Home, Opportunity, Planning, and Equity (HOPE) Advisory Board Meeting
Approved Minutes
September 28, 2022 from 4 pm to 6 pm
ZOOM Meeting

Members Present:	Catherine Biscoe; Ricardo Contreras; Bryan Cotter; Joel Goodwin; George Grosch* (co-Chair); Barbara Hanley; Melissa Isavoran; Briae Lewis* (Co-Chair); Cindee Lolik* (Business Associate); Charles Maughan* (Mayor's designee); Pegge McGuire* (CSC Director); Andrea Myhre; Jan Napack* (Corvallis City Council); Chanale Propst; Nancy Wyse* (Chair of Board of Commissioners).
Excused:	Karyle Butcher; Anita Earl; Ari Grossman-Naples; Caden DeLoach
Absent:	
Staff Present:	Julie Arena (Benton County Health, HOPE Program Coordinator); Paula Felipe (Benton County Public Health, recorder); Kailee Olson, Health Department Communications Coordinator.
Guests:	
	*Executive Committee Members.

I. **Welcome and Introductions**. New member welcome. Reminder of culture of agreements. Reece Stotsenberg can no longer can serve on the board due to other commitments, so HOPE members wish him the best and will miss him.

II. **Public Comments (limited to 2-3 minutes)**. No Comments.

III. **Approval of Minutes**: **MOTION** made by Andrea Myhre to approve the August Minutes; **Seconded** by Charles Maughan; All in favor; **MOTION** passed. Abstained due to not being in attendance at the August meeting: Ricardo Contreras; Caden Deloach; Jan Napack; Nancy Wyse.

IV. **Educational Component: Community Health Centers (CHC) of Benton and Linn Counties. Carla Jones, Executive director (works with Suzanne Hoffman, Health Depart Director) runs 6 clinics, serves vulnerable populations. Dr. Jennifer Micek, DO Physician, Assistant Medical Director**

- Who we are:
  - Local Health care system
  - Team-based
  - Patient-centered
- What we do:
  - Physical, behavioral, dental care
  - Prevention and management
  - Across Benton/Linn Counties
- Where we go from here:
  - Continued partnership
  - Sharing the CHC model
  - Improved community health
- Over 1400 community health centers provided care at more than 14,000 locations in 2021.
- In 2021, served 30 million patients in a single year.

- Non Profit; patient-governed organizations that provide high quality primary health care to America's medically underserved communities regardless of income or insurance status.
- Federal, State, and Local Funding:
    - Receive grants under the Health Center program, section 330 of the Public Health Services Act
    - Insurance payments (including value-based payments)
    - State Medicaid, Medicare, private insurance
    - InterCommunity Health Network-CCO, Trillium CCO, PacificSource CCO
    - Grants- state, local, federal
    - Covid, agricultural worker health, innovative projects
    - County support
- Graphic of department (Rainbow chart) person centered services; shows how all work together for community health.
    - Alsea Health Center
    - Benton Health Center
    - East Linn Health Center
    - Lincoln Health Center
    - Monroe Health Center
    - Sweet Home Health Center
    - Dental sites; Benton Health and Boys and Girls Club
    - Lebanon veterans program
    - Schools
    - Events in community
    - Work closely with COI and get referrals
- See slide on breakdown of population, languages, age, total number of visits
    - 34% of our patients identify as members of racial or ethnic minority groups- this is more than two time (or greater) those who identify this way in local communities
    - In Benton County 17.7% identified as something other than white, non-Hispanic
    - In Linn County 13.6% identified as something other than white, non-Hispanic
    - Average 4.5 visits per patient per year
    - See slide on profile by insurance status; poverty level; and racial/ethnic identity
    - Substance Use Disorder; addictions and access to services.
- What we do:
- Services provided: Physical Health Care; Behavioral Health Care; Dental Health Care; and Community Connections.
- PH nurse identified TB patient needed treatment; give them medication; he interacted with nurse; prior he had diabetes and needed to get back into care. Houseless and needed insulin; see Joe in Shelter and he had many ER visits since 2020; and last ER visit in January; no ER visits since Jan 2022. We keep working with him.
- Outcomes; why this work matters:
    - ER visits are less frequent;
    - Mobile; visits in clinic; since Jan 2020 increase visits off site; in homes and corner of 3rd and Monroe;
- Higher Complexity Care Team: Provider: Jennifer Micek, DO
- Medical Assistant: Kathy Collins
- Qualified Mental Health Associate: Jessyca Delepine
- Working together with:

