Address Poverty and Enhance Self-Sufficiency
Regional Health Improvement Plan Workgroup

Join Zoom Meeting
https://us02web.zoom.us/j/85737344809?pwd=R1VtamUwbktCVDg2MjBOWGIybWJWQT09

Join by phone:
+1 253 215 8782
Meeting ID: 857 3734 4809
Passcode: 813612

June 20, 2023
11:00am – 12:30pm

Aim/Goal
Individuals and families in Central Oregon experiencing poverty are provided equitable access and connected to appropriate resources that help them overcome obstacles to self-sufficiency and address health-related challenges.
Future State Metrics - Condensed
1. Increase high school graduation rates among economically disadvantaged students 2. Decrease food insecurity 3. Decrease percent of income constrained households 4. Decrease housing and transportation costs as a percent of income

AGENDA

11:00-11:15 AM   Welcome, Land Acknowledgement, Introductions, Announcements

11:15-11:40 AM   Investment Guidelines (Oregon Health Authority-Health Related Services)—Tricia Wilder & Kristen Tobias, PacificSource

11:40-12:00 PM   Senior Food Insecurity update & next steps

11:15-12:30 PM   RFP development based on ALICE Listening Session results

Working Document: https://docs.google.com/presentation/d/1jYwyGwMt-Uj2QtW2lNBIRF9cijI_4HaSlYgqw_28uLg/edit?usp=sharing

Workgroup Budget: https://docs.google.com/spreadsheets/d/1Gw9dL6ilRe1olGhJRMIoxg9pEUofJ-KzU5WnscBbEX8/edit?usp=sharing

CENTRAL OREGON
HEALTH
COUNCIL

Address Poverty and Enhance Self-Sufficiency
Regional Health Improvement Plan Workgroup

Future State Metrics – Full Detail

1. By December 2023, Central Oregon graduations rate among economically disadvantaged students will improve by 3 percentage points to:

2023 Central Oregon Graduations Rate for Economically Disadvantaged	
Crook	76.60%
Deschutes	77.30%
Jefferson	83.40%

2a. By December 2023, decrease the % of total population reported as food insecure by 2 percentage points to:

County	% of (total) Population Food Insecure
Crook	13%
Deschutes	11%
Jefferson	11.3%

2b. By December 2023, develop a regional metric to evaluate food insecurity among seniors in our community (ages 65+).

3. By December 2023, decrease the population of households living at the poverty level and income constrained by 2 percentage points to:

Crook: 27%
Deschutes: 24%
Jefferson: 32%

4. By December 2023, reduce combined housing and transportation cost for residents as a percent of income in their respective counties to no more than:

Crook County: 64%
Deschutes: 55%
Jefferson: 55%

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."

Central Oregon HEALTH Council

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 chances, 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.

Address Poverty and Enhance Self-Sufficiency

Background: Why are we talking about this?

1990s Mill Closures / Timber Industry Decline **2000s** Population Growth in Central Oregon 　　The Great Recession 　　Decreasing safety net – "War on Poor" 　　Local workforce displacement 　　Widening Opportunity Gap	Central Oregon has grown rapidly over the past two decades. Individual communities face different economic and social challenges associated with this development, including increased unemployment, lack of affordable housing, and income inequality. There is significant evidence linking poverty to health disparities and poor outcomes.

Current Condition: What's happening right now?

- 9-17% of residents in Central Oregon lived in poverty between 2013 and 2017
- Almost 50% of the region's renters are considered to be cost burdened
- Almost 25% of the civilian labor force in Warm Springs is experiencing unemployment

Current State Metrics:
1. 2018 Central Oregon graduation rates were significantly lower among economically disadvantaged students
2. Food Insecurity by County: Crook 15%, Deschutes 13%, Jefferson 13.3%
3. Income constrained households: Crook 29%, Deschutes 26%, Jefferson 34%
4. Housing and transportation costs combined as a percent of income: Crook 67%, Deschutes 58%, Jefferson 58%

Goal Statement: Where do we want to be in 4 years?

Aim/Goal
Individuals and families in Central Oregon experiencing poverty are provided equitable access and connected to appropriate resources that help them overcome obstacles to self-sufficiency and address health-related challenges.

Future State Metrics - By December 2023:
1. Increase high school graduation rates among economically disadvantaged students
2. Decrease food insecurity
3. Decrease percent of income constrained households
4. Decrease housing and transportation costs as a percent of income

Analysis: What's keeping us from getting there?

- Demand exceeds supply for range of housing needs required
- Disjointed Systems
- Funding/Educational system is designed not to meet the needs of historically marginalized students
- Inactive response to Awareness, Barriers and Cultural Sensitivity
- Transportation can be inaccessible due to distance/economic
- Inequity of resources for income constrained families
- Scarcity culture promotes exclusionary programming
- Historical classism and racist structures undervalue and constrain people
- Complex & excessive restrictions to access safety nets

Date updated: 1.2023

Strategic Direction: What are we going to try?

