

Council

- Brad Porterfield, Chair,
Consumer Representative
Latino Community
Association
- Larry Kogovsek, Vice
Chair, Community
Representative
- Mayra Benitez
Consumer Representative
- Conor Carlsen
Consumer Representative
- Natalie Chavez
Jefferson County Health
Department
- Jolene Greene
Consumer Representative
- Linda Johnson
Community
Representative
- Elaine Knobbs-Seasholtz
Mosaic Medical
- Lauren Kustudick
Consumer Representative
- Tom Kuhn
Deschutes County
- Jennifer Little
Klamath County
- Theresa Olander
Consumer Representative
- Elizabeth Schmitt
Consumer Representative
- Mandee Seeley
Consumer Representative
- Ken Wilhelm
United Way
- Cris Woodard
Community
Representative
- Regina Sanchez
Crook County Health
Department



August 19, 2021

VIRTUAL

Video Conference Link In Calendar Invite

Conference Line: 1.669.900.6833

Meeting ID: 861.0355.0703#

Passcode: 492445#

- 12:00 – 12:20 **Welcome—Brad Porterfield**
- Public Comment
 - Approval of Meeting Minutes
- 12:20 – 1:10 **Community Health Projects Letters of Interest Decisions—
MaCayla Arsenault & Gwen Jones**
- 1:10 – 1:20 **Emerging Issues Process—Brad Porterfield**
- 1:20 – 1:30 **Flexible Services—Krtisten Tobias**

Five Finger Voting:

0: No go! Serious concerns

1: Serious reservations and prefer to resolve concerns before supporting it

2: Some concerns, but will go along with it

3: Support the idea

4: Strong support, but will not champion it

5: Absolutely, best idea ever, willing to champion it

“The overarching purpose of the CAC is to ensure the COHC remains responsive to consumer and community health needs.”—COHC CAC Charter

Overview of Process to Address Emerging Issues:

- 1) Issue Emerges
- 2) Gather Information
- 3) Review Information
- 4) Reflect
- 5) Decide
- 6) Act
- 7) Track and Monitor

Escalation Route



Step	Details	Tool
Gather Information	What is the issues? Is it within CAC Scope? What does the Grievance and Appeal data tell us? Who is impacted? What do their experiences tell us? Are they involved in CAC? Is there RHIP or other COHC work happening here?	CAC Charter Innovator Agent At A Glance Emerging Issues Tracker
Review Information	Is this long-term systemic issue? Does it need an immediate answer? Is it clinical? Treatment or preventative?	
Reflect	How does this line up with CAC values of equitable access, responsiveness to person's needs, consistent care	CAC Charter
Decide	Is there CAC consensus about if and/or how CAC should address this? Why or why not? What is the proposed next step? What other issues are inline to be addressed? Which should be handled first? Second?	Focused Conversation Five finger voting
Act	Who will complete the next step? By when?	Escalation Map Innovator Agent At A Glance
Track and Monitor	Set agenda reminder and report outs. Record and update status on Emerging Issue Tracker Repeat as needed as new information surfaces	Emerging Issue Tracker

CAC Emerging Issues Tracker

[illegible][illegible]

CHARTER: Central Oregon Health Council Community Advisory Council

The Community Advisory Council (CAC) is chartered by the Central Oregon Health Council (COHC) Board of Directors to advise and make recommendations to it on the strategic direction of the organization. The overarching purpose of the CAC is to ensure the COHC remains responsive to consumer and community health needs. The CAC is intended to enable consumers, which will comprise a majority of the CAC, to take an active role in improving their own health and that of their family and community members.

The CAC will provide guidance and feedback to the COHC in the following areas:

1. COHC Work Plan
2. Regional Health Improvement Plan
3. Regional Health Assessment
4. Development, implementation and evaluation of innovative initiatives, programs, services and activities

The CAC will assist the COHC through the following roles and activities:

1. Serve as a conduit for residents of each geographic area in the region to ask questions and raise concerns
2. Identify opportunities to improve population health in the Central Oregon region
3. Advocate for COHC preventive care practices
4. Maximize engagement of those enrolled in the Oregon Health Plan ("OHP")
5. Provide advice to help COHC link the community's medical and non-medical services to overcome barriers to health
6. Provide a link back to community constituents to aid in achieving the COHC Vision and Guiding Principles

Members of the CAC will be recruited to represent the diversity of the Central Oregon community and may include race/ethnicity, age, gender identity, sexual orientation, disability, and geographic location as a criteria for selection. CAC members should possess a collaborative working style, and provide expertise and insight in the areas of social services, public safety and community resources. Individuals with a broad community perspective on health matters will be preferred.

Innovator Agent At-A-Glance (June 2021)

External Relations, Oregon Health Authority (OHA)

Innovator Agent Role and Purpose:

SB 1580 required the Oregon Health Authority (OHA) to assign an Innovator Agent to work with each Coordinated Care Organization (CCO) as the single point of contact between the CCO and the authority. Innovator Agents work to advance local efforts with CCO's with a focus on health equity, Tribal relationships, behavioral health, integrating health and social determinates of health. The Innovator Agents also have a role in emerging statewide priorities such as the COVID 19 pandemic and Oregon wildfire response. Innovator Agents understand the health needs of the region, the strengths, and gaps of the health resources in the CCO. They share these needs and gaps to OHA to ensure statewide and local coordination. They also research at best practices for health care transformation and share innovative ideas at the local level. They prioritize elevating the Oregon Health Plan member's voice both within CCO operations and OHA.

Innovator Agents are able to support Community Advisory Councils (CACs) and the community with any questions that arise – individual member questions to systems and policy questions. Innovator Agents may engage other OHA contacts and departments to best answer a question or resolve an issue, but there is no issue or question too big or small to engage an Innovator Agent around. Particularly, if someone has reached out to others about something and not been able to get their question answered or issue resolved. In general, Innovator Agents' main objective is to ensure statewide and local coordination of resources and health care.

Community Input and Support At-A-Glance:

