

1. Contact Information

- a. Contact information for the person submitting the application (who will serve as the point person for this grant cycle), including name, title, organization, email address and weekday telephone number. **Madison Riethman, Assistant Director, Columbia County Public Health, madison.riethman@columbiacountyor.gov, 971-813-9313.**
- b. Contact information for program staff whom you would like to be a part of the grantee cohort and workshops (optional).
- c. Type of organization (please note, you must be a rural hospital, clinic, local public health organization or community-based organization. Rural locations are defined by the Federal Office of Rural Health Policy. You can check to see if your location is designated by FORHP as rural by using the Am I Rural? Tool):
 - i. Community-based organization and/or nonprofit
 - ii. Critical Access Hospital (CAH)
 - iii. Other hospital type (non-CAH)
 - iv. Public health organization**
 - v. Rural Health Clinic (RHC)
 - vi. Other clinic type (non-RHC)
 - vii. Other
- d. If you are a non-CAH organization, do you plan to collaborate with a CAH or CAH-owned RHC? (Please note, if you are partnering with a CAH or CAH-owned RHC, you must submit a letter of support from them as additional documentation):
 - i. Yes, this program will partner with a CAH or CAH-owned RHC. I am partnering with _____ (please provide name of organization and the email address for your main contact at this organization). Please see this list for hospitals in Oregon that are designated as CAHs.
 - ii. No, this program will not partner with a CAH or CAH-owned RHC.**
 - iii. N/A: I am applying as a CAH or CAH-owned RHC.
- e. As part of the grant process, grantees are expected to attend cohort meetings and workshops to the best of their ability.
 - i. I affirm that my team will participate in the cohort meetings and workshops to the best of our ability.**

2. Project Description:

a. Short title for the proposed project. (maximum 75 characters) **Shortcut to Support: Increasing access to public health resources with mobile outreach services**

b. Amount of funding requested. **\$10,000**

c. Executive summary/overview of proposed project. (maximum 1700 characters)
What will this program consist of? What is the goal for the program? What do you hope to accomplish? What are the major components of this program?

Columbia County Public Health proposes to launch a mobile, community-driven rural health outreach program utilizing the County's existing mobile health van to expand access to essential public health and preventive services in underserved and geographically remote areas of Columbia County. While the mobile unit and equipment are already in place, limited financial resources have prevented full implementation; support from the ORH Rural Population Health Incubator Program will enable program rollout, partnerships, and sustained operations.

The goal of this program is to reduce health inequities and improve population health outcomes by bringing coordinated, evidence-based services directly to communities with limited access to care due to geography, income, transportation barriers, or system involvement. Services offered through the mobile unit will be tailored to community-specific needs and delivered in collaboration with trusted local partners.

Major components of the program include: (1) maternal and child health outreach, including education, resource navigation, lactation support, and perinatal mental health services; (2) targeted immunization clinics in areas with low vaccine uptake or high school exclusion rates; (3) communicable disease prevention and harm reduction activities, including STI, HIV, Hepatitis C, and HPV screening, reproductive health kit distribution, and health education; and (4) substance use prevention, harm reduction, and coordination of care, with a focus on justice system-involved individuals.

Through this flexible, scalable model, Columbia County Public Health aims to strengthen community partnerships, improve early identification and prevention of health risks, and build a sustainable rural outreach infrastructure that can adapt to emerging public health needs.

d. Please list the primary locations that your program will serve. You can list up to 10 locations. There is an option to list countywide or statewide programs.

The program will serve communities countywide across Columbia County. Priority outreach will focus on geographically remote and underserved areas, including the

communities of Vernonia, Rainier, Clatskanie, Deer Island, and unincorporated areas in the northern and western portions of the county where access to health care and public health services is limited.

e. Description of the identified population health need(s) in your community and supporting evidence of the need. (maximum 1700 characters including spaces) Why is this program needed? Who will this program serve? Why was this population chosen? How will the population be impacted by this program?

Columbia County faces persistent and documented population health challenges driven by rural geography, socioeconomic disparities, and limited access to health care services. Community health assessments and planning documents identify barriers related to transportation, provider shortages, and uneven distribution of preventive and clinical services, particularly in remote and low-income areas of the county (CCPH Strategic Plan 2023-2028).