- Strengthening Foundation of Individual and Community Health
- Empowering All People and Communities Through Inclusive and Collaborative Partnerships
- Connecting People and Establishing Pathways to Enhance Community Resources
- Boosting Advocacy to Address Systemic Factors Contributing to Poverty

Focused Implementation: What are our specific actions? (who, what, when, where?)

When	What	
02/21	Invest in programs to increase HS graduation rates	Funded
02/22	Invest in regional ALICE listening sessions	Funded
02/22	Invest in programs to decrease food insecurity	Funded
01/23	Sr. Food Insecurity Measure Development	RFP Released
05/23	ALICE Investment Strategy	In Development

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

{insert}

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

Budget	Spent	Available
$12,000,000	$7,184,584.04	$4,815,416

Workgroup	Spent	Available
Address Poverty	$941,993.79	$1,058,006.21
Behavioral Health	$1,954,157.00	$45,843.00
Physical Health	$1,117,158.56	$882,841.44
Stable Housing	$1,129,654.00	$870,346.00
Substance and Alcohol Misuse	$617,494.69	$1,382,505.31
Upstream Prevention	$1,424,126.00	$575,874.00

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<tr><td colspan="6" align="center">**POVERTY**
2023 Budget</td></tr>
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		POVERTY 2023 Budget			

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<tr><td colspan="6" align="center">**Overview**</td></tr>
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		Budget	**Spent**	**Available**	
	5-Year	$2,000,000	$941,993.79	**$1,058,006.21**	

<table><tr><td colspan="6" align="center">**By Future State Measure (5 year)**</td></tr></table>

	Budget* [1]	**Spent**	**Available [2]**	**Currently Allocated [3]**	**Projected Available [4]**	**Notes [5]**
ALICE	$485,499.40	$45,700.00 [6]	$439,799.40		$439,799.40	
Food Insecurity	$485,499.40	$307,092.00 [7]	$178,407.40	$150,000.00	$28,407.40	
Housing/Transportation	$485,499.40	$43,200.00 [8]	$442,299.40		$442,299.40	
High School Graduation	$518,501.79	$521,001.79	-$2,500.00		-$2,500.00	Measure budget adjusted due to HS Grad overspending

*Budget for each FSM reflects the agreed upon 5 year 'soft budget' of $493,750 minus the portion contributed to shared minigrant budget.

<table><tr><td colspan="6" align="center">**Investments**</td></tr></table>

Organization	**Process**	**Project**	**Award**	**Decision Date**	**Future State Measure**	**Latest Report**

School of Public Policy
Oregon State University
Bexell Hall, Suite 300
Corvallis, Oregon 97331
P 541-737-2811/**F** 541-737-2289
liberalarts.oregonstate.edu/spp

April 3, 2023

Dear Colleagues at the Central Oregon Health Council,

I have been gratified to be included in some of your meetings of the past couple years, addressing senior food insecurity in Central Oregon. I received the call for proposals for the new effort to assess the scope and progress on this problem in your service area. After thinking it over carefully, I don't feel like I can pursue this project for this reason: I am concerned that any estimates of senior food insecurity that can be obtained will not be precise enough to achieve the Council's goals. I hope the explanation included here will show why. And in offering this, I offer to participate in your on-going deliberations about how to proceed. I will be as blunt as I would be with my academic colleagues here on campus, knowing that you have given much thought already to how we can reduce senior food insecurity. I have tried for over 20 years to figure out how to solve the methodological puzzle conveyed in your call your proposals and am offering to come alongside your process of figuring this out.

My understanding is that to assess progress in achieving the Council's goals, you want to know what is the number of food insecure seniors now (baseline) and then want to monitor that progress over time, using a method that will be practical, efficient, reasonably priced, and will produce a measure of senior food insecurity that is precise enough and thus sensitive enough to detect improvements (or lack thereof) over time. This is indeed the "holy grail" of local data that many communities and non-profits are looking for when wishing to assess the effectiveness of local efforts.

The main point I wish to make is that sampling is the problem, not measurement, and this produces a nearly intractable problem. The sample sizes that you can realistically attain will not produce estimates that are precise enough to allow you to confidently measure any change in food insecurity. But there may be some undervalued solutions to consider.

We have measures of food insecurity that are reasonably valid (such as the USDA food security supplement of the Current Population Survey), and its derivatives whether they be the 18, 10, 6, or 2 item instruments. These permit us to categorize senior households as food insecure or not, or in some cases as experiencing food insufficiency, or other related concepts. Any of these could be used repeatedly over time, and other related demographic and contextual data could be collected about these seniors to identify particular groups and places most vulnerable, or

improving, or declining. If there are problems with these measures of food insecurity, modest changes could be made, but this is easy to do, if not easy to defend to critics who are measurement "purists".