Type of Input	Brief Description	Example(s)	Primary OHA Contact(s)	Innovator Agent Role
Individual OHP Member or someone enrolling in OHP	A question or concern pertaining to one individual OHP member.	I was unable to access the transportation benefit. Where does someone go if they are having a hard	1)CCO Member Services: for accessing care or issues getting care; to file a complaint and/or grievance. 2)OHP Client Services: benefit questions or concerns; to file a complaint and/or grievance. 3)CPOP Team: for OHP enrollment support.	Advocate to make sure the issue is resolved. Liaison for complex issues between multiple parties. Strategic Problem Solver: identifying themes of individual issues for

		time enrolling in OHP?	4)Ombuds Program: if someone has completed the complaint, appeals and hearing steps and are not happy with how OHA or their CCO addressed their concerns, they can ask the OHA ombudsperson for help.	larger system-level issues/concerns. Engage stakeholders in problem solving discussions as necessary. Share best practices and innovations.
OHP Benefits	A question or concern about what is or is not covered by OHP.	<p>What is my coverage for?</p> <p>Why isn't "XYZ" covered?</p> <p>There is a gap in the community in terms of coverage for ____ under OHP. Who do I talk to about this?</p>	<p>1)Member Handbook: reference guide for all covered benefiss through OHP; how to file a grievance or appeal.</p> <p>2)CCO Member Services: understanding and accessing OHP benefits; to file a greivance or appeal.</p> <p>3)OHP Client Services: questions about what services OHP covers and does not cover, to file a greivance or appeal.</p> <p>4)Ombuds Program: if someone has completed the complaint, appeals and hearing steps and are not happy with how OHA or their CCO addressed their concerns, they can ask the OHA ombudsperson for help.</p> <p>5)HERC: ranks health care condition and treatment pairs in order of clinical effectiveness and cost-effectiveness. The HERC determines the OHP Prioritized List of Health Services.</p>	<p>Advocate to make sure the issue is resolved.</p> <p>Liaison for understanding member concerns.</p> <p>Strategic Problem Solver: identifying themes of benefit coverage and gaps. Engage keystakeholders in conversations about emerging themes and member input. Share best practices and innovations.</p>
Medicaid Operations	A logisital issue with Medicaid enrollment or other technical issues.	My information is incorrect on my medical record.	<p>1)CCO Member Services: understanding and accessing OHP benefits; to file a greivance or appeal.</p> <p>2)OHP Client Services: questions about what services OHP covers and does not cover, to file a greivance or appeal.</p> <p>3)CPOP Team: for OHP enrollment support.</p>	<p>Advocate to make sure the issue is resolved.</p> <p>Liaison for complex issues between multiple parties.</p>

		<p>I moved but my address is not updated.</p> <p>People I know say they are having difficulty with the ONE Eligibility system.</p>	<p>4)Ombuds Program: if someone has completed the complaint, appeals and hearing steps and are not happy with how OHA or their CCO addressed their concerns, they can ask the OHA ombudsperson for help.</p>	<p>Strategic Problem Solver: identifying themes of individual issues for larger system-level issues/concerns. Engage stakeholders in problem solving discussions as necessary. Share best practices and innovations.</p>
Community Member	<p>A question or concern from the community about any health or health care related topic.</p>	<p>What is the the SHARE Initiative?</p> <p>Why isn't everyone covered under OHP?</p> <p>What is OHA doing about the opioid crisis?</p>	<p>1)Subject matter expert: someone at OHA with specific and deep knowledge about a toipic, i.e. substance use disorder, diabetes, OHP benefits, health equity, etc.</p> <p>2)Innovator Agent: the person within OHA actively working with your local CCOs and CACs on health system transformation and health equity.</p>	<p>Listen to questions and concerns.</p> <p>Advocate for community member voices.</p> <p>Strategic Problem Solver: identifying themes of individual issues for larger system-level issues/concerns. Engage stakeholders in problem solving discussions as necessary. Share best practices and innovations.</p>
Community Advisory Council (CAC)	<p>A question or concern from a CAC member</p>	<p>We need guidance from OHA on ABC topic ...</p>	<p>1)Subject matter expert: someone at OHA with specific and deep knowledge about a toipic, i.e. substance use disorder, diabetes, OHP benefits, health equity, etc.</p>	<p>Listen to questions and concerns.</p>

		Is there any technical assistance offered around addressing housing as a social determinant of health?	2)Innovator Agent: the person within OHA actively working with your local CCOs and CACs on health system transformation and health equity.	<p>Advocate for CAC member voices.</p> <p>Strategic Problem Solver: identifying themes of individual issues for larger system-level issues/concerns. Engage stakeholders in problem solving discussions as necessary. Share best practices and innovations. Bring forward technical assistance and other resources to support the work of the CAC. Share information with the CAC proactively on upcoming learning opportunities and other resources.</p>
System-level	Questions that involve and or impact the larger health care system in Oregon.	<p>There is a shortage of Behavioral Health providers in Oregon. How are we dealing with this as a state?</p> <p>Implementing a statewide health</p>	<p>1)Subject matter expert: someone at OHA with specific and deep knowledge about a toipic, i.e. substance use disorder, diabetes, OHP benefits, etc.</p> <p>2)Innovator Agent: the person within OHA actively working with your local CCOs and CACs on health system transformation and health equity.</p>	<p>Listen to questions and concerns.</p> <p>Advocate for community member voices.</p> <p>Strategic Problem Solver: identifying themes of individual issues for larger system-level issues/concerns. Engage stakeholders in problem solving discussions as</p>

		information exchange is a best practice implemented in other states. What is Oregon's solution for sharing health information?		necessary. Share best practices and innovations. Share information with the CCO, Board and CAC on system-level initiatives and opportunities.
OHA Policy	Questions about internal OHA policies.	<p>What is the deadline for "ABC" required deliverable?</p> <p>I have a question about something outlined as part of the required health equity plan.</p>	<p>1)Health Systems Division at OHA to discuss contract deliverables, requirements and deliverables.</p> <p>2)Subject matter expert: someone at OHA with specific and deep knowledge about a topic, i.e. substance use disorder, diabetes, OHP benefits, health equity, etc. The Transformation Center and Office of Equity and Inclusion are also resources for specific technical assistance on health care transformation and health equity topics and requirements.</p> <p>3)Innovator Agent: the person within OHA actively working with your local CCOs and CACs on health system transformation and health equity.</p>	<p>Listen to questions and concerns.</p> <p>Advocate for community member voices.</p> <p>Strategic Problem Solver: identifying themes of individual issues for larger system-level issues/concerns. Engage stakeholders in problem solving discussions as necessary. Share best practices and innovations. Share information on OHA policy changes and considerations with the CCO, Board and CAC.</p>

Statewide Policy	Questions about Oregon statewide policies and legislation	Statewide legislation CCO Quality Metrics 1115 Medicaid Waiver	<p>1)Subject matter expert: someone at OHA with specific and deep knowledge about a topic, i.e. Medicaid, quality and metrics, emerging legislation, REALD data, etc.</p> <p>2)Government Relations can also be a resource for technical assistance on statewide policies and legislation.</p> <p>3)Innovator Agent: the person within OHA actively working with your local CCOs and CACs on health system transformation and health equity.</p>	<p>Listen to questions and concerns.</p> <p>Advocate for community member voices.</p> <p>Strategic Problem Solver: identifying themes of individual issues for larger system-level issues/concerns. Engage stakeholders in problem solving discussions as necessary. Share best practices and innovations. Share information on statewide policy changes and considerations with the CCO, Board and CAC.</p>
-------------------------	---	--	--	--

Resources and Contact Information:

- [CCO Contact Information](#)
- [OHP Client Services](#)
- [OHA CPOP Program](#)
- [OHA Ombuds Program](#)
- [OHA Health Systems Division](#)
- [OHA Transformation Center](#)
- [OHA Government Relations](#)
- [OHA Office of Equity and Inclusion](#)
- [Oregon HERC](#)

Abbreviations:

OHA = Oregon Health Authority

OHP = Oregon Health Plan

CCO = Coordinated Care Organization

CAC = Community Advisory Council

CPOP = Community Partner and Outreach Program

HERC = Oregon Health Evidence Review Commission

REALD = Race, Ethnicity, Language, and Disability

2020 Community Health Projects

Progress Report

June, 2021

Friends of the Children-Central Oregon

Latest Report Submitted 5/3/2021

Supporting Under-Served Children & Their Families through the Pandemic

Adapting the paid, professional mentoring program that Friends of the Children provides to serve families' unique needs during the pandemic. This includes supplying families with food, assisting payment for phone and internet, and launching a remote mentoring program.

