ALL IN FOR HEALTH
JACKSON & JOSEPHINE COUNTIES

JACKSON AND JOSEPHINE COUNTIES

Community Health Improvement Plan 2019-2022

June 2019

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To Our Community,

It is with gratitude and pride that we introduce All in for Health 2019-2022 Community Health Improvement Plan (CHIP) for Jackson and Josephine Counties.

While the creation of a collaborative regional CHIP was launched and stewarded by Jefferson Regional Health Alliance, All in for Health is a community-wide initiative involving the engagement and expertise of organizations and individuals from multiple sectors across our two-county region. Thank you to all who've participated in, and provided support for, the collaborative planning process so far. If you're new to All in for Health, we encourage you to join in as we implement the plan and begin to take action as a community.

As a community, we recognize the circumstances in which people are born, live, learn, work and age directly shape their health and well-being, and that no single organization or sector can improve the health of the community alone. This 2019-2022 CHIP provides the framework for mobilizing community action through partnerships to improve the health of all Jackson and Josephine County residents, particularly our most vulnerable.

All in for Health focuses on three areas of need identified and prioritized by our community:

- Behavioral Health & Well-Being (mental health and substance use)
- Housing for All (safe, affordable, appropriate housing)
- Families Matter (parenting support and life skills)

To address these needs, we are committed to:

- pursuing the priorities, goals and strategies described in this plan
- sharing our work and learning from each other to inform collective action
- aligning plans and programs of our organizations with these priorities and goals
- facilitating partnerships and leveraging resources to achieve these goals
- continuing to build a health system that supports these priorities and meets the needs of our communities

Implementing this plan will involve partnerships among health care providers, local governments, educators, community-based and non-profit organizations, and community members. All in for Health invites individuals and organizations throughout the region to come together to create a healthier community because "A healthy community is everyone's business."

Angela Warren
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VISION AND VALUES

Our vision describes the ultimate aspirational result that we are collectively working toward.

Our communities are healthy, inclusive, engaged, and empowered. Everyone lives in an environment that supports health and has access to the resources they need for well-being.

Our values describe the core principles that guide us along the way.

Equity. Committing to tackling root causes of inequity to ensure health and well-being are within everyone's reach.

Inclusive community voice. Engaging diverse populations and perspectives to keep community voice central throughout our process.

Collaboration. Working together respectfully to seek common ground and build meaningful partnerships for the benefit of the community.

Accountability. Meeting responsibilities to partners and the community by acting with transparency and integrity.

Communication. Communicating openly, honestly, and respectfully with partners and the public.

EXECUTIVE SUMMARY

The factors that impact individual and community health are complex and require collaborative work across sectors to address them. The 2019-2022 All in for Health: Jackson and Josephine Counties Community Health Improvement Plan (CHIP) is a community-level strategic plan that outlines how multiple organizational partners, working together, will collectively address priority health issues over the next three years to improve overall health and well-being within the region.

The work of developing the CHIP included:

- Creating a shared vision and set of values
- Selecting priority areas for health improvement work
- Setting goals and strategies for each priority area
- Defining population outcome measures for monitoring progress

The development of this plan was informed by significant engagement with the community. One hundred individuals from 60 diverse community organizations participated in the process by taking part in stakeholder meetings or serving as members of the steering committee or CHIP workgroups.

Selection of priority areas was based on the 2018 Community Health Assessment (CHA) of Jackson and Josephine Counties, which used population data and input from community members to identify regional health issues. In a multi-step process, stakeholders reviewed the CHA and identified the following three priority areas for the CHIP:

- Behavioral Health (including mental health and substance use)
- Housing
- Parenting Support & Life Skills

Workgroups, formed around each of the priority areas, met frequently over an eight-week period to develop the goals, strategies, and population outcome measures that will be used to shape community action and track progress. During the course of this work, the groups were asked to consider several overarching aims including reducing the impact of poverty, addressing health inequities, focusing on upstream prevention, and fostering overall well-being.

The next steps are to build and carry out action plans for each goal. The target for initial action plan development is Fall 2019, with the beginning of implementation by early 2020. Progress will be reported on a regular basis, and will be used to modify the CHIP and action plans as needed to reflect new information and changing community needs.

This CHIP belongs to the Jackson and Josephine Counties' regional community. The more community members and partner organizations engage with these health improvement efforts, the more successful they will be. All in for Health encourages everyone to review the priorities and goals, reflect on the strategies, and consider how they can join in these efforts. To get involved or for questions about this document, please contact All in for Health Project Coordinator Angela Warren at: angela@jeffersonregionalhealthalliance.org

BACKGROUND

WHAT IS A COMMUNITY HEALTH IMPROVEMENT PLAN?

Improving community health is not something that any one agency or organization can accomplish alone. It involves planning and collective action to generate solutions to community problems.

A community health improvement plan (CHIP) is a community-based blueprint for improving population health and public health system performance. It lays out a long-term, strategic effort to address health-related issues in the community. It looks beyond individual organizations' priorities and actions, and outlines the ways multiple organizations, working together, will address the community's top priorities to improve overall health and well-being.

The CHIP is developed after the community health assessment (CHA) and is based on the CHA results. The CHA provides data and information to identify community health issues which are then prioritized by the community. The CHIP is used to describe how community stakeholders will address the health priorities identified through the CHA.

Benefits of a collaborative regional CHIP include:

- Collective impact to achieve improved community health
- Stronger partnerships and improved organizational coordination
- Broader awareness and visibility of efforts
- Increased public health system capacity to adapt to change and tackle a variety of issues
- Sharing of best practices, successes, and lessons learned
- Increased efficiency in use of resources

All in for Health: Jackson & Josephine Counties

All in for Health: Jackson & Josephine Counties is a regional community health improvement initiative stewarded by Jefferson Regional Health Alliance (JRHA). JRHA is a non-profit, multi-sector leadership collaborative focused on improving the health and health care resources of communities in Jackson and Josephine Counties (https://jeffersonregionalhealthalliance.org/). It includes representation from hospital systems, public health departments, coordinated care organizations and other insurers, federally qualified health centers, behavioral health providers, and many other health-related organizations, agencies, and initiatives.