No matter what instrument we use for these measures, people are categorized into 2 or 4 groups (food insecure v. secure; OR, very-low, low, moderate, high). If we survey a random sample of seniors (a daunting task actually), we cannot get an estimate that is any more precise than perhaps 2 to 3 percentages points. That is, if we obtain a sample of, for example, 400 random seniors, our estimates will have to be "plus/minus 4.9 percentage points" ($p < .05$). A sample of 800 would have an estimate of "plus/minus 3.5 percentage points" ($p < .05$). In some applications, that level of imprecision is acceptable, but not under these conditions. The two conditions most relevant are as follows.

First, the national average food insecurity rate for seniors in 2021 was 7.1%. In Oregon, in 2019-2021 it was around 6.9% (+/- 4 percentage points). You can see right away here that the Oregon number is both similar to the US, <u>and</u> that the margin of error around the Oregon number is quite large (with a sample of perhaps 150 seniors). It leaves us wondering if the Oregon rate is anywhere from 2.9% to 10.9%. Even with a larger sample of, for example, 1,000 seniors in Central Oregon, we would expect the rate to be not unlike the Oregon and US numbers, and to be plus or minus a few percentage points. This is useful enough for assessing orders of magnitude (it's in the single digits; not a third or half of all seniors). But this large margin of error brings up the second condition; namely, estimating change over time. If the Health Council wishes to monitor change over time, there is no way to detect any reasonably expected improvement when any one estimate is so imprecise. Even with a large sample of 1,000 seniors you would need to see a decline of over 3 percentage points to confidently detect any change and that would be literally cutting in half or by a third the total number of food insecure seniors. That might be possible over 10 years, but you would not know year to year.

In short, sample size is the big obstacle, even if we have an excellent measurement instrument. This does not yet address the challenges of obtaining a sample that is representative of seniors. With cooperation of county health officials at public health clinics and local providers, it might be possible to obtain a non-representative, yet repeated sample year after year, but sample size is still a problem. In a fully cooperative world of non-competing, highly coordinated health-service-providing organizations, perhaps a large sample that represents a sizeable fraction of all seniors, could be examined. But I suspect it is in fact this lack of coordination and cooperation that has kept the medical community from solving this assessment puzzle so far.

If I am right about the concerns I've raised, then some possible directions I suggest are as follows, both while assessing other proposals or considering new endeavors in the future.

a) In this selection process of proposals, require researchers who propose a new metric or measurement instrument to fully describe the level of precision their method can achieve, and make sure that the level of precision is sufficient for achieving your goals of assessing change over time. While I have not discussed it above explicitly, this concern is

even more problematic when we wish to "drill down" to assess needs and improvements at an even more granular level such as within individual counties.

b) Consider focusing research on just low-income seniors since their food insecurity rate will be well outside of the single-digits, and they are the target group that advocates and safety net programs are directed toward anyway. For example, if only federally funded health clinics were to share with you their food insecurity data collected in whatever new efforts are underway to assess social determinants of health, this metric itself might be all you need to monitor year to year. That is, you could just see how the food security status of all patients at this or that clinic changed year to year, hence no longer really "sampling" per se.

c) Reconsider whether eliminating senior food insecurity is in fact a goal that can be assessed. It's a worthy goal, but if it can't be measured, perhaps it will be necessary to reimagine how we frame it. Perhaps a "proxy goal" could be "enhance SNAP participation rates by "x"% among qualified seniors" or "increase the investments in health food boxes for low income seniors by "y"". The former can be measured easily with help from ODHS and assessment of their administrative data. The latter by working with community partners to measure their services. In other words, while we wish to reduce food insecurity, we may not be able to measure it directly, but we can measure the expansion of efforts that we know reduce food insecurity.

d) Finally, while I am someone who usually wants to see quantitative change as a measure of improvement, qualitative methods can tell you much about what is changing over time in the conditions of low income seniors, and might provide sufficiently convincing, encouraging, and challenging information for assessing the need for different efforts to improve senior food insecurity. Investment in more efforts such as the recent Oregon Food Bank project that gathered focus groups of immigrants to assess policy needs (see the new Food for All Oregonians legislation) could be as instructive for your purposes as using numerical reductions (again, that holy grail) to assess achievement of Council goals.

I am available for further conversation about these things, for participation in assessment of proposals that will be submitted this Spring, and/or possible alternative contracting with OSU to pursue some of these topics in the coming year.

Most sincerely,

Mark Edwards
Oregon State University
medwards@oregonstate.edu

Hi MaCayla,

I had a chance to look over the RFA, and I have reservations about being able to deliver what is requested based on two challenges, which I'll describe here in case it's helpful at all! (Most of my work is figuring out how specific subpopulations' experiences of food insecurity are unique and trying to emphasize how tailoring to those experiences would increase program effectiveness and people's well-being. So I do empathize with the desire to tailor measurement and social service responses to older adults. It may just be that the methods I'd use to do each of the two main purposes here would be totally different from each other).