Objective Progress	Status	Timeline on track?	Yes
By 12/30/2020, FOTCCO will ensure that each of our youth (48) and their Friends (6) have the devices, virtual connection capacities, and support frameworks necessary to continue working together remotely.	Complete		
By August 2021, assess the need of family members, to inform the development of a social worker position description, and begin the recruitment process. This will help FOTCCO expand our service model to become a 2Gen site by 2022.	In Progress	Estimated Completion Date	12/31/2021
By 10/31/2020, we will launch a pilot of a new LMS developed by nationally recognized researchers & leaders using the principles of Empowerment Evaluation (e.g. community ownership and inclusion), in preparation for full launch in the spring of 2021	In Progress	Encountering Challenges?	No
By June 2021, FOTCCO will complement the new Learning Management System with a supported accountability app specifically created for youth.	In Progress	Next Report Due	12/13/2021

Grantee Comments

This project has taught us patience and perseverance, implementing technology supports while youth are engaged in online learning has been a great challenge. Our number one value is put children first, when we keep that value at the core of our work, we are required to constantly challenged to pivot. ex: implementing an app when youth already spend too much time on devices. The biggest take away of our data collection is that we need a Caregiver support person as soon as possible, the pandemic has caused many stressors on parents which has a downward trickle affect our their children. Seeking resources for caregivers has been at the core of our work this year.

Mosaic Medical

Latest Report Submitted 4/4/2021

Improving Communication and Language Access Services for Mosaic Medical Patients

Purchasing communication kits and devices with accessories and software to implement remote video interpretation services (for spoken and signed languages) at eight Mosaic Medical locations in Central Oregon.

Objective Progress	Status	Timeline on track?	Yes
Beginning December 1, 2020, 100% of patients who cannot hear well will be offered pocket talkers as a tool to support communication during their visit to all Mosaic family practice clinics.	In Progress		
By December 1, 2020 Mosaic will deploy document magnifiers to be used by over 500 patients.	Complete	Estimated Completion Date	10/31/2021
By 02.2021, select the vendor to enable video remote interpreting. By 04.2021, purchase two dedicated devices and test internet bandwidth. By 10.2021, train care teams for the systems. By 06.2022, purchase as many devices as need determines.	In Progress	Encountering Challenges?	No
Mosaic will create and translate letters and flyers in the next five languages of preference that explain access and rights to interpreting services at our clinics. These will be mailed to patients and posted in our community by October 1, 2021.	In Progress		
By October 2021, launch a patient survey for 100% of patients who access video interpretation services at family practice clinics. Aggregate results of this survey will be shared in the final project report (10.2022)	In Progress	Next Report Due	11/1/2021

Grantee Comments

{none}

Mountain Star Family Relief Nursery

Latest Report Submitted 4/1/2021

Early Childhood Literacy Project

Adding a preschool program in Madras and Prineville will focus on increasing access to high-quality early care and education for historically underserved children and their families. This project's focus is on children's early childhood development, social-emotional development, health, literacy, and school readiness to ensure they are cognitively, physically, socially, and emotionally ready for kindergarten.

Objective Progress	Status	Timeline on track?	Yes
By August 31, 2021, 5-year old children in each of our three preschool classrooms will attain the following (average) capital letter recognition: Crook (Prineville) – 13.1 letters; Deschutes (Bend) – 13.4 letters; Jefferson (Madras) – 10.4 letters.	In Progress	Estimated Completion Date	8/31/2021
By August 2021, 85% of enrolled children will meet or exceed widely held expectations for upper case letter recognition: age 0-2 years (up to 1 letter); age 2-3 years (1-4 letters); age 3-4 years (2-10 letters); age 4-5 years (5-26 letters).	In Progress	Encountering Challenges?	Yes*
By August 31, 2021, 85% of enrolled children will meet or exceed widely held expectations in literacy development.	In Progress		
By August 31, 2021, the number of enrolled families who report reading with their children for 15 minutes or more, four or more days a week will increase by 10%.	In Progress	Next Report Due	10/7/2021

2020 Community Health Projects

June, 2021

Progress Report

Grantee Comments

*Due to the increase in COVID-19 cases in Central Oregon last fall/winter, we have had to move programs from full-time to hybrid (half the regular number of class days) and even to all virtual services for a short time. This interrupted the learning for some children, and has potentially decreased the overall learning for this school year. We also have not been able to complete our regular in-home home visits with families, which has made direct communication regarding literacy difficult. We are looking forward to moving back into regular services this spring as local case numbers decrease and our staff get vaccinated. We hope to be able to "catch up" on some of this lost class time and opportunities for learning, and continue to encourage early literacy among our families. In line with MountainStar's mission, we strive to help reduce stressors in the lives of the families we serve, however the ongoing crisis of living in the midst of the pandemic means that "reading to my children for 15 minutes every day" can be low on a parent's list of priorities. We have attempted to maintain regular connections with families through front porch/yard home visits, phone calls, and video/virtual meetings. It is not yet clear if our education efforts will help increase the time/frequency of caregivers reading to their children at home. We delivered at-home learning activities (along with food boxes and other basic needs supports) during virtual and hybrid services. "Family night" learning events with local librarians were hosted virtually, with dinner delivered earlier in the day to help enable families to participate in the event. MountainStar staff (instead of local librarians) handed out book donations to each child.

Crook County Health Department

Latest Report Submitted 6/17/2021

Improving Access to the Diabetes Prevention Program for Underserved Populations

Supporting the Diabetes Prevention Program, a 16-week cohort designed for individuals diagnosed with prediabetes who may avoid a diagnosis of type 2 diabetes through changes in their diet and exercise. This will be achieved through marketing, training trainers, and sustainability planning.

