Council Members

- **Brad Porterfield, Chair, Consumer Representative Latino Community Association**
- **Mayra Benitez Consumer Representative**
- **Conor Carlsen Consumer Representative**
- **Natalie Chavez Jefferson County Health Department**
- **Miranda Hill Klamath County Representative**
- **Linda Johnson Community Representative**
- **Elaine Knobbs-Seasholtz Mosaic Medical**
- **Larry Kogovsek Community Representative**
- **Tom Kuhn Deschutes County Health Services**
- **Lauren Kustudick Consumer Representative**
- **Theresa Olander Consumer Representative**
- **Regina Sanchez Crook County Health Department**
- **Elizabeth Schmitt Consumer Representative**
- **Mandee Seeley Consumer Representative**
- **Stacy Shaw Consumer Representative**
- **Ken Wilhelm United Way of Deschutes Co.**

Central Oregon Health Council

COMMUNITY ADVISORY COUNCIL

February 17, 2022
VIRTUAL
Video Conference Link In Calendar Invite
Conference Line: 1.669.900.6833
Meeting ID: 852 966 546#
Passcode: 400494#

12:00-12:20 **Welcome – Brad Porterfield (CAC)**
- **Land Acknowledgement**
- **Meeting Practices**
- **Introductions**
- **Welcome New Vice-Chair**
- **Public Comment & Patient Story**
- **Approval of Meeting Notes – January**

12:20-12:30 **CAC Members Small Group Breakout Session**

12:30-12:55 **2021 Community Health Projects Discussion & Vote – MaCayla Arsenault (COHC)**

12:55-1:15 **Health Equity Plan: Member Facing Document Review – Kristen Tobias & Tricia Wilder (PacificSource)**

1:15-1:30 **Review Dental Care Organization Conversation Agenda – Gwen Jones (COHC)**

Five Finger Voting:
0: No go! Serious concerns
1: Serious reservations, 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

The Central Oregon Health Council encourages persons with disabilities to participate in all programs and activities. This event/location is accessible to people with disabilities. If you need accommodations to make participation possible please call (541) 306-3523 or email macayla.arsenault@cohealthcouncil.org

Land Acknowledgement

We recognize and acknowledge the indigenous land of which we live, work, learn, play, and grow. This is the land of the Warm Springs, Wasco, Northern Paiute, Tenino, Klamath, Molalla, and Yahooskin. We acknowledge them as the past, present, and future caretakers of this land. It is on their traditional land where we partner to improve the health and well-being of Central Oregonians. We aspire to be good guests honoring the concept in the Warm Springs culture: "This land is for you to know and live upon and pass on to the children."

Community Advisory Council (CAC)
Meeting Changes: What to Expect

We want the CAC to be a warm and welcoming place for all. We want to ensure all CAC members feel comfortable to fully participate and contribute. To do this we are making some adjustments to how our CAC meetings are run. These changes are:

- Making the meetings less institutional and formal to create a warmer and more welcoming atmosphere. Examples are using more plain language, having more conversations and less presentations, and simpler voting instead of motioning.

- Renaming each attendee in Zoom with their role; either a CAC Member, Support Staff, or Guest. This will help easily identify who's who in the virtual space especially for guests and those members who are new.

- Asking all supporting staff from COHC, PacificSource, and the OHA to share why they are attending and what their role is in supporting the Community Advisory Council.

- Inviting all CAC members in attendance to share input during discussions and before decisions are made. We want to prioritizing Consumer Representatives and make sure all voices are heard. Guests in attendance are invited to contribute to the conversation when requested by the CAC Chair or Vice Chair.

- Building relationships between CAC members. We will be setting aside time at each meeting for CAC members to go into a virtual break out room, answer icebreaker questions or chat about anything they'd like.

Patient Story

The patient story that I want to share is about the first time I had to navigate our health care system while on OHP. I have always had private insurance until I had my first daughter, and everything was smooth sailing until my daughter started preschool. Once my daughter started preschool she started to get sick more than normal; even more so than a typical kid just starting school. After several months of her being sick off and on I tried to schedule her an appointment with CLINIC A because each time she got sick it was worse than the time before. And it always ended up in her lungs, so having asthma myself I was concerned she too had asthma.

My initial conversation with CLINIC A was frustrating and discouraging. I called, asked for an appointment and I was told my insurance only covered one well-child check a year. I felt like after she had checked my daughter's insurance the tone of the conversation had changed from bubbly and helpful to annoyed and belittling. I still remember it all these years later. I still pushed for an appointment because I had a health concern for my daughter, the person making the appointment told me I should just call the nurse hotline with concerns when they happen and gave me information. I explained I would be calling a lot I think my daughter has asthma I want her to be seen. So, they finally gave me an appointment for three weeks later with a nurse. My daughter would need to see a nurse first before a doctor I was told.

Between the time I called CLINIC A and her appointment my daughter was in the ER because she had difficulties breathing and a temperature of 105. The scary part was how quickly her breathing worsened in the middle of the night. After 5 hours in the ER and telling the Doctor I think my daughter has asthma, I was told to talk to my daughters PCP. At the time my daughters PCP had retired from CLINIC A, and we were establishing care with a new provider at CLINIC A who she had seen before school started. My daughter was released once her oxygen levels stabilized. She was prescribed antibiotics and a nebulizer after an x-ray showed she had pneumonia.

The next morning, I called CLINIC A back and asked to switch my daughter's appointment from a nurse to an appointment with a doctor. I was given the same script and they reluctantly got her scheduled a few days later with the same doctor she saw before school started.

Once, we were at the appointment I explained to the doctor our family history of asthma and the recent health complications, how the nebulizer resolved her symptoms, and ER visit since our last appointment. I told them I think my daughter has asthma and how bad this was affecting her quality of life. I was told by the doctor that my insurance would not pay for treatment until my daughter had a certain number of incidences proving she needed treatment for asthma. I was dumbfounded.

After, the antibiotics and the nebulizer treatments my daughter was back to her healthy self. I used the nebulizer as need for asthma symptoms (I'm familiar with asthma so I do know the signs). I had also received a phone call from VENDOR A saying I needed to return the machine to them because the prescription was up. I asked how I could keep it and they said there needs to be a new prescription. So, I called my daughters doctors office and left a message. Eventually my call was returned, and I was told that my daughter doesn't have a medical need for the nebulizer and to return the machine. I again expressed my concerns about asthma and that the nebulizer resolved her symptoms. And I asked what if she can't breathe again what do I do if I have nothing to help her? They told me take her to the ER.

I refused to return the nebulizer and continued to use it, my daughter didn't get sick and was able to live a somewhat normal life for a couple more weeks. Until I ran out of albuterol for the machine and of course my daughter got sick. Her symptoms worsened quickly, and I rushed her to the ER again. I again explained everything especially after being ridiculed by the ER doctor about my daughter's health and them telling me I'm lucky something worse didn't happen this time, it was a close one. That she may need to be admitted because of her slow response to treatment and depleted oxygen levels. My mom who was a paramedic most my life growing up told me to request the respiratory specialist that was on call while at the ER, so I did, and the ER doctor agreed to page them. While waiting for the specialist the nurse taking care of my daughter pulled me aside and apologized for how our healthcare system works while on OHP, then snuck me a handful of albuterol for the nebulizer. Yes, the one I was holding captive. I know that this was illegal, and I know that can be very

dangerous, but I am very familiar with how to distribute the medication properly and made that clear when I spoke with the ER doctor. The nurse witnessed the conversation between the doctor and me.

When the Specialist got to my daughters ER room some hours later, they review my daughter's chart after I had told them everything that was going on. The specialist seemed upset about CLINIC A's reluctant behavior and explained that they weren't wrong about the insurance company and that there are other ways to code or talk to OHP when the patient has severe asthma complications like my daughter's. They told me when I call CLINIC A what to say and how to word it so that I would get an appointment quicker, they also asked for the PCP name and what time CLINIC A opened so they could personally call them. My daughter was eventually released from the ER after about 6 hours.

I called CLINIC A said what the specialist told me to say and requested a new doctor, one who was more familiar with asthma. I was able to get an appointment immediately, I think it helped that there was a note from the ER Specialist on my daughters file before I called, the Specialist had called right before me like they said they would. CLINIC A had already reserved a spot for my daughter with a new provider before I even called.

We went to see the new doctor that day, and they said, "It is obvious to me your daughter has asthma and I'm sorry for everything she has had to go through and everything you have had to go through just to hear these words. I can't change what has already happened, but I can help now." I was so happy to hear her say that. The new doctor put in a new prescription for the nebulizer and a refill of albuterol along with an inhaler. She referred us to a respiratory specialist, and we also scheduled another appointment with her two weeks later to see how she was responding to medication. This doctor was my kids PCP until they retired.

There is a lot more to this story but for time purposes I summed it up the best I could. What I didn't mention is how my daughter cried when she thought that I was going to give back the nebulizer or the times she cried when we ran out of medicine. No one, especially a child should ever have to experience that feeling of running out medication. I didn't mention how she would break the blood vessels in her face and eyes from coughing so hard or how lethargic she looked on a regular basis.

I also didn't mention that I also had another daughter who was 2 at the time and she missed me. I was so exhausted from working full-time, caring for a sick kid, and trying to advocate for my sick daughter to fully be present for my youngest at that time. I was also going through a separation during all of this and didn't have a lot of support from their dad. I would often have to tend to my youngest while talking to providers and she would have to go to the ER until I could get ahold of my mom to come pick her up. I remember the horrible feeling trying to rush my oldest daughter into the ER and carrying her, while my youngest cried for me because she was tired and scared late at night walking into the ER, I pleaded with her to please walk with me, and I would hold her soon. The amount of stress that this situation caused, has probably shaved a few years off my life as well as impacted our family in a lot of ways.

The reason I chose this story to share with you all is because the flaws in our health care system while on OHP has continued to repeat themselves throughout the years. The only difference is I knew what to say and how to say it to get appointments and to be taken seriously when issues arose. Through the years I have shared my experiences with friends and family members to help educate or what felt like train them on how to navigate through our health care system while on OHP.

My oldest daughter at the time was 4 and she is now 12. She has not had an ER visit for asthma complication in almost 7 years. This is because her asthma is well managed, preventative care is amazing! That means she is seen when issues arise, so her medication can be adjusted before her symptoms get worse. I had access to a specialist who further educated me on asthma. We were and are a team that cares for my daughter and that was possible because of OHP.

My concerns are with our healthcare system and the patients on OHP that are not able to advocate or press the issue of quality care like I was able to. I am concerned about the amount of people who have suffered because of flaws in the system and who are still suffering. I would like to see more support for our providers

and staff in the form of education on health disparities. Additionally, I want their voice to be heard about the issues they experience while trying to treat people on OHP. I cannot fathom any other way to fix a flawed system except working together to resolve the issues.

If there are any follow up questions; I am happy to answer them.

Thank you for listening!

COHC Community Advisory Council
Held virtually via Zoom
January 20, 2022

CAC Members Present:
Brad Porterfield, Chair, Consumer Representative
Conor Carlsen, Consumer Representative
Elaine Knobbs-Seasholtz, Mosaic Medical
Elizabeth Schmitt, Consumer Representative
Ken Wilhelm, United Way of Central Oregon
Mandee Seeley, Consumer Representative
Mayra Benitez, Consumer Representative
Stacy Shaw, Consumer Representative
Theresa Olander, Consumer Representative
Tom Kuhn, Deschutes County Health Services

CAC Members Absent:
Larry Kogosvek, Vice Chair, Consumer Representative
Lauren Kustudick, Consumer Representative
Linda Johnson, Community Representative
Miranda Hill, Klamath County Public Health
Natalie Chavez, Jefferson County Health
Regina Sanchez, Crook County Health Department

COHC Staff Present:
Donna Mills, Central Oregon Health Council
MaCayla Arsenault, Central Oregon Health Council
Gwen Jones, Central Oregon Health Council
Renee Wirth, Central Oregon Health Council
Kelley Adams, Central Oregon Health Council
Camille Smith, Central Oregon Health Council

Support & Guests Present:
Kristen Tobias, PacificSource
Tricia Wilder, PacificSource
Carolyn Black, Oregon Health Insurance Marketplace
Tania Curiel, Oregon Health Authority
Sarah Dobra, Oregon Health Authority
Jessica Waltman, PacificSource
Miguel Herrada, PacificSource
Leilani Brewer, PacificSource

Introductions

- Introductions were made and Brad Porterfield welcomed all attendees.

