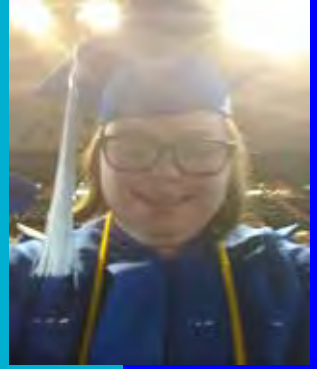
Disability Equity Center

Allison Hobgood and Abby Mulcahy,
with Laura Estreich

IHN-CCO Pilot PROPOSAL

IHN-CCO Pilot PROPOSAL

Disability equity center



Laura Estreich /Allison Hobgood/Abby Mulcahy
disability equity center team

DEC Intern Laura Estreich

I am Laura EStreich 19 years old. am wings student

I am born with down syndrome with heart defect repair found out have down syndrome with disability with heart defect repair

I am intern at disability equity center am research partner i do research project with on people with disability. am part of this Grant add some Information why we chose disability equity center corvallis community

What is disability equity center

The disability equity center in corvallis is a place made by and for disabled people it is an organization that believes disability can be powerful and beautiful you can discover yourself at disability equality center or help someone else discover who they are we are about disability pride and changing the world to make it better for disabled people the disability equality center can help educate people about things related to disability and be a resource for disabled people in our community

Disability equity center corvallis community

This about this is place people with disability and for disabled people orangzation around corvallis community the disability equity center that believes people with disability

The Disability Equity Center (DEC) in Corvallis is a community center made by and for disabled people. We are an organization built on disability culture, pride, and a fierce determination to make the world equitable for everyone. The DEC brings disabled people from the margins of society to the center and offers a safe space for coalition, community building, and social connection. The DEC serves as a resource center for disabled people and their allies, and it enables concrete connections between people across the disability community in the Willamette Valley. We also help educate our local community about ableism and change social misperceptions about people with disabilities.

Pilot Summary and Goals

- **The Disability Equity Center (DEC) is a visionary grassroots community cultural center built by and for disabled people.**
- 3-Pronged Approach
  - meet the diverse needs of **people living with disabilities**, as well as their family and friends, as a resource, community, and cultural center for disabled people and their allies
  - address the specific needs of **healthcare providers**, concentrating on gaps and augmenting partnerships across formal disability support services
  - educate our **local community** about ableism and change social misperceptions about people with disabilities

Member and Community Need

- **Living with Disabilities in the Willamette Valley**
  - Decentralized resources
  - Lack of community and socialization
  - Limited voice
- **IHN-CCO Member Impact**
  - Healthcare navigation and resource support
  - Social Determinants of Health
  - Changes in health and healthcare use

System Transformation

- **Innovation**
  - **Community**
    - Centering disabled people and their needs and voices
    - Decreasing social isolation
  - **Education**
    - Internal - peer-to-peer programming and supports
    - External - intersectional disability-related curriculum
  - **Resource Hub**
    - People with disabilities
    - Healthcare providers
    - Linking organizations
  - **Leadership**
    - Identify, strategize, and fill gaps in support
    - Visionary advocacy
      - Increased public transportation options
      - Increased ADA-compliance
      - Targeted disability-centric healthcare

Partnerships/Collaboration

- Benton County Developmental Diversity Program
- Corvallis Daytime Drop-in Center
- Corvallis Multicultural Literacy Center
- MidValley Trans Support Network
- DevNW
- NAACP
- Linn Benton Health Equity Alliance
- Rural Organizing Project
- Cornerstone Associates
- Senior and Disability Services at Oregon Cascades West Council of Governments
- Arc of Benton County
- Good Samaritan Church
- Unitarian Universalist Church
- Old Mill Center for Children and Families
- Corvallis Housing First
- Oregon State University
  - Impact
  - Disabled Students Union
  - ADA30
- Western Oregon State University
- Willamette University
- Corvallis School District & WINGS Transition Program
- Vina Moses
- CARDV
- National Federation of the Blind
- Corvallis Parks & Recreation
- Mid-Willamette National Organization for Women
- Home Life, Inc
- Jackson Street Youth Shelter
- Shangri-La
- Community Outreach, Inc
- IHN CCO