All in for Health began in 2016 when JRHA formed the CHA steering committee. The steering committee worked to build partnerships and design a regional collaborative process to look at community-wide issues impacting health. In December 2018, the project's first regional CHA was completed. The group elected to build on the success of this collaborative effort by embarking on a collective health improvement planning process and adopted the name *All in for Health: Jackson & Josephine Counties*. Moving forward, the intent is to continue the health improvement planning cycle for the region, providing monitoring for the implementation of the CHIP and producing a new assessment and improvement plan every three years.

Jackson and Josephine Counties Overview

Jackson and Josephine Counties are located in southwestern Oregon, along the northern border of California. The two counties cover a total land area of over 4,420 square miles[1] and are home to an estimated total population of 305,595 (2018)[2]. Interstate 5 runs through both counties and the larger population centers of the region all lie along its corridor.

The area has a relatively mild climate and diverse geography with rivers, valleys, hills, and mountains. The area's natural beauty, pleasant climate, and access to wilderness were frequently mentioned by community members as regional strengths during the 2018 CHA process.

Jackson County[2]

6th largest county in Oregon by population

Total population (2018): 219,200

Number of incorporated cities: 11

Population living in incorporated cities: 68%

Largest city (2018 population): Medford (80,378)

Josephine County[2]

12th largest county in Oregon by population

Total population (2018): 86,395

Number of incorporated cities: 2

Population living in incorporated cities: 45%

Largest city (2018 population): Grants Pass (37,285)

The two counties have a tradition of working together and share many resources, such as higher education services, a council of governments, and an Early Learning HUB. Several health care organizations provide services within both counties.

While there are differences between the two counties, particularly in population density and rural-urban distribution, there are several key demographic similarities[3]:

- The vast majority of the population (>80%) identifies as White, non-Hispanic, with less racial and ethnic diversity than the state of Oregon overall.
- Individuals identifying as Hispanic or Latino are the fastest growing segment of the population and the second largest racial/ethnic group in the region.
- The population trends older with relatively high proportions (>20%) of community members aged 65 and older.
- A large percentage of individuals (>40%) live below 200% of the federal poverty level.

The 2018 Community Health Assessment of Jackson and Josephine Counties also revealed that the two counties share the same top health issues and concerns, which supports taking a regional approach to health improvement planning.

A detailed description of demographics, economic characteristics, and health status is available in the community health assessment which can be found at: https://jeffersonregionalhealthalliance.org/what-we-do/2018-community-health-assessment/

PLANNING PROCESS

GUIDING FRAMEWORK: MOBILIZING FOR ACTION THROUGH PLANNING & PARTNERSHIPS

The Jackson and Josephine Counties CHIP was developed utilizing Mobilizing for Action through Planning and Partnerships (MAPP), a community-driven strategic planning process for improving community health.[4] It provides a framework for convening partners, identifying and prioritizing health issues, and taking action to improve community health.

There are six phases to the MAPP process which encompasses both community health assessment and health improvement planning. The first, third, and part of the fourth phase were completed as part of the 2018 CHA process. These included organizing and developing the partnership, conducting

the four MAPP assessments, identification of key health challenges for the region, and initial prioritization of top strategic issues. The CHIP process continued the work and involved completing the second, fourth, and fifth phases of MAPP: visioning, final selection of strategic issues to be addressed by the community (referred to as priority areas in this CHIP), and development of goals and strategies. Phase six of the MAPP process, which involves creating, implementing, and evaluating action plans to carry out the strategies outlined in this document, will begin in the second half of 2019 and continue throughout the identified time period for this CHIP.

PARTNERSHIP STRUCTURE FOR CHIP DEVELOPMENT

To develop a CHIP that meets the needs of the regional community and provide a structure for sustained implementation efforts, All in for Health: Jackson and Josephine County engaged partners through the following avenues:

A **core team** of four individuals, including the All in for Health project coordinator, handled the day-to-day planning, coordination, and facilitation for the process.

The All in for Health **steering committee**, comprised of representatives from 17 regional health system partner organizations, provided process guidance and support for development of both the CHA and CHIP.

The **Jefferson Regional Health Alliance (JRHA) board**, comprised of regional health system leadership, authorized the effort, provided ultimate oversight of the steering committee and core team, secured needed financing and resources, and provided strategic leadership to guide and support the initiative.

Workgroups, comprised of stakeholders from a broader collection of community organizations, developed the goals, strategies, and population outcome measures for each priority area.

Coordinated Care Organization (CCO) **Community Advisory Councils** (CACs), comprised of Oregon Health Plan members and other community stakeholders, provided additional oversight for CHIP development from the perspective of the region's three CCOs. CAC members participated in community stakeholder meetings and workgroups, and recommended organizational adoption of the CHIP to their respective CCO boards.

CHIP TIMELINE

April – July 2018	Engagement of community to identify regional health issues * • Focus groups • Community forums • Community survey • Stakeholder interviews
October 2018	Initial prioritization of regional health issues *
December 2018	CHA data presentations to JRHA, steering committee, and key stakeholders Initial CHIP process planning
January 2019	Release of final CHA report Finalization of CHIP process plan Final selection of top three priority areas
February 2019	Selection of workgroup co-chairs Steering committee visioning session Community stakeholder meeting to identify current efforts and potential areas of focus for CHIP priority areas
March 2019	Vision and value statements finalized First workgroup meetings
April 2019	Continued workgroup meetings to develop goals, strategies, and population outcome measures
May 2019	Finalization of goals, strategies, and population outcome measures Drafting and review of CHIP document
June 2019	CHIP document finalized Internal CHIP approval by steering committee organizations

* Part of the assessment process

COMMUNITY ENGAGEMENT

The development of this plan was informed by significant engagement with the community. Initial identification of priority areas was grounded in community feedback gathered through focus groups, community forums, and a community survey conducted during the community health assessment process. Over 1,100 community members were engaged through these efforts and the resultant feedback was utilized throughout the CHIP development process to inform selection of the vision, values, priority areas, and strategies.

Community partner organizations were engaged through participation on the All in for Health steering committee, workgroups, and JRHA board. Additional community partners were engaged through stakeholder input meetings and workgroup outreach for specific subject-matter expertise. In total, 100 professionals representing 60 community organizations participated in the development of the CHIP.

