.

Outcomes and impacts

- Participants in the Bridging Program have an **80-85 percent exit rate into other housing or shelter options** (versus 13 percent for Jackson County emergency shelter system and 30 percent nationwide).
- SHARE program evaluation is ongoing to ultimately show the impact of transitional housing programming and encourage policymakers to develop cross-sector, collaborative solutions.

ACCESS success stories

- ACCESS worked with several partners to support an individual who had been unhoused, experienced sexual assault and trafficking and faced difficulty accessing shelter due to her disability. The Bridging Program provided her safe, accessible shelter with supports, ultimately finding her long-term housing.
- ACCESS received a referral from a local domestic violence service provider for a mother and her young children. The provider connected them to a housing voucher but couldn't find housing before their shelter stay was exhausted. The Bridging Program sheltered and supported them in finding a safe, stable home within a few weeks.

Challenges

- **Resource constraints:** Securing adequate, ongoing resources to meet the growing demand for transitional housing and continuity of services in Jackson County remains a challenge. Our primary goal is to get individuals into a safe, supportive space where their **health and well-being** are top priority, while behind the scenes we continue exploring creative ways to braid funding to support member-centered programming.
- **Complex coordination:** Ensuring seamless coordination between participants transitionally housed across multiple properties, case managers, care teams and housing authorities can be complex and time consuming.

Keys to success

- **Collaborative planning:** The success of this program is rooted in the collaborative efforts between JCC and ACCESS to adapt and respond to challenges as they arise.
- **Holistic support:** ACCESS uses a comprehensive plan beyond housing, including outreach, case management, landlord engagement, financial assistance, service support and community partnerships.
- **Participant-centered approach:** Every participants' journey is unique; housing is not a one-size-fits-all solution. Tailoring case management to meet individual needs ensures each person receives the support to achieve stable, long-term housing.

Next steps

Increase avenues to support members in need of medical respite post-hospital discharge, increasing the likelihood of gaining housing stability and improving health outcomes.

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A Collective Approach to Maximize Impact: Regional Housing Impact Fund

Columbia Pacific CCO

In 2020, Columbia Pacific CCO (CPCCO) established the **Regional Housing Impact Fund.** This is a collective approach and funding pool to address housing needs in Clatsop, Columbia and Tillamook counties:

- **More than $4.8 million** invested through the impact model itself since 2020, with investments designed to leverage and secure additional funding.
- **Leverages several funding sources,** including SHARE, HRS flexible services, HRS community benefit initiative and other sources, while collaborating with partners who address affordable housing like CareOregon, CCO risk share partners and hospitals that prioritize housing in their community health plans.
- **Supports housing and housing supports in key areas:** housing stock, houselessness services, housing supports, traditional health worker workforce and health-related social needs (HRSN) readiness.

Process details

CPCCO's strategy prioritizes region-identified needs and engages cross-sector partners to maximize impact:

- **Centers community voice**, working with community partners and Oregon Health Plan (OHP) members to understand the need and inform housing strategies; aligns with the Regional Health Improvement Plan's (2025–2029) continued prioritized topic of housing.
- **Engages cross-sector partners** to direct investments toward a coordinated regional approach to increasing and improving housing stock.
- **Invests in projects early** to help projects get started and attract other funding sources (first-in funding, predevelopment funding, site control, gap funding and capacity funding).

Outcomes and impacts

Since 2020, the Regional Housing Impact Fund approach has supported advancing housing stock, services and supports. Some highlights include:

- 318 units of new **affordable housing** and 20 units of **supportive housing** (SHARE)

- $87,943 in **hotel or motel vouchers** to shelter 68 OHP members in transition in 2023 (HRS)
- **Home improvements** (weatherization, safety quality) to 46 OHP members' homes (SHARE)
- Increased access to **no-barrier, congregate shelter** — serving 14–28 people per night — through staffing infrastructure improvements (SHARE)
- Development of eight **microshelters** and 40 **transitional housing units**

Challenges

- Accruing initial start-up funds for development of affordable housing.
- Navigating local zoning, land use requirements and public sentiment specific to each county often slowed down the process or prevented projects from starting.

Keys to success

- Teamwork from key leaders in each local area, key developers interested in building affordable housing and commitment from CPCCO leadership and board.
- Leveraging housing funding sources across sectors.
- Patience, a good sense of humor and taking the long view.