Health Equity Plan

- **Removing Obstacles**
  - Resource navigation and support
  - Knowledgeable, equitable healthcare providers
  - Linking existing support systems
- **Fostering Community**
  - Coalition building
  - Social connection
  - Decreased isolation and stigma
- **Coming Home**
  - Self-discovery
  - Disability Pride

Definition of Success

- **Outcomes and Measures**
  - **Community**
    - Open hours and peer-to-peer programming
  - **Education**
    - Develop internal and external programming
  - **Resource Hub**
    - Link support systems and navigation tools
    - Identify and develop nontraditional healthcare service supports
  - **Leadership**
    - Visionary advocacy and activism
- **At the conclusion of this pilot**
  - foundation for 3-5 years of sustainable DEC function
  - testimonials and impact statements

Sustainability Plan

- **Programs**
  - Informed by community needs
  - Carried out by community members
  - Possible in-house billable services and referrals
- **Diverse funding streams**
  - Social Justice Fund NW
  - Benton Community Foundation
  - Oregon Community Foundation
  - MRG Foundation
  - Northwest Health Foundation
  - Collins Foundation

DST Member Questions?

Building a Trauma-Informed Community of Practice within IHN

Trillium Family Services

IHN-CCO Pilot PROPOSAL

Pilot Summary and Goals

This pilot is specifically designed to bring IHN-CCO cross-sector provider communities together through a series of training modules and consultation sessions to develop a shared understanding and tools for creating a trauma-informed culture and system of care grounded in equity and connection.

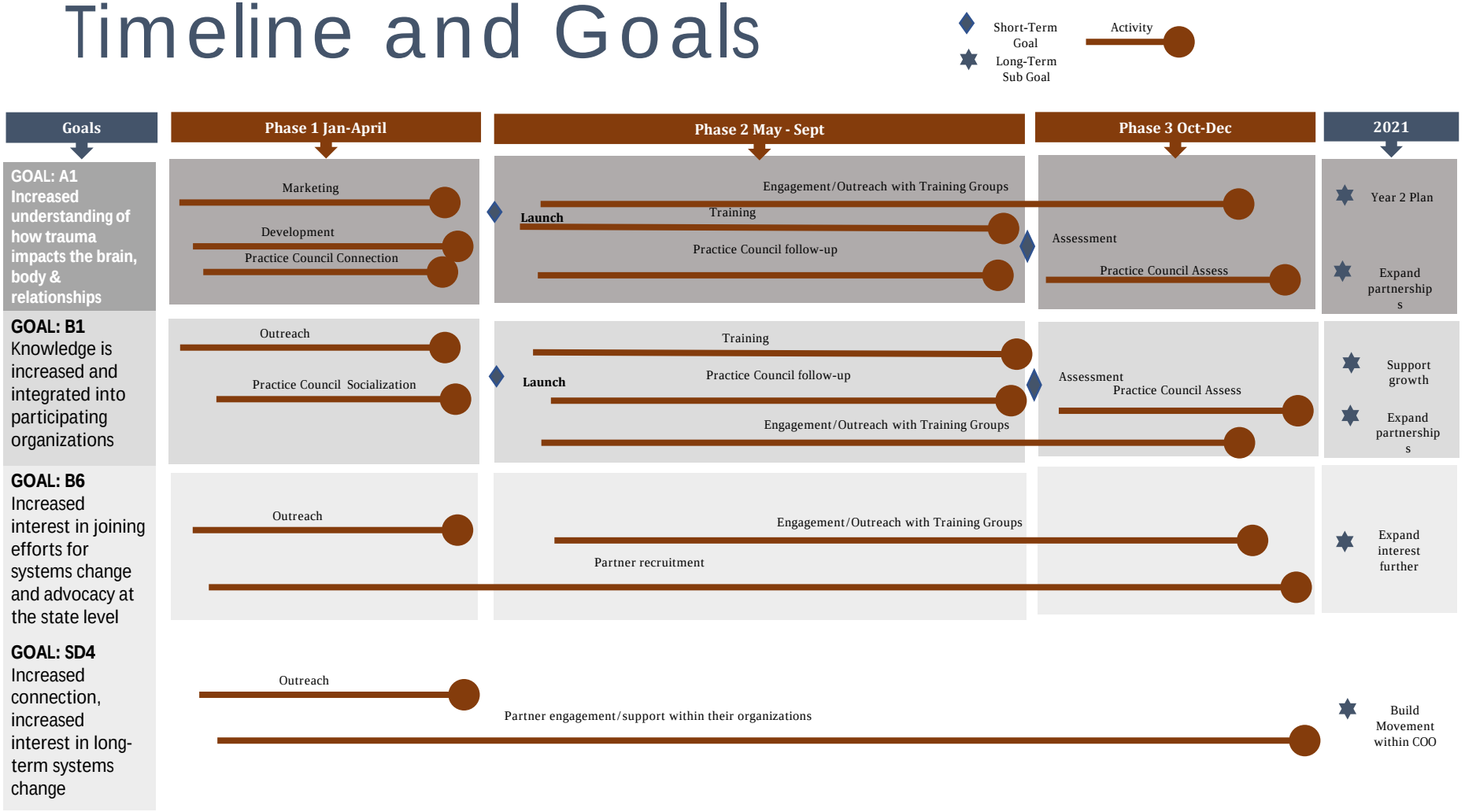
- **Goal #1**: Each participant has increased understanding of how trauma impacts the brain, body and relationships with self, others and the systems of support within our community.
- **Goal #2:** Knowledge is increased and integrated into participating organizations.
- **Goal #3**: Increased number of trauma informed therapists and service delivery professionals; increased interest in joining efforts for systems change and advocacy at the state and local levels**.**
- **Goal #4**: Increased connection to other members, increased interest in expanding activities related to Trauma Informed Care to support long-term systems change.