Objective Progress	Status	Timeline on track?	Yes
By January 31st, 2021, enroll 10 Oregon Health Plan participants in the Diabetes Prevention Program (DPP) in Crook County.	In Progress	Estimated Completion Date	12/31/2021
Between October 31st, 2020, and January 31st, 2021, generate 15 referrals of OHP clients to the Diabetes Prevention Program (DPP) from health-care providers in Crook County.	In Progress	Encountering Challenges?	Yes*
By June 2021, identify at least two champions in Jefferson County for DPP delivery, with at least one champion will be able to deliver the program in Spanish.	Complete	Next Report Due	2/14/2022
From January of 2021-December of 2021, conduct a virtual DPP cohort with 10 OHP participants enrolled, making tablets, electronic fitness trackers, and wifi capabilities available for each.	In Progress		
By December 31st, 2020, interview 25 people in Crook County that are OHP eligible regarding DPP and barriers to participation.	Withdrawn		

Grantee Comments

*One of our objectives was to work with Quon Design and Communication to interview 25 OHP eligible people in Crook County about DPP and barriers to participation by December 31st, 2021. This was a timeline error on our part. If we would have tried to complete this objective, there wouldn't have been time to create a marketing strategy that could be launched to recruit participants for a January start date. As an alternative we conducted a visioning session and included participants from the target audience. We also shared the proposed marketing graphics through email with several individuals who fit the target age to get their feedback on which themes resonated with them.

*Provider referrals continue to be a challenge. One provider at Mosaic Medical referred patients using the electronic referrals we have set up. I have been working on other strategies to increase the referrals for the July Cohort. I have met with representatives from St. Charles who said they would start to use the Unite Us platform to refer, and I plan on setting meetings with providers over the next month to get the upcoming class and the referral options on their radar.

Lifetime Vision Care

Latest Report Submitted 3/15/2021

Vision and Learning

Provide rehabilitative services for children and adults in the form of vision therapy that would ultimately affect success in school, work, and life. Lifetime Vision Care would provide these services either at no cost or ½ cost to patients who would otherwise not be able to afford it.

Objective Progress	Status	Timeline on track?	Yes
From September 2020 - September 2021, provide either 12, 6-week vision therapy programs at no cost, or 24, 6-week programs at 1/2 cost to income-eligible patients. The option of free or 1/2 cost will be based on patient budgets. #'s will be reported	In Progress	Estimated Completion Date	9/30/2021
By September 2020, before the program begins, determine income eligibility based on cost and available funds, income determination either fully or partially funded, and sliding scale.	Complete	Encountering Challenges?	No
Aggregate the post-program completion evaluations through 9.30.2021, and report results within the final project report.	In Progress	Next Report Due	11/15/2021

Grantee Comments

We and our eligible patients are very appreciative of the access to this service that wouldn't otherwise be available to them. Results are yielding patients with higher confidence with visual skills necessary for scholastic achievement as well as life skills.

Boys & Girls Clubs of Bend

Latest Report Submitted 3/2/2021

Education & Social-Emotional Support for Low-Income Youth

Create stability and build resilience in school-aged youth and parents who are disproportionately affected by the health and economic impacts of COVID-19 and school closure. This will be achieved by providing academic, social, and emotional support in a safe environment by waiving program fees, providing homework help, tutoring, and supporting distance learning.

2020 Community Health Projects

June, 2021

Progress Report

Objective Progress	Status	Timeline on track?	Yes
Between September 14, 2020 and June 18, 2021, Boys & Girls Clubs of Bend will waive \$400 of program fees on average per youth per month for at least 100 income-eligible youth, ages 6-18 in Deschutes County.	In Progress	Estimated Completion Date	6/18/2021
Between September 14, 2020 and June 18, 2021, Boys & Girls Clubs of Bend will support distance learning for 36 Middle and High School youth who are economically disadvantaged, with a goal of 100% on-time grade progression and 100% graduation rate.	Complete	Encountering Challenges?	Yes*
Between September 14, 2020 and June 18, 2021, Boys & Girls Clubs of Bend will conduct high yield learning activities and provide homework help, tutoring, and support for distance learning for 95 elementary-aged youth.	Complete	Next Report Due	8/2/2021
Grantee Comments			
<p>*Many of our youth returned to in-person learning this month. We saw a reduction in enrollment once school began, due mainly to our families wanting to reduce multiple exposures between school cohorts and our Club cohorts.</p> <p>We have changed our program schedule to dovetail with new school schedules, providing 5 days of after school programming for youth in grades K-3 and full day programming for youth in grades 4-12. We originally anticipated being able to increase our enrollment numbers with a transition to a hybrid school schedule, but guidelines from the Oregon Health Authority prevented that expansion.</p>			

Central Oregon Environmental Center

Latest Report Submitted 6/7/2021

Garden for Every School program

Improve science education resources, student nutrition, and environmental literacy outcomes in students at area school districts. The Garden for Every School program uses three key strategies, offering "Educator Assistance", delivering "Garden Lessons", and maintaining a "Learning and Demonstration Garden", to provide comprehensive support for schools to create, sustain, and integrate gardens.

Objective Progress	Status	Timeline on track?	Yes
Year 1 – 140 Students on track to receive 10+ hours of garden lessons in 2021/22 Year 2 – 200+ students receive 10+ hours of garden lessons/school year Year 3 – 200+ students receive 10+ hours of garden lessons /school year	In Progress	Estimated Completion Date	12/31/2023
Number of Students engaged with cafeteria tastings at schools and summer lunch sites. Year 1 – 100 - 1,000 (depending on COVID-19 impacts) Year 2 – 1,000+ Year 3 – 1,000+ -Numbers may vary based on total student populations at schools.	In Progress	Encountering Challenges?	Yes*
At each school where our staff work, staff will engage wellness committees to gauge the school's culture of health. • Year 1 – 3 schools or programs • Year 2 – 4 schools or programs • Year 3 – 4 schools or programs	In Progress	Next Report Due	2/1/2022
Numbers may vary based on schools served each year. Year 1 – 200 – 300 kids (COVID- 19 contingency plan is virtual/video visits) Year 2 – 200 – 300 kids attending Year 3 – 200 – 300 kids attending	In Progress		
COVID-19 may impact access to gardens in spring 2021, projections may vary accordingly. # of kids accessing gardens currently or previously funded across Central Oregon: Year 1 – 1,000+ Year 2 – 1,500+ Year 3 – 2,000+	In Progress		
Year 1 – 48 garden-based lessons Year 2 – 96 garden-based lessons Year 3 – 96 garden-based lessons	In Progress		

Grantee Comments

*COVID-19 continues to make planning a challenge. Administrative staff are burdened with constantly changing guidelines, as are educators. This reality makes communications challenging, and also creates barriers to scheduling time with students. Field trips this spring were not a possibility and it's unclear when they will be possible again; hopefully this fall. We will continue to make videos and zoom calls to keep students connected to our learning garden and/or Sakari farms.

Also, in fall 2020 (prior to the start of this grant funding timeline) our FoodCorps service member resigned due to personal challenges related to COVID-19. This impacted our ability to accomplish as much as planned in Spring 2021. The hiring process for a new FoodCorps service member is currently under way.

Healing Reins Therapeutic Riding Center

Latest Report Submitted 6/6/2021

"Stay in the Saddle" Scholarship Program

Provide 5400 scholarship hours of ongoing weekly Therapeutic Horsemanship lessons to 90 individuals of all ages with varying disabilities amidst the ongoing COVID19 pandemic. The goal is to partner with schools to teach equine assisted life skills including: teaching work ethic, relationship development and camaraderie. This program will also assist participants recovering from substance abuse issues to develop strong coping mechanisms.