PRIORITY AREA SELECTION

A stakeholder meeting, facilitated by a consultant from Health Resources in Action, was convened in October 2018 as part of the CHA process to discuss preliminary results of the CHA and identify preliminary priority areas for community health improvement work. The consultant gave an overview presentation of 15 key themes that emerged during analysis of qualitative and quantitative data, and facilitated group discussion about the findings.

CHA KEY THEMES

Substance Use
Housing
Mental Health
Poverty & Employment
Parenting & Life Skills
Education & Workforce
Health care Access
Aging
Food Insecurity
Fragmentation of Services
Oral Health
Communicable Disease
Community Safety
Transportation
Environmental Health

Participants were then asked to individually select their top five priority themes based on consideration of relevance, appropriateness, impact, and feasibility. Group multi-voting resulted in selection of six top community priorities.

On January 30, 2019 the JRHA board held a strategic planning retreat during which board members finalized the selection of priority areas for the regional CHIP. As the board discussed the six key issues identified in the regional CHA, they considered a host of criteria including:

- Breadth of community impact
- Degree to which addressing the priority requires multi-sector collaboration
- Existing work in the community and the potential to leverage resources and align programs
- Opportunities to focus on upstream prevention
- Feasibility and sustainability

This final prioritization process by the JRHA board narrowed the list of CHIP priority areas to three:

- Behavioral Health – including mental health and substance use
- Housing
- Parenting Support & Life Skills

In choosing the final three priority areas, the board recognized that reducing poverty, addressing health inequities, and fostering well-being are overarching goals, woven into all three of the priorities, and that they should be a lens applied throughout the CHIP.

Priority areas: Broad, health-related areas for CHIP work identified through the prioritization process which was informed by CHA data.

Goals: Long-range statements of desired community health or wellbeing outcomes within each priority area.

Population outcome measures: Indicators which help to quantify health improvement progress within each priority area.

Strategies: General approaches that will be utilized to achieve a goal.

Goal, Strategy, and Population Outcome Measure Selection

Following final selection of the CHIP priority areas by the JRHA board, three workgroups were formed – Behavioral Health & Wellness, Housing for All, and Families Matter – each focused on one of the priority areas. Workgroups were comprised primarily of persons with subject matter expertise within the priority area, and sought to balance representation from Jackson and Josephine Counties as well as representation between various types of stakeholders. All workgroups had participation from CCO Community Advisory Council members.

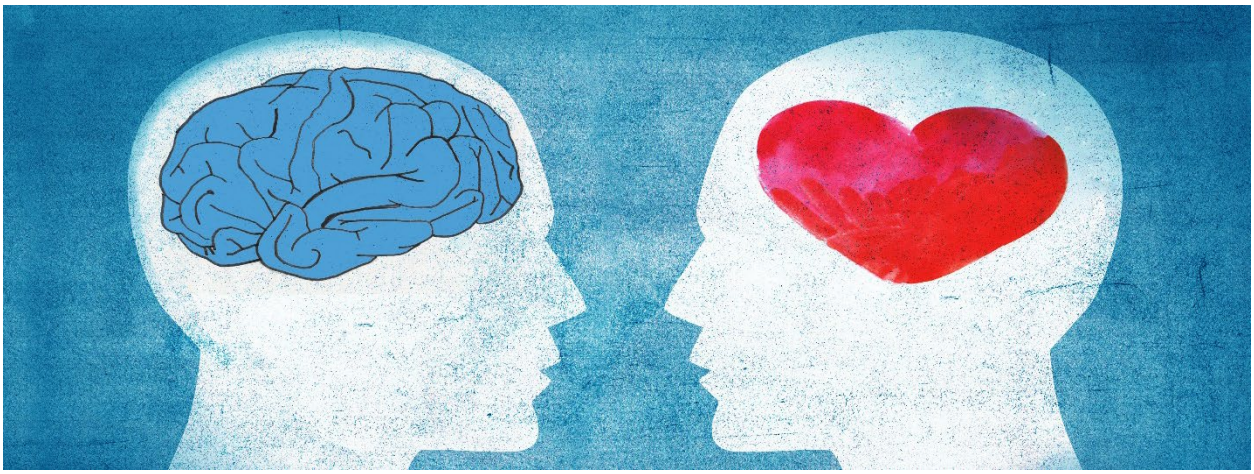
Co-chairs, supported by the All in for Health core team, led their workgroups through several meetings from late March through mid-May to select goals, strategies, and population outcome measures for their respective priority areas. To help guide this work, the co-chairs were given CHIP handbooks which were developed by the core team and inspired by the Kansas Health Institute's *Community Health Improvement Planning (CHIP) Handbook* (2015).

Considerations utilized by the workgroups in developing goals and strategies included:

- Findings from the CHA, including community survey and focus group results
- Feedback from the February community stakeholder meeting
- Upstream or root causes of community health issues
- Alignment with the All in for Health vision and values
- Evidence-base within each priority area
- State-level health priorities
- Existing programs and work within the community
- Balancing of short-, medium-, and long-term strategies

Considerations utilized by the workgroups in selecting population outcome measures included:

- Availability of quality and timely data on a reliable and consistent basis
- Relationship to chosen goals and strategies
- Ability of the measure to communicate to a diverse audience



BEHAVIORAL HEALTH

The term behavioral health includes both mental health and substance use. It encompasses mental disorders, substance misuse, substance use disorders, and other addictions, as well as mental well-being. These areas are joined together under the umbrella of "behavioral health" in recognition of the brain-basis of these conditions, high degree of co-occurrence between mental disorders and substance misuse, strong stigma associated with them, and the historical difficulty they have had in getting equal acknowledgement with physical health conditions.

Behavioral health conditions are common, affecting people across the lifespan. They can range in severity from mild to severe. The link between mental and physical health is strong, and people with behavioral health conditions, particularly those with severe illness, are more likely to experience chronic physical health conditions such as diabetes, asthma, heart disease, lung disease, and cancer. [5,6,7] Other impacts to individuals, families, and communities, which vary with the severity and particular illness, may include decreased school performance, impaired social-emotional connection, familial trauma, increased accidents, loss of productivity, and loss of life.[8,9,10]

Mental disorder: A health condition that is characterized by alterations in thinking, mood, and/or behavior that is associated with distress and/or impaired functioning.[7]

Substance misuse: The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or those around them.[8]

Substance use disorder: A chronic, relapsing mental disorder characterized by compulsive substance-seeking and use despite adverse consequences.[9]

Altogether, there is a high cost to community medical, educational, social service, and criminal and civil justice systems.

