



Behavioral Health: Increase Access and Coordination
Regional Health Improvement Plan Workgroup

Join Zoom Meeting

<https://us02web.zoom.us/j/89240423046?pwd=bkpudUk3UWpNdFpxTlhNUWZpVnVlQT09>

Join by phone:

+1 669 900 6833

Meeting ID: 892 4042 3046

Passcode: 839385

September 21, 2022

1:00-2:30pm

Aim/Goal
Increase equitable access to skilled and coordinated care between specialty behavioral health* and the larger health system, including primary care, while decreasing barriers to ensure an effective and timely response. *Specialty behavioral health: behavioral health, substance abuse, and developmental services that are delivered outside of primary care.
Future State Metrics
1. Increase availability of behavioral health providers in marginalized areas of the region. 2. Increase timeliness and engagement when referred from primary care to specialty behavioral health. 3. Standardize screening processes for appropriate levels of follow-up care across services.

AGENDA

- 1:00 - 1:10 PM Welcome, Land Acknowledgement & Guiding Principles, Announcements
- 1:10 – 1:40 PM [Equity Review](#)
- 1:40 – 2:25 PM Implementation Plan
 - Review of Strategic Directions and Identifying Next Shared Actions
- 2:25 - 2:30 PM Wrap Up and Next Steps

Working Document: https://docs.google.com/presentation/d/1jx7QDra_SVxVYXNktj9No7ODu_dGeDhXfJ4CsBa-Oo0/edit?usp=sharing

Workgroup Budget: <https://docs.google.com/spreadsheets/d/1Gw9dL6ilRe1olGhJRMloXg9pEUofJ-KzU5WnscBbEX8/edit?usp=sharing>



Behavioral Health: Increase Access and Coordination

Regional Health Improvement Plan Workgroup

Future State Metrics – Full Detail

1. By December 2023, improve the availability of behavioral health providers in the marginalized areas of the region (La Pine, Madras, Redmond) to exceed the Oregon average for rural areas of 0.62 in 2019 as measured by 'mental health providers per 1,000 population
2. By December 2023, a method is developed to measure timeliness and engagement with specialty behavioral health referred from primary care.
3. By December 2023, a method is developed to standardize screening processes to assure clients receive the appropriate level of care and follow-up across various services in Central Oregon.

Land Acknowledgment

We recognize and acknowledge the indigenous land on 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 that 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."

Behavioral Health: Increase Access & Coordination

RHIP Workgroup Virtual Meeting

Regional Health Improvement Plan (RHIP) Workgroup

Guiding Principles

Shared Focus

We come together to improve the health and well-being of individuals living in various and diverse communities throughout Central Oregon region. We use the Regional Health Improvement Plan (RHIP) as our guide. It is our region's shared vision of current problems and our aims. As workgroup partners we develop agreed-upon actions to solve the issues and keep the needs of our communities as the main focus.

Shared Metrics

We measure progress, process and outcomes through a shared lens. We use the Regional Health Assessment (RHA), Regional Health Improvement Plan and community dashboard.

Partner with Priority Populations

The individuals living in our diverse Central Oregon communities are the center of our work. We make every effort to include people from every part of the region in our workgroups, discussions, processes and decisions.

Collaborate to Solve Complex Issues

Inviting diverse perspectives from throughout the Central Oregon region deepens our shared understanding of complex issues and propels us toward better progress and outcomes. We practice frequent, structured, open communication to build trust, assure shared objectives, and create common motivation. We respect the privacy and sensitivity of information partners share.

Coordinate Collective Efforts

We are made up of diverse partner organizations and individuals with unique strengths, skills, and resources. We coordinate our efforts and use our unique strengths and skills to meet the goals of the RHIP.

Learn and Adapt Together

We embrace shared learning and a growth mindset. We create a space that allows for mistakes, failures, second changes, and a celebration of brave attempts. We adjust and apply our learnings to the complex and changing landscape of health and well-being in Central Oregon.

Five-Year Investment Overview
All Workgroups
 January 2020–December 2024

Budget	Spent	Available
\$12,000,000	\$7,021,309	\$4,978,691

Workgroup	Spent	Available
Address Poverty	\$941,994	\$1,058,006
Behavioral Health	\$1,874,623	\$125,377
Physical Health	\$1,116,132	\$883,868
Stable Housing	\$1,119,654	\$880,346
Substance and Alcohol Misuse	\$580,580	\$1,419,420
Upstream Prevention	\$1,388,326	\$611,674

BEHAVIORAL HEALTH 2022 Budget

Overview

	Budget	Spent	Available
5-Year	\$2,000,000	\$1,874,623	\$125,377
Cycle to Date	\$1,000,000	\$1,874,623	-\$874,623
Yearly Mini-Grant	\$50,000	\$10,000	\$40,000

*Review mini-grant budget in August

By Future State Measure (5 year)

	Budget*	Spent	Available	Currently Allocated	Projected Available	Notes
Rural Providers	\$641,666.66	\$1,027,338.00	-\$385,671.34		-\$385,671.34	
Timeliness Engagement	\$641,666.66	\$554,450.00	\$87,216.66		\$87,216.66	
Screening Method	\$641,666.66	\$265,335.00	\$376,331.66		\$376,331.66	

*Budget for each FSM reflects the agreed upon 5 year 'soft budget' minus the portion contributed to shared minigrant budget.