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InterCommunity Health Network CCO

Service Integration Teams (SIT) in the CCO Toolbox

InterCommunity Health Network (IHN) CCO; Samaritan Health Services Foundation

In 2023, IHN-CCO and Samaritan Health Services Foundation established a collaborative framework for coordinated resource and service delivery through the **Service Integration Team (SIT) model:**

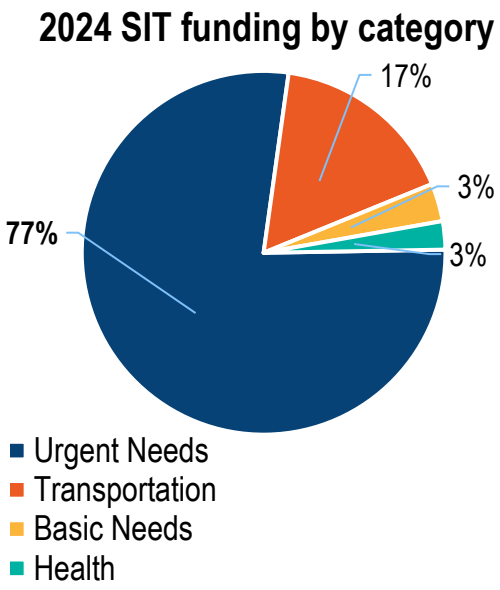
- Developed in Polk County nearly 30 years ago and adopted in many rural communities within Oregon.
- Connects identified community needs to a **network of 54 community and clinical partners** in East Linn County.
- Coordinates HRS and leveraged funding streams to address community needs.
- **$21,647.46** funded through **HRS CBI** for program administration in 2023.
- **$15,187.64** funded through August 2024 through **HRS flexible services** for costs of identified member needs.

Funding process details

- Available to all community members (Medicaid and non-Medicaid) of East Linn County to identify and fulfill unmet needs.
- If the team member is unable to fulfill the need themselves or through local community resources, funds are requested through the Service Integration Team:
  - Submitted via online request form through a partnering agency or advocate on behalf of community members and voted on by the committee for approval.
  - Funding is intended to meet a one-time need (up to $600) with a plan in place (though situation-dependent).
  - Approved funding requests are provided through HRS funds, supported by leveraged contributions from community organizations and distributed directly to an organization or business. Funds cannot be made payable to an individual or family member.

Outcomes and impacts

- In 2023, **44 households** were assisted through SIT (average of **$492** per household).
- In 2024, IHN-CCO invested **$15,974** along with **$5,363** leveraged funds, helping **39 households**.
- **77 percent** of funding in 2024 addressed **urgent needs**, such as rent and utilities.
- **69 percent** of households had at least one member enrolled in IHN-CCO.



Challenges

- **Delays in issuing urgent funding:** With 77 percent of requests in 2024 for urgent needs, a plan to distribute funds in a timely manner included creating expedited arrangements with accounts payable, promissory notes, access to credit cards and collaboration with SIT members who issue expeditious payments.
- **Ensuring SIT funds were used only as a last resort:** The SIT coordinator works with the SIT member to ensure all resources have been researched before submitting a funding request. Creating resource guides and encouraging member networking assists with this challenge.

Keys to success

- **Dedicated staff to carry the work forward:** Having a full-time coordinator to effectively manage and oversee the program is critical to success, ensuring smooth coordination, communicating consistently and driving objectives forward.
- **Robust community engagement and relationship-building:** Active outreach and engagement of diverse perspectives and resources are essential to expand the program's reach and enrich its overall impact. The SIT coordinator develops and maintains collaborative relationships with the public and partners; an example of this is the Property Managers' Appreciation event to thank local property managers.

Next steps

- Developing a website for SIT and actively engaging additional partners; anticipating an expansion of SIT to rural communities in Linn, Benton and Lincoln counties.

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Stepping Up to Be Better Funding Partners: Adventures in a Single-Entry Request for Proposals and Braiding Funds

Yamhill Community Care (YCCO)

In 2023, YCCO launched the innovative, single-entry funding model **Yamhill Community Care Community Grant Joint Funding Request for Proposals (RFP)** for investments in the social determinants of health and equity. This model creates equitable access to resources for community partners and demonstrates tangible impact in communities:

- Invested **$3.6 million** in **2024, braiding five funding streams:** SHARE, community health improvement plan – HRS (CHIP), early learning, traditional health worker training and certification, and Community Prevention and Wellness.
- Coordinated 2024 applicants with a **sixth funding stream** – community capacity building funds (CCBF).