The first difficulty is sampling. The raw number of older adults in the four counties and Warm Springs is small, and sampling from people who touch OA services will definitely make the data non-representative. That may be fine, if the purpose is to connect people with services they need or determine how to allocate services or track change with individuals touched by services. But it wouldn't help measure OA FI in the community as a whole or track changes over time.

The second is measurement, and I've only developed a different point of view on this recently. I've been involved in a 4+ year study to create a measure of FI unique to college students. After alllllll of that work, our final analysis shows that our new tool doesn't produce more information or better estimates than the standard 6-item or 18-item USDA tools. So I take from that experience that even though lots of subpopulations have unique experiences of FI, the closed-ended measurement of those experiences is not the best way to understand what needs exist in a population with regard to food access. And having different tools prevents us from comparing to state, county, or national data or other populations as needed. (And we've spent four years basically to say, let's just keep doing it how we were doing it, even though it isn't perfect). Qualitative approaches (asking OA themselves, asking caretakers, asking stakeholders and social service providers who work with them) may help stakeholders understand the challenges of OA FI a bit better, but I also think the RFA indicates that a lot is already known. The question of allocating resources more effectively also seems answerable using qualitative approaches.

I have also been working a lot on older adult food insecurity in the last few years. In talking to social service providers, we learned a lot about what is going well and not so well in terms of resources/services related to older adult FI. I'm attaching two things for your review – one, our first paper about the topic, which focuses on COVID changes that helped and hurt older adults, and two, a presentation from yesterday that summarizes recommendations/strategies that social service providers had to improve older adult FI (with the strategies summarized in a third attachment just for ease of navigation). (We're writing this paper now, but it won't be out for a while. This list is the closest we have ready to share). Yesterday, we talked to about 21-22 older adult providers who came to our workshop, and they largely concurred with the folks we interviewed about what is needed.

I do think it's feasible to measure the preferred qualities list – use of food assistance programs, health status and daily functioning, connection to social services and health care services, access barriers, etc. But I think this could be done MUCH more cheaply than $150k with a compendium of tools that already exist. This would help understand the unique challenges of OA and help direct resources and

improve/tailor services, but it wouldn't contribute to the goal of measuring/monitoring FI in the broader community.

I'm happy to chat about this more if that would be helpful.

Stephanie

SOCIAL SERVICE PROVIDERS' STRATEGIES TO IMPROVE OLDER ADULTS' FOOD SECURITY

Stephanie Grutzmacher
Associate Professor
Global Health, Nutrition, OSU CPHHS

Maureen Quinn Lores
FCH-SNAP-Education Program Coordinator
Washington County, OSU Extension

Oregon State University
College of Public Health and Human Sciences

SESSION OVERVIEW

- Our research findings
  - Older adults' use of SNAP
  - Older adults' food access during COVID
  - Social service providers' strategies to improve older adult food access
- Reflection and discussion
  - What strategies do you use?
  - What strategies might you use in the future?

OLDER ADULT FOOD SECURITY STUDIES

SNAP participation

1. What factors explain older adults' under-enrollment in SNAP?

Barriers to and facilitators of food security

2. How do social service providers describe older adults' food access during COVID?

3. What strategies do they use to promote older adult food security?
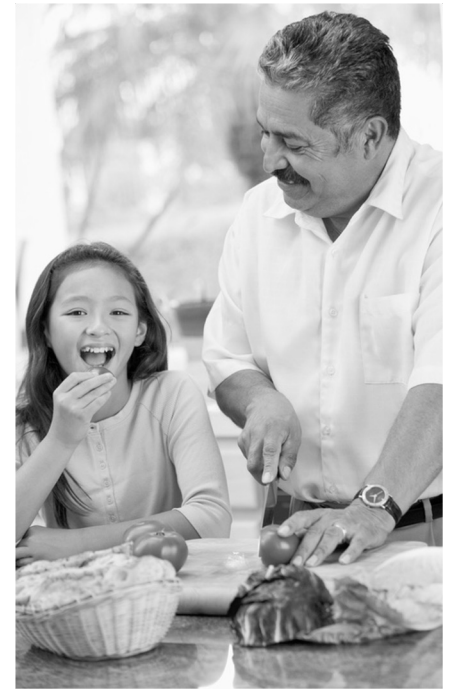
OREGON OLDER ADULT SNAP USE