2022 Investments

Organization	Process	Project	Award	Decision Date	Future State Measure	Latest Report
Catalyst Counseling & Consulting, LLC	Mini-Grant Application (2020-2023 RHIP)	Mental Health Groups For Teens	\$2,500.00	5.16.2022	drawn from shared mini-grant budget	Improve availability of behavioral health providers in marginalized areas (La Pine, Madras, Redmond)

Creach Consulting, LLC	Standard Grant Standardize Behavioral Health Screening Across Providers Consultant Application (2020-2024 RHIP)	Advancing Integrated Care Central Oregon: Increase Access & Coordination - Screening and Communication Addendum	\$265,335.00	6.7.2022	Standardize screening processes for appropriate levels of follow-up care across services		
East Cascade Works Central Oregon Behavioral Health Consortium	Standard Grant Rural Central Oregon Behavioral Health Workforce Improvement (2020-2024 RHIP)	Central Oregon Behavioral Health Consortium: Rural Training Improvement Initiative	\$500,000.00	7.1.2022	Improve availability of behavioral health providers in marginalized areas (La Pine, Madras, Redmond)		
St. Charles Health System, Inc.	Standard Grant Rural Central Oregon Behavioral Health Workforce Improvement (2020-2024 RHIP)	SCHS/ OHSU Psychiatry Residency Program	\$498,546.00	7.1.2022	Improve availability of behavioral health providers in marginalized areas (La Pine, Madras, Redmond)		
Infinite Healing Solutions	Mini-Grant Application (2020-2023 RHIP)	Project Dr. Cloud	\$2,500.00	7.1.2022	drawn from shared mini-grant budget		Improve availability of behavioral health providers in marginalized areas
Infinite Healing Solutions	Mini-Grant Application (2020-2023 RHIP)	Infinite Healing Advocacy, Outreach and Marketing Campaign	\$5,000.00	7.1.2022	drawn from shared mini-grant budget		Improve availability of behavioral health providers in marginalized areas

Behavioral Health: Increase Access and Coordination

Background: Why are we talking about this?	
1990s Mill Closures / Timber Industry Decline State Hospitals Deinstitutionalized US Wars impact on Veterans 2000s Population Growth in Central Oregon Housing shortage Rising suicide rates Tech Advancement & Screen Time	Mental health affects how we think, feel and act. It determines how we handle stress, relate to others, and make choices. Mental health challenges can increase the risk of physical health problems such as stroke and heart disease. Individuals benefit significantly from intensive coordination of care and outreach activities, which are less available in remote areas of Central Oregon.

Current Condition: What's happening right now?
<ul style="list-style-type: none"> Approximately 1 in 4 adults over 55 in Central Oregon reported a diagnosis of depression Percentage of students who reported feeling sad or hopeless has been generally trending upward 64% of individuals who died by suicide visited their primary care provider within one year prior to their death Current State Metrics: <ol style="list-style-type: none"> Availability of behavioral health providers is less in the rural areas of the region No way to measure timeliness and engagement with specialty behavioral health when referred by primary care No standardize screening processes for appropriate levels of follow-up care across services

Goal Statement: Where do we want to be in 4 years?
Aim/Goal Increase equitable access to skilled and coordinated care between specialty behavioral health and the larger health system, including primary care, while decreasing barriers to ensure an effective and timely response. Future State Metrics - By December 2023: <ol style="list-style-type: none"> Increase availability of behavioral health providers in marginalized areas of the region. Increase timeliness and engagement when referred from primary care to specialty behavioral health. Standardize screening processes for appropriate levels of follow-up care across services.

Analysis: What's keeping us from getting there?
<ul style="list-style-type: none"> Care is culturally inappropriate and unresponsive Behavioral Health Careers are undervalued, underappreciated and not at parity with medical health Siloed communication and coordination across systems and agencies Behavioral Health Conditions are viewed as a character weakness Systemic undervaluing & underfunding of Behavioral Health Disjointed systems do not address whole person care

Date updated: 8.2022
Strategic Direction: What are we going to try?
<ul style="list-style-type: none"> Strengthening and Expanding the Behavioral Health Workforce Improving Coordination and Access to Culturally Responsive Behavioral Health Care Normalizing and Destigmatizing Mental Health Across the Lifespan Advocating and Lobbying for Behavioral Health Funding at Parity with Physical Health

Focused Implementation: What are our specific actions? (who, what, when, where?)			
Future State Measure	What	When	Who/How
3	Standardize screening processes and communication to assure clients receive the appropriate level of care and follow-up	2022-2024	Addendum to Timeliness and Engagement Project
2	Identify, create or adapt regional measure for timeliness and engagement and integrate into payer models	2021 - 2024	Consultant, Creach Consulting Group, LLC.
1	Create a community-driven behavioral health workforce development pipeline prioritizing rural areas	2022 - 2025	Behavioral Health Consortium; St.Charles Health System

Follow-Up: What's working? What have we learned?
{insert}

Behavioral Health Access and Coordination

Root Cause Barriers: What is blocking us from moving toward our future state measures?