Training Overview

For this transformative pilot program, we propose six trainings starting in January 2021 with length, format and group sizes dependent on IHN network member capacity and potential logistical scenarios

- **Module 1:Trauma, Risk & Resilience:**
- **Module 2: Health Equity, System Inequities and the Pair of ACEs**
- **Module 3: Trauma Informed Care Movement in Health Delivery Systems**
- **Module 4: Self in the System**
- **Module 5: Sustainable Systems Change**
- **Module 6: Operationalizing Systems Change**
- **Practice Council Model**

IHN-CCO Pilot Proposal Timeline and Goals



System Transformation

- Innovation: The pilot promotes the Triple Aim of health care by offering a shared understanding for all sectors of the community and blends Trauma Informed principles with principles of Building Community Resilience for an entire CCO geographic area.
- This understanding supports transformation through healthier communities with less expense based on medical treatment, juvenile justice and other social service safety net costs.
- Pilot project will support the micro and macro-level work of empowering Practice Councils to engage with complex problems inherent within service delivery systems.
- Key tenant of the training includes elevation of community voice in efforts to reduce silos within access to systems of care.

Member and Community Need

Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Partnerships/Collaboration

- Our cross-sector partners, and therefore their clients or service users, will participate in this active dialogue surrounding trauma and resilience, and integrate information into the work that they do collaboratively with other partners. We intend to partner with lHN's network organizations as training recipients.
  - **DevNW** will partner on the project as a site location and training recipient, focusing on housing to community members who deal with health equity issues.
  - **Linn-Benton-Lincoln (LBL) ESD** will modify educational service delivery systems to be more trauma informed for populations with health disparities and inequities.
  - **Samaritan Health** will partner to enhance their delivery of their medical practices through hospitals, clinics, and as an organization.
- Committed Partners: Jackson Street Shelter, Old Mill Center, Benton County PLWG, Olalla Center, Lincoln County CASA, Lincoln County Juvenile Dept, Lincoln County PLWG, ABC House, Linn County Juvenile Dept. and Linn County Health Dept.

Health Equity Plan

- We cannot talk about trauma-informed care without addressing Diversity, Equity and Inclusion.
- Training modules and activities will unpack system inequities of racism, poverty, access to housing, food and the criminal justice system. We will actively engage participants in understanding how these adversities contribute to poor health other social determinant outcomes within our communities.
- Our cross-sector partners represent a diverse array of organizations involved in social determinants of health: housing, education, and physical health.
- Training participants will be asked to share information with their organizations and engage with material through Practice Councils.

Definition of Success

What data will you use to measure success?

- Comprehensive qualitative and quantitative evaluation surveys at the beginning and end of each session to measure participant knowledge, activity relevance and readiness for action (using stages of change assessments).