Objective Progress	Status	Timeline on track?	Yes
--------------------	--------	--------------------	-----

2020 Community Health Projects

June, 2021

Progress Report

Between January 2021 and December 2021, Healing Reins will provide 5400 scholarship hours of ongoing weekly scholarship support to 90 participants.	In Progress
Between January 2021 and December 2021, a minimum of 20 participants will attend our Therapeutic Horsemanship program to assist in their educational IEP plan or 504 plans for physical or behavioral therapy related goals and requirements.	In Progress
From January to December 2021, a minimum of 40 participants will attend our Therapeutic Horsemanship program to earn Physical Education credits towards their educational goals.	In Progress
From January - December 2021, a minimum of 65% of participants from our substance abuse recovery partner programs will develop one new coping skill per eight week session through their participation in Therapeutic Horsemanship programs.	In Progress

Estimated Completion Date	12/31/2021
Encountering Challenges?	Yes*
Next Report Due	2/14/2022

Grantee Comments

*We have encountered challenges in facilitating our SMART Objective #3 in relation to providing 40 participants with the ability to earn PE credits towards their educational goals. Bend-La Pine schools started the 2020-2021 school year with Distance Learning shortly after we submitted our grant request to COHC. We have contacted Bend-La Pine's Athletic Director, Dave Williams, as well as Jessica Anderson who works in adaptive physical education for the district. While there was great interest from both parties in partnering with Healing Reins to offer school PE credits, they did not have enough staffing resources during the pandemic to implement such a program in the 2020-2021 school year.

We are continuing discussions with Dave and Jessica in order to offer this service as an alternative option for students who may not be returning to the classroom due to family preference in September of 2021 or who are still behind in PE credits.

The learning gap is going to be an issue for many years even after all COVID19 restrictions have been lifted. Even though limited resources prevented us from offering this option as quickly as we would have liked, we will continue to work with Bend-La Pine and other schools and school districts to offer PE credits.

As an equine assisted therapy and learning center, Healing Reins provides a social and physical outlet for school aged children. While many after school programs are just beginning to re-open now, we have been able to provide 161 school aged children a physical outlet throughout the pandemic.

Outside of the Bend-La Pine district, we have been able to offer New Leaf Academy students horsemanship as a PE elective. Students attend horsemanship and can earn 10 points total for the day: 2 points for being on time and prepared and 8 points for participation.

With the funding support of this COHC grant, Healing Reins has been able to return to its pre-COVID19 service and scholarship levels, while still operating under COVID19 restrictions, and with expanding our services to replace lost school-based programs! We know that the project has been successful. We will continue to use the tools described in the Evaluation section of our original application to evaluate the success of the program. These tools have assisted in a summative evaluation to help adjust the needs of the program now, at the halfway point, and will assist us in developing a formative assessment to report the successes of the Stay In The Saddle scholarship program. We will inform COHC of the continued success of the program by completing the required reports at the conclusion of the grant period.

Jefferson County Public Health

Latest Report Submitted 5/3/2021

Jefferson County Syringe Exchange Program

Utilize public health staff to provide clean, sterile syringes, sharps collection containers, fentanyl test strips, naloxone to intravenous drug users, and any other individual that seeks the services on a drop-in basis at the Jefferson County Public Health building. This program will also provide opportunities to educate first responders and community members and provide supplies, such as Narcan, that is used for the complete or partial reversal of opioid overdoses.

Objective Progress	Status
By December 15th, 2020, the first 3 months' worth of supplies, as identified in the budget, will be purchased and stored at Jefferson County Public Health in order to implement the program.	In Progress
By February 1st, 2021, the syringe exchange staff will receive all training necessary to implement the program including safe transactions of used syringes and naloxone.	Complete
By January 1st, 2021, all clinics, treatment providers, the hospital, and homeless outreach agencies in Jefferson County will be informed of the program and how to access services, and at least one partner will install a drop box at their building.	In Progress
Between March 1st, 2021 through November 1st, 2022, JCPH will provide services by installing a 24/7 dropbox, accepting walk-ins for syringe and naloxone kits, and offering education and referrals to internal and external services.	In Progress
By February 1st, 2021, establish a method for collecting and analyzing anonymous information on services provided to the community.	In Progress
By January 31st, 2022, use data collected and community support to advocate for ongoing funding through the Board of County Commissioners and other potential funders.	In Progress

Timeline on track?	No
Estimated Completion Date	10/1/2022
Encountering Challenges?	Yes*
Next Report Due	12/7/2021

Grantee Comments

*Due to COVID-19, we have not been able to fully commit clinic operational hours due to our clinic staff supporting COVID-19 testing/vaccine clinics. We are still drafting our official Harm Reduction program policy but need clinic staff input to complete the policy. Warm Springs Prevention which has agreed to support the new program has not been available due to COVID-19. This impacts our ability to coordinate and purchase the large syringe drop bin and location for Warm Springs. With current and ongoing COVID-19 guidelines in place, we have not been able to complete the community assessment survey that can help decision-makers understand the need for a Harm Reduction Program (with the Syringe Exchange Program).

Thank you for your continued support as we continue to provide COVID-19 response here in Jefferson County.

2020 Community Health Projects

June, 2021

Progress Report

Cascade Peer and Self-Help Center		Latest Report Submitted 4/28/2021	
Cascade Peer and Self-Help Center Accessibility			
Having access to more computers and online services will be an important addition to the CPASHC program to enhance the well being and mental health of their clients. An additional 5 computers will create more availability allowing the staff to assist clients in searching for resources, helping with applications, and accessing educational material.			
Objective Progress	Status	Timeline on track?	Yes
From November 1, 2020 through October 30, 2021 10 additional uses of the computer by clients and assisted by staff will occur each week.	In Progress	Estimated Completion Date	10/29/2021
From November 1, 2020, through October 30, 2021, through staff observation and client reports, 8 clients will become more independent and skilled in their use of the computer for the purpose of connecting with community resources.	In Progress	Encountering Challenges?	No
		Next Report Due	12/13/2021
Grantee Comments			
{none}			