Land Acknowledgement

- Tom Kuhn read the Land Acknowledgement (see January packet for statement).

Meeting Practices

- Brad Porterfield reviewed the Meeting Practices and how the CAC meetings are meant to be welcoming for all (see January packet).

Public Comment/Patient Story

- Brad welcomed public comment or a patient story.
- Kristen Tobias from PacificSource let the CAC know that Assurance Wireless will no longer be the Oregon LifeLine cell phone provider. You will need to set up a new plan with Access Wireless. Kristen will forward the updated member flyers with this information when available. If you need information on how to change your provider before the flyers are available feel free to contact Kristen.
- No new patient story this month.

Approval of December Meeting Notes

- Brad Porterfield asked the CAC members in attendance to vote on approving the notes from December.
- Elaine Knobbs-Seasholtz asked to add her request for the emerging issue of OHP assisters having long wait times and that she could get a specific story for next month.
    - ACTION ITEM: Kelley to add Elaine's emerging issue to the December notes and follow-up with Elaine for a story for February.
- There were no objections to December Meeting Notes, so they are approved.

CAC Member Small Group Breakout Session

- Part of the Meeting Practices is to include time for CAC members to get to know each other better. 10 minutes will be set aside at each meeting for CAC members to go into a virtual break out room, answer icebreaker questions or chat about anything they'd like.

Vice-Chair Nominees

- MaCayla Arsenault introduced Elizabeth Schmitt and Regina Sanchez as the Vice-Chair candidates.
- Regina Sanchez is taking time off in January so we will try to get a statement from her.
- Elizabeth Schmitt was present to give a brief statement on why she was interested in the role of Vice-Chair.
- A quick survey to vote for your next Vice-Chair will be emailed along with the CAC Chair Roles & Responsibilities for your reference.

2021 Community Health Projects Update

- MaCayla Arsenault updated the CAC on the latest organizations that were asked to fill out the full applications for the remaining Community Health Projects funds. Treehouse Therapies, Lifetime Vision and Thrive Central Oregon have until February 1st to submit their application.
- Look for the applications to review at the beginning of February and a vote will take place at the February 17th meeting.

Emerging Issues Follow Up – Periodontal Care

- Kristen Tobias from PacificSource reminded the CAC of the proposal of inviting representatives from the 3 Central Oregon DCO's (Dental Care Organizations) to attend a CAC meeting and hear first-hand the concerns and access issued that have happened.
- Gwen Jones led the conversation about "**what do you want the DCO's (Dental Care Organizations) to know before the conversation in March?**"
    - Curious of the cost comparison if there was more preventive or immediate care. Could they pull those numbers? Would they save money if things were "easier" to get care?
    - Get real answers on why dentists won't work with OHP.
    - Why won't dentists see OHP members?
    - Would it be possible for a consumer OHP member to choose their dentist and apply for reimbursement with the understanding that out-of-pocket expenses may apply? Give consumers more options.
    - Opening ideas and conversations about some different ways things could potentially be structured.
    - Get care where you want it, how you want it.
- "**Is there anything that causes you hesitation or nervousness about meeting with the DCO executives?**"
    - Worried that at the meeting there might be a non-response or will there actually be change from this conversation or continuing conversations?
    - Concern that this could be a "check the box" activity.
    - Is it going to be meaningful? Will there be an outcome?
- "**One or two things that you want the DCO's to know before the conversation?**"
    - Letting the DCO's know about the barriers like traveling to have care and the out-of-pocket expenses. This also causes burdens on people regarding childcare, work, etc. Or might cause them to avoid care then get worse and end up having a more expensive procedure needed.
    - Immediate care is not immediate for OHP members. Appointment wait times and delays.
- "**What would you like to happen or start because of this conversation?**"
    - Policy reform that brings better care.
    - Invite House Representative, Oregon Legislature
    - More OHP dental providers in Central Oregon.

- "**What values that you want to hold during this conversation?**"
    - Equity – what kinds of trainings are the DCO's receiving specifically around the Medicaid population.
    - Hoping it will be problem solving, collaborative, respectful.
    - Having the opportunity to work together to come up with some solutions.
    - No pointing fingers.
    - Recognizing the validity of what is being shared.
    - Unbiased listening. Hear both sides.
- "**How would you like this to impact your relationship with the DCO's?**"
    - Positive impact
    - Both sides trying to help each other. Same team. Same direction.
    - Determine if there will be ongoing discussions to continue progress.
- "**How do you want to prepare the DCO's and what do you want the DCO's to know before they come? And what do you want before the conversation?**"
    - STATS with personal stories
    - The barriers shared so they have time to reflect or do research
    - Grievance & Appeal statistics
    - CAC Purpose & Goals
- "**How do you want the conversation structured?**"
    - Agreed topics and time frame for each
    - Q&A structured rather than presentations.
    - Share patient stories
- Brad Porterfield requested a draft of how the DCO/CAC meeting would be structured to review at the February meeting.
    - ACTION ITEM: Gwen Jones to draft a meeting structure for review at the February meeting.

Health Equity Plan Update & Grievance and Appeals Video

- Miguel Herrada, Leilani Brewer, and Jessica Waltman from PacificSource presented on the Grievance & Appeals, Health Equity Plan Update. The purpose is to update the CAC with this years changes to the Health Equity Plan, share the new grievance and appeal resource and talk about ideas that PacificSource can do around these topics.
- A short video was shown about how PacificSource can help when you have problems with your coverage.
    - ACTION ITEM: Kelley Adams will send the CAC members an email with the presentation and link to view the video.

Form Name:

2021 Community Health Project Full Application

Thrive Central Oregon

Thrive Central Oregon- Housing Retention

RHIP Workgroup:

Future State Measure:

Application Snapshot	
Amount Requested	$79,282.00
Organization Contact	Sarah Mahnke
Contact Phone	541-728-1022
Contact Email	sarah@thrivecentraloregon.org
Organization Address	405 SW 6th Street Suite A Redmond, OR 97756
Website	http://cohealthcouncil.org/
Project Lead	Sarah Mahnke
Project Lead email	sarah@thrivecentraloregon.org

Note: * indicates required questions

Part One: Project Highlights

Project Name*

Name of Project.

Thrive Central Oregon- Housing Retention

Amount Requested*

Please list the total amount of funds requested for this project.

The funding request needs to be between $5,000 to $80,000.
Anything over $80,000 or under $5,000 will be denied.

$79,282.00

Project Duration*

How many months will the project last?

24

Towns Included in Project*

Which of the following towns in Central Oregon will your project include?

Bend
La Pine
Madras
Metolius
Powell Butte
Prineville
Redmond
Sisters
Sunriver
Terrebonne
Tumalo
Warm Springs

Other Towns

If you chose 'other' above, please share the name of the town or towns included in your project.

Name of Project Lead*

Please provide the first and last name of the project lead for this funding request.

Sarah Mahnke

Email for Project Lead*

Please provide an email address for the project lead.

sarah@thrivecentraloregon.org

Phone Number of Project Lead*

Please provide the best phone number to reach the project lead.

541-527-9871

Diversity, Equity, and Inclusion (DEI) Statement

Does your organization have a Diversity, Equity, and Inclusion (DEI) statement?

Have a formal DEI Policy

DEI Statement

If your organization has a completed DEI statement, please copy and paste it here.

We will promote equity throughout our organization by valuing the richness of the Central Oregon community.

We recognize people have varying degrees of access to opportunities based on current and historical inequities. These inequities are based on race, gender, socio-economic status, national origin, ethnicity, culture, disability, age, faith, gender identity and sexual orientation.
When provided opportunities, people have the power to make positive movement in their lives. In order to fulfill our role of navigating barriers and bridging the gap, we believe that we must champion equity on both an individual and institutional level. We strive to promote a spirit of inclusivity from within our organization and to work in collaboration with others to dismantle structural barriers to personal fulfillment.

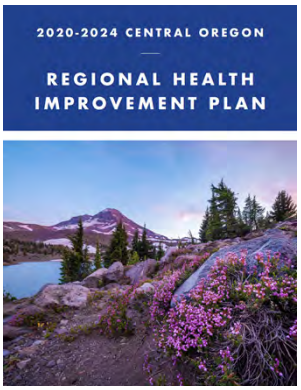
We commit ourselves to:
Honor the dignity and worth of all people, and provide services that meet the unique needs of every individual
Build deep, collaborative relationships rooted in respect
Center equity, diversity, and inclusion in the foundation of our practices, policies and procedures
Provide ongoing opportunities for staff and board to engage in meaningful dialogue around diversity, equity, and inclusion
Learn as we venture on this journey to become a more inclusive and equitable organization

We recognize that this work takes time, energy, and financial resources. We acknowledge that we will make mistakes along the way. Our commitment to uphold equity, hold ourselves accountable to our values, and serve our community remains steadfast.

Part Two: Project Checklist

2020-2024 Regional Health Improvement Plan Priority Areas*

Please review the aim for each of the six priority areas for the 2020-2024 Regional Health Improvement Plan by clicking on the image:



Based on the aim of each priority area, please select which area(s) of focus that your project aligns with:

Stable Housing and Supports

Alignment With the Regional Health Improvement Plan*

Based on the priority area(s) you selected above, share how your project aligns with the aim(s).

The aim of our project is to increase case management supports to households being connected to rent assistance across Central Oregon. Thrive Central Oregon has received over 1 million dollars in emergency rent and mortgage assistance in the past year, that will continue to be dispersed into the coming year. While this assistance is vital to the work we are doing in our communities to obtain or maintain affordable and permanent housing, this funding does not allow for the level of case management support that we know is needed to stop the cycle of homelessness. We strongly believe in an upstream approach when working with those who seek our services. While we are grateful to provide an emergency payment in the present, we know those payments are not the answer to sustaining permanent housing. We are most interested in supporting families in learning how to increase their knowledge and utilize community resources to avoid losing their housing and economic stability in the future. Supporting households with this service requires increased case management supports to address the myriad needs families are faced with, beyond the rent payment.

Oregon Health Plan (OHP)*

Will your community project be available to and serve individuals who qualify for the Oregon Health Plan (OHP)?

Yes

Tribal Nations

Please select which tribal nations your project will engage?

Confederated Tribes of Warm Springs

Serving Tribal Nations*

If applicable, please describe how your project will serve at least one of the tribal nations listed below:

- *Cow Creek Band of Umpqua Tribe of Indians*
- *Confederated Tribes of Warm Springs*
- *Klamath Tribes*

If your project does not serve a tribal nation, please state:

Our services are open to all who seek them, and are available to the Confederated Tribes of Warm Springs either over the phone or through any of our walk-in sites. We do not have a walk-in site within Warm Springs at this time. We disseminate information about out services through partners in the Health and Human Services, Child Welfare and Housing Authority offices within Warm Springs.

Social Determinants of Health*

*How does your project address **social determinants of health**?*

Thrive provides respectful engagement and hands-on case management services which include the following:
• Housing: rent payments, permanent and affordable housing search, completing applications, filing appeals and eviction prevention
• Health: completing OHP applications, connection and coordination with physical and mental health providers
• Employment: job search, referral and connection to employment supports and resume assistance
• Social Security: submitting applications for benefits for those unable to work
• Basic needs: connection to utility assistance, food and clothing resources

Individuals who seek support from Thrive are greeted with respect and assistance in connecting them to the services they seek. Affordable and accessible housing is a primary need that is addressed. Thrive is currently connecting 5-10 families per month with the affordable housing they seek, while placing dozens more onto housing lists that will provide an affordable option in the future. An emphasis of our work is to increase knowledge and utilization of community resources for those who seek our services so that individuals are empowered to meet their own housing and financial needs in the future. We know that the services we provide are improving health outcomes, as those with housing and financial stability have increased access to the medical and mental health care they are needing.