At the end of your pilot, what will have changed?

- Each participant has increased understanding of how trauma impacts the brain, body and relationships with self and systems.
- Knowledge is increased and integrated into participating organizations.
- Increased number of trauma informed therapists and service delivery professionals; Increased interest in joining efforts for systems change and advocacy at the local and State level.
- Increased connection to other members, increased interest in expanding Trauma Informed Care activities to support long-term systems change.
- County-specific communities of practice will be empowered and thriving!

Sustainability Plan

Sustainability Overview: The pilot offers shared understanding of how trauma impacts all of us, thus supporting transformation through healthier communities with less expense based on medical treatment, juvenile justice and other social service safety net costs.

- Scalable: Option to easily add training cohorts.
- Transferrable: Based on concepts that are manualized and therefore portable.
- Sustainable: Bolsters a learning collaborative of practice groups designed continue beyond the duration of the project.
  - Practice Councils
  - Module 5: Sustainable Systems Change

DST Member Questions?

Healthy Homes Together

Albany Partnership for Housing & Community Development

Family Tree Relief Nursery

IHN-CCO Pilot PROPOSAL

Pilot Summary and Goals

- Healthy Homes Together (HHT) will integrate Traditional Health Workers (THW's) into the Housing Services Program at Albany Partnership for Housing & Community Development (APHCD), located in Linn County. In addition HHT will promote systems change through regional support of THW's working in the housing sector.
- Goal #1- *Supporting residents in maintaining stable and safe housing.*
- Goal #2 - *Improving healthcare access for members*
- Goal #3 - *Positively impacting behavioral health of members*
- Goal #4 - *Identifying and improving social determinants of health*
- *Goal #5 - Support and provide trainings and resources to THWs*

Member and Community Need

- THWs will be working with APHCD residents
- An overwhelming majority of the 377 residents qualify OHP
- HHT will customize the type of THW and the services provided to each of the four properties
- Region-wide systems change will be addressed through activities to support THWs working in housing throughout the region

System Transformation

- Spread the practice of utilizing THWs in housing to residents in Linn County
- Expanding and formalizing the partnership between APHCD and Family Tree while working with DevNW to learn from their experiences
- Increase efficiency and reduce duplication
- Create space for THWs to network and promote system change

Partnerships/Collaboration

- Current Partnerships- APHCD, FTRN, DevNW, CHANCE, Capitol Dental , and Linn County Mental Health
- APHCD and FTRN currently work with many other organizations to provide resident-centered services
- Both APHCD and FTRN have worked for years, and even decades, to develop working relationships with other community and medical organizations. This project will formalize and expand those opportunities
- Continually expanding partnerships in an intentional way is integral to HHT
- With data from resident surveys, the partnerships developed will target resident needs and desires

Health Equity Plan

- Housing is a significant factor in positive health outcomes
- APHCD serves diverse populations
  - People of color make up 25% of residents (Linn County 9%)
  - People with disabilities make up 19% of resident (Linn County 17%)
- Surveys in multiple modes and translated into Spanish
  - Surveys will be created with input from social devise professionals in the Latino community and development disabilities sector.
- Type/s of THWs and services provided will be tailored to the needs identified by residents

Definition of Success

- Highlights will include:
  - Increase percent of residents maintaining safe housing
  - Increase percent receiving appropriate health care
  - Access services related to substance use, mental health, parenting, peer services while ever-increasing health equity.
  - Work at the system level to support THWs in housing
- Combination of data sources- APHCD data, claims data, and tracking data compiled by THWs, and resident's self evaluations
- Resident centered health services will be widely available to APHCD residents. In addition, THWs in the housing sector will develop networks and increase knowledge of housing services.

Sustainability Plan

- Funding and in-kind resources already in place
  - APHCD, FTRN
- Transition to FTRN contracting
- Continued fundraising and grant opportunities

DST Member Questions?

- Thank you for your time. We appreciate the opportunity to share our plans and hopes for the future.

Linn County Crisis Outreach Response

Shirley Byrd

IHN-CCO Pilot PROPOSAL

Pilot Summary and Goals

It is FAC's mission to establish trust and inspire hope by providing access to resources, services, and education to those who are experiencing homelessness and housing instability.