Central Oregon Pediatric Associates		Latest Report Submitted 6/17/2021	
Integrating Community Health Workers (CHW) into Pediatric Primary Care to Improve Health Equity			
COPA will recruit and hire a CHW to join the COPA Redmond clinic care team whose role will be to collaborate between primary care, public health, and community organizations. The CHW will assist pediatric patients and families attain optimum health and well-being through health education, screening for SDoH, coordination, and navigation to appropriate community resources.			
Objective Progress	Status	Timeline on track?	No
By October 1, 2020, COPA will recruit and hire a CHW to join the COPA Redmond clinic care team.	Completed	Estimated Completion Date	9/30/2021
By October 31, 2020, a CHW will be trained to internal business processes, SDoH screening tools, and community resources. The training will align with the Oregon Community Health Workers Association (OCHWA) professional curriculum and standards.	Completed	Encountering Challenges?	Yes*
By September 30, 2021, COPA Redmond CHW will screen 20% of the patients seen in the Redmond Clinic using the HRSN SDoH screening tool.	In Progress	Next Report Due	11/15/2021
By September 30, 2021, the COPA Redmond CHW program will report the total number of screening and navigations to appropriate community resources.	In Progress		
By September 30, 2021, patients and families will experience improved satisfaction and experience at the COPA Redmond Clinic, as evidenced by a 2% increase in the COPA Redmond CAHPS Overall Provider Rating score to 93.4%	In Progress		
Grantee Comments			
<p>*1. Recruitment and hiring for the CHW position during a pandemic. In September 2020, we filled the position but the candidate changed their mind due to it being an in-person role in the Redmond Clinic. In December 2020, we recruited and filled the position for the second time, but the candidate decided to not relocate to Central Oregon during the pandemic. The current CHW started at COPA on 2/22/2021.</p> <p>2. COPA requested to not have to learn 2 systems and asked that we work with Unite Us/Connect Oregon directly and have AHC and Unite Us/Connect Oregon work together to share data. This required us to establish new and additional Business Associate Agreements (BAA) between Connect Oregon and AHC so that we can share screening information appropriately. New BAA is in pending status with Connect Oregon and until this is completed we are unable to report screening data to AHC.</p> <p>3. CHW priority patient/family identification process is not efficient. COPA Redmond Clinic sees between 250-300 patients per week. Knowing that the CHW is unable to make contact with all patients, it is a challenge to identify high priority patients that the CHW should connect with each day. Having existing social complexity data on our patients would greatly improve this process and this is something that we do not currently have in our system.</p>			

Volunteers in Medicine Clinic of the Cascades		Latest Report Submitted 4/2/2021	
Telehealth Diabetes Education: Addressing Physical Health For Low-income Latino Families			
Empower 36 low-income Latinos who are diabetic or pre-diabetic to make lifestyle and diet choices leading to documented health improvements, and build a replicable model to engage patients in making their own decisions to support whole-family health. VIM will implement a diabetes education, coaching, and assessment program through virtual connections in one-on-one sessions.			
Objective Progress	Status	Timeline on track?	Yes
Between October 1, 2020 and September 30, 2022 VIM will provide eight-week diabetes education and coaching sessions and three follow ups via individual phone or video contact for 36 patients.	In Progress	Estimated Completion Date	9/30/2022
100% of patients who participate will receive a weekly grocery gift card of \$25 for each session, for a maximum of \$275, with food planning prior to issuance and follow up the next week on patient success.	In Progress	Encountering Challenges?	Yes*
In October and November 2020, VIM will update the attached preliminary Diabetes Self Management Matrix, and from December 2020 to September 2022 VIM will refine the model based on patient surveys, qualitative assessment, A1c levels.	In Progress	Next Report Due	11/1/2021
VIM will measure A1c levels at least annually for prediabetic patients, every six months for diabetic patients, and every three months of patients with high A1c.	In Progress		

2020 Community Health Projects

June, 2021

Progress Report

Grantee Comments

*The biggest challenge by far has been retrieving certain data from our Epic electronic medical records system. We completed our Epic installation in January 2020 with plans to implement population-based reporting, alerts, and flow charts during the year. However, the entire organization shifted to the pandemic response in March.

The challenge with data retrieval is that reporting is typically based on either insurance billing codes or clinical trial enrollment. VIM neither receives reimbursements nor conducts clinical trials, so we do not have that coding in place. The impacts are that we have not been able to track A1c levels and statin usage among diabetic patients (as proposed for this grant), and some metrics include duplicated patient counts.

Our next step is to add the Reliance data reporting system that our partner, St. Charles Health System (SCHS), already has in place. This reporting system has a diabetic module. Medical Director John Letovsky, MD has enlisted a new volunteer nurse from Oregon Health & Science University (OHSU) who recently moved to Bend. She is deeply versed in Epic reporting and is engaged in preliminary research on the available report formats and templates. Because custom reports are complex to produce in Epic and may require rewrites with system upgrades, we are looking for existing reports that can be modified to meet the reporting needs of free clinics like VIM.

REACH OUT NP

Latest Report Submitted 6/11/2021

Outreach Support

Enhance the stability and well being of some of the most vulnerable members of our community by providing services necessary to help them achieve new levels of self-sufficiency and health. This includes providing outreach to 500 individuals/families struggling with poverty, providing medical referrals to 144 individuals, providing referrals/access to housing support to 120 people/families, and providing resources and referrals to 180 individuals seeking mental health support.

Objective Progress

Status

Between January, 2021 - December 2021, REACH will provide outreach to 500 individuals/families struggling with poverty to connect them with resources, such as cell phones, solar charges and minutes to address poverty and increase self-sufficiency.

Between January, 2021 and December, 2021, REACH will provide medical referrals to 144 individuals that will provide needed medical care and prescription assistance.

Between January, 2021 and December, 2021, REACH will provide 120 referrals/access to housing support partners, motel rooms and shelter programs for 120 people/families.

Between January, 2021 and December, 2021, REACH will provide resources and referrals to 180 individuals seeking mental health support, addiction recovery programs or bus tickets to family that can provide a stable living environment

By 12.31.2021, add 20 new partnerships and schedule 12 presentations in-person or via Zoom.

In Progress

In Progress

In Progress

In Progress

In Progress

Timeline on track?	Yes
Estimated Completion Date	12/31/2021
Encountering Challenges?	No
Next Report Due	1/17/2022

Grantee Comments

In the past year REACH has started 2 new programs, Safe Parking known as Safe Haven and a Clean up project called Clean Start. Safe Haven provides a safe place for someone living in a vehicle to park and call home. Intakes are completed, guidelines signed and in partnership with local churches and/or other agencies people can park in the their lot. REACH provides case management, oversight, on site bathrooms and hand washing station as well as client assistance for daily essential needs. We have had 12 guests to date, 5 have moved to permanent housing, 2 moved out of the area and we are continuing to work with the remaining people as they move to greater independence and self sufficiency. Clean Start is supported by the BottleDrop to provide opportunities for our unhoused community members to provide street clean up in the Central District. The program provides gift card assistance, letters of recommendation and can account for court ordered community service.

Thrive Central Oregon

Latest Report Submitted 4/12/2021

Thrive Central Oregon- COVID support

Adding a temporary COVID support specialist will provide permanent housing and resource support services to 500 COVID-19 impacted households within Central Oregon, including North Klamath and the Confederated Tribes of Warm Springs. This project is intended to benefit individuals and families who are marginalized, homeless, or at-risk of becoming homeless by meeting the needs of housing and economic stability.

Objective Progress

Status

By June 30, 2021, this position will link 500 unique individuals impacted by COVID-19 to the specific housing, unemployment, and resources they seek.