Social Determinants of Health (Continued)*

Please select which social determinant(s) of health your project will primarily address:

Economic Stability
Social and Community Health

Serving Those Severely Impacted by System Barriers*

If applicable, please describe how your project will serve those severely impacted by system barriers?

In the past year and a half our services have transitioned from being in person, to remote, to now offering a hybrid option of service connection over the phone, through email, or at our walk-in sites. We find these options are increasing access to our services across Central Oregon. Those we sit with report navigation and access barriers when it comes to connecting with community resources. Complicated systems, long waits and poor communication are primary barriers that we work together to overcome. We provide respectful and knowledgeable service in Spanish and English. Solving the housing and financial issues that people are faced with, side by side, lead to positive outcomes in the present and increased self-efficacy for the future.

Serving Rural Communities*

*If applicable, please describe how your project serves rural communities. You can find a definition of rural **HERE.***

Our services are provided across Central Oregon. From Warm Springs to North Klamath. Our rural communities have resource limitations that are dramatically greater than Bend and Redmond. Our data reflects that the addition of phone and email services has been particularly impactful to the communities we serve in Madras, Prineville and La Pine. We are grateful that many of the resources we are connecting folks to have transitioned to an online format, furthering our ability to provide assistance over the phone which has dramatically increased our reach to, and access by, these communities.

Equity*

Please describe how your project applies Diversity, Equity, and Inclusion principles and practices.

Our model of service provision at TCO is based on those we sit with being the expert of their lives and having the agency to choose the resources they are interested in connecting to. We serve individuals and families living in poverty in Central Oregon by striving to break down barriers and reduce stigma when accessing social services. We aim to bridge the gap for community members, meeting them where they are in public spaces and providing vital connection to resources and support.
When provided opportunities, people have the power to make positive movement in their lives. We offer relationship based work. Intentional space for open dialogue to keep improving services/ meeting changing needs.

Feedback requests are standard as we work to develop our services. We strive to recognize the position of power we are unintentionally in, as the "holder of resource knowledge". Our strategy is to literally and figuratively sit along side those we work with, sharing the information we have, absorbing the knowledge and feedback they provide, to move toward the outcome they are seeking.

Part Three: Project Details

Timeline - Project Start Date*

*Please provide an estimated **start date** for your project.*

04/01/2022

Timeline - Project End Date*

*Please provide an estimated **end date** for your project.*

03/31/2024

Project Aim*

Please describe the overarching aim of this project. (An aim is the large (thinking big) desired result of your project. The aim serves as the foundation for developing your program objectives. Please limit the aim to one sentence.)

The aim of our project is to pair case management support and skill development with housing assistance payments, to ensure long term, stable housing for individuals and families when the assistance payments end.

Project Description/Overview*

Please describe your project.

Thrive services target individuals and families living in poverty. Recognizing that access to services is a primary reason individuals are unable to connect to resources, Thrive is located where people already are, utilizing meal sites and public spaces, like libraries, to come in from the outdoors. This approach increases access to those needing supports. Thrive is opening sites back up and disseminating information about our ongoing programs and support through community partners, posting notices around Central Oregon at grocery stores, bus stations, churches, and food box distribution locations.

This housing project is meant to increase wrap-around supports for households connecting to rent and mortgage assistance. While we have significant financial support for rent, mortgage, move-in costs and utilities, we are lacking the needed case management hours to provide the level of support we are accustomed to providing those we work with. Our work has developed over the last year, branching out from connecting people to the affordable housing and resources they sought, to also assisting them with emergency payments to maintain their housing and

not fall behind while establishing more stable income streams. We are grateful for Eviction Moratoriums and know that people feel most stable when they are able to keep up on their bills. We have housing funds to assist with these needs, but we need to maintain staffing support for these individuals as they navigate complicated systems. We are interested in working with people to create opportunities and solutions that not only meet their needs in the present, but provide space for empowerment for individuals to better understand and take advantage of strategies that can support them in the future. This project's aim is to provide these services to households receiving temporary assistance, in and out of Thrive's current case load, to increase a households safety net as they time out of limited assistance. We would also like to use our role within the Coordinated Entry system to better support households as they are referred to that program, through assisting them with housing lists on the front end, so they are more prepared when they have the opportunity to utilize rent assistance.

Funding from COHC, matched with funds we have through OHA, and the city's of Redmond and Bend, would provide an initial 2-year role for a Community Outreach Advocate to focus on housing retention for households across Central Oregon.

Why is this project needed?*

Please describe the identified need for this project.

Thrive has been the grateful recipient of emergency funds to keep people housed over the last two years. The funds were incredibly useful and needed in a time when so many would have lost their housing without the additional support. In this period of increased housing assistance, the gap we have seen develop is in support services to help households address the underlying needs that leave them without a safety net when emergency situations arise. This project is meant to address that gap, pairing case management services with those receiving Thrive's rent assistance and for those seeking our support that are exiting out of Rapid Rehousing assistance programs. Through our participation in Coordinated Entry, we have identified gaps that can leave households both unprepared to receive and lose housing assistance. We would like the opportunity to provide these households an increased chance of success in obtaining and maintaining their housing.

Part Four: Project Objectives

Objective Description #1*

What is trying to be accomplished?

Housing retention support will be offered to 300 households (annually) receiving rent assistance, either through Thrive Central Oregon, or in partnership with community organizations that have rent assistance, but not the capacity to provide wrap around and transitional support when their funding ends.

SMART Objective #1 (Target/Future State)*

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

A community outreach advocate will work directly with 600 households from April 2022- March 2024 that have received housing assistance, to ensure they have the needed tools to access resources in our region to create long term stability.

Baseline Data for Objective #1 (Current State)*

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

We are making over 100 monthly payments for assistance to households across Central Oregon. Households can receive up to 3 payments for assistance. We will be targeting services to this population that generally pass through our payment assistance services quickly.

Objective Description #2*

What is trying to be accomplished?

Annually- Of the 300 households offered these supports, we will connect 75% of them with additional benefits that will offer a reinforced "safety net" for the future.

SMART Objective #2 (Target/Future State)*

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Annually- Of households receiving payment assistance, 225 will be connected to 500 resources that will increase their financial and housing stability, EG., affordable properties, benefits, employment, SNAP, basic needs, and/or utility assistance.

Baseline Data for Objective #2 (Current State)*

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

We average 2.25 services per unduplicated individual in a given month.

Objective Description #3

What is trying to be accomplished?

We will help fill the gap of providing housing retention support for households on time limited assistance, either through our program, or in support of partner agency's efforts.

SMART Objective #3 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Annually- We will provide Housing Retention services to 15 Rapid Rehousing supported households to help them transition to affordable housing prior to their benefit expiring and being faced with eviction.

Baseline Data for Objective #3 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

We are receiving 2- 5 monthly self-referrals from households that are "timing out" on Rapid ReHousing assistance and at risk of eviction.

Objective Description #4

What is trying to be accomplished?

Increase opportunities for access to affordable housing by reaching out to 100 households annually on the Coordinated Entry list, as they are added.

SMART Objective #4 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

We will reach out to 100 households annually, who come through Coordinated Entry to put them on Affordable housing lists, while they wait to be chosen for rent assistance.

Baseline Data for Objective #4 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Coordinated Entry meetings reflect an average of 20 additions on a biweekly basis.

Objective Description #5

What is trying to be accomplished?

N/A

SMART Objective #5 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

N/A

Baseline Data for Objective #5 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

N/A

Objective Description #6

What is trying to be accomplished?

N/A

SMART Objective #6 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

N/A

Baseline Data for Objective #6 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

N/A

Part Five: Project Support

Project Collaboration & Partnerships*

How have you worked with community partners and/or the people being served to develop this project?

How do you plan to continue to work together throughout this project?

As a community service provider and assistance payment source, we are seeing the gaps that are occurring between our and other systems. We would like two years to pursue addressing those gaps, with a plan to continue if the services prove effective.

We have consistent requests from those that seek our services to help keep them housed when their RapidRehousing assistance is ending. Seeing this, we also want to ensure that we are doing all we can to equip those that utilize Thrive's assistance payments to navigate income loss and increasing housing costs. These experiences informed this Housing Retention proposal. We want to increase services to those we are currently assisting with payments, but also loop in partner agency clients that are receiving limited time assistance, and/ or those that are being added to the Coordinated Entry system. This proposal is aimed to support low-income households that are connected through Thrive Central Oregon, NeighborImpact, and/or Coordinated Entry. This intersection is where we see an increasing amount of housing instability and support needs. Our priority in this project is to first connect these services to those that are self-referring for assistance, but we also envision being able to assist NeighborImpact and the Coordinated Entry system in their efforts as we are permitted.

Optional: Community Support Letter #1

Please attach any letters of support that you have received for this project. You may attach up to 5. Letters must be uploaded separately.

Optional: Community Support Letter #2

Optional: Community Support Letter #3

Optional: Community Support Letter #4

Optional: Community Support Letter #5

Best Practice*

What, if any, are the emerging best practices and/or evidence-based guidelines upon which this project is based?

Please write

This project is reflective of the value of social determinants of health, supporting housing needs to improve health and overall outcomes.

Fidelity*

If your program is evidence-based or best practice, will it be reviewed for fidelity?

Please write

N/A

Evaluation*

Please share with us how you plan to evaluate this project.

Thrive has proven itself as a viable model that provides critical services to a previously unrecognized and underserved population seeking assistance resources throughout Central Oregon. Utilizing HMIS (Homeless Management Information System), we track the number of people served; their gender, age, income level and housing status. We also track services sought and referral connections made.
As we are able to develop this idea with community partners, we will be looking to them for feedback about the efficacy of these services. We also expect to see an increase in households having an actual option for housing, when their assistance payments are approved through Coordinated Entry and and other housing assistance programs.
Thrive staff and volunteers follow up with clients through phone calls, email and an online survey option to evaluate our interactions and level of assistance with individuals. To date those surveys have reflected an overwhelmingly positive response of both respectful interactions as well as connection to needed services and improved outcomes due to the support of Thrive staff.

How will we know if the project is successful?*

This project will be considered successful when we meet our listed target goals of connecting households to housing and financial resource support prior, during and after housing payments, increasing their stability and providing space for them to reach their own goals of self-sufficiency.

Optional: MOU or MOA

Optional: MOU or MOA

Optional: MOU or MOA

Part Six: Budget Information

Project Budget*

*Please download the Central Oregon Health Council's budget document, found **here.** After downloading and completing the budget document, please upload it below.*

TCO-COHC-HR 22.24.pdf

Funding Request - Year One*

$39,641.00

Funding Request - Year Two

$39,641.00

Funding Request - Year Three

Funding Match*

Are you seeking any funding matches or additional contributions to support your project? If so, provide the organization/entity name that will be providing the match.

If you are not seeking a match, please write

We will be using funds from the Oregon Health Authority, city's of Redmond and Bend to match our funding request and provide housing retention support for an initial 2-years.