Giordono, Rothwell, Grutzmacher, & Edwards, 2021

- Used Oregon SNAP administrative data (2014-2018), people ages 51-64 in 2014 (n=95,467)
- Examined chances of leaving SNAP
- 1/3 are long-term participants (>55 mo.)
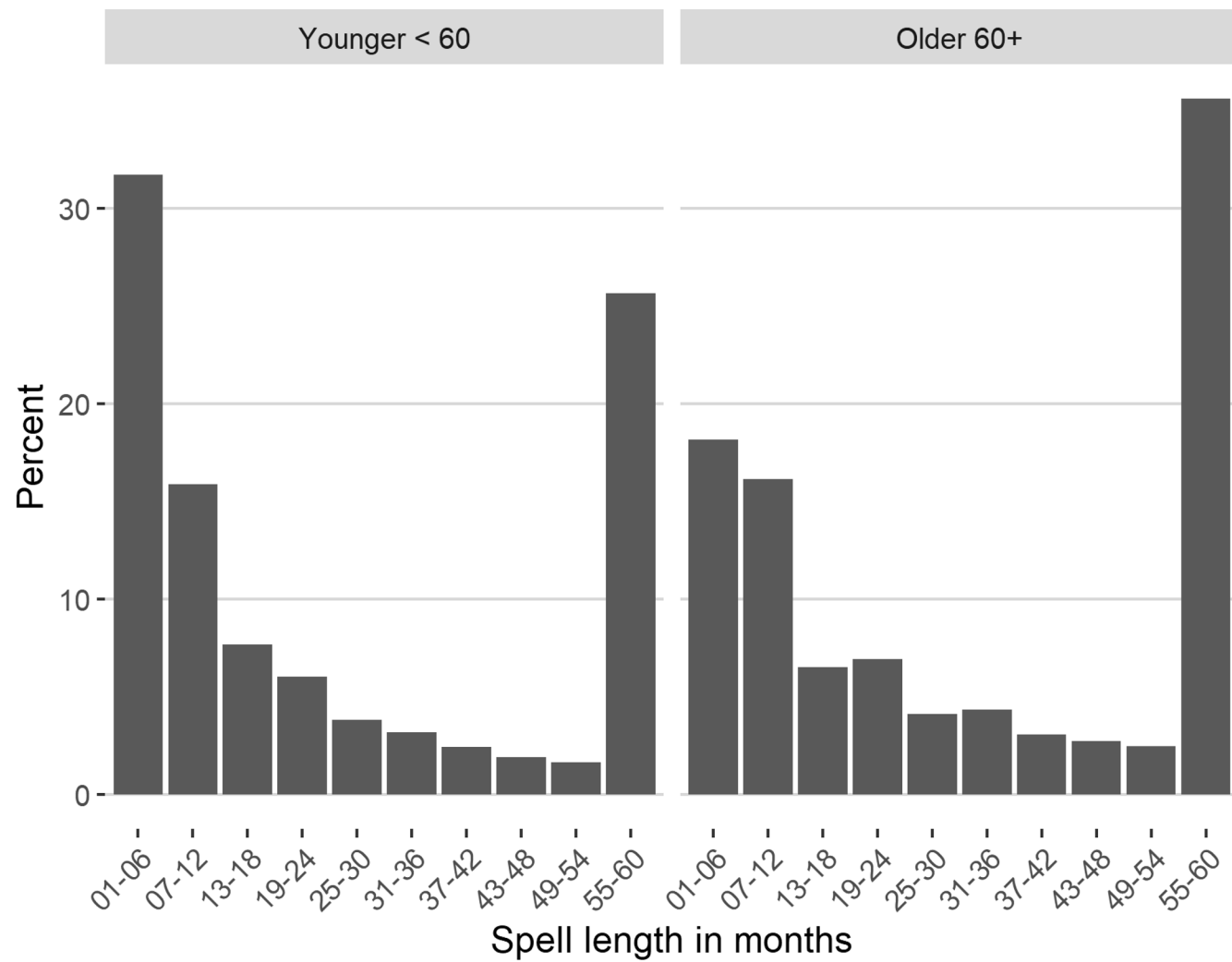
WHO LEAVES SNAP?

- Pre-retirement and younger adults were more likely to exit, have shorter stays on SNAP

- Latino/a, male, first-time participants, and those with a wage earner or children in the home were all more likely to exit

- Lower SNAP participation is probably tied to limited take-up rather than limited persistence
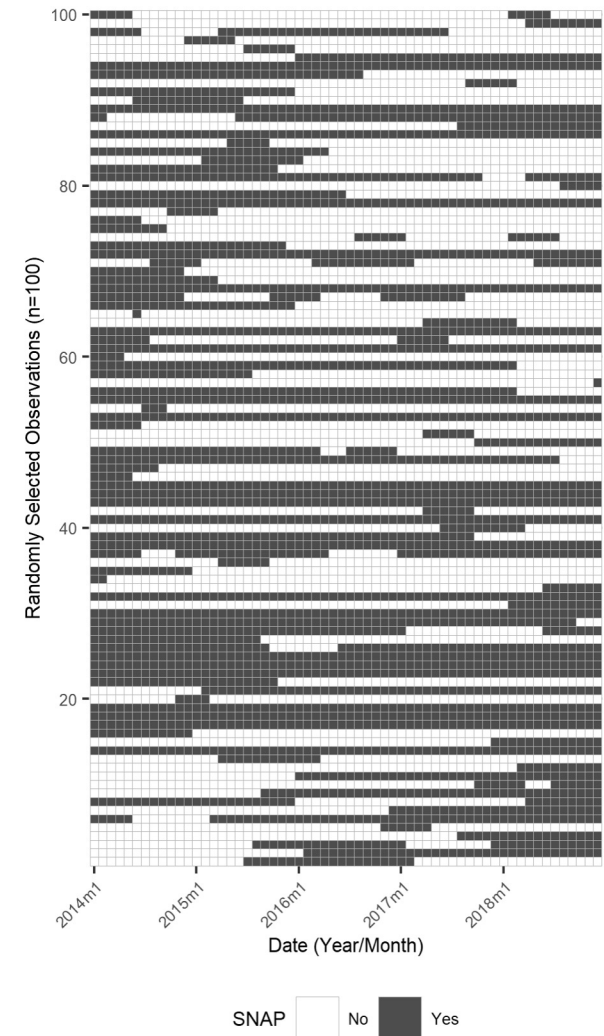
FOOD SECURITY BARRIERS AND FACILITATORS