By June 30, 2021, we will educate 100% of households (N=500) regarding their housing, legal, and employment rights. Disseminating materials in conjunction with Legal Aid Services of Oregon, as appropriate.

In Progress

In Progress

Timeline on track?	Yes
Estimated Completion Date	6/30/2021
Encountering Challenges?	No
Next Report Due	8/3/2021

Grantee Comments

Thank you for helping us to leverage rent and mortgage assistance to create a longer lasting impact in our community.

DAWNS House

Latest Report Submitted 5/12/2021

Transitions Program

Provide access to healthy stable housing to participants in the "Transitions Program" by partnering with private market rental agencies, property owners, COAR, and HUD Workforce housing to reduce the cycle of poverty, homelessness, addiction and criminality. All eligible residents will also be enrolled in OHP, have an established PCP, and a dentist.

2020 Community Health Projects

June, 2021

Progress Report

Objective Progress	Status	Timeline on track?	Yes
From October 2020 thru Dec. 2021 DAWNS House will gain 10-15 strong partnerships with private market rental agencies/property owners/COAR/HUD Workforce housing.	In Progress	Estimated Completion Date	12/15/2021
From 1.1.2021 to 12.31.2021, we will accept 30 female felons into our Dean Swift home as participants in the "Transitions Program", with a minimum 14 successfully completing the program.	In Progress	Encountering Challenges?	Yes*
By Dec. 2021 100% of eligible residents will be enrolled in OHP, have an established PCP, and a dentist.	In Progress	Next Report Due	1/17/2022

Grantee Comments

*As we all know in the last year rental prices have inflated tremendously, this has made it difficult to find housing the women can afford, this is very frustrating because we set out to crush the barrier of felons gaining access to housing and we have done just that but now they cant afford the housing costs. booooo

Warm Springs Community Action Team

Latest Report Submitted 4/5/2021

Economic Resilience and Healthy Families in Warm Springs

WSCAT seeks to sustain up to 35 businesses and 50 tribal business enterprises with direct and supported aid in the form of small grants for key expenses and technical assistance. Ultimately, this will help up to 200 adults and children to afford direct basic needs and improve overall health outcomes.

Objective Progress	Status	Timeline on track?	Yes
By Aug 31, 2021, WSCAT will have helped up to 35 tribally-owned reservation businesses and 50 tribal business enterprises to stay open and adapt to COVID-19 conditions, by providing direct cash assistance for supplies, rent, utilities, payroll.	In Progress	Estimated Completion Date	7/31/2021
By August 31, 2021, WSCAT will have helped up to 35 tribally-owned reservation businesses and 50 enterprises to stay open and adapt to COVID-19 business and economic changes through technical assistance, mentoring, coaching, and matched savings.	In Progress	Encountering Challenges?	No
By Aug 31, 2021, WSCAT tribal business aid and technical assistance programs will have sustained tribal businesses and helped up to 200 adults and children to afford direct basic needs, such as water, food, clothing, shelter, medical care.	In Progress	Next Report Due	10/4/2021

Grantee Comments

We are extremely grateful for this funding. It continues to help us fund a young tribal member as our small business promotion specialist, and we believe we will be able to leverage this funding into a full-time. long term position for her.

Habitat for Humanity of La Pine Sunriver

Latest Report Submitted 4/6/2021

Critical Home Repairs and Health and Housing Data Systems

Provide households in South County and North Klamath County with key health and safety repairs, ensuring that households living below the poverty level can retain access to safe and stable housing and make needed repairs to improve accessibility and safety. This will reduce the financial burden by freeing family income for other needs.

Objective Progress	Status	Timeline on track?	Yes
With project funds, by August 31, 2021, Habitat for Humanity of La Pine Sunriver will provide 15-20 (out of 35-40 total) health and safety repairs to households in Southern Deschutes and North Klamath counties.	In Progress	Estimated Completion Date	9/30/2021
By 3.31.21, create a draft intake/referral form to track the health-related needs of low-income/income-limited households.	In Progress	Encountering Challenges?	No
By 8.31.21, finalize & share the intake/referral form tracking the health-related needs of low-income/income-limited households	In Progress	Next Report Due	10/5/2021
By 8.31.2021, provide 15-20 (of 35-40) households with repairs that lead to a housing situation that is safe, stable, and supportive of health, and 5% of household income will be saved for other immediate needs with these repairs provided by HFHLPs.	In Progress		
By 8.31.2021, establish three new health-related partnerships in south Deschutes and Northern Klamath counties.	Completed		

Grantee Comments

We look forward to sharing updates as the work proceeds through the spring and summer. Thank you for your partnership!

High Desert ESD

Latest Report Submitted 7/4/2021

Conectando Familias Migrantes

Hire a Migrant Family Partner Liaison who will become the bridge to community health and human resource services to 125 Migrant Families in the Central Oregon region. The Migrant Family Partnership Liaison will provide resources to reduce poverty, support them to access community agencies, and connect with health care, physical activities and nutrition services.

Objective Progress	Status	Timeline on track?	Yes
Between November 2020 and February 2022, the Migrant Family Partner Liaison will provide resources to 125 Migrant Families to reduce poverty and support them to access community agencies in Central Oregon.	In Progress	Estimated Completion Date	2/28/2022

2020 Community Health Projects

June, 2021

Progress Report

Between November 2020 and February 2022, the Migrant Family Partner Liaison will connect 125 Migrant families in Central Oregon with health care, physical activities and nutrition services.	In Progress	Encountering Challenges?	No
Between November 2020 and February 2022, because of the assistance from the Migrant Family Partner Liaison, 125 Migrant families in Central Oregon will report a connection to and an understanding of community resources.	In Progress	Next Report Due	4/11/2022

Grantee Comments

{none}

Samara Learning Center

Latest Report Submitted 7/11/2021

Samara Learning Center's MAPLE Tutoring Project for Struggling Youth

Increase the access to Samara's MAPLE Tutoring Program and promote the growth of self-sufficiency and well-being in struggling students. The MAPLE Tutoring Project impacts likelihood of high school graduation, provides social/emotional support, equitable access, 2Gen approach, decrease of frequent utilizers, and increase/promotes self-sufficiency and well-being.