Care is culturally inappropriate and unresponsive	Siloed communication and coordination across systems and agencies	Systemic undervaluing & underfunding Behavioral Health	BH careers are undervalued, under-appreciated and not at parity with medical health	BH conditions are viewed as a character weakness	Disjointed systems do not address whole person care
Cultural barrier of trust with minority groups (Persons of Color, veterans, etc)	Systems & policy do not support care coordination	Funding lessons from COVID (billing codes, purchase of phones/tablets)	Limited pathways to BH careers in region (recruitment of HS, minority & Bilingual)	Culture of individualism (pull yourself up by your bootstraps)	Basic needs (housing, transportation, communication) trump behavioral needs
Insufficient knowledge of dyadic therapies for children/families	Needs assessments differ between groups	High cost of living/insufficient reimbursement rates	Education & training for providers from marginalized groups	Stigma: neuroscience vs. Flawed character	Insurance limitations for undocumented & incarcerated people
Insufficient knowledge of dyadic therapies for children/families	Organizations are siloed/don't communicate	Prioritization of screening tools which are reimbursed	Career trajectory out of agency work leaving a "brain drain"		Unaffordable and inaccessible technology
Screening processes are not humanistic	Behavioral health operates in silos	Insurance reimbursement policies	Incentives for rural providers, practice & communication		
	Dysfunctional Provider Directories	Need for more residential beds	Remote location work not incentivized		
	HIPAA/Privacy Myths	Services are not political priority	Wages don't match cost of living		
		Mental Health dollars cannot cross county lines	Need for bilingual BH specialists		
		Funding Payor Issues			

STRATEGIC DIRECTIONS: What Moves Us Toward Our 2023 Practical Visions

Promote Comprehensive Staffing Retention Models	Expand, Train, and Support the Workforce	Develop and Pay Traditional Health Workers
<ul style="list-style-type: none"> • Incentivize providers to work in rural areas • Pursue incentivizing local psychiatric nursing jobs with COCC, OHSU, Linfield • Pay to Stay programs through PacificSource to support providers working in rural and underserved communities • More hiring incentives and research around our veterans. 	<ul style="list-style-type: none"> • Pursue OHSU psychiatric resident rotation for child psychiatrists • Having Mental Health be developed as a career path in large and small communities, by educating high school students about career • Early recruitment of a diverse workforce – start in elementary and middle schools • Develop shadowing program of BH careers for high schoolers • Develop relationships between the health council and local schools with mental health programs like OSU/PSU • Increase people of color in the workforce; what opportunities to partner with COCC, OSU, OHSU 	<ul style="list-style-type: none"> • Develop a “Promotora program” within the different community groups • Train people from local neighborhoods into THW, CHW jobs in those communities. Churches as a source of contact • Develop and highlight BH opportunities for peer delivered services • Pilot project for employing and reimbursing THW and Peer Support Specialists

Strengthening & Expanding the Behavioral Health Workforce

Increase Coordination and Access	Increase Cultural Responsiveness of Service Delivery
<ul style="list-style-type: none"> • Connect CHW with Latinx community to better connect care to communities • Build centralized streamlined referral hub or team • Not just about access but about quality of services received; could be measured, e.g. completion of treatment • Host monthly provider meetings • Develop method to measure timeliness and engagement with specialty behavioral health • Develop closed loop referral processes • Offer transportation to and from Central Oregon Communities 	<ul style="list-style-type: none"> • Build community coalition capacity to address health inequities related to substance use and mental health • Use Culturally and Linguistically Appropriate Services (CLAS) Standards • Cultural needs assessment for BH • Have experience engaging with Latinx parents, supporting them in accessing behavioral health services • Project where seasoned providers attempt to reach specific populations based upon culture, diagnosis, etc. and provide culturally-based treatment • Provide same sex interpreter and/or traditional health workers for women patients • Behavioral Health screening at intake in the individuals’ primary language • Communicate in a more meaningful, basic, and understandable way.

Improving Coordination and Access to Culturally Responsive Behavioral Health Care

Promote Mental Health for All across the lifespan

- Identify and implement strategies to work collaboratively with organizations whose activities advance health equity and promote Health in All Policies
- Destigmatize by putting on a program for junior high and high school students. Partner with Younity.
- Partner with NAMI of Central Oregon (National Alliance of Mental Illness) to host an event to destigmatize mental illness
- Provide monthly rotational community events to destigmatize mental health
- Host a Zoom presentation on a topic that would cover destigmatization
- Utilize high level speakers strategically to dispel the myth that mental health is a character weakness.

**Normalizing
and
Destigmatizing
Mental Health
Across the
Lifespan**

Advocate for Better Funding

- Pay for insurance advocate to advocate for higher reimbursement for Behavioral Health services
- Lobby at the state level for funding for providers
- Advocate to have (BIPOC) traditional approaches reimbursed
- Create value based contracting that has metrics tied to access, engagement and outcomes
- Value based contracting

**Advocating and
Lobbying for
Behavioral
Health Funding
at Parity with
Physical Health**



Form Name:

2021 BH Investment Annual Report: Year One

Central Oregon Veteran & Community Outreach, Inc, dba Central Oregon Veterans Outreach
 COVO Homeless Veteran Behavioral Health Services Enhancement

FollowUp Snapshot	
Amount Requested	\$1,041,000.00
Organization Contact	Kathy Skidmore
Contact Phone	541-383-2793
Contact Email	covo@covo-us.org
Organization Address	61510 S Hwy 97 Suite 100 Bend, OR 97702
Website	http://cohealthcouncil.org/
Project Lead	Kathy Skidmore
Project Lead email	kathy.skidmore@covo-us.org

RHIP Workgroup:

Future State Measure:

Note: * indicates required questions

Contact Information

Organization Name*

Central Oregon Veteran & Community Outreach, Inc.