- Interviewed social service providers (n=22) from 13 public and private agencies across Oregon in Feb-May '21
- Roles included program coordination, case management, client services, outreach, and community health
- 95% female; mean age 42; 63% white, 23% biracial, & 9% Latinx

OLDER ADULT FOOD ACCESS DURING COVID

Munger, Speirs, Grutzmacher, & Edwards, 2023
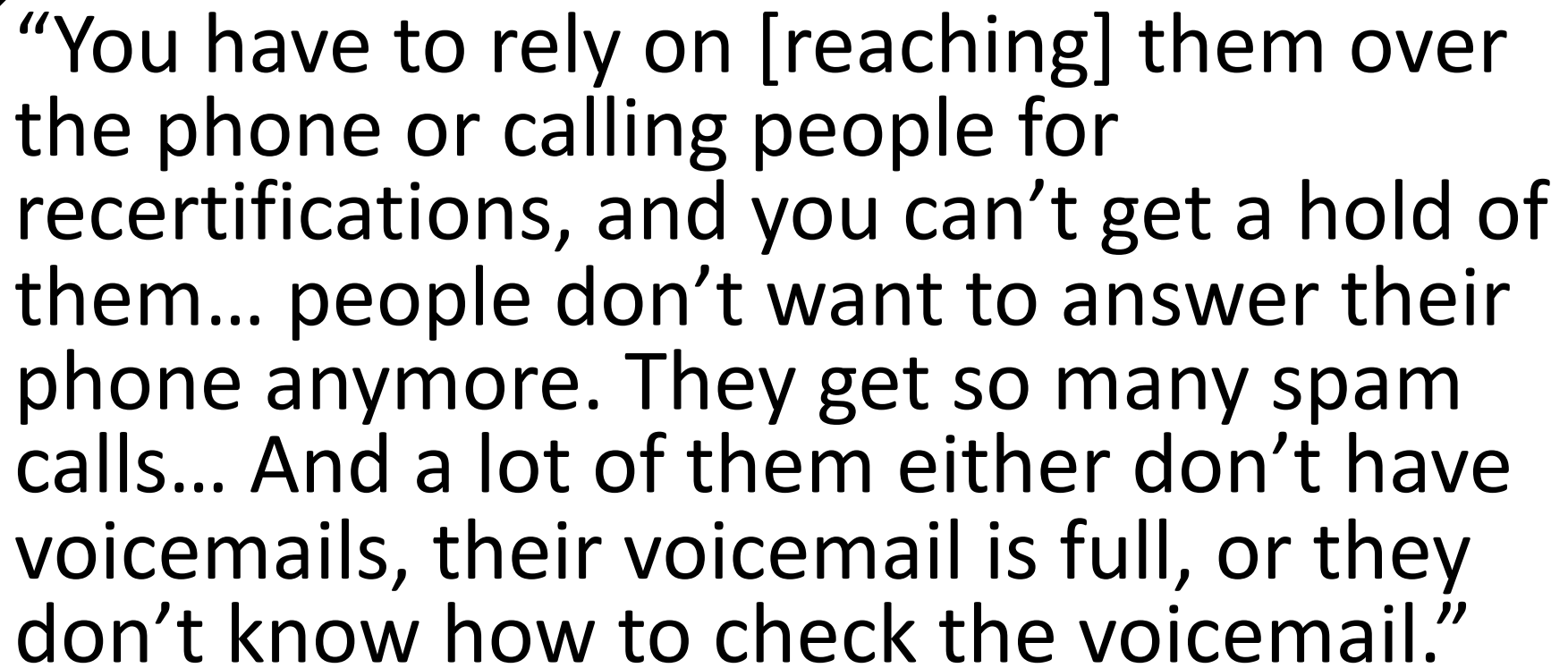
Increased government assistance
- Increased SNAP benefits
- Government program access

Social distancing guidelines
- Staying home and keeping others out of the home
- Social support
- Program delivery modes
- Technology's role in program access

"So, people [eligible for only the minimum SNAP amount] maybe wouldn't have applied [before the Supplemental Emergency Allotment] because they'd only get $16, now are applying because they get the full benefit. Previously it may not have been worth their time, and now it's like, *'oh, well, that could really help.'*"

Aging and Disability Resource Center (ADRC) Specialist

"You have to rely on [reaching] them over the phone or calling people for recertifications, and you can't get a hold of them... people don't want to answer their phone anymore. They get so many spam calls... And a lot of them either don't have voicemails, their voicemail is full, or they don't know how to check the voicemail."