- **Goal 1** increase stability, self sufficiency and well being through crisis intervention and advocacy for the homeless and home at risk individuals through an extensive network of collaboration partners.
- **Goal 2** Provide a continuum of care through new techniques and technologies to deliver coordinated and individualized case management.
- **Goal 3** Promote educational opportunities to clients, partners and community that facilitates healing, recovery and well being.

Member and Community Need

Linn County Homeless 2020-

Total Linn County Surveys= 327	**Albany- 226**
	Lebanon- 51
	Mill City- 5
	Sweet Home- 45
Total Sheltered Surveys= 155	
Total Unsheltered Survesy= 172	
Total Veterans Surveys= 31	
1 year or Longer in Community= 243	16 participants did not answer this question
Under age of 25 Surveys= 44	
Victims of DV= 29	
First Time Homeless= 139	
Co-Occuring self Identified Disability Conditions= 199	
Over 60 Years old= 38	

- Spreading Promising Practices
- Transformational actions
- Health Equity Rural access
- Continuity of Care Health Improvements
- Improved access telehealth practices
- Reduced cost of care

System Transformation

Transformation through:

- Spreading Promising Practices - This program will extend partner programs and services to the homeless and homeless at risk that would otherwise be unable to have access in rural Linn County. It includes new practices of traditional health care work on the streets directly with the clients.
- A mobile crisis intervention ambulance in Linn County that responds to non-criminal situations including substance abuse, mental and emotional crisis, disorientation, welfare check, and dispute facilitation - providing check ups, brief intervention, and transport to services needed and can directly connect clients to partner services and programs.
- We can improve on medical and behavioral health usage by use of tele-health technologies. The rural model includes the ability to move through large rural areas and reach people who are less likely to seek out medical resources on their own. This will increase the number of at risk people served in Linn County.
- Individualized case management plans will reduce overall economic costs while Increase the number of clients who exit to safe and stable housing, connect to valuable partner services and reduce need for emergency services.

Partnerships/Collaboration

- This is a small sample of the more than 25 close community partnership ranging from housing to trauma classes for those in need.

Partner	Task	IMPACTED STRATEGY	SDOH
Samaritan Health Services Miranda Miller, Director of Primary Care (Corvallis) – mmiller@samhealth.org	• Case mgmt. • Coordinated care • Aftercare mgmt. • Client Contact • Advocacy	Transformational Health Equity Health Improvement Improve Access	SD4
Homeless Outreach Project Wendie Wunderwald, VP Patient Services wwundere@samhealth.org	• Advocacy • Education	Transformational Health Equity Improve Access	SD4
Linn County Health Todd Noble, Linn County Health Administrator tnoble@co.linn.or.us	• Telehealth • Behavioral Health • Harm reduction • Education • HIV testing	Transformational Health Equity Health Improvement Improve Access	SD4
Lebanon Alcohol and Drug Treatment center	• A&D Counseling • A&D Housing	Transformational Health Equity Health Improvement Improve Access	SD1 SD4
Community Service Consortium (Housing) Pegge Mcguire, Acting Director – pmcguire@communityservices.us	• Housing • Rent Assistance	Transformational Health Equity Health Improvement Improve Access	SD1 SD3 SD4
Oxford House Housing (Housing) Mike Davis – Director - **voltagemd@comcast.net**	• A&D Housing	Transformational Health Equity Health Improvement Improve Access	SD1 SD4

Health Equity Plan

- Mobile outreach and the Hub programs would provide a spectrum of resources and services to connect people to the relevant ones for their particular living situation
- Extend the reach of medical providers to often unreachable clients
- Rural America experiences many rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities. All of which FAC addresses with our partners and services

Definition of Success

Outcomes	Area Of Opportunity
Increase the percentage of members who receive appropriate care	Increase Coordinated Case management
Increase the percentage of members in care understanding	Client contacts, classes and resource delivery
Improve access to health, legal and community services	Visits to providers, Mobile Telehealth connection to providers
Increase community behavioral awareness and reduce stigma through advocacy	Behavioral health partner service access, education and community building
Increase use of behavioral services	Mobile Telehealth connection and Client referrals
Improve care for members experiencing mental health crisis.	Care coordination with partners
Increase the percentage of members who have safe, * accessible, housing.	Clients provided survival housing essentials
Increase the percentage of members who have access to affordable transportation.	Transportation vouchers and rides to partner services
Increase the percentage of members who have access food.	Clients provided Survival food
Increase health equity	Connection, education, transportation to a marginalized population

- Increase the number of clients who exit to safe and stable housing, connect to valuable partner services and reduce need for emergency services.