The causes of behavioral health disorders are complex and not fully understood. There is, however, abundant and growing evidence on improving individual and community health in this area. Key areas to address include prevention; access, coordination, and integration of care; and harm reduction. Of high importance is addressing the stigma associated with behavioral health conditions in order to ensure dignity and decrease traumatization of those affected by these conditions.

WHY THIS IS A REGIONAL PRIORITY: SITUATIONAL ANALYSIS

What we saw in the Community Health Assessment (CHA) data:

- Youth have relatively high rates of alcohol and marijuana use, and adults have relatively high rates of smoking.
- Substance use-related hospitalization rates are high for all substances.
- Suicide rates and alcohol-induced mortality are high.
- A high percentage of youth have indicators of poor mental health such as signs of depression, consideration of suicide, and frequent mental distress.
- High numbers of youth report living with someone who is depressed or mentally ill, someone who is a problem drinker, or someone who uses street drugs.

What we heard from the community during the CHA process:

- Mental health and substance use are among the top health-related concerns for community members.
- There is a high prevalence of depression and anxiety across the age spectrum, with concerns about ability to access mental health care services, limited availability of mental health providers, and stigma associated with seeking care.
- Older adults, people experiencing homelessness, veterans, low-income families and individuals, and middle- and high-school aged youth are populations for whom mental health is of particular concern.
- Substance use issues of importance to the community include opioid use, methamphetamine use, and youth drug use, particularly the widespread use of marijuana among youth.

Additional key concerns from CHIP workgroup and stakeholder discussions:

- Complex nature of the behavioral health care system and the need for system navigation and coordination.
- Access and care continuity issues due to insurance gaps, particularly for Medicare, private insurance, and incarcerated/justice-involved populations.
- Lack of parity with physical health in terms of investments and reimbursement.
- Impact of public stigma and recurring trauma on people with behavioral health conditions.
- Substance use disorder treatment system capacity.
- Behavioral health conditions as a root cause of other regional community health issues such as communicable disease issues, homelessness, and childhood trauma.

This regional priority area aligns with the Oregon 2020-2024 State Health Improvement Plan (SHIP) priority area of Behavioral Health (including mental health and substance use).

WHAT WE WILL DO ABOUT IT: GOALS AND STRATEGIES

Goal 1: Mitigate the effects of trauma

Strategies

a. Provide education and promote community awareness around the effects of childhood trauma, including education for parents
b. Promote and adopt trauma-informed policies and practices throughout the community
c. Build youth resilience skills

Goal 2: Decrease social isolation and loneliness in youth and older adults

Strategies

a. Build youth social skills
b. Implement and expand mentoring and social connection programs
c. Implement and expand community service programs and projects

Goal 3: Equip our community with the knowledge, tools, and resources to empathetically accept and help individuals in need of behavioral health supports

Strategies

a. Disseminate information to health care providers, social service providers, and the general public on behavioral health conditions, appropriate approaches to interacting with and treating persons with behavioral health conditions, and available services
b. Increase the number, frequency, visibility, and reach of evidence-based behavioral health trainings
c. Promote the use of 211 and ensure behavioral health system organizations keep 211 information up-to-date

Goal 4: Prevent use and misuse of substances

Strategies

a. Promote policies that advance substance-free social norms and reduce youth access to substances*, such as restricting advertising, reducing retail outlet density, and promoting retail licensing
b. Implement programs and initiatives to prevent substance use during pregnancy
c. Build youth self-regulation skills
d. Provide education and disseminate information on risks associated with use and misuse of substances
e. Educate providers on safe prescribing practices and promote safe prescribing policies

* *including tobacco, inhalant delivery systems, marijuana, and alcohol*

Goal 5: Reduce harm associated with mental health and substance use through use of community-wide approaches

Strategies

a. Increase awareness and access to Narcan, including increasing awareness of the Good Samaritan Law as it relates to overdose
b. Utilize and promote evidence-based practices aimed at suicide prevention and postvention
c. Increase access to clean injection supplies and syringe services programs for people who inject drugs

Goal 6: Ensure access and coordination of care for people impacted by mental health and substance use disorders

Strategies

a. Expand patient information sharing between providers
b. Promote development and implementation of standardized community protocols and practice standards for mental health and substance use disorders
c. Increase behavioral health pre-treatment/pre-recovery programs
d. Expand behavioral health peer support programs

How We Will Monitor Progress: Population Outcome Measures

- Suicide rate
- Accidental overdose mortality rate
- Drug overdose hospitalization rate for all drugs
- Percent 8th and 11th graders contemplating suicide
- Percent 8th and 11th graders attempting suicide
- 8th and 11th grader past 30-day alcohol use
- 8th and 11th grader past 30-day marijuana use
- 11th grader past 30-day e-cigarette use
- Percent 6th, 8th, and 11th graders with weak positive youth development

HOUSING

There is growing recognition that where a person lives – their zip code, their neighborhood, their housing – has a significant impact on their health and well-being. Housing acts as both a social and physical determinant of health.

The affordability of housing affects the socioeconomic, physical, and mental well-being of individuals and families. People who can comfortably afford their housing, have more money to spend on other expenses, and are less likely to forgo medical care, have inadequate nutrition, or report poor health.[11,12] High housing-cost burden is associated with greater housing instability. At its extreme, housing instability can lead to homelessness. However, even less extreme forms of instability, such as multiple moves or simply being behind on rent, are associated with negative health outcomes including high stress, depression, and poor physical health in adults, and depression, behavioral problems, lower academic achievement, and increased hospitalizations in children.[11,13,14]

Lower-cost housing is often substandard or poorly maintained. Physical hazards within

Housing is generally considered affordable when all costs associated with housing, including basic utilities, is less than 30% of household income

Social determinants of health: Social factors of the environment in which people are born, live, and age which impacts health, functioning, and/or quality of life outcomes. Examples include availability of resources to meet daily needs, exposure to neighborhood crime, and access to quality schools.[16]

Physical determinants of health: Physical conditions of the environment in which people are born, live, and age which impacts health, functioning, and/or quality of life outcomes. Examples include exposure to toxic substances and physical barriers (especially for people with disabilities).[16]

low quality homes may include mold, lead paint, radon, and pests. Children are especially vulnerable to poor health outcomes from these safety hazards.[11,12,13] Another group particularly affected by the housing environment are people who experience physical disabilities, including older adults.[11,13] Housing features aimed at accessibility and injury-prevention, such as ramps, wider doorways, curbless showers, and grab bars, may be difficult to find and expensive to add.