ORH's 2025 Areas of Unmet Health Care Needs Report further highlights gaps in Columbia County, particularly in areas such as Clatskanie and Vernonia, whose scores of 40 and 47 fall below the state average. Across all Columbia County sites, access to primary care services was a major barrier—one we have also heard directly from partners and community members.

A lack of transportation resources has long been cited as a barrier to individuals in accessing health and social services. Columbia County has very minimal public transportation resources (1 line that runs between St. Helens and Portland once daily), and few to no paid transportation services such as Uber, Lyft, or private taxi services. Many roads are single lane and in heavily forested or elevated locations, making transportation during winter months or inclement weather more challenging.

This program is needed to bring essential public health services directly to communities that experience the greatest access barriers, including residents of rural and remote areas, low-income households, people who are uninsured or underinsured, pregnant and parenting individuals, and individuals involved in the justice system. These populations were prioritized because data show they are more likely to experience delayed care, lower preventive service uptake, and poorer health outcomes compared to county and state averages.

By leveraging Columbia County Public Health's existing mobile health van and partnering with trusted local organizations, this program will reduce structural barriers to care and respond directly to community-identified needs. Expected impacts include increased access to preventive services, improved immunization coverage, earlier identification and

prevention of communicable disease, strengthened maternal and child health supports, and improved connection to care and services for individuals affected by substance use. Collectively, this mobile, community-driven approach advances health equity and supports healthier outcomes across Columbia County.

f. What is the current status of this program? (to establish a baseline) (maximum 1000 characters) Has this program started yet? What stage is this program in (planning, early implementation, etc.)? What have you accomplished for this program at this point? All stages of programs are welcome.

This program has not yet launched and is currently in the late planning and readiness phase. Columbia County Public Health has completed substantial foundational work to support implementation, including securing and equipping a mobile health van, purchasing initial supplies and resources, and conducting internal and community-informed assessments to identify priority health needs, target populations, and geographic areas of greatest unmet need.

Staff have evaluated potential delivery approaches, assessed logistical requirements, and engaged in early coordination with internal programs and community partners to inform offerings. While the van is not yet operational due to limited funding for ongoing supplies, contract staff, and program support, the infrastructure and planning necessary for implementation are in place.

Funding through the ORH Rural Population Health Incubator Program would enable full program launch and transition from planning to active service delivery, allowing Columbia County Public Health to operationalize this mobile, community-driven approach to improving access to care in rural and underserved areas of the county.

g. If the project is derived from an evidence-based model, please describe and cite the model on which it is based. (maximum 1000 characters) (Optional) Are you using another program or model as a guide for your program? Is there research-based evidence showing the potential impact of this program/your approach?

This project is informed by results from other public health-led mobile health programs implemented nationwide, which demonstrate effectiveness in improving access to preventive services and reducing health disparities in rural and underserved communities. Mobile health models have been shown to increase uptake of immunizations, maternal and child health services, communicable disease screening, harm reduction services, and linkage to care by reducing barriers related to transportation, cost, stigma, and geographic isolation.

Public health mobile units are particularly effective when services are tailored to community-identified needs and delivered in partnership with trusted local organizations. This evidence-based strategy aligns with rural population health best practices and informs the structure, service mix, and outreach approach of Columbia County Public Health's mobile health program.

3. Priority population:

a. Check off the populations your program is specifically prioritizing:

- i. Communities of color
- ii. Tribes and indigenous communities
- iii. People with disabilities
- iv. LGBTQIA+ people
- v. People experiencing houselessness
- vi. People experiencing substance use and/or mental health disorders
- vii. People experiencing chronic health conditions
- viii. People currently or previously incarcerated
- ix. Uninsured and/or Medicaid populations
- x. Older adults
- xi. Other: Geographically isolated communities
- xii. Other: Pregnant and parenting individuals and families
- xii. Other: Youth

b. Please describe how your program aims to increase the health of your priority population. (maximum 1500 characters)

This program will improve the health of prioritized populations by bringing essential public health and preventive services directly to communities that face geographic, financial, and structural barriers to care. By deploying a mobile health van to rural, remote, and underserved areas of Columbia County, the program increases timely access to services that prevent disease, support early intervention, and promote long-term health.

Services will be tailored to community-identified needs and may include:

- Immunizations
- Maternal and child health education and support, including perinatal mental health and lactation services
- Communicable disease screening, testing, and prevention, including reproductive health education and supplies

- Substance use prevention, tobacco cessation support, and connections to mental/behavioral health care.