Funding Match Amount (if not applicable, leave blank)

$70,872.00

Process Following Submission

Application Files

Applicant File Uploads

- TCO-COHC-HR 22.24.pdf

Thrive Central Oregon- Housing Retention FINAL			
COHC Program Budget April 2022-March 2024			
Expenses	**Year 1 COHC Request**	**Year 2 COHC Request**	**Additional funding sources (OHA, Redmond, Bend) for years 1 and 2**
Personnel			
Community Outreach Advocate- Housing Retention (1 FTE @ $23.82/	*24,773*	*24,773*	*49,546*
Taxes on the above @ 12%	*2,973*	*2,973*	*5,945*
Health Insurance	*3,120*	*3,120*	*6,240*
Program Administration (Executive Director coordination, Finance & Grant management, staff support and oversight, financial, record and book keeping @ 15%)	*3,716*	*3,716*	*7,432*
Benefits and taxes on the above @ 23%	*855*	*855*	*1,709*
Subtotal personnel	***35,436***	***35,436***	***70,872***
Non-personnel			
Office supplies @ $35/ month	*420*	*420*	
Office Equipment	*500*	*500*	
Printing @ $25/ month	*300*	*300*	
Technical Support (cell phone, plan and laptop)	*1,210*	*1,210*	
Professional Support & Development @ $70/ month	*840*	*840*	
Professional Insurances	*575*	*575*	
Bus tickets and gas cards for clients	*360*	*360*	
Subtotal non-personnel	***4,205***	***4,205***	
Total Annual Expense for 1 FTE			***75,077***
Match funding for 2-year project (OHA, Redmond, Bend)			***70,872***
Total 2-year cost for Housing Retention Project			***150,154***
Total 2-year request for COHC 2022-2024	***39,641***	***39,641***	***79,282***

Form Name:

2021 Community Health Project Full Application

Treehouse Therapies Associates

Physical, Occupational and Behavioral Health Therapeutic Group Services

Application Snapshot	
Amount Requested	$45,000.00
Organization Contact	Christen Eby
Contact Phone	541-647-8802
Contact Email	christen@treehousetherapies.com
Organization Address	2125 NE Daggett Ln Bend, OR 97701 PO Box 1397 Bend, OR 97709
Website	http://cohealthcouncil.org/
Project Lead	Christen Eby
Project Lead email	christen@treehousetherapies.com

RHIP Workgroup:

Future State Measure:

Note: * indicates required questions

Part One: Project Highlights

Project Name*

Name of Project.

Physical, Occupational and Behavioral Health Therapeutic Group Services

Amount Requested*

Please list the total amount of funds requested for this project.

The funding request needs to be between $5,000 to $80,000.
Anything over $80,000 or under $5,000 will be denied.

$45,000.00

Project Duration*

How many months will the project last?

12

Towns Included in Project*

Which of the following towns in Central Oregon will your project include?

Bend
Culver
La Pine
Madras
Powell Butte
Prineville
Redmond
Sisters
Sunriver
Terrebonne
Tumalo
Warm Springs

Other Towns

If you chose 'other' above, please share the name of the town or towns included in your project.

Name of Project Lead*

Please provide the first and last name of the project lead for this funding request.

Christen Eby

Email for Project Lead*

Please provide an email address for the project lead.

christen@treehousetherapies.com

Phone Number of Project Lead*

Please provide the best phone number to reach the project lead.

541-647-8802

Diversity, Equity, and Inclusion (DEI) Statement

Does your organization have a Diversity, Equity, and Inclusion (DEI) statement?

Have a formal DEI Policy

DEI Statement

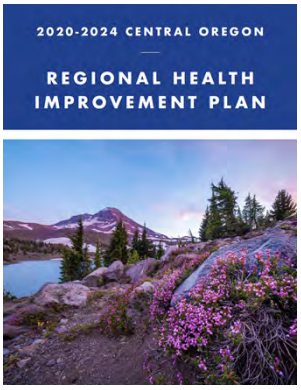
If your organization has a completed DEI statement, please copy and paste it here.

We embrace and encourage our employee and client differences in age, color, disability, ethnicity, family or marital status, gender identity or expression, language, national origin, physical and mental ability, political affiliation, race, religion, sexual orientation, socio-economic status, veteran status, and other characteristics that make humans unique.

Part Two: Project Checklist

2020-2024 Regional Health Improvement Plan Priority Areas*

Please review the aim for each of the six priority areas for the 2020-2024 Regional Health Improvement Plan by clicking on the image:



Based on the aim of each priority area, please select which area(s) of focus that your project aligns with:

Behavioral Health: Increase Assess and Coordination
Promote Enhanced Physical Health Across Communities
Upstream Prevention: Promotion of Individual Well-Being

Alignment With the Regional Health Improvement Plan*

Based on the priority area(s) you selected above, share how your project aligns with the aim(s).

Behavioral Health: Our project increases access to behavioral health by increasing our team capacity to serve more clients at once. For group therapy, we combine behavioral health with occupational and physical therapy to increase coordination among providers and to involve parents directly in therapy. We have over 300 children on our waitlist. Most of them need a combination of Occupational Therapy and Behavioral Health. Our groups give them access to multiple services at once and serve multiple families at once. We also increase access to behavioral health by removing financial barriers; we provide therapy regardless of insurance or financial limitations.

Physical Health: We serve children who require physical therapy and occupational therapy to improve their physical health. We coordinate with primary care providers to address health care needs related to physical and occupational therapy. Our group therapy model includes simultaneous parent education so that they can continue exercises at home. As their physical, social, self care and regulation skills improve, children are better able to engage in physical, recreational and social activities at home, at school and in community, helping to improve the overall physical and emotional health of each child we serve.

Upstream: Our project promotes individual well-being by grouping families facing similar challenges and encouraging them to learn together. Children experience improved social, emotional and physical skills and parents gain knowledge to create better outcomes for their children at home and in the community.

Oregon Health Plan (OHP)*

Will your community project be available to and serve individuals who qualify for the Oregon Health Plan (OHP)?

Yes

Tribal Nations

Please select which tribal nations your project will engage?

Confederated Tribes of Warm Springs

Serving Tribal Nations*

If applicable, please describe how your project will serve at least one of the tribal nations listed below:

- *Cow Creek Band of Umpqua Tribe of Indians*
- *Confederated Tribes of Warm Springs*
- *Klamath Tribes*

If your project does not serve a tribal nation, please state:

Confederated Tribes of Warm Springs:
In January 2022, we opened a new satellite clinic located at the Warm Springs Early Childhood Learning Center, in partnership with the Central Oregon Disability Support Network. It is our goal that, in addition to traditional one-on-one physical therapy, occupational therapy and behavioral health services, we will also be able to offer the same group therapy options in Warm Springs. Groups will be created according to the needs in the community and by matching children with similar needs. We will also create simultaneous parent groups to offer support, community, and education according to the needs and diagnosis of their children. At this time, implementation of our Pediatric Group Therapy Project in Warm Springs is still in the needs assessment and feasibility study stage, since we just opened the Warm Springs satellite clinic in January 2022.

Social Determinants of Health*

*How does your project address **social determinants of health**?*

Health Care: Group therapy is facilitated by a multidisciplinary health care team to address the whole child. This project enables us to serve children who require more than one type of therapy and who would benefit from a group setting. This project also increases our capacity to provide care to children and families on our waitlist. With over 300 children on our waitlist, we need to create a more efficient way to serve children and families.

Social & Community Health: Physical, occupational, and behavioral health therapy enable children and families to overcome physical and mental barriers and to better access home, school, and the community. Parents of children with special needs and foster parents often feel isolated and overwhelmed. This project gives parents a place to receive education as well as support from professionals and peers. During the pandemic, children with special needs have been negatively affected in the areas of social skills and interactions. In our group therapy programs children learn in a natural group setting with their own peers, thus increasing social skills and community connections.

Education: Group pediatric therapy with simultaneous parent support increases the health literacy of parents and directly contributes to better educational outcomes for their children. Educating parents about their child's diagnosis or special needs empowers them to continue the progress made in their children's therapy sessions. It also informs them on how to advocate for their children in their child's education environment and which accommodations to ask for.

Social Determinants of Health (Continued)*

Please select which social determinant(s) of health your project will primarily address:

Education
Social and Community Health
Health and Health Care

Serving Those Severely Impacted by System Barriers*

If applicable, please describe how your project will serve those severely impacted by system barriers?

With a waitlist of over 300 children across Central Oregon, we feel that all of Central Oregon, including Bend, is underserved when it comes to providing equitable care for children with disabilities and for children in the foster care system. Children in the foster care system are severely impacted by system barriers. Children with disabilities and special needs experience inequality in our community and have been disproportionately impacted by the pandemic. In addition to reducing the number of children on our waitlist, one of the goals of our group therapy program is to help to compensate for some of the learning losses that have occurred during the pandemic.

Treehouse Therapies was founded on the principle of seeing a need in our community and responding to it. When we opened our first clinic, there weren't any multidisciplinary pediatric therapeutic clinics even in Bend! We have established four clinics in areas where there were previously limited pediatric therapeutic services, including our newly opened location in Warm Springs. By providing multiple forms of therapy at all of our locations, we increase the availability of therapy for children and families in areas that are underserved. By creating group therapy services for families facing similar issues, we further increase the availability of therapy and community connections.

Group therapy services will have the benefit of occurring in the evenings, after "normal" business hours so that working families can participate without missing work or school, and without having to arrange for childcare.

Serving Rural Communities*

If applicable, please describe how your project serves rural communities. You can find a definition of rural ***HERE.***

Families from Madras and Jefferson County will be able to access group therapy services through our Warm Springs location. While we will not be able to secure a location directly in areas such as Prineville and La Pine, we have designed the Group Therapy Services program so that families can participate at our Bend, Redmond or Warm Springs locations. Group therapy happens in the evening so parents do not have to miss work or pull all

children out of school. Group therapy serves the entire family so parents also do not have to worry about arranging for childcare. Some of our group programs are also offered online when appropriate and applicable.

Equity*

Please describe how your project applies Diversity, Equity, and Inclusion principles and practices.

Diversity, Equity and Inclusion are at the core of Treehouse Therapies services so that everyone feels valued, supported and inspired to achieve individual and common goals. As a nonprofit pediatric therapy clinic, we provide compassionate and comprehensive therapy programs for all children regardless of their ability to pay.

The children we serve are largely diversely-“abled”. They come to us with a variety of special needs. Our group therapy program will help children with various special needs come together to learn, socialize, and overcome obstacles together.

The idea behind simultaneous pediatric group therapy and parent support is to serve more children from all parts of our community and reduce our waitlist as much as possible. Group therapy that happens outside of "normal" business hours makes it more accessible for working families. It also keeps children in school, while at the same time providing them with the tools to be more successful in school.

Foster parents in particular often find it difficult to talk about the trauma issues they face even with their own family and friends. By participating in a group of fellow foster parents and led by professional therapists, foster parents will have the space to discuss the issues they and their families are struggling with. They will also gain skills and resources to be successful foster parents for their children. They will have peace of mind knowing that they have a support group of their own and that their kids are nearby, safe, and receiving occupational and behavioral health therapies at the same time.

Part Three: Project Details

Timeline - Project Start Date*

*Please provide an estimated **start date** for your project.*

04/01/2022

Timeline - Project End Date*

*Please provide an estimated **end date** for your project.*

03/31/2023

Project Aim*

Please describe the overarching aim of this project. (An aim is the large (thinking big) desired result of your project. The aim serves as the foundation for developing your program objectives. Please limit the aim to one sentence.)

The aim is to provide group therapy programs that increase our capacity to work with children who have been underserved during the pandemic. This includes school aged children and their parents for simultaneous therapy, support, and training.

Project Description/Overview*

Please describe your project.

Group Therapy Services includes simultaneous therapy, support, and training for children with disabilities and special needs, children in the foster care system (or both), and their parents. The groups will be led by physical therapists, occupational therapists and behavioral health professionals. The program includes weekly multidisciplinary group therapy for the children with simultaneous parent education and support groups for their parents. By providing both services at the same time, parents can receive the counseling support they need while their children are receiving the therapy they need. Group therapy will be offered in the evenings so that we can use our existing clinic space outside of traditional one-on-one therapy hours and so that working families from all over the region can participate without missing work or school. Parents will have the peace of mind of knowing that their children are receiving the therapy services they need, while they, the parents, receive support and parent education, without having to worry about arranging childcare.

Our group therapy programs will be offered at all four locations (Redmond, Warm Springs and two in Bend) to make group therapy accessible to all areas of Central Oregon. Within the group context, therapists will work with the children and their parents to meet their individual needs.

Our waitlist for occupational and behavioral health therapy has grown to nearly 300 children. Most of the children on our waitlist have been referred to us due to behavioral concerns. Normally, it would take us 14 - 16 months to get through a waitlist that long, so our staff and leadership have used feedback from parents to create this program. Children on the waitlist for traditional one-on-one therapy could be seen in our specialty group therapy programs in a much more efficient manner. The simultaneous parent groups give parents the skills and support they need to make an immediate impact.