Supportive housing: A strategy that combines affordable housing with intensive coordinated services to help people struggling with chronic physical and/or mental health issues maintain stable housing and receive appropriate health care.[15]

Connecting affordable housing to needed support services can be an effective way to help the most vulnerable people in a community attain and maintain housing. Supportive housing has been shown to increase housing stability and decrease use of costly systems, such as emergency health care and criminal justice, for people with severe mental or substance use disorders who experience homelessness.[15] This model may also hold promise for other populations vulnerable to homelessness and housing instability.[11,15]

WHY THIS IS A REGIONAL PRIORITY: SITUATIONAL ANALYSIS

What we saw in the Community Health Assessment (CHA) data:

- Median housing costs are high relative to median income.
- There are large proportions of households paying more than 30% of their income on housing costs, especially among renters.
- A substantial proportion of households report severe housing problems (incomplete kitchen facilities, incomplete plumbing facilities, crowded conditions, or cost burden greater than 50%)
- There are a relatively high percentage of school-age children experiencing homelessness.
- A large proportion of households are unable to afford the basic costs of living.

What we heard from the community during the CHA process:

- Housing, including affordability, safety, and homelessness, was the issue of highest concern for community members.

- Cost was of particular concern for renters, low-income community members, and non-White community members. Safety and quality were also of particular concern to renters who feel vulnerable in asking for housing repairs and improvements.
- Individuals and families have difficulty with affording other living costs – food, medical care, transportation, child care – due to the high cost of housing. Low area wages make it difficult to improve their circumstances.
- Employers find that the cost of housing negatively affects their ability to recruit employees to the area, which in turn affects their ability to provide needed medical and social services.

Additional key concerns and context from CHIP workgroup and stakeholder discussions:

- Importance of ADA accessible housing for people who experience disabilities, including older adults wanting to age in place.
- Need for safe transitional housing and services for people in addictions recovery, post-hospital discharge, and post-incarceration.
- Veterans and homeless families as priority populations.
- Connection between housing location and access to transportation.
- Key role of policy and advocacy in addressing the issue.
- Need to cultivate a shared sense of understanding and responsibility within the community on the issue.

This regional priority area aligns with the Oregon 2020-2024 SHIP priority area of Economic drivers of health (including issues related to housing, living wage, food security, and transportation).

WHAT WE WILL DO ABOUT IT: GOALS AND STRATEGIES

Goal 1: Increase the percentage of households paying no more than 30% of their income on housing

Strategies

a. Increase supply of housing that costs less than 30% of area median income through new construction and rehabilitation of existing housing stock
    1. Expand upon and replicate successes within the region
    2. Learn from challenges that cities have faced
    3. Promote a "Yes in my back yard" (YIMBY) attitude
    4. Elevate housing on the agenda of community and economic development
    5. Repair and maintain existing affordable housing stock, both owner-occupied and rental

b. Advocate for and enact zoning and land use policy changes to support affordable housing options
c. Identify and fund specific neighborhood revitalization projects
d. Increase wages relative to cost of living
    1. Conduct internal wage assessments – organizations, agencies, and businesses
    2. Increase earning potential in the community through economic and community development such as increasing tourism and industry professions paying at or above a living wage

Goal 2: Increase percentage of individuals living in housing that is safe, accessible, and connected to community and services

Strategies

a. Build connections between housing providers and service providers
b. Expand utilization of resources that assist people in attaining housing
    1. Provide support services targeted to homeless families and individuals who are seeking housing options
    2. Expand resources for rental assistance
    3. Reduce barriers to housing
c. Invest in the development and operation of more permanent supportive housing and transitional housing
    1. Pre- and post-addiction recovery housing
    2. Housing with mental health support
    3. Post-incarceration/corrections housing
    4. Hospital discharge housing
d. Develop accessible units for specific needs
    1. ADA accessible
    2. Aging safely in place
    3. Multigenerational

How We Will Monitor Progress: Population Outcome Measures

- Percent of households paying more than 30% of income on housing
- Homelessness rates for K-12 students
- Housing vacancy rates
- Length of housing program waitlists
- Average duration of time on housing program waitlists

PARENTING SUPPORT AND LIFE SKILLS

The experiences of childhood, particularly early childhood when the brain is undergoing its most rapid development, have long-term effects on physical, emotional, and social well-being.[17,18] Thus, one of the most impactful things that can be done to lay the foundation for health throughout the lifespan is to ensure positive physical and social environments for children.

A growing body of research reveals that stress and trauma during early life increase a person's chances of poor health outcomes as an adult. Adverse childhood experiences (ACEs), such as abuse, neglect, or witnessing violence, have been linked to chronic disease, mental health conditions, substance misuse, smoking, and high-risk sexual behavior later in life.[19,20] Other, more insidious stressors, such as poverty, food insecurity, and unsafe neighborhoods, also have a traumatic effect and are associated with obesity, poor academic achievement, and difficulties with social functioning and emotional regulation.[18,19,21]

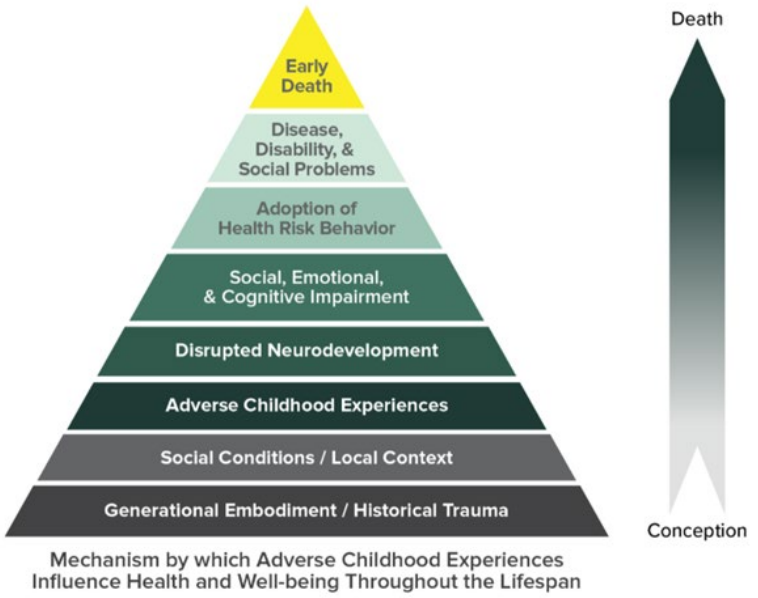
While childhood is a time of particular vulnerability, it is also a time of significant opportunity. The presence of individual, family, and community protective factors in a child's life are associated with improved health and economic outcomes in adulthood.[18,19,22] Parents and other caregivers can play a key role in instilling protective factors, such as secure child-adult attachment, and buffering children from the effects of stress and adversity. In order to