Sustainability Plan

This pilot will sustain itself after the funding period by private and corporate donors, internal fundraising activities, enhanced partnerships, and grant opportunities.

- **Innovative** - This pilot is innovative because it is one of a kind in the Linn County area connecting partner programs and services to those who are difficult to reach.
- **Scalable** - This pilot can easily be expanded and can grow with demand as well as into other areas.
- **Transferable** - This pilot can be reproduced in other counties to better serve their marginalized populations,

DST Member Questions?

Unity Shelter Service Coordination

Unity Shelter, operating under the Unitarian Univeralist Fellowship of Corvallis

IHN-CCO Pilot PROPOSAL

Pilot Summary and Goals

- Improve health outcomes for IHN-CCO members and non-members in shelter and transitional housing settings by strengthening service coordination, system navigation, case management and referrals.

- Goal #1: Improve the health and well-being of IHN-CCO members and others in the community experiencing homelessness
- Goal #2: Integrate and improve delivery of case management across Unity Shelter programs
- Goal #3: Integrate an equity and diversity lens across Unity Shelter programs

Member and Community Need

- Talking points:
  - Target Population: Individual men and women, and women with children using Unity Shelter services. Previous season: 25% female, 20% veterans, minorities disproportionately represented as compared to housed population.
  - IHN-CCO Member Impact: 65% of clients served in Samaritan study of men's shelter clients. 340 clients served across all programs in 2019-2020.
  - Community Needs: Stronger more integrated response to needs of the homeless community, to deliver improved health and housing outcomes, and better manage system capacity and costs.

System Transformation

Innovative partnerships delivering improved outcomes at lower system cost, with clear reporting of outcomes and issues builds an adaptable and scalable model for other communities served seeking to improve health for a vulnerable population.

- Builds on a solid foundation of community partnerships
  - Strengthens partnership between healthcare, housing and social services
  - Builds on the proven success of THWs to positively impact health outcomes and service utilization
  - Creates a framework for future, sustainable service delivery, with a common data structure, clear reporting, and stronger interfaces between organizations

Partnerships/Collaboration

- Current partnerships include
  - Corvallis Housing First
  - Benton County Health Department
  - Samaritan Health Services: SamCare Mobile Medicine, Homeless Resource Team, Homeless Vulnerable Patient Workgroup
  - Community Services Consortium and other partners in housing, veterans services, food security
- Partnership with Samaritan Health Services will be enhanced by the addition of a Traditional Health Worker to Unity Shelter, and will help bridge gaps across social service and healthcare sectors.

Health Equity Plan

- Addressing health equity and reduce health disparities
  - Normalize access to healthcare and other services through delivery in safe and familiar settings
  - Assess Unity Shelter and partner program delivery through an equity lens
  - Gather regular feedback from clients and partners to assess experiences, identify areas for improvement
  - Train staff and volunteers on equity and inclusion topics, to address implicit and explicit bias in service delivery
  - Remove barriers to access services through teleservice portal access at each Unity Shelter location, and encourage service delivery providers to utilize digital service delivery where feasible

Definition of Success

- Measures & Outcomes
  - Baseline data, metrics development and reporting plan approved, toolset enabled
  - Improved health outcomes, case management, referral completion, and appropriate service utilization
  - Lower health and other service equity concerns
- Data will include Shelterware demographic data, case management reports, and shared data through partner agreements
- Improved health and well-being, higher service utilization, especially PCP engagement, and stronger, coordinated referrals between network of cross-sector service providers

Sustainability Plan

- Unity Shelter brings together three programs with strong community support, and a history of successful fundraising and grant development.
- Current funding partners include City of Corvallis, Benton County, Benton Community Foundation, United Way, Community Development Block Grant and Emergency Food and Shelter Programs (federal), foundations and private donors.
- Unity Shelter Board committed to developing a sustainable, braided approach to funding.
- Exploring opportunities for APM qualified/reimbursable service delivery.