> I have never evaluated every child in my centers before, and I found that it was very helpful in identifying children that need support earlier.

> The funding from YCCO was blended with other grants to sustain our program. We couldn't spend the funds as quickly as we anticipated and requested an extension for the grant period. The request was approved, and we appreciated the trust to continue using the funds into the next fiscal year.

Process details

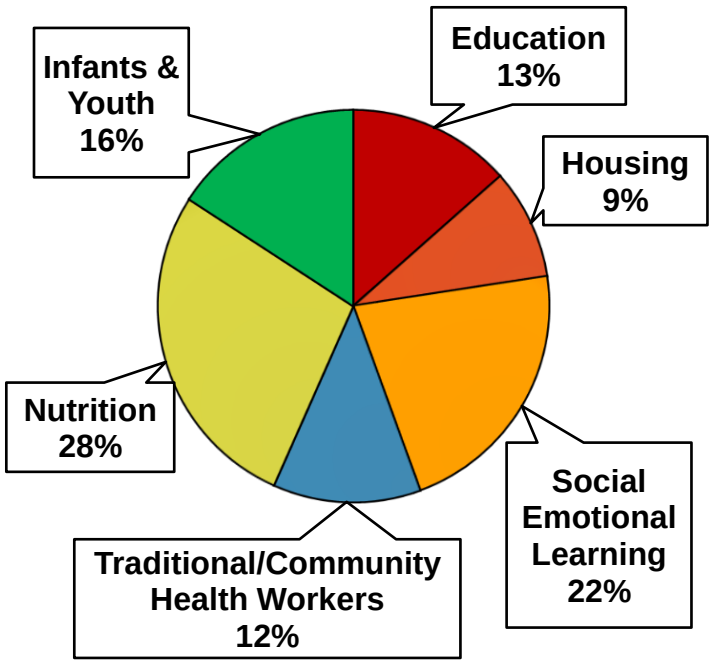
- **Single-entry, universal funding application** to support access, equity and efficiency. A working group of all internal funding program leads met for 12 months to combine and revise a common RFP and application.
- **High-touch application process**, offering webinars and Q&A with translation available, resources and a funding contact email to answer questions, alignment inquiries and technical assistance requests.
- **Multi-step review process:** 1) Staff initial review for funding stream alignment; 2) staff and external partner rubric review and scoring; 3) scoring compilation and review; 4) ranking and alignment with CHIP, community health assessment (CHA) and strategic plans; 5) community advisory council and Community Prevention & Wellness review; 6) board review and slate funding approval.
- **In-person site visits** have bolstered relationships, understanding of community work and opportunity for guidance to ensure complete, accurate reporting to best measure outcomes. YCCO staff offer technical assistance for report writing.

Outcomes and impacts

In summer 2024, YCCO **awarded funding to 27 local community-based organizations** through its Joint Multi-Tiered Community Funds and CCBF. Highlights of projects include:

- **Shared nutrition strategies: $714,371**
  Investments align closely with the CHA and Nutrition Oregon Campaign strategic plan to support goals for food pantry infrastructure, culturally specific foods, nutrition education and access.
- **Early learning case study: $18,000**
  Imagination Library in Yamhill County braided early learning hub funds with CHIP (HRS) funds to cover a larger population and ensure non-English language or bilingual books are distributed.

Funding by Sector



Challenges

- Navigating requirements and regulations of different funding sources.
- Communicating clearly with applicants to ensure combined application was simple and uncomplicated.
- Developing a fair evaluation process that was transparent, equitable and still flexible.

Keys to success

- Re-evaluate processes and evolve in response to feedback from community partners.
- Develop pathways for trust-based relationships with funding partners.
- Discover new ways to leverage separate-yet-related sources of funding for maximum program support.

Next steps

Continue to develop the fund, focusing future investments on identified needs: youth programs, nutrition, workforce development, suicide prevention programs and increased support for local Spanish-speaking and Tribal communities.

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