Protective factors: Conditions or attributes of individuals, families, communities, or the larger society that mitigate or eliminate risk.[22]

Toxic stress: Strong, frequent, and/or prolonged adversity that stimulates the body's biological and emotional responses to stress.[19]

serve this role, however, parents and caregivers need a full set of their own protective factors and supports, such as social connections, resilience skills, family-friendly work policies, access to quality child care, and other needed support services.[17,22] The need for community support in building these factors is especially great for those caregivers who experienced trauma in their own childhoods or live with toxic stress.

Adverse Childhood Experiences (ACEs): term used to describe all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18.[23]



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

WHY THIS IS A REGIONAL PRIORITY: SITUATIONAL ANALYSIS

What we saw in the Community Health Assessment (CHA) data:

- Rates of child abuse and neglect are high.
- Large numbers of youth and low-income adults report trauma and adverse experiences.
- A substantial proportion of households experience food insecurity.
- There are relatively high proportions of children living in poverty and school-age children experiencing homelessness.
- The percentage of three- to four-year olds enrolled in preschool is low.
- Median center-based child care costs are high relative to median income.

What we heard from the community during the CHA process:

- Cost of living is among the top issues that impacts community members.
- Families feel a high degree of conflict between the demands of parenting and the demands of supporting their family financially.
- There is a lack of child care providers generally and affordable child care specifically. Concern about the cost of child care is especially felt among women and non-White members of the community.
- Parents feel that they have limited knowledge and skill for parenting, stigma around asking for help, and a lack of community connection for support.

Additional concerns and context from CHIP workgroup and stakeholder discussions:

Families report living in unstable homes and neighborhoods, have limited access to nutrition and exercise, lack knowledge of existing help available, struggle to find and afford child care, and may feel unwelcome in their communities. Many children lack a caring adult in their lives.

It is clear that families are struggling and resources are stretched incredibly thin in our area. One story during the CHIP development process detailed a home visitor noticing a calendar with multiple names marked in for the month. When asked what all those names were, the client said those are the home visit appointments she had during the month. She couldn't remember what agencies they all were, but knew she had to be home for them. Families are overburdened by requirements from each supporting agency and the lack of coordination among those agencies to be client-centered. In an ideal world, every member of our community would be aware of what is happening to our most vulnerable neighbors, what role they can play to lend a hand, whether they are a business owner, student, or retiree, and how they can mobilize to improve the health and well-being of our community because… Families Matter.

This regional priority area aligns with the Oregon 2020-2024 SHIP priority areas of (1) Adversity, trauma, and toxic stress, and (2) Economic drivers of health (including issues related to housing, living wage, food security, and transportation).

What We Will Do About It: Goals and Strategies

Goal 1: Families are nurtured and strengthened through the building of family protective factors.

Strategies

a. Increase parental resilience
b. Increase knowledge of parenting and child development
c. Increase parent social connections
d. Increase access to concrete supports in times of need
e. Increase social-emotional competence of children

Goal 2: Families have access to safe, affordable, and appropriate child care

Strategies

a. Promote and adopt family-supporting policies within regional organizations and businesses
b. Increase high quality, affordable, and accessible child care and respite programs
c. Increase supports and recognition of caregivers (including professional and relational)
d. Investigate, identify, or create benchmark data for monitoring regional access to safe, affordable, and appropriate child care

Goal 3: Families have ample healthy and affordable food

Strategies

a. Reduce food insecurity for children and families
b. Increase access to healthy foods for children and families

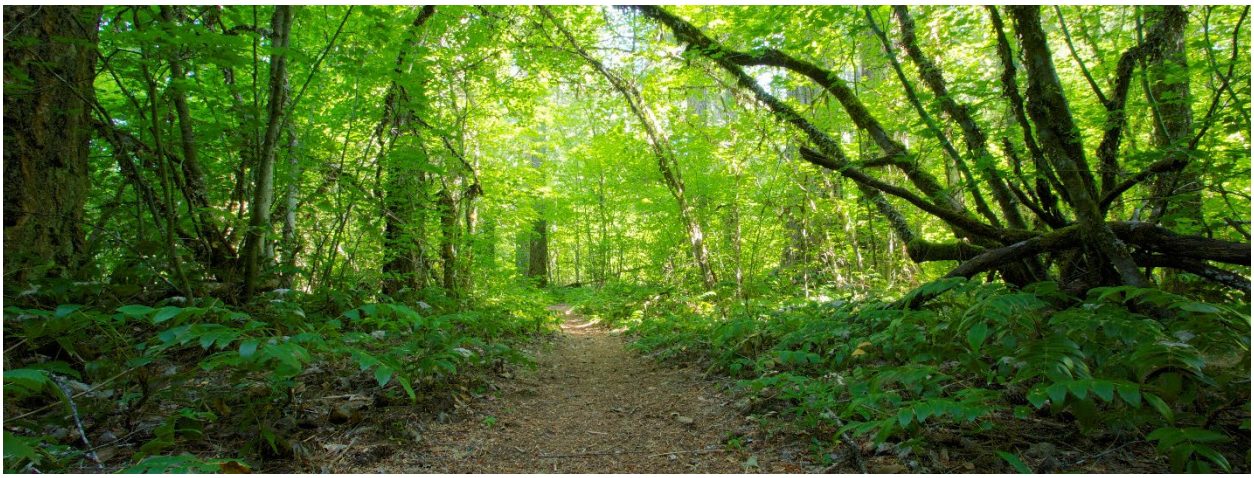
Goal 4: Community-based organizations create a coordinated and collaborative service-delivery system