Project Name

COVO Homeless Veteran Behavioral Health Services Enhancement

Date you are submitting this annual report*

08/28/2022

Name and Title of Submitter*

Kathy Skidmore, Executive Officer

Email Address*

covo@covo-us.org

Phone Number*

15413832793

Project Details

Annual Report: Primary Activities*

*Please describe the **project** and primary activities.*

Our vision with this grant funding is a meld of outreach, case management and clinical behavioral health support for Veterans who are experiencing homelessness in the Central Oregon region, with the objectives as follows:

- increasing homeless outreach staffing capacity, primarily with peer support specialists
- engaging behavioral health therapists that specialize in helping Veterans effectively
- create a comprehensive resource directory of local (Central Oregon) behavioral health support for Veterans by surveying Veterans to learn what they want and need, and providers to learn what they offer and what needs they see as unmet

- support the capacity of the Continuum of Care (CoC) to create a Quality By-Name List, a process that has been proven in many areas of the country to be a highly effective method of connecting those experiencing homelessness to services and housing, strengthens the network of entities who provide services to combat homelessness, and raises community awareness buy-in to address the issue of homelessness on the local level.

Annual Report: Summary of Results*

Please provide a summary of the results, outcomes, and benefits of the project, including a current overall assessment of its success and impact to date.

We have a Veteran Peer Support Specialist with OHA certification on staff who does Outreach to find and connect with Veterans, engaging in camp, street and shelter outreach and is a first contact on calls from Veterans to COVO. The Peer Support Specialist builds relationships with the Veterans and connects them to other services at COVO and with appropriate community providers. A primary goal is to ensure access to appropriate programs for substance and mental health treatment when they are ready. During the first year of this funding, our Veteran Peer Support Specialist had contact with 122 individual Veterans.

We hired a Veteran who has an MSW as a Behavioral Health Specialist to work onsite at the Central Oregon Veterans Village, which we opened in November 2021. This was an important position to have onsite the incoming shelter residents learned together how to navigate the newness of the Village daily living structure. The Behavioral Health Specialist, who is working toward licensure and is under supervision by a community LCSW with Oregon supervisor credentials, to provide ongoing counseling to Village Veterans, is available for mental health crisis intervention, facilitates connecting Veterans to community and VA service providers for Veterans who desire mental health or substance abuse treatment, and participates in case conferencing with COVO housing case managers, Veteran services coordinator, health care navigator and the site coordinator, for Village clients. The Behavioral Health Specialist also worked with Veterans not enrolled in the Village. Our Health Care Navigator assisted Veterans in accessing and following through with both medical and behavioral health care, helping Veterans with multiple health issues and complex care keep track of their services.

We have an agreement with LCSW who is providing assessments and counseling to Veterans at the Village and Veterans receiving other COVO services. This LCSW, who is also a Veteran, acts as advisor to COVO direct services staff on cases for behavioral health issues with clients, and attends weekly house meetings with all residents and Village staff as part of the support team. He provides ongoing individual counseling to Veterans who opt to engage with him, and can continue to see them after they exit the Village ,or support their transition to another community or VA therapist.

COVO is working closely with the Continuum of Care on the Quality By Name List (QBNL). COVO is the only organization that had an existing By Name List. Though our list is Veteran-only our experience has been significant influence in shaping the CoC process and development of a CoC-wide QBNL. We participate in the QBNL and Coordinated Entry System (CES) twice-weekly case management meetings that began in 2022 and our representative to the CES and QBNL groups is supporting the HMIS coordinator and CoC team for these projects as processes and data management planning evolves.

Annual Report: Stories*

*Please provide a **brief story or quote** that illustrates how this project has had a positive impact on the Central Oregon region.*

Two local media stories on Veterans served by COVO and sheltered at the Veteran Village give insight on the effectiveness of the Village and the behavioral health support we have been able to provide with this project. As the Veterans have given permission to the media outlets to have their names, story and pictures made public, these quotes can be shared. A link to the full articles with credits to the publisher and writers is included after each Veteran's quote.

An article produced and published by the Bend Bulletin on one of our clients, John, tells his story exceptionally well. Quotes are excerpted from the published article.

'... Steele's story reflects the challenges of many unhoused veterans ... including a distrust of authorities after years where the institutions he represented did not serve him.

Though he was long reluctant to accept help, he's come to trust the staff at the Veterans Village. ... "One of the things that I found when I finally decided to come to the village here was that they were more willing to help than the common homeless person realized." '

Link to full article with credits: https://www.bendbulletin.com/localstate/local-veteran-finds-shelter-in-bend-after-years-of-struggle/article_d037841c-0239-11ed-8460-2b5ba641ab75.html

Another published story on a Veteran who was served at the Veterans Village and moved to his own rental housing also captures what we can offer Veterans for services, safe living and social connections and support from peers. Quotes are excerpted from a Central Oregon Daily video and article.

' " He says Veterans Village helped him figure out his Veteran's Administration benefits, obtain treatment for his health issues and find permanent housing... "There are counselors available. There are treatment plans available for those who think they want treatment or need treatment. There are things for everybody who comes," Jacobsen said. " '

Link to full story with credits: <https://centraloregondaily.com/first-graduate-leaves-veterans-village-heading-for-permanent-housing/>

Across the country, programs for Veterans experiencing homelessness set an example and offer templates for success to communities for successfully moving those experiencing homelessness toward improved health, stability and ultimately housing. As John, quoted above, says, his experience with the Village showed him there is willingness in Central Oregon to help anyone who is homeless, not just Veterans. From the first planning session for the Veterans Village, the partners with the vision for the project wanted it to offer as template for success to encourage more options in Central Oregon for serving the homeless community at large. The wrap-around services that now includes behavioral health support are at the heart of making this program successful.