The program emphasizes prevention, early identification, and connection to ongoing care by integrating education, screening, and referral within each outreach event. Through partnerships with local organizations and health providers, individuals will be linked to follow-up services and resources that support continuity of care beyond the mobile visit. Collectively, this approach improves health outcomes by increasing preventive service uptake, reducing avoidable illness and complications, and advancing health equity across Columbia County's rural communities.

4. Program administration:

- a. Description of persons responsible for the project, as well as their roles and experience. (maximum 1200 characters)

The Columbia County Public Health Assistant Director, Madison Riethman, will be primarily responsible for this project. Madison has experience leading rural health-focused grant initiatives, including those related to mobile community health services. In addition, CCPH staff members including two community health promotion specialists, a communicable disease intervention specialist, and an emergency preparedness coordinator (also a certified CHW) will be engaged to support various outreach events, depending on each event's focus. All these staff have experience leading or supporting community health outreach events and activities.

- b. Will this program partner with other community institutions? Please select all that apply.

- i. Hospitals or clinics
- ii. Local public health departments
- iii. EMS
- iv. Schools
- v. Nonprofit organizations
- vi. Local, county and/or state public officials
- vii. Relevant associations
- viii. College/university
- ix. Other _____
- x. None

- c. List of the partner organizations and their role in your program. (maximum 1200 characters)

- Columbia Health Services (clinic) – Clinical support/connections to care, program feedback & input
- OHSU (clinic) - Clinical support/connections to care, health/medical officer support, program feedback & input
- Columbia Community Mental Health (behavioral/mental health clinic) - Clinical support/connections to care, program feedback & input
- Scappoose Rural Fire Protection District (Fire/EMS agency) – Partnership with Community Paramedicine program, program feedback & input
- Columbia County public schools (Schools) – outreach, education, awareness, program feedback & input
- Oregon Mobile Integrated Healthcare Coalition (association) – technical support, evidence-based resource identification
- Columbia County Local Drug and Alcohol Policy Committee (association) - program feedback & input, partnership building
- Columbia County Health Coalition (association) - program feedback & input, partnership building

5. Project goals, timeline and evaluation:

a. Provide at least one and up to three program goals. For example, “To improve the safety, efficiency, and quality of care for 50 primary care clinic patients by implementing and sustaining a care coordination management program by December 2026.” (maximum 1000 characters)

1. Launch and operate a mobile health van program that conducts at least 10 community health outreach events across rural and underserved areas of Columbia County by the end of the project period.
2. Increase access to and uptake of preventive services by providing immunizations, maternal and child health education and support, and communicable disease screening or prevention services to at least 100 priority-population participants through mobile outreach events by the end of the project period.
3. To improve early identification of health needs and connection to ongoing care by screening, educating, and referring at least 50 individuals for follow-up services related to perinatal health, communicable disease, substance use, or primary care during mobile outreach activities by the end of the project period.

b. Please provide a timeline for major project milestones to achieve the aforementioned goal(s). For example, “By October 2026, we will have hired a Community Health Worker to serve as a patient navigator for the primary care clinic patients. By December 2026, the CHW will have made x number of visits with x

number of patients... etc.” List all major projected milestones for this specific goal.
(maximum 1000 characters)

April–May 2026:

Finalize program design, priority populations, and service offerings based on community health needs; secure remaining supplies, contracts, and partner agreements needed to support mobile service delivery; finalize outreach schedule and target locations in rural and underserved areas of Columbia County.

By June 2026:

Complete staff training and internal protocols for mobile outreach; formalize referral pathways with health care, behavioral health, maternal and child health, and community partners; begin outreach and promotion of mobile health events.

By July–September 2026:

Launch mobile health van operations and conduct at least 3 community outreach events; begin delivery of immunizations, maternal and child health education and support, communicable disease screening and prevention, and substance use–related services; initiate data collection and tracking systems.

By October–December 2026:

Expand mobile outreach to additional priority locations; complete a cumulative total of at least 7 outreach events by the end of 2026; provide preventive services to at least 70 priority-population participants; screen/refer at least 35 individuals for follow-up care or services.

By January–March 2027:

Sustain regular mobile outreach operations; conduct at least 10 total outreach events; provide preventive services/education to at least 100 total participants; screen, educate, and refer at least 50 individuals for follow-up services related to perinatal health, communicable disease, substance use, or primary care.