Parental involvement is critical for client success, because in typical therapy we often only see our clients for one hour per week. Parents of children who experience disabilities as well as foster parents are often overwhelmed and need support and education. Our parent groups offer diagnosis-specific tools and education in a supportive environment with other parents whose children experience similar challenges. Parent groups will be facilitated by our trained professionals to collaborate and problem-solve together.

We started pilot groups in 2021. The preliminary findings from self-assessments are very promising. Children have improved social, emotional and physical skills. Parents have gained knowledge and support to effect better outcomes for their children at home and in the community. In our foster family groups, parents report decreased burnout and improved family dynamics.

Given the needs in our community, we plan to create group therapy services for Social Skills, Conquering Emotional Regulation, Picky Eaters, Kindergarten Readiness, Down Syndrome, Cerebral Palsy, Autism, Toe Walking, Sensory Processing Disorder, Foster Family Groups, Handwriting Groups, Fine Motor Skill Groups, and Bike Camp and more.

We have hired a Care Coordinator to help increase coordination of group therapy with other health needs. Our Care Coordinator coordinates care among our providers and is in communication with school therapists and teachers, primary care providers, equipment vendors, and more, to make sure our pediatric patients receive whole person care.

Our group therapy services will address health inequities for children with disabilities and children in the foster care system in several ways. First, this project will increase access to multiple therapies at one time, for clients currently in one-on-one therapy and those still on our waitlist. Second, we provide compassionate, comprehensive, and affordable therapy programs regardless of insurance or financial limitations. Third, group therapy services will direct resources to children with diagnoses and family situations that usually cause them to be marginalized and overlooked in our community. Children with diagnoses such as emotional behavioral disorder, attention deficit disorder, sensory processing disorder, autism spectrum disorder and other physical, developmental and psychological development disorders, and children in the foster care system all experience inequity in our community and in our local healthcare systems. For too long, medical providers have been reducing services for those who qualify for medicaid for financial or diagnosis reasons. Our group therapy project redirects resources to those children who have been marginalized in our community due to their reliance on the medicaid and foster care systems.

Why is this project needed?*

Please describe the identified need for this project.

This project is needed in order to expand our team capacity to serve more pediatric clients and their parents at one time. By conducting group therapy for kids and support and training groups for parents simultaneously, we can provide parents with tools to use at home to support their children. The pandemic has also had a social emotional impact on parents. The combination of childcare deserts, distance learning, and being cut off from resources is resulting in record levels of parental burnout. Parents need support too. Our simultaneous pediatric group therapy and parental support groups offer foster parents and parents of children with special needs emotional support, as well as training and education that empowers them!

This project is needed because children with disabilities were cut off from school-based physical, occupational and behavioral health therapy during distance and hybrid learning and suffered disproportionately to their neurotypical peers. Even though children in Central Oregon schools are technically back at school "in person," the pandemic continues to impact their access to education with record absentee levels among faculty, staff and students. The Washington Post reported in June 2021 on “How America failed students with disabilities during the pandemic” about this exact issue. The article described how, if our students with disabilities do not resume therapeutic treatment as soon as possible, the damage could become permanent. Our group therapy program is targeted to bring those kids in our community, especially from families who rely on medicaid and Oregon Health Plan, back to parity with their peers and set them up for academic success, as much as possible. Funds from COHC will directly impact the lives of children that have struggled academically during distance learning due to diagnoses

such as emotional behavioral disorder, attention deficit disorder, sensory processing disorder, autism spectrum disorder and other developmental and psychological development disorders.

The pandemic has affected us as a service provider with record cancellation levels among our staff and our patients. Our waitlist continues to grow and we struggle to keep up with staffing and workforce shortages.

With over 300 children who experience disabilities on our waitlist, children are not getting the behavioral health, occupational therapy and physical therapy care they need. Normally, it would take us more than a year to get through a waitlist that long. Our staff and leadership have used feedback from parents on the waitlist, and the parents and children currently receiving traditional one-on-one therapeutics, to create this program.

By creating therapy groups, we aim to help close the gaps that the pandemic has created for kids with physical, social, emotional, and behavioral needs.

Part Four: Project Objectives

Objective Description #1*

What is trying to be accomplished?

Our first objective is to get children off our waitlist and into therapy groups. Our goal is to reduce the amount of time children have to wait before they begin to receive services.

SMART Objective #1 (Target/Future State)*

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

By March 31, 2023, we will reduce our waitlist by at least one third (or 100 children) and reduce the amount of time it takes to serve 100 children from 14-16 months to 9-10 months.

Baseline Data for Objective #1 (Current State)*

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Our waitlist currently has 300 children waiting for services. It currently would take us 14-16 months to serve that many children.

Objective Description #2*

What is trying to be accomplished?

Measurable outcomes for children in group therapy include improvements in social interaction skills, collaborative problem solving, emotional regulation, executive functioning, gross and fine motor skills, gross motor planning, and sensory processing. Within the group context, therapists will work with the children to meet their individual needs and set individual goals.

SMART Objective #2 (Target/Future State)*

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

By March 31, 2023, 90% of children in group therapy will achieve at least one objective goal in a functional area by the end of the group session.

Baseline Data for Objective #2 (Current State)*

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

The starting point is that children are waiting on a waitlist. They are not receiving services. Therefore, they therefore have unmet physical, occupational, and/or behavioral health care needs.

Objective Description #3

What is trying to be accomplished?

Our objectives for parents of children with disabilities, include:

-Experience less burnout
-Increase sense of well-being for all
-Increase confidence in ability to advocate for children in schools and in the community
-Increase knowledge of supports and activities that help their children succeed at home, in school and in the community
-Increase self-care

Within each family, parents and children will be able to set their own behavioral health and occupational therapy goals.

SMART Objective #3 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

By March 23, 2023, 100% of parents of children with disabilities, in our group therapy program, will experience increased knowledge base, increased self care, reduction in burnout, and increased sense of well being for all.

Baseline Data for Objective #3 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

In general, the starting point is that the pandemic is causing massive burnout among parents. Specific, personal baseline data will be collected at the start of the groups through a self-assessment survey at intake and upon exiting the program. Our therapists will also assess each participant's progress weekly, or as often as they access our services.

Objective Description #4

What is trying to be accomplished?

Our objectives for foster parents in our group therapy program include:

-Increased longevity within the foster system
-Improved foster parent retention
-Increased self-transparency and taking more breaks for self-care
-Reduced foster parent burnout
-Reduced placement changes for foster children
-Increased sense of well-being for all

Within each family, the parents and children will be able to set their own behavioral health and occupational therapy goals.

SMART Objective #4 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

By March 23, 2023, 100% of foster parents of children in our group therapy program will experience increased knowledge base, increased self care, reduction in burnout, and increased sense of well being for all.

Baseline Data for Objective #4 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Current state will be established at the beginning of each group therapy session by having participants complete a behavioral health self-assessment survey at intake and upon exiting the program. We can also access quantitative and qualitative information from DHS. DHS would be able to provide information regarding the average amount of time foster parents take between cases, if they take sabbaticals of up to one year, and their overall length of tenure as foster parents.

Objective Description #5

What is trying to be accomplished?

SMART Objective #5 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Baseline Data for Objective #5 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Objective Description #6

What is trying to be accomplished?

SMART Objective #6 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Baseline Data for Objective #6 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Part Five: Project Support

Project Collaboration & Partnerships*

How have you worked with community partners and/or the people being served to develop this project?

How do you plan to continue to work together throughout this project?

We have collaborated with the Central Oregon Foster Parent Association as well as Child Welfare services at Oregon Department of Human Services to create and begin to offer our group therapy services.

We have also partnered with The Hero Makers and Think Kids for Collaborative Problem Solving training during our group meetings. We continue to partner with and consult with Healing Reins Behavioral Health Program and Thrive Mental Health regarding the behavioral needs of our community and of our mutual clients.

In Warm Springs, our partners are Central Oregon Disability Support Network and the Warm Springs Early Childhood Education Center.

We will continue to work with these groups to serve our mutual clientele and to incorporate their needs and services into our programs.

Optional: Community Support Letter #1

Please attach any letters of support that you have received for this project. You may attach up to 5. Letters must be uploaded separately.

Treehouse-Letter-of-Support-from-Thrive.pdf

Optional: Community Support Letter #2

letterofsupportth-from-HRTRC.pdf

Optional: Community Support Letter #3

COFPA_TTA Reference Letter.pdf

Optional: Community Support Letter #4

Treehouse-support-letter-from-summit.pdf

Optional: Community Support Letter #5

Best Practice*

What, if any, are the emerging best practices and/or evidence-based guidelines upon which this project is based?

Please write

Our groups will be led by professional, licensed, pediatric physical, occupational and behavioral health therapists who are required by the licenses they hold to provide evidence-based care and to maintain a current knowledge base through annual continuing education requirements.

To be able to bill insurance for individual therapeutic treatments, our clinic also has to maintain best practices in charting, billing, policies, background checks and professional development. Our therapists have to use specific, evidence-based, tests and measures to quantify improvement at every visit in order to be reimbursed by insurance. We have to uphold and be consistent with these practices even for services, such as group therapy, that may not be reimbursable by insurance.

Fidelity*

If your program is evidence-based or best practice, will it be reviewed for fidelity?

Please write

Yes, we are a member clinic of the Northwest Rehabilitation Alliance (NWRA). NWRA regularly reviews our clinic for safety, convenience and accessibility. They ensure that our therapists' licenses are updated and posted, they perform an annual chart review on our charting, and they require that we update background checks on all of our therapists monthly. We have to be credentialed through NWRA in order to be able to contract with insurance companies.

Evaluation*

Please share with us how you plan to evaluate this project.

For the pediatric physical therapy, occupational therapy, and behavioral health therapy, progress will be measured at intake, exit, and each time families access our group therapy care. Within each family, the parents and children will be able to set their own behavioral health and occupational therapy goals.

The measurable outcomes for the children participating in group therapy will be determined by the needs and goals of each child and their family. Each child has their own unique individual functional and behavioral goals. Clinical measurable outcomes will be seen in the areas of:

Physical Therapy:
Gross motor skills, functional age-appropriate skills and accessing school, home, and the community physically

Occupational Therapy:
Fine motor skills, sensory processing, self regulation. Accessing and working at home, school and in the community physically and socially

Behavioral Therapy:
Addressing mental health and behavior issues will foster an overall sense of well being, improve function, relationships and social interactions at home, at school and in the community.

For the parent support groups, we will measure these outcomes by having participants complete a behavioral health self-assessment survey at intake and upon exiting the program. Our therapists will also assess each participant’s progress weekly, or as often as they access our services.

For foster parents, we can also access quantitative and qualitative information from DHS. DHS would be able to provide information regarding the average amount of time foster parents take between cases, if they take sabbaticals of up to one year, and their overall length of tenure as foster parents.

Our team care coordination meetings will be where we assess the progress & success of each individual child and family, and where we assess the progress and success of the program overall.

We will evaluate the overall success of the program and measurable outcomes for the program itself at each care coordination meeting and at the conclusion of the funding period. This will allow us to evaluate whether we were successful in reducing our waitlist and serving more children and if we need to continue the group therapy or if it has served its purpose. If we need to continue, then develop plans based on what went well and what needs improvement.

How will we know if the project is successful?*

We will know this project is successful if we can reduce our waitlist by reducing the number of children waiting to be enrolled in pediatric therapeutic services and by reducing the amount of time it takes to provide services to them.

Our vision is that parents of children with special needs will have the knowledge and resources they need to advocate for their children and to care for themselves and their families. Foster parents will experience less burnout, take fewer sabbaticals, and stay in the foster system longer.

We will also know that this project is successful when group therapy becomes a fun option that makes learning more accessible by working with other children of about the same age, and not solely because it's the only option we have to be able to serve everyone waiting for therapeutic services.