- Substance Use Disorder team (SUD)
- Assertive Community Treatment team (ACT)
- Early Assessment and Support Alliance (EASA)
- County Behavioral Health (BH)
- CHC Dental team
- Goals serving 150 patients a month—see slide.

- The HCC team has better diabetic control than national and other health center data. Hypertension control is about the same as other health centers.
- Great patient feedback.
- Where we go from here
- Work with Local Government Partners and Healthcare Partners and Community Based Partners.
- Opportunities; demand outweighs supply of resources.
- Jessica joined team in 2019: position grant funded.
- She worked with Joe; Jessica had 157 visits/interactions with Joe.
- Secured a housing voucher for him; he needs to apply; on disability.
- Limitations on funding and ability to work at CHC;
- Joes is success story in many ways; has income now and possible housing
- Joe's behavior ambivalent. Left the shelter.
- When transition from unhoused to housed; huge change in lifestyle. Can be isolating.
- Address the whole person; behavioral; mental health; social; finances.
- Jessyca Delepine gained experience getting vouchers for housing and help them to build the home; so rewarding and can be frustrating; time crunch when vouchers expire.

QUESTIONS:

Barbara Hanley: Thank you Carla and Jessica for overview of CHC: In subgroup of HOPE, looking at using data from CHC and Samaritan Health and looking at usage of services, medical sheltering: encourage you to reach out to Chris Campbell for the info and hope to get the funding streams for Jessica. Carla will follow up with Chris on data. Re: high cost services prevented; save funds.

Andrea: already working with them on 3rd street commons

Melissa: OHA got 1115 waiver (several types) approved; social determinants of health. Separate financial bucket for services.

V. Community Updates: (see slide)

- Street Outreach Response Team (SORT) is hosting a wisdom panel to share experiences from homeless outreach. 10/10/2022 from 1-2pm.
- 78th Annual Oregon Public Health Association (OPHA) Conference on Monday, October 17th & Tuesday, October 18th, 2022 at OSU. Keynote speaker Dr. Marisa Zapata on Housing Really Ends Homelessness.
- Farmworker Housing Development has opened in Lebanon – Casa Latinos Unidos involved.
- Ricardo: housing developing (phase 1 for farm workers—23 apartments); phase 2; later this year. Casa Latinos has partnerships and provide supportive services to housing developments and residents can receive wrap around support services in Lebanon and Sweet Home area. Ricardo said Casa Latinos is very happy with partnerships and been able to do collaborate with CSC; public health, including working on another project--rapid community assessment with farmer worker community.

VI. City and County Update

- Affordable Housing and Sheltering added capacity (next two slides on Emergency Shelter Capacity and Affordable Housing Options)
- Outreach to rural cities in Benton County about Pilot and County Code update:
- HB 4123 pilot – MOU due Oct. 1.
    - County Code – removing sunset date to allow up to 3 vehicles on religious institution property in county unincorporated areas.
    - Doing outreach and engagement with city managers in Benton County to invite participation and hear feedback about communication needs and other rural perspectives.
    - Will be engaging service providers, religious institutions, and other community partners (ie. VFW, Chambers of Commerce)
- ROCKit facilitation to implement a coordinated entry system for data improvement and prioritizing most vulnerable folks experiencing homelessness.
- ROCKit is a *Resource Organizer for Communities Kit* that helps communities chart a path to solving local challenges by focusing on the assets and resources already on hand.
- https://www.communityrockit.org/
- ROCKit Communities:
    - Participate in a 90-day process that develops a roadmap for asset mapping and community engagement
    - Create an asset map and capacity inventory to help ROCKit implementers identify community resources
    - Commit to specific, actionable items and to measuring ongoing process
    - Receive hands-on help selecting focus areas, as well as facilitating and implementing the process