Strategies

a. Align policy and funding to increase impact and sustainability
b. Streamline delivery system to decrease duplication of services
c. Promote the use of common language and training resources
d. Increase data sharing and communication capacities
e. Investigate, identify, or create benchmark data for monitoring coordination of the regional service-delivery system

How We Will Monitor Progress: Population Outcome Measures

- Child abuse/neglect victim rate per 1,000 population (under 18)
- Percent of 8th and 11th graders who report ever feeling they had no one to protect them
- Percent 8th and 11th graders reporting the following ACEs
    - Parental divorce or separation
    - Living with a problem drinker or alcoholic
    - Living with someone who uses/used street drugs
    - Living with a household member who is/was depressed or mentally ill
- Percent 8th and 11th graders who report ever feeling they did not have enough to eat
- Percent population food insecure
- Percent students eligible for free and reduced lunch
- Percent 8th and 11th graders reporting consuming five or more servings of fruit and vegetables per day



NEXT STEPS

This Community Health Improvement Plan (CHIP) lays out an ambitious set of goals and strategies for the community to improve the health of the Jackson and Josephine County region. The next step is to move from planning to implementation by building and carrying out action plans for each goal.

ACTION PLAN DEVELOPMENT

To build action plans, individual community organizations and multi-organization collaboratives will review the goals and strategies laid out in the CHIP, decide which strategies they will implement, and develop organizational objectives, action steps, and process measures. Organizational objectives, action steps, and process measures will lay out how each organization will apply the CHIP strategies over the next one to three years, what they aim to accomplish during that time, and how they will measure and report on their work. The All in for Health core team, steering committee, and workgroups will provide guidance and technical assistance to partners during this process and will compile submitted objectives into action plans. While the target for initial action plan development is Fall 2019, the CHIP action plans will be living documents which will undergo additions and modifications throughout the life of this CHIP.

Organizational objectives: Short to intermediate measureable outcome statements of desired organizational or collaborative activities with specific timeframes for implementation.

Action steps: Activities that need to be completed to accomplish an organizational objective.

Process measures: Indicators that help to quantify the achievement of an organizational objective or action step.

Monitoring and Reporting Progress

As the work of implementing the CHIP strategies is being carried out by community partners, agencies, and coalitions, All in for Health will assess progress by monitoring action step completion, performance measures, and population outcome measures. Reports of progress will be made to participating partners and the community at-large on a regular basis, including an annual written report. Workgroups will utilize progress reports as well as the sharing of successes and lessons learned to evaluate strategies and adjust the approach to their priority areas as needed. Like the action plans, the CHIP is intended to be a living document and will be modified to reflect new information and changing community needs.

Expanding the Effort and Gathering Feedback

The more community members and partner organizations engage with these health improvement efforts, the more successful we will be. To ensure that this plan works for all communities within the Jackson-Josephine region, All in for Health will continue gathering community feedback and recruiting new partners throughout the three-year life of this CHIP.

We invite YOU to join! If you are interested in joining a workgroup, submitting an organizational objective, providing feedback on CHIP strategies, or would just like more information about the CHIP, please contact All in for Health Project Coordinator Angela Warren at angela@jeffersonregionalhealthalliance.org.

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APPENDICES

APPENDIX A

ACRONYM LIST

ACEs	Adverse Childhood Experiences
ADA	Americans with Disabilities Act
CAC	Community Advisory Council
CCO	Coordinated Care Organization
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
HUD	US Department of Housing and Urban Development
JRHA	Jefferson Regional Health Alliance
MAPP	Mobilizing for Action through Planning and Partnerships
NACCHO	National Association of County and City Health Officials
SAMHSA	Substance Abuse and Mental Health Services Administration
SHIP	State Health Improvement Plan
YIMBY	Yes In My Backyard

APPENDIX B

KEY TERMS

211
A nonprofit contact center that connects people with health and social service providers.

Accessible
A term that describes the usability of a product or service by people with disabilities.[24]

Action steps
Activities that need to be completed to accomplish an organizational objective.

Adverse Childhood Experiences (ACE)
Term used to describe traumatic experiences occurring before the age of 18. The original ACE study defined seven specific types of experiences, but the term has since been broadened to include all types of abuse, neglect, and other potentially traumatic experiences. Examples include physical, psychological, or sexual abuse; living with someone who is mentally ill or suffers from addiction; having a household member who has gone to prison; or witnessing violence.[20,23]

Aging in place
The ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level[24]

Americans with Disabilities Act (ADA)
Civil rights law passed in 1990 that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.[25]

Behavioral health
Term inclusive of both mental health and substance use. Encompasses the promotion of mental health, resilience and well-being; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.[5]

Community Advisory Council (CAC)
An advisory body to a CCO, comprised of community members and stakeholders. Oregon Health Plan consumer representatives must comprise a majority of the members. The CAC oversees the work of the CHA and the CHIP with the CCO.

Community Health Assessment (CHA)
A systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community.[26]

Community Health Improvement Plan (CHIP)
A long-term, systematic effort to address public health problems at the community level on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities, and coordinate and target resources.[26]

Coordinated Care Organization (CCO)
Organization that implements the Oregon Health Plan/Medicaid program for its members. CCOs coordinate care for physical health, mental health, substance use disorder, oral health and other health needs for an individual with a focus on the triple aim: better care, better outcomes and reduced costs.

Food insecurity
Lack of consistent access to enough food for an active, healthy life because of a lack of money or other resources. Includes reduced quality, variety, and desirability of diet in addition to disrupted eating patterns and reduced food intake.[27]

Goal
Long-range statement of a desired community health or wellbeing outcome within a priority area.

Harm reduction
A strategy directed toward individuals or groups that aims to reduce the harms associated with certain behaviors. Term most commonly applied to substance use. Examples in the area of substance use include programs that aim to reduce infectious disease and overdose among people who inject drugs, such as needle exchange and safe injection sites.[28]

Housing instability
Encompasses a number of housing challenges, such as trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing.[29]

Mental disorder
A health condition that is characterized by alterations in thinking, mood, and/or behavior that is associated with distress and/or impaired functioning.[7]

Mobilizing for Action through Planning and Partnerships (MAPP)
A community-driven strategic planning process for improving community health. Provides a framework for convening partners, identifying and prioritizing health issues, and taking action to improve community health. Includes six phases: (1) organizing for success, (2) visioning, (3) conducting the four MAPP assessments, (4) identifying strategic issues, (5) formulating goals and strategies, and (6) action cycle.[4]

Organizational objective
Short to intermediate statement of a desired outcome for organizational or collaborative activities.