Permission to Share Annual Report Stories*

Please indicate whether or not the COHC has permission to use the story or quote you provided above in social media and/or other mediums/publications.

Yes, the COHC is permitted to publicly share the stories I've shared above.

Project Completion at Time of Annual Report*

Please indicate whether your project is complete or in progress. If it is in progress, please estimate the percent complete at the time of this report.

My project is in progress and is approximately 0-25% complete

Timeline*

If your project is in progress, please indicate whether you are on track with the timelines indicated in your application.

My project is in progress, but we are behind the timelines indicated in our application

Estimated Completion Date for Project at Time of Annual Report

Please provide an estimated completion date for your project. If your project is complete, leave blank.

07/01/2025

Are you encountering any problems or challenges in fulfilling the terms of the project agreement?*

No

Mid-Course Problems or Challenges (Continued)*

If you stated that you are encountering problems or challenges in fulfilling the terms of the grant agreement, provide detail below. Please explain what mid-course corrections you plan to implement to help mitigate those challenges/barriers.

If you are not encountering challenges, please type N/A.

In 2021 and early 2022 we were encountering challenges with completing Objective #4 per our estimated timeline for first year of the grant funding. Key community partners committed to developing this project had professional and personal changes that took them off the project. COVO, like so many other employers, experienced extraordinary hiring and staff retention challenges. The impact of COVID on our volunteer force continued into 2022, decreasing from 15 weekly volunteers to 5 and increasing workload on paid staff. The combination of bringing live a new project like the Veterans Village and the hiring/staffing challenges pushed out the time line of our #4 Objective.

Both our staffing and community partner engagement to support this project is back in place. COVO engaged a human resources consultant to support hiring, and in 2022 we have had more success than in 2021 in filling positions and keeping staff. As well, the gradual lightening of COVID restrictions in 2022 has community partners re-engaging and being more accessible. We have both partners re-engaged and new partners coming to the table.

Mid-Course Community Connections*

*Are there any **connections within the community** that the COHC can help facilitate that might be helpful with respect to the implementation or success of your project?*

Yes

Mid-Course Community Connections (Continued)

Please provide detail on the community connections that you feel the COHC might be able to help with.

Please note, we strive to make connections and break-down siloes whenever possible. We will do our best to facilitate a relationship with the party or parties you mention.

Connections with behavioral health providers are a priority so we can do an effective survey of available resources for Veterans. We hope this project will build a coalition of providers serving Veterans that will promote connections between providers and programs to better coordinate care, improve accessibility to behavioral health support and provide an expanded scope of treatment options locally for Veterans and their families. One thing that has become clear is that many therapists who are treating Veterans and their families do not know of each other and their services, so out of this project we hope will come a local coalition or connected network of professionals addressing and advocating for improved behavioral health services across the broad spectrum of government-provided and private care options.

Progress on Sustainability*

If applicable, please describe any progress made toward sustaining this project beyond the current granted funds. Please provide details about other resources secured and plans for receiving additional funding sources.

Please write

We are looking at the sustainability of the services and projects this funding supports to continue past the 4 year funding cycle, specifically for direct services. We are also looking at funding opportunities during this 4 year cycle to complement, enhance or expand the services we can offer under this funding.

Older Adults Served

*Please provide the unique number of individuals ages **60+** served to date by this project*

74

Adults Served

Please provide the unique number of individuals ages 18-59 served to date by this project.

118

Children & Adolescents Served

Please provide the unique number of adolescents and children ages 17 & under served by this project.

0

SMART Objective #1 (Target/Future State)

By June of 2025, 15-25 homeless Veterans per year; 60-100 over 4 years. The Village will house 15 Veterans; length of stay will vary. Based on COVO's past experience with transitional housing (Home of the Brave 2011-2018) average stay is 8 months.

Objective #1: Progress*

Please provide your current progress on this objective.

The cabins were completed in phases, the first 5 in November 2021 for our opening and all 15 completed July 2022. We have sheltered Veterans at the Village for 8 months of this first grant year, with a total of 15 Veterans accessing shelter at the Village during those 8 months. Two Veterans screened for the Village but were not able to provide sufficient self-care to be comfortable and safe alone in a cabin. We worked with them to find assisted living, one in a facility here in Central Oregon and the other at the state Veteran Home in Lebanon.

The Village shelters a Veteran up to two years, relieving them of pressure to find housing, and giving time to make healthy choices for physical, financial, mental and emotional well-being. Our onsite Behavioral Health Specialist developed an initial assessment which helped to inform our case manager's work with each Veteran to develop individual service plans. All Veterans at the Village are connected with a case manager for support.

SMART Objective #2 (Target/Future State)

Annually from July 2021-June 2025, connect 75 Veterans experiencing homelessness each year (300 total) to behavioral health services and quality of life supports.

Objective #2: Progress*

Please provide your current progress on this objective.

If your proposal only contained one objective, please type N/A.

87 Veterans were connected to one or more of the following health and quality of life supports:

Behavioral health supports (to peer support specialists or licensed therapists) , medical care, benefits enhancement (VA medical and disability, SSDI), OHP (low-income Veterans with VA medical eligibility who income qualify for OHP can have both for insurance coverage).