Optional: MOU or MOA

Optional: MOU or MOA

Optional: MOU or MOA

Part Six: Budget Information

Project Budget*

*Please download the Central Oregon Health Council's budget document, found **here.** After downloading and completing the budget document, please upload it below.*

CAC-Community-Benefits-Project-Budget-Final-Treehouse-Therapies-2022.xlsx

Funding Request - Year One*

$45,000.00

Funding Request - Year Two

Funding Request - Year Three

Funding Match*

Are you seeking any funding matches or additional contributions to support your project? If so, provide the organization/entity name that will be providing the match.

If you are not seeking a match, please write

Yes, we have already received funding from Oregon Community Foundation and United Way of Central Oregon for the initial Pilot Programs for our group therapy projects during 2021 and 2022. The initial funding periods for OCF and United Way will expire by August 2023. We plan to re-apply to both OCF and United Way in 2022 as well as other foundational and public funding opportunities that become available in 2022, including Medline and US Bank. We are also looking into the possibility of billing insurance where possible for group therapy. Insurance billing for group therapy is usually very limited, however.

Funding Match Amount (if not applicable, leave blank)

$39,751.00

Process Following Submission

Application Files

Applicant File Uploads

- Treehouse-Letter-of-Support-from-Thrive.pdf
- letterofsupportth-from-HRTRC.pdf
- COFPA_TTA Reference Letter.pdf
- Treehouse-support-letter-from-summit.pdf
- CAC-Community-Benefits-Project-Budget-Final-Treehouse-Therapies-2022.xlsx

Thrive Mental Health
Phone: 541-390-7288
15 SW Colorado Suite 220
Bend, OR 97702
https://thrivementalhealththerapy.com/

To Whom it May Concern:

Treehouse Therapies is an imperative agency in our Central Oregon Community. They offer innovative and comprehensive services for youth and families. Treehouse consistently modifies and evolves based on the needs of their clients. We know the mental health system is bursting and Tree house has been creative in how they can fill that gap by offering quality care and timely access to their clients.

The therapy groups they are creating and offering to the community increases the access points. Not only does it provide a needed resource, it also creates a network for participants to feel heard and validated by other humans. Groups normalize the experience and decrease the isolation and loneliness that many are experiencing.

Treehouse has proven their treatment effectiveness and I fully stand behind their work and community.

Please do not hesitate to contact me if you have any further questions.

Best regards,
Katie Steele. LMFT

License Number: T0919
NPI: 1104078336
Tax ID: 46-4128946

"to heal with horses"

A non profit organization
501c3 #931279550

Executive Director
Polly Cohen

Development Director
Ali Burke

Operations Manager
Penny Campbell

P.O. Box 5593
Bend, OR 97708
Phone 541-382-9410
www.healingreins.org

January 27, 2022

To Whom it May Concern,

It is my pleasure to write a letter of support for Treehouse Therapies application to the COHC Community Health Projects. I fully support the efforts of Treehouse Therapies as they seek funding from your foundation to grow their multidisciplinary group therapy programs. The proposal being submitted will allow this vital organization to create innovated groups that not only assist the emotional needs of the child but also their families.

Treehouse Therapies remains Central Oregon's only non-profit pediatric clinic specializing in physical therapy, occupational therapy and behavioral health. Healing Reins has had the privilege of collaborating with them for over 7 years. As our community grows, so too does the need for Treehouse Therapies specialized services. Your support of their proposal will make a meaningful difference in the lives of vulnerable youth and families all over our region who require the help that only Treehouse Therapies can provide.

Thank you for your consideration.

Sincerely,

Polly Cohen

Polly Cohen
Executive Director
Healing Reins Therapeutic Riding Center

January 1,2022

To Whom it May Concern,

As the only support Association in Central Oregon for Foster Parents. COFPA has been partnering with Treehouse Therapies for the last 3 years. Most of the children who come into care need some if not all of the services that Treehouse provides. We have many of our pediatric community in foster care that are clients of Treehouse and are getting BH, OT and PT services. These services are critical for our foster care community as the children in foster care have not had regular checkups and are on the higher end of the ACES scale.

Treehouse is consistently evolving and developing programs to better support not just the children in the foster care system, but the biological families and the resource families. One example is they created a support group for Resource Parents when no other organization in the area could get this program going, including ODHS.

The continued evolution and development of programs continues to strengthen the entire family during the time the child is in foster care and even after.

Treehouse has proven their consistency in treatment for the entire family not just the child, which increases the effectiveness of treatment.

Please don't hesitate to call me with any further questions.

Sincerely,

Alayna Weimer

Executive Director COFPA

www.centraloregonfosterparentsassociation.org

January 27th, 2022

To Whom It May Concern-

I am writing this letter to convey my utmost support of Treehouse Therapies. As you may know, Treehouse is a multi-specialty pediatric therapeutic organization with several locations in Central Oregon. As a pediatrician in Central Oregon for over 8 years, I can say without hesitation that the services that Treehouse provides to the children (and parents) of Central Oregon is unparalleled.

Their dedication to going above and beyond in order to suit the needs of the children in our area is outstanding. They are extremely accessible to the providers in the community and are innovative in finding ways to reach as many children as possible despite back-logs in referrals. We are currently experiencing what I would call a crisis in Central Oregon in terms of mental health and behavioral/parenting issues. Treehouse Therapies is committed to doing their best to help in this crisis, but as a non-profit organization, they rely on outside support. I know firsthand that they utilize these resources in whichever way allows them to best serve as many children and parents as possible.

Treehouse Therapies is a fantastic organization and Central Oregon would not be the same in terms of its pediatric care without them. I hope that you will join me in supporting them in whatever capacity you are able to do so.

Sincerely,

Jennifer Schroeder, MD

Jennifer Schroeder, MD

(503) 756-3632

Project Budget

Total Requested Project Funds from the Community Advisory Council:	$45,000

Personnel Costs: Name	Position (FTE dedicated to this	Salary for this project	Benefits	Total Cost	Amount Requested
Behavioral Health Therapist 1	*8-10 hours/month	$8,400	$420	$8,820	$8,000
Behavioral Health Therapist 2	*8-10 hours/month	$8,400	$420	$8,820	$8,000
Occupational Therapist 1	*8-10 hours/month	$8,400	$420	$8,820	$4,000
Occupational Therapist 2	*8-10 hours/month	$8,400	$420	$8,820	$4,000
Physical Therapist 1	*4-5 hours/month	$4,200	$210	$4,410	$2,200
Physical Therapist 2	*4-5 hours/month	$4,200	$210	$4,410	$2,200
Care Coordinator	0.12 FTE	$7,056	$847	$7,903	$4,000
Executive Director	*2 hours/month	$1,269	$279	$1,548	$0
	Sub-Total: Personnel	$ 50,325	$3,226	$53,551	$32,400

Materials & Supplies	Total Cost	Amount Requested
Snacks	$8,000	$4,000
Therapeutic Equipment & Supplies	$10,000	$5,000
Sub-Total: Materials & Supplies	$18,000	$9,000

Travel Expenses	Total Cost	Amount Requested
N/A		
Sub-Total: Travel Expenses	$0	$0

Consultants & Contracted Services	Total Cost	Amount Requested
Collaborative Problem Solving Consultant - Direct work with patients in t	$6,000	$0
Sub-Total: Consultants & Contracted Services	$6,000	$0

Meeting Expenses	Total Cost	Amount Requested
Planning & Evaluation Meetings	$5,200	$2,600
Sub-Total: Meeting Expenses	$5,200	$2,600

Professional Training and Development	Total Cost	Amount Requested
Collaborative Problem Solving Professional Development	$2,000	$1,000
Sub-Total: Professional Training and Development	$2,000	$1,000

Other Budget Items	Total Cost	Amount Requested
N/A		
Sub-Total: Other Budget Items	$0	$0
Total Project Budget	$84,751	$45,000

***Budget Narrative and Explanation:**

• Our full-time Behavorial Health and Occupational Therapists will spend about 8-10 hours per month therapy project; Physical Therapists will spend about 4-6 hours each month on this project. We listed hours per month because we feel that is more clear representation of the time our therapists will spend

• Our Care Coordinator will spend 20 hours month coordinating care among our therapy team and activities and instruction, organizing the groups, managing materials and supplies as well as scheduling communication between families and therapists and coordination of group therapy with other health Coordinator coordinates care among our providers and is in communication with school therapists and care providers, equipment vendors, and more, to make sure our pediatric patients receive whole person

• The Executive Director will spend 2-3 hours per month overseeing and evaluating the therapy group

• Monthly Coordination of Care meetings ensure that our clients receive consistent therapeutic modalities and that their needs are being met 100%. We include in-clinic time only in salaries. The main cost of the coordination of care meetings is to pay our therapists for their time spent during the monthly meetings which usually take about 1.5 hours each.

• Our pilot therapy groups have identified Collaborative Problem Solving as a need to create a trauma-collaborative experience for all participants. Our budget for 2022-2023 includes a Collaborative Problem consultant to provide direct services for group therapy particpants and professional development for that they can begin to incorporate Collaborative Problem Solving in their therapy work directly.

• This budget represents the ideal amount needed to reach our goals 100%. We can adjust the scope of match the amount of money we actually raise.

Form Name:

2021 Community Health Project Full Application

Lifetime Vision Care

Vision Learning and Vision Success

RHIP Workgroup:

Future State Measure:

Application Snapshot	
Amount Requested	$7,200.00
Organization Contact	Derri Sandberg
Contact Phone	541-382-3242
Contact Email	dsandberg@lvcbend.com
Organization Address	901 NW Carlon Ave Suite 2 Bend, OR 97703
Website	http://cohealthcouncil.org/
Project Lead	Shantia Hinderlider
Project Lead email	vt@lvcbend.com

Note: * indicates required questions

Part One: Project Highlights

Project Name*

Name of Project.

Vision Learning and Vision Success

Amount Requested*

Please list the total amount of funds requested for this project.

The funding request needs to be between $5,000 to $80,000.
Anything over $80,000 or under $5,000 will be denied.

$7,200.00

Project Duration*

How many months will the project last?

12

Towns Included in Project*

Which of the following towns in Central Oregon will your project include?

Bend
Camp Sherman
Chemult
Crescent
Crescent Lake Junction
Culver
Gilchrist
La Pine
Madras
Metolius
Powell Butte
Prineville
Redmond
Sisters
Sunriver
Terrebonne
Tumalo

Warm Springs

Other Towns

If you chose 'other' above, please share the name of the town or towns included in your project.

Bend

Name of Project Lead*

Please provide the first and last name of the project lead for this funding request.

Shantia Hinderlider

Email for Project Lead*

Please provide an email address for the project lead.

vt@lvcbend.com

Phone Number of Project Lead*

Please provide the best phone number to reach the project lead.

5413823242

Diversity, Equity, and Inclusion (DEI) Statement

Does your organization have a Diversity, Equity, and Inclusion (DEI) statement?

Have a drafted DEI Policy

DEI Statement

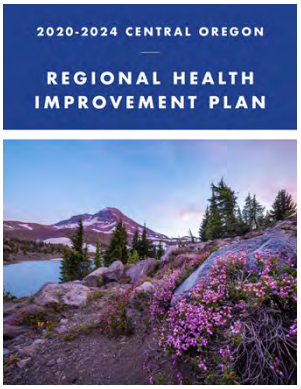
If your organization has a completed DEI statement, please copy and paste it here.

We want to ensure that the recipients of this grant will benefit their vision or eye care needs, without barriers such as poverty, access to healthcare and discrimination. We service not only Central Oregon but many outlying rural areas in the state. We have frequently had patients travel to participate in vision therapy programs and other vision rehabilitation treatments in the past and with the past grant.

Part Two: Project Checklist

2020-2024 Regional Health Improvement Plan Priority Areas*

Please review the aim for each of the six priority areas for the 2020-2024 Regional Health Improvement Plan by clicking on the image:



Based on the aim of each priority area, please select which area(s) of focus that your project aligns with:

Address Poverty and Enhance Self-Sufficiency
Upstream Prevention: Promotion of Individual Well-Being

Alignment With the Regional Health Improvement Plan*

Based on the priority area(s) you selected above, share how your project aligns with the aim(s).