Meals on Wheels Case Manager

SOCIAL SERVICE PROVIDER STRATEGIES & RECOMMENDATIONS

Munger, Speirs, Edwards, Linnell, Quinn Lores, & Grutzmacher, in progress

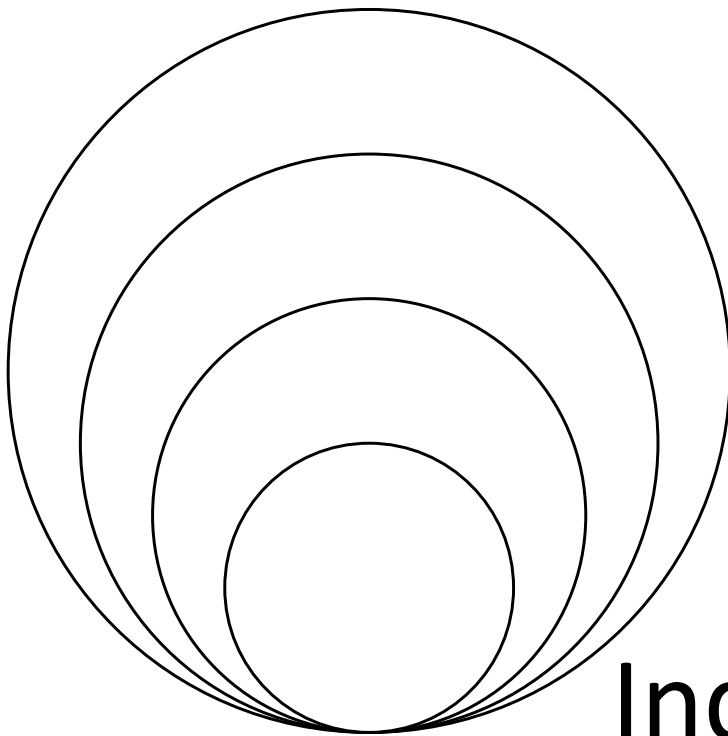# SOCIAL ECOLOGICAL MODEL

Social/Policy

Community

Institutional

Interpersonal

Individual

INDIVIDUAL-LEVEL STRATEGIES

- Education and "marketing" about food assistance programs
  - Explain how the program works
  - Explain how to make the most of benefits
- Provide individual support to navigate barriers and connect to resources
- Dispel misconceptions
- Address stigma

"Just about every time I talk to somebody who doesn't want to sign up for SNAP, it's because they think that by them getting SNAP, they are taking SNAP away from somebody else. So they think, *'Well, I don't really need it. I can make do because I don't want- somebody else probably needs it more.'* So I have to explain to them just because you're receiving it doesn't mean you're taking it away from anybody else."

Program Eligibility Specialist

INTERPERSONAL-LEVEL STRATEGIES

- Build relationships with clients
- Integrate social support into programs

"I think whether that person needs community or more like a one-on-one connection, that's going to be a part of it, too. Rather than filling out this application online. And I know that's where our world is going, but I think there's something to be said for older adults who really need that connection piece. And someone who's going to help them walk through getting connected to our resource, which is why community health workers are so great."

Community Health Worker at Non-Profit

INSTITUTION-LEVEL STRATEGIES

- Increase language accessibility
- Restructure or add food provision services
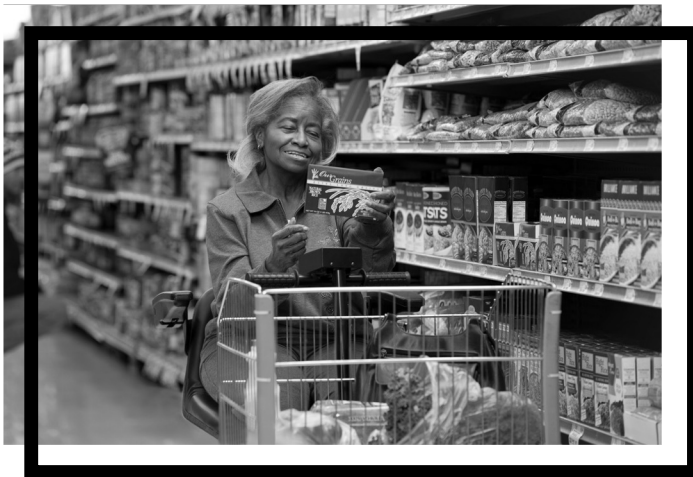
COMMUNITY-LEVEL STRATEGIES