We had an MSW student (in their final year and under supervision of a LCSW) on staff, an OHA trained Veteran Peer Support Specialist, and an LCSW consultant to provide direct service for behavioral health, and also as part of the team of case managers, an experienced Veteran services specialist and a Health Care Navigator (who is also an OHP assister), to help clients navigate to community and VA providers for services and support them in following up and keeping appointments.

SMART Objective #3 (Target/Future State)

By July 2021- we will partner with the regional HMIS Lead for Veterans Village data capture/reporting; by June 2022 we will have agreements with partners to give HMIS support as defined by the CoC for a Quality By Name (QBNL) List.

Objective #3: Progress*

Please provide your current progress on this objective.

If your proposal only contained two objectives, please type N/A.

In 2022 a new position to manage HMIS was staffed for the CoC to oversee HMIS for Coordinated Entry and the Quality By Name List (QBNL). This gives HMIS support specifically for these two programs to all participating agencies and shifted the need for COVO's support for other agencies in HMIS data entry. Our representative to the Coordinated Entry and QBNL projects works closely with the HMIS Coordinated Entry coordinator to analyze and refine data in HMIS for these and other projects. An COVO is a key participant in both Coordinated Entry and Built for Zero, and one of the largest contributors to the Central Oregon HMIS data through multiple programs. An agreement with the HMIS administrator early in 2022 was to postpone developing an HMIS program for the Veterans Village due to the staffing for HMIS and changing HMIS support for our region to OHCS. Partnering with the HMIS Lead for a Veterans Village specific data reporting module in HMIS will happen in Year 2 of this project.

SMART Objective #4 (Target/Future State)

By 6.2022- Develop surveys for minimum 30 behavioral health providers, target 1500 Veteran surveys. Document veterans numbers in program, satisfaction survey, and feedback from the providers.

Through June 2025 resurvey, tabulate, summarize yearly.

Objective #4: Progress*

Please provide your current progress on this objective.

If your proposal only contains less than four objectives, please type N/A.

Community partnerships were in place at the time of grant submission, planning to begin surveys after the Veterans Village launch. 2 challenges: key partners had professional/personal life changes that took them out of the project; and, COVO experienced extraordinary hiring and staffing retention challenges while at the same time bringing the Village live, which significantly impacted staffing new projects.

The project status now is as follows:

- partners on board once again (Veteran and non-Veteran mental health providers, experienced researchers, homelessness service providers, Veteran organization representatives) who are inviting other voices to the table for an advisory group for the surveys (one for providers, one for Veterans)
- COVO staff in place including: new admin position to track communications and data entry; masters level counseling and social work interns; new database online in fall 2022 that can incorporate process/data for this project

SMART Objective #5 (Target/Future State)

Objective #5: Progress*

Please provide your current progress on this objective.

If your proposal only contains less than five objectives, please type N/A.

N/A

SMART Objective #6 (Target/Future State)

Objective #6: Progress*

Please provide your current progress on this objective.

If your proposal only contains less than six objectives, please type N/A.

N/A

Annual report: Photos Associated with Project

Please attach any photos you would like to share associated with your project. You may attach up to three. Photos must be uploaded separately under the 'photo attachment' headings below this question. Please indicate whether the COHC may share and/or publish these photos publicly.

N/A: Please select this option ONLY if you did not share any photos

Annual Report: Photo Attachment #1

Please briefly describe the photo.

Annual Report: Photo Attachment #2

Please briefly describe the photo.

Annual Report: Photo Attachment #3

Please briefly describe the photo.

Additional Reports

If you have any additional dashboards or reports, you may attach the first one here.

This is optional.

Please note, you must attach files one at a time separately, for a maximum of three files.

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Please provide a brief description of each document you are attaching.

File Upload/Report 2

If you have an additional report, you may attach it here. Please briefly describe the file you are uploading.

File Upload/Report 3

If you have an additional report, you may attach it here. Please briefly describe the file you are uploading.

Other Comments for Annual Report

Is there anything else you would like us to know?

The numbers served by age group listed above, totaling 192, are numbers of Veterans identified as homeless or at risk for homelessness and not the total of all Veterans served by COVO.

This funding is making a positive difference in our ability to provided direct services for behavioral health for our Veteran clients, the capability to strengthen and expand partnerships and with those partners explore/develop new strategies for making behavioral health support more appealing and accessible to all Central Oregon Veterans, not just those experiencing poverty and homelessness. We are so grateful to the Central Oregon Health Council for this support. We anticipate being on track for the remainder of the funding cycle.

FollowUp Files

Applicant File Uploads

No files were uploaded



Form Name:

2021 BH Investment Annual Report: Year One

Council on Aging of Central Oregon

CoA Caring Connections Behavioral Health Program: Reduce Isolation and Loneliness in Older Adults

RHIP Workgroup:

FollowUp Snapshot	
Amount Requested	\$137,837.00
Organization Contact	Steven Remington
Contact Phone	541-323-0442
Contact Email	sremington@councilonaging.org
Organization Address	373 NE GREENWOOD AVE BEND, OR 97701
Website	http://cohealthcouncil.org/
Project Lead	Cassie Regimbal, Client Services Director
Project Lead email	cmcguire@councilonaging.org

Future State Measure:

Note: * indicates required questions

Contact Information

Organization Name*

Council on Aging of Central Oregon

Project Name

CoA Caring Connections Behavioral Health Program: Reduce Isolation and Loneliness in Older Adults

Date you are submitting this annual report*

08/31/2022

Name and Title of Submitter*

Steven Remington, Director of Development

Email Address*

sremington@councilonaging.org

Phone Number*

541-323-0442

Project Details

Annual Report: Primary Activities*

*Please describe the **project** and primary activities.*

This expansion project will connect volunteers with isolated older adults in the Crook and Jefferson Counties (and the outlying rural and frontier areas in Central Oregon) via weekly phone calls. Through the relatively new Caring Connections program, a simple weekly phone call can mean the world to seniors who do not have regular contact with friends or family. The program is designed to support seniors 60+ who may be living alone, have limited family support or limited connections with people on a day-to-day basis. The program offers isolated seniors a great way to make new friends and to have someone checking in on their wellbeing.