DST Member Questions?

Youth Peer Support

Youth Era

IHN-CCO Pilot PROPOSAL

Pilot Summary and Goals

- **Summary:** Youth Era will hire, certify, and implement 2 community-based youth peer support specialists to serve vulnerable youth and young adults in Benton, Linn, and Lincoln Counties.
- **Goal:** Promote health equity by reducing the onset of behaviors and recidivism correlated to suicide, ER visits, homelessness, criminal behavior, and substance abuse.
- **Strategies:** Building trusting and transparent peer support relationships, improving access to essential services, and strengthening protective factors.

Member and Community Need

- **Target Population:** Youth and young adults 14-25 - particularly those belonging to marginalized subgroups with higher needs (i.e., mental health, homelessness, addiction)
- **Member Impact:** We estimate that 75-90% of the youth served will be IHN-CCO Members
- **Community Needs:** homelessness, poverty, lack of transportation, limited healthy food access, familial instability/conflict, substance abuse, and system-involvement

System Transformation

- Young people are falling through the cracks and entering our systems as adults with higher costs and more unique needs.
- To fill these gaps and meet youth needs, Youth Era creates programs and services that are responsive and adaptable to youth culture
- We integrate innovative online tools (social media, virtual drop-in centers, peer support on Twitch) into our community-based peer support model to engage and support system-wary youth

System Transformation

- We adapt our model to suit the needs and interests of the youth and young adults who live there.
- Staff to travel to meet youth where they are at (in rural communities) and provide support however is most accessible.
- For IHN-CCO Members, we have identified two areas of focus: Substance Abuse and Mental Health.

System Transformation

- **Focus Area:** 22% of IHN-CCO Members access emergency departments due to substance-related disorders
  - **Strategy:** Partnering with YES House to provide peer support to youth and young adults experiencing mental health and substance/alcohol abuse challenges
- **Focus Area:** Approximately 36% of IHN-CCO Members have a diagnosed mental illness, although the number experiencing mental health challenges is likely higher.
  - **Strategy:** Providing stigma-aware connections to mental health services in the primary care setting and system-navigation support for those entering these systems for the first time

Source: OHA, IHN-CCO Membership Data, July 2017-June 2018

Partnerships/Collaboration

- **Partner:** YES House (Residential and Outpatient)
- **Role:** House 1 community-based youth peer support specialist and refer to Youth Era for peer support.
- **Focus:** Providing support to youth and young adults experiencing mental health and substance/alcohol abuse challenges by:
  - Supporting youth in their recovery
  - Decreasing access barriers to essential services
  - Addressing the stigma they experience from system involvement

Partnerships/Collaboration

- Local SOC has received regular barrier submissions regarding youth lacking access to youth-led services and supportive peer relationships.
- If funded, Youth Era will take an active role in the System of Care to:
  - Represent youth voice
  - Receive referrals for peer support
  - Support these communities in meeting the mental, behavioral, and physical health needs of youth and young adults in the region.

Health Equity Plan

- Youth Era believes in a **holistic view** of health and wellness - we are passionate about providing **individualized** and **stigma-aware** opportunities for youth to create healthy and well-rounded lives

- All youth have a **voice** in the services they receive

- We are committed to working with youth and system partners to:
  - Identify health disparities;
  - Identify the precise strengths and needs of the youth who face them, and;
  - Develop concrete actions to help close those gaps.

Definition of Success

- Youth Era will utilize Search Institute's 40 Developmental Assets model to support youth in identifying the barriers they experience as they work toward gaining targeted Assets
- Measure program outcomes using Asset checklists, youth satisfaction surveys, and other tools as requested
- At the end of our pilot, we hope to have increased protective factors for the youth in Benton, Linn, and Lincoln Counties through the provision of innovative peer support and access to essential services.

Sustainability Plan

- Youth Era regularly applies for additional funding
- Committed to developing our relationships with community MH agencies to contract to bill for youth peer support.
- Continued funding and community support for this pilot could result in (among other options):
  - Integration of more YPSS into YES House
  - Integration into other youth-serving agencies and systems
  - Delivery of virtual peer support training
  - Provision of virtual support groups
  - Establishment of a Youth Era drop-in center

DST Member Questions?