VII. Community Services Consortium (CSC) (Pegge McGuire) Continuum of Care:

- Pegge McGuire is executive director. pmcguire@communityservices.us
- Continuum of care:
- Required by HUD beginning in 1994 for:
- Awarding and Distribution of competitive funds
- To inform location homeless planning and response
- Reauthorized under the HEARTH Act and other legislation in 2010's
- Who makes up a CoC?
- Community Action Agencies
- Public Housing Authorities
- Behavioral Health Providers
- Veteran Service Providers (including county Veteran Service Officers)
- Culturally Specific Service Providers
- Shelter Providers
- Affordable Housing Developers
- Housing and Supportive Services Providers
- Who governs a CoC?
- Municipalities
- Community Action Agencies (CAAs)
- Non-profit service providers

- Geographic make-up of a CoC
- City or County
- Multiple counties
- State
- Regional communities
- What is a CoC responsible for doing?
- Homeless response systems planning
- Homeless Management Information System oversight/reporting
- Coordinated Entry and Assessment
- Data gathering and analytics
- Annual Point in Time Count of the unhoused
- Applying for competitive funds from HUD
- What does CSC currently do?
- HMIS oversight (accuracy, training, reporting)
- PITC coordination
- Manages CE lists for our region
- Veteran lists
- CoC project oversight
- On-going planning and stakeholder consultation for improvement required
- Informs local planning and processes
- Uses an approved Homeless Management Information System (HMIS)
- Must cover full COC region
- Defines central prioritizing principles (1 or 2) for most effective use of resources
- Prevents those with severe needs from languishing in shelter or on streets
- Continuum controls list, vulnerability assessment tool, and policies for use
- Not a waitlist! The majority of clients on the list will NEVER be served due to lack of available housing options.
- Counties approve of proposed plan to form continnum, including what budget would look like and what we would have to add to fit the HUD requirements. Begin talking about it; who takes responsibility for each piece.
- Andrea: thank you so much—makes it clear the path forward. Appreciate it.
- Pegge: thank you for helping to make our local voice heard.

VIII. HOPE Public Engagement and Community Feedback

- Update about where City Council is in the process of updating Social services funding at city.
- HOPE Co-Chairs met with Task Force representative.
- End of year timeline to finalize new policy.
- Level of community engagement.
- George: Briae and I met with Paul, etc about social services policy. Offered to assist them. We are waiting to hear from them. I meet with Paul Bilotta next week. Jan: come up with path forward; surveying providers; collecting information. Next meeting Oct 5 at 4:30 pm and meet in Nov and Dec and hope to finish it by end of year.
- For more information on the Task Force: https://www.corvallisoregon.gov/bc-sscptf

- To sign up for updates on this process, go to this page: https://www.corvallisoregon.gov/stay-connected
- Check the box for "Social Services Council Policy Task Force"
- Then put their email in towards the bottom.

IX. Next Steps

- Upcoming HOPE Meetings:
- October 26 – normal 4th Wednesday of the month
- Date changes for Nov and Dec:
- November 9th 4-6pm
- December 14th 4-6pm
- HOPE Implementation team working on:
- HB 4123 Pilot MOU, structure, and roles for a coordinated office.
- Improving data by working toward coordinated entry with provider input. Facilitated by ROCKit to create action items to move forward implementation.

X. Meeting was Adjourned at 6 pm.