The original objective was to connect an additional 50-100 older adults in Crook and Jefferson Counties with our trained volunteers. We have since adjusted our expectations to 30 seniors in the rural/frontier outlying areas.

The primary internal activities, generally speaking are:

- client identification, recruitment and interaction
- data gathering for grant reporting
- database management
- data analysis
- recruit, train and supervise volunteers
- coordinate with volunteer manager
- coordinate with Program Manager
- coordinate with Case Managers
- coordinate messaging with marketing
- outreach across the three counties
- presentations, one-on-one meetings, events

To measure our progress and success with the program, we start by having the older adults complete a survey that will measure baseline levels of isolation, loneliness, nutritional risk and other social determinants of health. Modeled on the UCLA 3Q Loneliness scale tool, we have worked with researchers at OHSU to identify a pre- and post-survey on loneliness and isolation to be able to measure the impact of weekly calls for program participants. We had hoped, by the end of May 2022, we could reassess each participant to measure any changes in the clients' perceptions of wellness and connection. The OHSU team currently has the data analysis from FY 2022, and we are expecting the findings in September, but our anecdotal evidence suggests a successful first year effort, albeit among a limited number of new participants in the Crook and Jefferson County cohorts.

Ultimately, we are confident, despite our setbacks, that facilitating this personal, repeated connection between older adults and volunteer callers will help stem feelings of loneliness and isolation and address other health and social issues before things can go seriously wrong for our clients.

Annual Report: Summary of Results*

Please provide a summary of the results, outcomes, and benefits of the project, including a current overall assessment of its success and impact to date.

This first year we struggled to create an outreach team, with our Outreach Coordinator leaving in the first two months of the project, and our Case Manager having mental health issues that impacted the job. Ultimately our Case Manager went on leave and after 3 months on Workers Comp, she quit - having left her work undone for several months. There was also an internal misunderstanding about the grant's geographic limitations, leading to an initial programming and marketing effort on all three counties as opposed to just Jefferson and Crook Counties. In addition, we have had a difficult time finding volunteers and clients for the program in this new, semi-post pandemic environment.

Consequently, we were only able to sign up 7 new senior clients in Crook and Jefferson Counties during this first part of the program.

Nevertheless, the seniors we did sign up have been very enthusiastic and grateful for the contact. We have learned a lot about the 'matching' process and are getting ever better at scheduling volunteers and clients that have some commonalities and interests that they both appreciate.

Since the inception of this program we have recruited and trained volunteers, written call scripts, designed outcomes reporting mechanisms, trained our volunteers and staff in the Mon Ami software call system and completed data collection for analysis by OHSU. The data collection is quite extensive and includes basic information, REALD data and regular client surveys using the UCLA Q3 Loneliness Scale.

We have developed marketing communications for older adult contacts outside our existing client population and enrolled users via personal recommendation from our client services team as well as social media and other agency outreach efforts.

Perhaps the most important outcome is our current double-down effort to hire a full-time Caring Connections Program Manager, get our marketing team back on track to advertise the program, and create an organization-wide push to get the word out among the senior population. We have had departmental meetings to brainstorm more ways to reach seniors and will, for example, be at more public gatherings (like the upcoming Latino Fest in Madras) where we can have one-on-one conversations with potential clients and volunteers.

Annual Report: Stories*

*Please provide a **brief story or quote** that illustrates how this project has had a positive impact on the Central Oregon region.*

Our Volunteer Manager, Marianne McClure, reported the following story:

"Recently, I matched a client with a volunteer. I first called the client and asked her our standard profile questions. In the course of the conversation she told me that she had one son and four daughters and had traveled in an RV for 13 years after she retired. I then had a conversation with the volunteer that I was going to match her with; I've been talking to each volunteer before they make their first call to the senior that they're matched with. I shared with the volunteer the little bit of information I had learned by talking with the client. The volunteer then shared that she also has five children - four sons and one daughter. The opposite genders of the client's children! She also communicated to me that after she retires that she'd like to travel in an RV. The volunteer was excited to hear that she had some things in common with her match! I called the client and shared a little bit about the volunteer who would be calling her on a weekly basis for a friendly chat. She too was pleasantly surprised and is looking forward to building a relationship."

Permission to Share Annual Report Stories*

Please indicate whether or not the COHC has permission to use the story or quote you provided above in social media and/or other mediums/publications.

Yes, the COHC is permitted to publicly share the stories I've shared above.

Project Completion at Time of Annual Report*

Please indicate whether your project is complete or in progress. If it is in progress, please estimate the percent complete at the time of this report.

My project is in progress and is approximately 26-50% complete

Timeline*

If your project is in progress, please indicate whether you are on track with the timelines indicated in your application.

My project is in progress, but we are behind the timelines indicated in our application

Estimated Completion Date for Project at Time of Annual Report

Please provide an estimated completion date for your project. If your project is complete, leave blank.