We will be able to provide vision and eyecare services to the recipients regardless of access to healthcare, income, or insurance coverage. We have patients daily that have a need for vision and eyecare services that are unable to afford them. Self sufficiency will be enhanced by giving patients proper vision function and eye health to promote learning, job efficiency and activities of daily living. We have countless of patients who have been given opportunities that support long term success in life because of the access to vision care.

Oregon Health Plan (OHP)*

Will your community project be available to and serve individuals who qualify for the Oregon Health Plan (OHP)?

Yes

Tribal Nations

Please select which tribal nations your project will engage?

Confederated Tribes of Warm Springs
Cow Creek Band of Umpqua Tribe of Indians
Klamath Tribes

Serving Tribal Nations*

If applicable, please describe how your project will serve at least one of the tribal nations listed below:

- *Cow Creek Band of Umpqua Tribe of Indians*
- *Confederated Tribes of Warm Springs*
- *Klamath Tribes*

If your project does not serve a tribal nation, please state:

Our project is open to any and all patients regardless of where they live.

Social Determinants of Health*

*How does your project address **social determinants of health**?*

Our project addresses social determinants of health in the following areas:
1. Access to health care services. By allowing patients who do not have insurance coverage to receive benefits.
2. Quality of education and job training. By supporting best vision and vision function to perform at optimal levels of education and jobs.
3. Language and literacy. By seeing optimally to improve visual function such as reading and comprehension.

Social Determinants of Health (Continued)*

Please select which social determinant(s) of health your project will primarily address:

Education
Social and Community Health
Health and Health Care

Serving Those Severely Impacted by System Barriers*

If applicable, please describe how your project will serve those severely impacted by system barriers?

The barriers that patients face with access to our resources include mainly access to health care services. Typically these patients may even have access to OHP however the services may still be not covered. In the past grant we were able to fund patients with partial or full financial assistance, based on their need, that would not have been able to participate if the help was not given.

Serving Rural Communities*

*If applicable, please describe how your project serves rural communities. You can find a definition of rural **HERE.***

Our practices has a history of serving patients in all regions of Oregon and will continue to do so at a greater level with the help of this grant.

Equity*

Please describe how your project applies Diversity, Equity, and Inclusion principles and practices.

Our services are not limited to anyone based on race, ethnicity, sexual orientation, discrimination, social economic status. In fact, grants like these help those underserved community members to have access to health care services, like vision treatments, that would otherwise be left untreated.

Part Three: Project Details

Timeline - Project Start Date*

*Please provide an estimated **start date** for your project.*

02/14/2022

Timeline - Project End Date*

*Please provide an estimated **end date** for your project.*

02/14/2023

Project Aim*

Please describe the overarching aim of this project. (An aim is the large (thinking big) desired result of your project. The aim serves as the foundation for developing your program objectives. Please limit the aim to one sentence.)

Our main overall goal is to provide vision treatment services to all patients regardless of financial resources. We often find access is available for routine/medical visits and patients receive a diagnosis but not always have access to treatment.

Project Description/Overview*

Please describe your project.

Our project will provide resources to patients in need so they may function at the highest level within their education or jobs.

Why is this project needed?*

Please describe the identified need for this project.

Again, patients often receive diagnoses and a treatment plan but cannot afford nor access the programs available and needed to help them, often due to financial obstacles.

Part Four: Project Objectives

Objective Description #1*

What is trying to be accomplished?

Provide access to vision treatment to 24 or more recipients in 1 year.

SMART Objective #1 (Target/Future State)*

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

By March 1, 2023, 24 patients will receive access to services.

Baseline Data for Objective #1 (Current State)*

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

We currently have no ($0) available grants to assist patients as of 01/07/2022.

Objective Description #2*

What is trying to be accomplished?

Measurable subjective or objective vision finding that improves after each patient's treatment is complete.

SMART Objective #2 (Target/Future State)*

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

100% of patients' visual findings for improvement will establish improvement from pre-treatment assessment to post-treatment assessment.

Baseline Data for Objective #2 (Current State)*

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Each finding would have a baseline measurement and post-treatment measurement for improvement.
Subjective findings could include headaches, focus, reading comprehension, for example.
Could include but not limited to visual acuity improvement, stereo 3D vision, accommodation (focus) facility, oculomotor tracking improvement, reading efficiency per King Devick timed tracking test)

Objective Description #3

What is trying to be accomplished?

SMART Objective #3 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Baseline Data for Objective #3 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Objective Description #4

What is trying to be accomplished?

SMART Objective #4 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Baseline Data for Objective #4 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Objective Description #5

What is trying to be accomplished?

SMART Objective #5 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Baseline Data for Objective #5 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Objective Description #6

What is trying to be accomplished?

SMART Objective #6 (Target/Future State)

Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Baseline Data for Objective #6 (Current State)

Please provide information that indicates where you are starting (current state data) as it relates to your SMART Objective.

Part Five: Project Support

Project Collaboration & Partnerships*

How have you worked with community partners and/or the people being served to develop this project?

How do you plan to continue to work together throughout this project?

We currently receive referrals from local doctors including primary care, optometry/ ophthalmology, neurology, tutors, learning specialists. This referral system is already in place and would be easy to notify these providers about our grant availability.

Optional: Community Support Letter #1

Please attach any letters of support that you have received for this project. You may attach up to 5. Letters must be uploaded separately.

Optional: Community Support Letter #2

Optional: Community Support Letter #3

Optional: Community Support Letter #4

Optional: Community Support Letter #5

Best Practice*

What, if any, are the emerging best practices and/or evidence-based guidelines upon which this project is based?

Please write

We are not uploading specific letters due to HIPAA concerns as they may contain patient data.

Fidelity*

If your program is evidence-based or best practice, will it be reviewed for fidelity?

Please write

We are not 100% sure of this question. We have a track record from 1995 of helping patients access care for vision treatment and services. We are dedicated to our cause.

Evaluation*

Please share with us how you plan to evaluate this project.

We have in place pre-treatment testing protocol with the doctor to determine proper diagnosis and treatment plan. We also have a post-treatment evaluation in place for every patient including a maintenance program.

How will we know if the project is successful?*

Patient feedback at the post-treatment evaluation is tracked and furthermore follow up is scheduled if needed.

Optional: MOU or MOA

Optional: MOU or MOA

Optional: MOU or MOA

Part Six: Budget Information

Project Budget*

*Please download the Central Oregon Health Council's budget document, found **here.** After downloading and completing the budget document, please upload it below.*

Vision and Leanring 2022 Budget.pdf

Funding Request - Year One*

$7,200.00

Funding Request - Year Two

Funding Request - Year Three

Funding Match*

Are you seeking any funding matches or additional contributions to support your project? If so, provide the organization/entity name that will be providing the match.

If you are not seeking a match, please write

NA

Funding Match Amount (if not applicable, leave blank)

Process Following Submission

Application Files

Applicant File Uploads

- Vision and Leanring 2022 Budget.pdf

Project to start 02/14/2022 and end 02/14/2023

$7200 total budget

Cost per treatment of vision therapy $100 per session at full assistance
Cost per treatment of vision therapy $50 per session at 50% assistance

Cost of glasses or other treatments pending specific need

Projected to assist patients based on need would be 72 sessions of vision therapy at full assistance to 144 sessions of vision therapy at 50% assistance.

This alone will help many patients, in addition other services if not using for vision therapy.

Make the Most of Your Doctor Visits

PacificSource Community Solutions

There are things you can do before, during, and after your doctor visit to help you get great care. Take a little time to plan ahead. This will help you get your questions answered, understand your treatment options, and know what you need to do next.

Getting Ready for Your Appointment

Make a list to take along

You'll find a helpful worksheet on the back of this guide. If you would rather make your own list, here are some things to include:

- **The questions you want to ask.** Examples: Why am I feeling this way? How am I doing? What else can I be doing to feel better? Have I had all the screening tests I need for my age?
- **What you need to tell or show your doctor.** This could include symptoms, family history, or if you've been around other people who've been sick.
- **All medications and supplements you currently take**. That includes over-the-counter medications, vitamins, and herbal remedies. Better yet, bring all these items with you so your doctor can see the labels.
- **Any allergies you have,** including bad reactions you've had to medications.

Think about asking someone to go with you

Consider taking a trusted friend or family member with you. This can be really helpful if you feel sick or have serious health problems. This person can help listen and take notes.

During Your Appointment

- **Explain why you're there.**
- **Answer the doctor's questions.** Your clear and complete answers help the doctor figure out what might be going on.
- **Listen to your doctor's diagnosis**. Do you understand what your provider is telling you? If questions come up, ask them.
- **Ask questions about any medications, tests, or procedures your doctor recommends.** Remember, more treatment doesn't always mean better care. It's smart to ask about risks, side effects, alternative treatment options, and what the doctor expects to learn from the procedure.
- **Ask any remaining questions from your list.** Ask anything your doctor hasn't already answered, and take notes.
- **Know what happens next.** Before you leave, make sure you're clear about the next steps and when they need to happen.

You can get this document in another language, large print, or another way that's best for you. Call toll-free (800) 431-4135. TTY users call (800) 735-2900.

Usted puede recibir este documento en otro idioma, impreso en letra más grande o de cualquier otra manera que sea mejor para usted. Llame al número gratuito (800) 431-4135. Los usuarios del servicio TTY pueden llamar al (800) 735-2900.

Follow Through

- **Do your part.** Most likely, you agreed to do something: come in for a test, schedule a follow-up appointment, try a new medication. Be sure to follow through.
- **Watch for possible problems.** For your safety, be alert in the hours and days after you start a new medication or treatment. If you notice any new symptoms or problems, let your doctor know right away.
- **Call back if you need to.** If you have new questions or concerns after your appointment, call your doctor's office. If you were expecting to get test results or schedule tests and haven't heard from anyone, call the doctor's office.

Use PacificSource as a Resource

Contact our Customer Service team when you have questions. We can help with:

- Tell you whether a surgery, procedure, or medication needs to be pre-approved.
- Help you find doctors in your plan's network.
- Answer questions about a claim or Explanation of Benefits (EOB) statement.

How to Ask Questions

Many people hold back on asking questions during their medical appointments. Some are embarrassed, think it will take too much time, or they're not sure what to say.

Asking questions can be hard. But remember, it's your body. You need—and deserve—to understand what your doctor or other health professional is telling you.

- Take your time and think about what the doctor has said.
- Ask questions that will help you clearly understand the diagnosis.
- Refer to your list of questions, or use the worksheet on the back of this brochure to guide you.

More Ways to Ask for Information

If you don't understand the answers to your initial questions, here are some ways to ask again:

I'm sorry, but I still don't really get that. Could you explain it in a different way?

I'm not sure I understand the reason for that test. What will we learn from doing it?

I'm still not clear on my treatment options. Could you write them down for me?

See last page for our doctor visit worksheet.

Prepare for your **Doctor Office Visit**

This form will help you remember important information. You may want to talk about these things with your doctor.

Doctor's name:	Date of office visit:

Complete this section **before** your appointment.

Questions or concerns (symptoms, when you first noticed them, relevant family history, etc.):	Prescription drugs, over-the-counter medicines, or supplements you are currently taking. List any allergies:

Complete the following sections **during** your appointment.

If your doctor recommends medication, tests, screenings, or procedures:

Diagnosis or condition being treated?	Name of the test or procedure?
What are the risks?	Are these tests routine or diagnostic?
Are there other options?	How do I prepare?

If your doctor writes a prescription:

What is the name of the medication?	Are there any side-effects?

At the end of the visit, ask:

Do I need to come back for another visit?	Can I call for test results?
What danger signs should I look for?	What else do I need to know?

Your Health and Wellness **Journey Map**

PacificSource Community Solutions

Your Healthcare Information **in One Spot**

This guide makes it easy to keep your healthcare information organized.