Objective Progress	Status	Timeline on track?	No
Subgoal: For the 2020-2021 school year, MAPLE Tutoring will serve at least 30 struggling students from Central Oregon.	In Progress	Estimated Completion Date	6/30/2022
Objective: For the 2021-2022 school year, MAPLE Tutoring will serve at least 45 struggling students from Central Oregon.	In Progress	Encountering Challenges?	Yes*
Sub: For the 2020-2021 sch. year, MAPLE Tutoring will serve struggling students from at least 9 different CO schools.	In Progress	Next Report Due	8/8/2022
Obj. For the 2021-2022 sch. year, MAPLE Tutoring will serve struggling students from at least 12 different CO schools.	In Progress		
By the end of the 20'-21 and 21'- 22' school years, 80% of 6th-12th grade students that attended MAPLE Tutoring at least 2hrs./weeks for at least 17 wks. will score at least an 18 on the Frostig Success Attributes: Stages of Growth Tracker.	In Progress		
By the end of the 20'-21 and 21'- 22' school years, 80% of 6th-12th grade students that attended MAPLE Tutoring at least 2hrs./weeks for at least 17 weeks will score at least a 15% improvement from their baseline T score on the BRIEF2.	In Progress		
By the end of the 20'-21 and 21'- 22' school years, 80% of 6th-12th grade students that attended MAPLE Tutoring at least 2hrs./weeks for at least 17 wks. will score at least a score of 40 on the Child & Youth Resilience Measure (PMK-CYRM-R).	In Progress		

Grantee Comments

2020 Community Health Projects

June, 2021

Progress Report

*A. DIDN'T WANT TO BE ONLINE

Parents/guardians stated they were not interested in having their kids doing more activities online. We had predicted some challenge to moving tutoring online, so added descriptions on our website of how we deal with common issues. Some families did agree to individual tutoring online, but none would join up for small group tutoring.

-MID-COURSE CORRECTIONS:

1. We are now able to meet in person.
2. We are using shaded outside spaces more on campus, including new donated picnic tables we pursued for this occasion.
3. We will still offer online access as well as in person.
4. We added a summer session to help students working on credit recovery, summer classes, etc. Those that showed interest in our small group tutoring were most often case workers, service providers, etc., but it was up to the clients to pursue the opportunity, and we did not get any sign ups.
5. We're expanding our marketing, including to homeschool communities.

B. PROJECT MANAGER'S HEALTH

I, Samara's executive director and this project's manager, contracted the human parvovirus before lockdown and developed chronic health issues to a higher degree than predicted. This would not have been too much of a problem because I still had stamina to work 40 hours a week, but due to difficulty hiring staff and board members having to leave, the amount of workload was above my ability at that time.

-MID-COURSE CORRECTIONS:

1. Proactively working on improving my health, and I'm now up to being able to work about 60 hours a week.
2. Delegation of responsibilities. (Details in "C" and "D")

C. STAFFING DIFFICULTIES

It was very difficult to hire new staff this year. We hired another teacher at the beginning of the '20-'21 school year, so I could concentrate on administration. Unfortunately, he developed severe health issues.

-MID-COURSE CORRECTIONS:

1. Since we couldn't hire another teacher, we concentrated on filling our Administrative Assistant position that became vacant earlier in the year, and we were able to find a wonderfully experienced person.
2. Increasing our substitute list.
3. Hiring at least one new teacher and other tutors. Now that the vaccines are out and more kids will be attending school and daycares in person, more people will be available to be hired. With our experience in teacher training, we will also expand in considering hiring someone with an emergency teaching credential.

D. BOARD MEMBER LOSS

Due to the various stresses this year, our working board dwindled.

-MID-COURSE CORRECTIONS:

1. We have three new board members 1.) Jennifer Murphy, a therapist 2.) Tobey Shaw, former principal of Frostig Center and Assistant Director of Special Education for a school district in Southern California 3.) Amy Yillik, former school psychologist and currently one of the High Desert ESD's Culture of Care coaches.
2. We have more people in which we are in discussion with joining, including a CPA and the founder of the Central Oregon Black Leaders Association.

Samara's Board and Administration are committed to growing our tutoring program and ways to offer our services to all those in need.



COHC Community Advisory Council

Held virtually via Zoom

June 17, 2021

Present:

Brad Porterfield, Chair, Consumer Representative
Larry Kogosvek, Vice Chair, Consumer Representative
Jolene Greene, Consumer Representative
Linda Johnson, Community Representative
Elaine Knobbs-Seasholtz, Mosaic Medical
Tom Kuhn, Deschutes County Health Services
Theresa Olander, Consumer Representative
Elizabeth Schmitt, Consumer Representative
Mandee Seeley, Consumer Representative
Ken Wilhelm, United Way of Central Oregon

Absent:

Mayra Benitez, Consumer Representative
Natalie Chavez, Jefferson County Health
Lauren Kustudick, Consumer Representative
Jennifer Little, Klamath County Public Health
Regina Sanchez, Crook County Health Department
Cris Woodard, Consumer Representative

Others Present:

MaCayla Arsenault, Central Oregon Health Council
Rebeckah Berry, Central Oregon Health Council
Tania Curiel, Oregon Health Authority
Rebecca Donell, Oregon Health Authority
Maddie Hagfors, Central Oregon Health Council
Buffy Hurtado, PacificSource
Gwen Jones, Central Oregon Health Council
Leslie Neugebauer
Renee Markus Hodin, Center for Consumer Engagement in Health Innovation
Donna Mills, Central Oregon Health Council
Kelsey Seymour, Central Oregon Health Council
Colleen Sinsky, FUSE

Introductions

- Introductions were made and Brad Porterfield welcomed all attendees.

Public Comment

- Brad welcomed public comment.
- Theresa Olander shared that an art gallery in downtown Bend is selling photographic prints celebrating Native American culture, and that the proceeds benefit the art institute in Warm Springs.

Approval of the Consent Agenda, Minutes

- Linda Johnson motioned to approve the minutes; Theresa Olander seconded. All were in favor, the motion passed unanimously.

SHARE Spending Plan

- Kristen Tobias defined the SHARE projects, noting that the program requires PacificSource Community Solutions to spend a portion of profits at the end of the year. She explained that profits from 2020 will be spent on Community Health Projects that address Social Determinants of Health focused on Equity. She explained that these monies cannot be combined with the Community Benefit Initiative (CBI) dollars dispensed annually by the CAC because of the short timeline.
- Colleen Sinsky shared that while Central Oregon FUSE has been around for a few years, this program that will be funded by the SHARE dollars has not been implemented here before. Theresa commented that the dollar amount appears small compared to the scope of work being attempted.
- MOTION: Ken Wilhelm motion to approve the FUSE budget for the SHARE project; Linda Johnson seconded. All were in favor, the motion passed unanimously.

Community Health Projects Process Development

- MaCayla Arsenault facilitated a discussion among CAC members regarding the award range for the Community Benefit Initiative (CBI) monies. The group decided to raise the award ceiling from \$50,000 last year to \$80,000 this year. The final range agreed upon was \$5,000-\$80,000.
- MaCayla reviewed the draft scoring matrix for the Letters of Interest (LOI). Mande Seely asked how reviewers should measure projects that apply Diversity, Equity, and Inclusion (DEI) policies and practices. Therese suggested applicants submit a copy of their DEI policy. Brad suggested the Central Oregon Diversity, Equity, and Inclusion (CODEI) Committee provide guidance on this topic.
- MaCayla asked the group if they are interested in including a question regarding project sustainability. After some discussion, the group elected not to ask about sustainable funding in the LOI.

Emerging Issues Process Update

- Brad elected to delay this agenda item until the next meeting due to time constraints.

Flexible Services

- Brad elected to delay this agenda item until the next meeting due to time constraints.