07/01/2023

Are you encountering any problems or challenges in fulfilling the terms of the project agreement?*

Yes

Mid-Course Problems or Challenges (Continued)*

If you stated that you are encountering problems or challenges in fulfilling the terms of the grant agreement, provide detail below. Please explain what mid-course corrections you plan to implement to help mitigate those challenges/barriers.

If you are not encountering challenges, please type N/A.

As noted previously, we have had challenges internally with staff hiring and retention, volunteer recruitment, and client participation.

We met with COHC grant manager Rebeckah Berry and have requested assistance from COHC/RHIP workgroups to seek out other perspectives on marketing and outreach. We are now engaging all COA staff in our word-of-mouth efforts to recruit and we have added additional budget resources to increase the street-level marketing efforts. With some additional time we are confident that these efforts will be successful.

In addition, by hiring a full-time Caring Connections Program Manager, we expect to see this program get some meaningful "lift" in the near future.

Mid-Course Community Connections*

*Are there any **connections within the community** that the COHC can help facilitate that might be helpful with respect to the implementation or success of your project?*

Yes

Mid-Course Community Connections (Continued)

Please provide detail on the community connections that you feel the COHC might be able to help with.

Please note, we strive to make connections and break-down siloes whenever possible. We will do our best to facilitate a relationship with the party or parties you mention.

I do believe we are connected to the appropriate organizations and people, but you don't know what you don't know. There are certainly groups we do not regularly connect with; specifically the faith communities that often have their own infrastructure for senior assistance. We have connected with Gwen Jones and have set up an initial consultation to discuss ideas and community connections. I think meeting with the RHIP and COHC workgroup members will help with the expansion efforts.

Progress on Sustainability*

If applicable, please describe any progress made toward sustaining this project beyond the current granted funds. Please provide details about other resources secured and plans for receiving additional funding sources.

Please write

We are beginning to work with USAging on sharing our progress and the analysis of our data for a national white paper on the effectiveness of these sorts of projects to address loneliness and isolation. We may be eligible for a \$30,000 grant through this program, which should help us continue to build the services, and we are actively seeking funds to support the full-time Caring Connections Program Manager in 2024/2025. We fully expect to continue offering these services as a long-term program.

Older Adults Served

Please provide the unique number of individuals ages 60+ served to date by this project

27

Adults Served

Please provide the unique number of individuals ages 18-59 served to date by this project.

0

Children & Adolescents Served

Please provide the unique number of adolescents and children ages **17 & under** served by this project.

0

SMART Objective #1 (Target/Future State)

By June 30, 2023, we will have 50 clients receiving weekly calls in Central Oregon with 15 clients residing in rural or frontier areas.

Objective #1: Progress*

Please provide your current progress on this objective.

As noted, we have enrolled seven new clients in Crook and Jefferson Counties thus far. We should have no problem with the adjusted SMART Objective of 15 in the expanded rural footprint (exclusive of the cities of Bend and Redmond). We currently have 20 new Bend/Redmond clients in the program, so we are more than halfway to our goal of 35. With our newly invigorated efforts our Future State should meet this objective handily.

SMART Objective #2 (Target/Future State)

By January 2023, we will have sufficient volunteers (estimated at 30 volunteers) to make weekly calls throughout Central Oregon.

Objective #2: Progress*

Please provide your current progress on this objective.

If your proposal only contained one objective, please type N/A.

Again, we are well on our way towards Objective #2, with nearly 30 volunteers currently making calls to Central Oregon seniors.

SMART Objective #3 (Target/Future State)

By June 30, 2023, we will have a network of 80-100 volunteers and clients that are connected through weekly calls in Central Oregon prioritizing rural and frontier communities

Objective #3: Progress*

Please provide your current progress on this objective.

If your proposal only contained two objectives, please type N/A.

We currently have 27 new clients receiving calls from 25+ volunteers, so adding another 30+ to the total, with the priority on rural and frontier communities, seems like a very achievable goal.

SMART Objective #4 (Target/Future State)

By June 30, 2023, we will have reduced loneliness and isolation by 10% specifically in rural and frontier areas of Central Oregon.

Objective #4: Progress*

Please provide your current progress on this objective.

If your proposal only contains less than four objectives, please type N/A.

Utilizing the UCLA Q3 Loneliness scale will allow us to measure the data we are collecting on clients in the rural and frontier areas. A 10% goal seems highly likely and we should have some measurement data by the end of September 2022, which will allow us to adjust our efforts if we are falling short. Consequently, I feel we have made progress here as well, although the data set is still very small.

SMART Objective #5 (Target/Future State)

Objective #5: Progress*

Please provide your current progress on this objective.

If your proposal only contains less than five objectives, please type N/A.

N/A

SMART Objective #6 (Target/Future State)

Objective #6: Progress*

Please provide your current progress on this objective.

If your proposal only contains less than six objectives, please type N/A.

N/A

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No, please do not publish and/or share these photos outside of the COHC

Annual Report: Photo Attachment #1

Please briefly describe the photo.

CC photo resized for grant.png

This is a photo of one of 9 pictures used for the Central Oregon Isolation and Loneliness campaign in 2021.

Annual Report: Photo Attachment #2

Please briefly describe the photo.

[Unanswered]

Annual Report: Photo Attachment #3

Please briefly describe the photo.

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FollowUp Files

Applicant File Uploads

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**IMAGINE
SOCIAL
DISTANCING
ALL.
THE.
TIME.**