Tip: Bring this guide with you to your doctor's appointment or local pharmacist. They can help you fill in the blanks or answer your questions.

Doctor _____ Phone _____

Doctor _____ Phone _____

Doctor _____ Phone _____

Appointment Tracker

Use this space to keep track of your appointments.

Date	Time	Doctor	Things to Talk About

Preventive Care Services

Preventive care is a big part of your overall healthcare. Yearly check-ups help you establish care with your doctor. This also helps you get appointment times faster when you need help. Use this space to keep track of recommended preventive healthcare.

Preventive Care Services	Frequency	Date
General Screenings and Care		
Blood Pressure	Every 1 to 5 years	
Cholesterol	Every 1 to 5 years	
Family Planning	Seek doctor recommendation	
Women's Cancer Screening		
Mammogram (Women over 50)	Every 1 to 2 years	
Cervical Cancer Screening	Seek doctor recommendation	
Colon Cancer Screening (Adults over 50)		
One of the following: • Fecal Occult Blood Test • Flexible Sigmoidoscopy • Screening Colonoscopy	 • Once a year • Once every 4 years • Once every 10 years	
Vaccines		
Influenza (flu)	Once a year	
Childhood vaccines	Seek doctor recommendation	

Please see your benefits book for details.

Questions to Ask My Doctor

Write the questions you want to ask your doctor to make the most of your appointment time. Here are some examples of questions you might ask:

- How can I stay healthy or get healthier?
- What can I do to improve my mental health or feel better?
- How can I increase my physical activity?

List your questions, concerns, and notes here:

Blood Pressure

If your blood pressure is outside the normal range, you may need additional follow-up care with your doctor. That's why you should have your blood pressure checked at least once per year. Your doctor will also likely get a blood pressure reading at each visit. Keep track of the date and rating for each blood pressure test. Talk with your doctor to learn more about a normal blood pressure range for you.

Date	Result

Date	Result

Other Screenings

While there are general recommendations for everyone, you will also have healthcare needs that are specific to you. This is where you can track those things. For example, if you have diabetes, you will want to keep track of your test results.

Tests/Screening	Date	Result

Health and Wellness Goals

Use this space to record your health and wellness goals. If you're not sure where to start, work with your doctor to set healthy, realistic goals.

Use the SMART goal-setting technique to help you set **s**pecific, **m**easurable, **a**ttainable, **r**ealistic, **t**imely goals. For more guidance, view the SMART goal worksheet at PacificSource.com/HealthGoals/SMART.pdf.

Nutrition Goals

Fitness/Physical Activity Goals

Other Health and Wellness Goals

(sleep, stress control, tobacco cessation, blood pressure, etc.)

Medications and Prescription

It's important to take your medications as recommended by your doctor. If you struggle with this because of problems with refills, contact us. Our Pharmacy Services team can help you with:

- Mail-order refills
- Automatic refills

Track your medications. This includes how much you should take (dosage), and how often you should take it (frequency).

Medication	Dosage	Frequency

Medicines can have possible side effects and interactions you should know about. Your doctor or pharmacist can tell you about those. Note them here.

Interactions and Possible Side Effects of Medication	What to Do

Answers to Common Questions

Where can I find my member ID number?

This is a nine-digit number that begins with "8." You'll find it on the front of your PacificSource Community Solutions member ID card.

Where can I find information about my plan and benefits?

You can learn more about your plan and how it works on our website. Visit www.CommunitySolutions.PacificSource.com. Use our search tools to find a doctor, pharmacy, or medication. You'll find a member handbook in the For Members section.

Download the myPacificSource app. Use our free app to access your member ID card, find a doctor, contact us, and more. To see your ID card, you will need to create an account using your Medicaid ID number. Sign up at intouch.pacificsource.com/members/account/signup/MD.

What is a Coordinated Care Organization (CCO)?

PacificSource Community Solutions is a CCO. We work with all types of doctors and providers. Together, we help people on the Oregon Health Plan (OHP) get healthcare.

I received two ID cards in the mail—an Oregon Health Plan (OHP) card and a PacificSource member ID card. Which do I show the doctor?

Take your PacificSource ID card to all of your healthcare appointments. Also take it to the pharmacy when you fill a prescription. Keep your OHP ID card in a safe place at home.

Resources

PacificSource Community Solutions: www.CommunitySolutions.PacificSource.com
myPacificSource Mobile App: www.PacificSource.com/mobile

Contact Us

If you have questions about your plan, call our Customer Service Department from 8:00 a.m. to 5:00 p.m., Monday through Friday.

Central Oregon
(541) 382-5920 - Local
(800) 431-4135 - Toll Free
(800) 735-2900 - TTY

Columbia Gorge
(855) 204-2965 - Toll Free
(800) 735-2900 - TTY

Additional Notes

You can get this document in another language, large print, or another way that's best for you. Call toll-free (800) 431-4135. TTY users call (800) 735-2900.

Usted puede recibir este documento en otro idioma, impreso en letra más grande o de cualquier otra manera que sea mejor para usted. Llame al número gratuito (800) 431-4135. Los usuarios del servicio TTY pueden llamar al (800) 735-2900.

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Oregon Health Plan (OHP)
Member Quick Start Guide

PacificSource Community Solutions

Welcome! We are happy to have you as a member. Getting up to speed with PacificSource is as easy as 1-2-3:

1. **Read your Member Handbook.** You will receive it soon, and it has complete info on your plan's benefits.
2. **Connect with a doctor.** Although a primary care provider was already assigned to you, you can also choose a new one at **CommunitySolutions.PacificSource.com.**
3. **Get the app.** If you have a smartphone, the **myPacificSource app** lets you search for doctors, view your Member ID and more.

How to get care

When you or a family member is hurt or sick, you have ways to get care.

24-Hour NurseLine

800-834-6150

Ask a registered nurse your health questions any time, day or night.

Seeing a Doctor

For routine care, see a doctor. When making an appointment, ask if you can see your doctor in person or from home (by phone or video through telehealth).

Urgent Care

If nearby, visit an urgent care location for things like:

- Cold or flu
- Sinus infection
- Bronchitis
- Minor burn, bumps, or other injuries

Emergency Care

Go to the emergency room or call 911 for cases such as:

- Trouble breathing
- Chest pain
- Severe head injury
- Poisoning
- Heavy bleeding

Need help scheduling an appointment or managing your care? Reach out to Customer Service at **800-431-4135, TTY 711**

Glad to have you with us.

PacificSource Community Solutions serves OHP members. We are local. Our parent company, PacificSource Health Plans, is a not-for-profit health insurer, and has served the Northwest since 1933.

Continued >

Depending on your plan, your PacificSource benefits may include:

Doctor's visits

Even if a primary doctor was already assigned to you, you can choose a new one. You can search our directory from the **myPacificSource app**, or by visiting our website**.**

Preventive care

Routine care, such as mammograms and other screenings, is included at no cost. You may also get free flu shots, well child visits, and vaccines. A full list can be found in the member handbook.

Pregnancy care

Coverage includes prenatal care for you and your baby, as well as labor and delivery, new-mother care, and care for your newborn until age one.

Dental care

Members with dental benefits can get teeth cleanings, exams, fillings, dentures, and more.

Mental health services

These may include counseling and therapy, as well as coverage for residential treatment, detox, and more.

Free rides to services

Need a way to get to doctor appointments? Free rides are possible through NEMT service. To learn how to set up a ride, see our website.

Prescription medications

Member benefits include coverage for prescription drugs, including home delivery. Find a list of drugs and in-network pharmacies at **CommunitySolutions.PacificSource.com**.

Medical interpreters

It is your right to have an interpreter at your medical appointments, and to get written material in a language you can read. Need help asking for an interpreter? Call us at **800-431-4135**.

Help with your wellness

We can connect you with Traditional Health Workers to support your health and wellness. Learn more on our website or contact Customer Service.

Other helpful services

We offer Intensive Care Coordination for members with complex healthcare needs, as well as Health Related Services that include things such as special equipment, classes, or special clothing/footwear. To learn more, contact our Customer Service team.

Renewals and address changes

You need to renew OHP coverage each year.

To do so, you can:

- Find a local OHP Application Assister at **Healthcare.Oregon.gov**
- Visit the One Health Portal at **One.Oregon.gov**
- Call OHP at **800-699-9075**

Have you moved? Let us know!

You can update your address and other info by contacting OHP at **800-273-0557**, or by logging in to your One Health Portal account at **One.Oregon.gov.**

Get in touch!

CommunitySolutions.PacificSource.com

800-431-4135
TTY 711

Hours:

October 1 – January 31:
7 days a week
from 8 a.m. to 8 p.m.

February 1 – September 30:
Monday to Friday
from 8 a.m. to 5 p.m.

Non-Emergent Medical Transportation Services (NEMT)

How can I get free rides to healthcare appointments?

Non-Emergent Medical Transportation is how you can get a ride to a covered healthcare appointment. This is for scheduled healthcare appointments, not emergencies. PacificSource Community Solutions provides transportation services to you in the area that you live.

There are many ways we can help you get to your appointment, which include:

- Bus pass or taxi service
- A ride from a volunteer driver
- Wheelchair accessible vehicle service
- Stretcher vehicle
- Reimbursement for driving yourself
- Non-emergent ambulance (If you need a non-emergent ambulance ride, the ambulance company will work with your NEMT provider. The ambulance company will get the records they need about the ride to make sure it is covered.)

Please note some rules may apply. Call your transportation provider or PacificSource Customer Service for more information. (Phone numbers are listed on the back.)

You can get this flyer in another language, large print, or another way that's best for you. Call us toll-free at (800) 431-4135, TTY users call (800) 735-2900.

Usted puede recibir este documento en otro idioma, impreso en letra más grande o de cualquier otra manera que sea mejor para usted. Llame al número gratuito (800) 431-4135. Los usuarios del servicio TTY pueden llamar al (800) 735-2900.

PacificSource Community Solutions

Who can get a ride?

You are eligible for a free ride to your covered appointment if:

- You are enrolled by PacificSource insurance through the Oregon Health Plan in Central Oregon, the Columbia Gorge, Lane, and Marion or Polk counties.
- You are traveling to a covered healthcare appointment or other healthcare service, such as Health-Related Services.
- If you have Medicaid and Medicare insurance, the ride can be provided to Medicaid and Medicare covered appointments.
- You need help getting there.

Children ages 12 and under must travel with a parent or guardian who is at least 18 years old.

Reimbursements

If you or someone else drives you to your appointment, you may be able to be paid back for part of the cost of the mileage. This is from your home to your appointment and back.

If you want to be reimbursed, you must report this to your NEMT provider within 45 days of the appointment, on the required documents provided by the NEMT provider. You do not need to call your NEMT provider before your appointment to be reimbursed.

If the ride is urgent and your transportation provider is closed, mileage, lodging, and meal expenses can be paid back afterward if it is verified and submitted within 45 days.

Always call 911 if you are having a medical emergency.

Scheduling a ride

Central Oregon, Columbia Gorge and Marion-Polk CCO Members

(Crook, Deschutes, Jefferson, Northern Klamath, Hood River, Wasco, Marion and Polk counties)

Call LogistiCare at:

- (855) 397-3619 Toll-free for Central Oregon
- (855) 397-3617 Toll-free for Columbia Gorge
- (844) 544-1397 Toll-free for Marion-Polk
- (800) 735-2900 TTY Central Oregon, Columbia Gorge and Marion-Polk

Hours: Monday – Friday 9:00 a.m. – 5:00 p.m. closed all major holidays (for routine trips)
7 days a week, 24 hrs a day (for urgent and discharge trips)

Lane County CCO Members

(Lane County)

Call RideSource (LTD) at:

- (541) 682-5566 Local
- (877) 800-9899 Toll-free
- (800) 735-2900 TTY

Hours: Monday – Friday 8:00 a.m. – 5:00 p.m. closed all major holidays

When you call, you will need to give some information about your trip:

- Time and location of your appointment
- Address where you need to be picked up
- If you have a car or a friend or family member that can take you to your appointment
- If you have any special needs for the ride