By April 2027:

Complete program evaluation, document outcomes and lessons learned, and develop recommendations for sustainability and future expansion.

c. Description of expected outcomes/accomplishments and how they will address the identified population health need in your area. Please include expected outcomes that you will be able to measure at the end of the grant period to indicate whether they were achieved (maximum 1500 characters). For example, “80% of primary care patients will have had a touchpoint with a patient navigator by the end

of the project period, thus working to improve ongoing patient support and population health outcomes.”

By the end of the grant period, Columbia County Public Health will have implemented a mobile health van program that contributes to measurable improvements in access to care, preventive service completion, and connection to ongoing services for rural and underserved populations.

Expected measurable outcomes include:

- Conducting at least 10 mobile outreach events that result in increased access to preventive services in priority communities.
- At least 70% of individuals referred through mobile outreach activities will successfully connect with the referred provider or service
- Increased completion of required immunizations among individuals served through mobile outreach, contributing to improved school immunization compliance in targeted communities.
- Improved early identification and follow-up for communicable disease, perinatal health, and substance use needs, as evidenced by documented follow-up engagement among at least 50 individuals served through the program.
- Strengthened referral and coordination pathways between public health and community partners, supporting continuity of care beyond the mobile encounter.

By reducing access barriers and supporting successful follow-up, the program is expected to reduce delayed care, prevent avoidable illness, and advance health equity across Columbia County.

d. How will you determine the success of this goal? Please outline your measures for evaluating whether you achieved the major goals of the program. Again, please use measures that you will be able to report on at the end of the grant period in the final report (maximum 1500 characters). For example, “We will evaluate the success of our program based on the patient navigator reaching 80% of primary care patients, as well as creating and evaluating a patient satisfaction survey. Further, health improvements for patients in the program will be tracked over x years.”

Success of this program will be evaluated using a combination of quantitative and qualitative outcome measures that can be documented and reported at the end of the grant period. Columbia County Public Health will track services delivered, referrals made, and follow-up outcomes using data systems/tracking sheets specifically designed for this program, as well as existing resources such as immunizations and communicable disease tracking and data systems.

Key measures of success will include:

- Number of mobile outreach events conducted, with a target of at least 10 events in rural and underserved areas.
- Number of individuals served through mobile outreach and receipt of preventive services, including immunizations, maternal and child health supports, and communicable disease screening or prevention.
- Percentage of individuals referred through mobile outreach who successfully connect with the referred provider or service, with a target of at least 70% connection to care.
- Immunization outcomes among participants, including completion of required immunizations and contribution to improved school immunization compliance in targeted communities.
- Documentation of follow-up engagement for individuals identified with perinatal health, communicable disease, substance use, or primary care needs.

Additional qualitative measures will include feedback from participants and community partners to assess perceived accessibility, usefulness of services, and effectiveness of referral pathways. Together, these measures will allow Columbia County Public Health to assess whether the program met its goals of improving access, strengthening continuity of care, and addressing documented population health needs.

e. How will this project be sustained after the grant year ends? (maximum 1000 characters)

This project will generate measurable outcomes to support long-term sustainability. Data collected during the grant period (including service utilization, successful referrals, and community health outcomes such as immunization completion rates and connection to care) will be used to demonstrate the program's value and impact on population health and access to services.

Following the grant year, Columbia County Public Health will use these results to pursue additional funding through grants, contracts, and public funding sources, including coordinated care organizations (CCOs), state and federal grant opportunities, and county general funds. Because key start-up investments, planning, and infrastructure development will be completed during the grant period, ongoing program operations are expected to be less resource intensive than initial launch.

In addition, the program's flexible, partnership-based model allows services to be adapted and integrated into existing public health workflows, increasing the feasibility of sustaining

mobile outreach activities using a combination of external funding and existing departmental resources beyond the grant period.

6. Budget:

a. Fill out the budget section using the template found here. Please note that the grant is up to \$10,000, and funds cannot support medical supplies or directly support patient care and/or food or drink. **See attached.**

7. Supplemental materials:

a. You have the option of uploading one additional document of your choosing to support your application. If you have a formal partnership with a CAH or CAH-owned RHC, please upload a letter of support. Please ensure this document is no longer than 2-3 pages.