- Develop referral networks and cross-agency partnerships
- Increase mobility of food assistance (food banks, shopping, delivery)
- Increase transportation and housing support

"[When] I do energy assistance for the program, we always have a spot. We always refer them to the food pantry. We always refer them to [Community Action Program]. We always refer them to Veggie Rx if they're not participating. Or, if they're a younger person, maybe to WIC or maybe to SNAP or we ask those questions... [Clients] become overwhelmed with the thought of having to apply for four different programs or something... If they come in, I can help walk them through and do my program at the same time they do the [Community Action Program]. You know, we need the same information help them fill out the application."
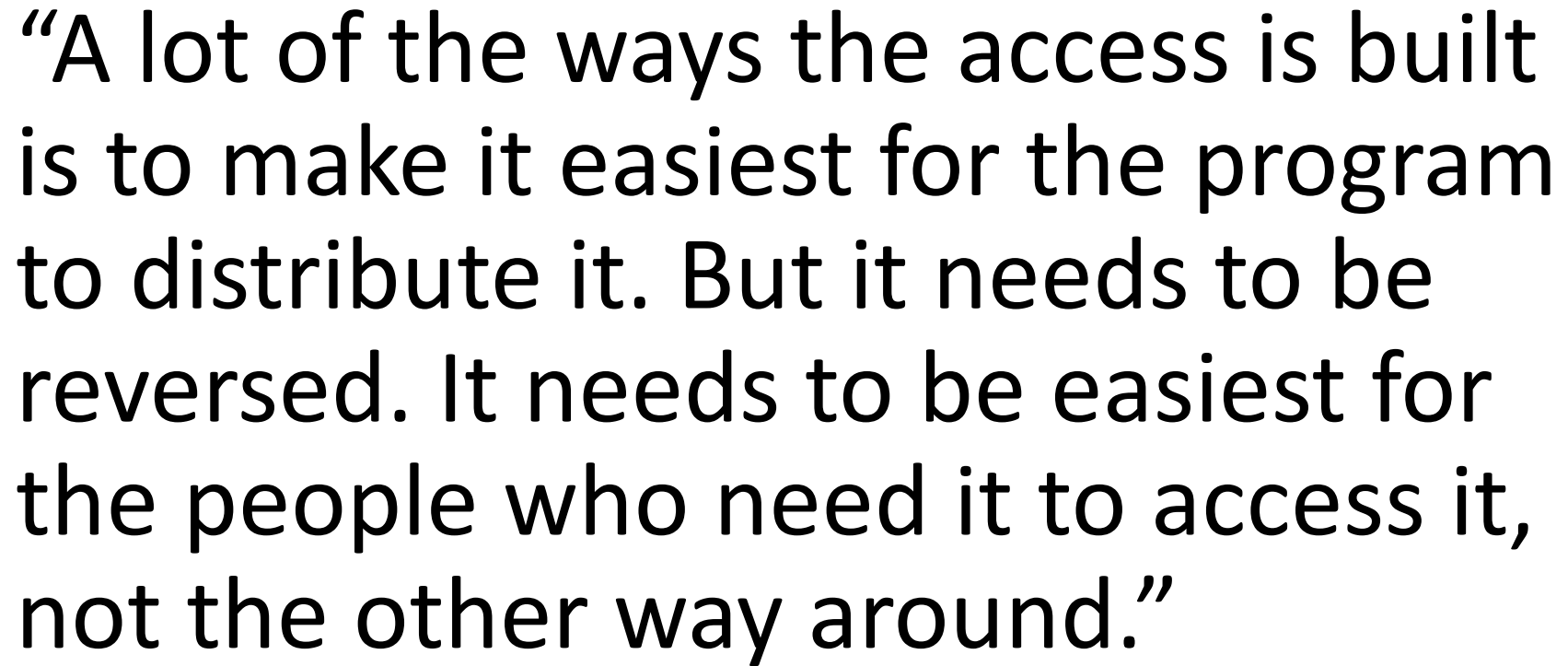
Services Coordinator

SOCIAL/POLICY-LEVEL STRATEGIES

- Bundle services
- Personalize/tailor services
- Strengthen SNAP
  - Expand incentives (Double Up Food Bucks, Veggie Rx)
  - Improve accessibility (eligibility, language, transportation, technology, application assistance)
  - Continue minimum allotment
  - Reduce application burden and other hassles

"Maybe making the applications and the notices easier to understand, because I definitely think a huge barrier to [using SNAP] is that [older adults] look at this 16-page application, and they're like, 'This is daunting. I don't even know what half these questions mean.' ...If it was more streamlined and it was clearer what we were asking and why, I think that would make things a lot easier for them."

Services Coordinator

"A lot of the ways the access is built is to make it easiest for the program to distribute it. But it needs to be reversed. It needs to be easiest for the people who need it to access it, not the other way around."

Meals on Wheels Administrator