Physical determinant of health
Physical condition of the environment in which people are born, live, learn, play, work, and age which impacts health, functioning, and/or quality of life outcomes. Refers to both the natural environment, such as weather or landscape features, and the built environment, such as housing, neighborhoods, schools, and workplaces. Examples include climate, exposure to toxic substances, physical barriers (especially for people with disabilities), and lighting.[16]

Population outcome measure
Indicator which helps to quantify health improvement progress within a priority area.

Postvention
An organized response in the aftermath of a suicide to facilitate the healing of individuals from the grief and distress of suicide loss, mitigate other negative effects of exposure to suicide, and/or prevent suicide among people who are at high risk after exposure to suicide.[30]

Priority area
Broad, health-related area for CHIP work identified through the prioritization process which was informed by CHA data.

Process measure
Indicator that helps to quantify the achievement of an organizational objective or action step.

Protective factors
Conditions or attributes of individuals, families, communities, or the larger society that mitigate or eliminate risk.[22]

Respite program
Program that provides parents and other caregivers with short-term child care services that offer temporary relief, improve family stability, and reduce the risk of abuse or neglect. Respite can be planned or offered during emergencies or times of crisis.[31]

Resilience
The process of managing stress and functioning well in a particular context when faced with adversity. Learned through exposure to challenging life events facilitated by supportive relationships and environments.[22]

Social determinant of health
Social factor of the environment in which people are born, live, learn, play, work, and age which impacts health, functioning, and/or quality of life outcomes. Examples include availability of resources to meet daily needs, social support and social interactions, access to quality schools and education, and exposure to crime, violence, and social disorder.[16]

State Health Improvement Plan (SHIP)
A long-term, systematic effort to address public health problems at the state level on the basis of the results of state health assessment activities and the state health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources.[26]

Strategy
General approach that will be used to achieve a goal.

Substance misuse
The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or those around them.[8]

Substance use disorder
A chronic, relapsing mental disorder characterized by compulsive substance-seeking and use despite adverse consequences.[9]

Supportive housing
A strategy that combines affordable housing with intensive coordinated services to help people struggling with chronic physical and/or mental health issues maintain stable housing and receive appropriate health care.[15]

Toxic stress

Strong, frequent, and/or prolonged adversity that stimulates the body's biological and emotional responses to stress. Can have a long-term negative impact on neurobiology, psychology, and physical health.[19,22]

Transitional housing

A project that facilitates the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months). Transitional housing includes housing primarily designed to serve deinstitutionalized homeless individuals, other homeless individuals with mental or physical disabilities, and homeless families with children.[32]

Trauma

Result of an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful with lasting adverse effects on the individual's functioning. Examples include physical, sexual, and emotional abuse; childhood neglect; witnessing or experiencing violence; natural or human-made disasters; poverty and discrimination.[19]

Yes In My Backyard (YIMBY)

Pro-development movement that promotes affordability and accessibility in community housing.

APPENDIX C

CHIP ALIGNMENT WITH STATE AND NATIONAL PRIORITIES

The priorities and goals outlined in the All in for Health: Jackson and Josephine Counties Community Health Improvement Plan (CHIP) align with both state and national health improvement priorities. The chart below outlines the relationship between the 2019-2022 regional CHIP, the 2020-2024 Oregon State Health Improvement Plan (SHIP)*, and the US Department of Health and Humans Services' Healthy People 2020.

Jackson and Josephine CHIP *Priority areas and goals*	**Oregon SHIP** *Priority areas*	**Healthy People 2020** *Topic areas*
Behavioral Health • Mitigate the effects of trauma • Decrease social isolation and loneliness in youth and older adults • Equip our community with the knowledge, tools, and resources to empathetically accept and help individuals in need of behavioral health supports • Prevent use and misuse of substances • Reduce harm associated with mental health and substance use through use of community-wide approaches • Ensure access and coordination of care for people impacted by mental health and substance use disorders	Behavioral Health (including mental health and substance use) Adversity, Trauma, and Toxic Stress	Mental Health and Mental Disorders Substance Abuse Tobacco Use Maternal, Infant, and Child Health – Pregnancy Health and Behaviors, Disability and Other Impairments Adolescent Health
Housing • Increase the percentage of households paying no more than 30% of their income on housing • Increase the percentage of individuals living in housing that is safe, accessible, and connected to services	Economic Drivers of Health (including issues related to housing, living wage, food security and transportation)	Social Determinants of Health – Economic Stability, Neighborhood and Built Environment

Jackson and Josephine CHIP *Priority areas and goals*	**Oregon SHIP** *Priority areas*	**Healthy People 2020** *Topic areas*
Parenting Support and Life Skills • Families are nurtured and strengthened through the building of family protective factors • Families have access to safe, affordable, and accessible child care • Families have ample healthy and affordable food • Community-based organizations create a coordinated and collaborative service delivery system	Adversity, Trauma, and Toxic Stress Economic Drivers of Health (including issues related to housing, living wage, food security and transportation)	Social Determinants of Health – Social and Community Context, Economic Stability Nutrition and Weight Status – Food Insecurity, Food and Nutrient Consumption Early and Middle Childhood Adolescent Health

* The 2020-2024 Oregon SHIP was developed concurrently with the All in for Health: Jackson & Josephine Counties CHIP. At the time of CHIP publication, only SHIP priority areas (Institutional Bias; Adversity, trauma, and toxic stress; Economic drivers of health; Access to equitable preventive care; and Behavioral health) were known. Additional areas of alignment may become clear once SHIP goals and strategies are developed. This chart will be updated following publication of the SHIP to more fully show alignment.

This CHIP was created on behalf of the following organizations who are committed to its implementation:

ALL IN FOR HEALTH

JACKSON & JOSEPHINE COUNTIES

A healthy community is everyone's business

An initiative of Jefferson Regional Health Alliance

https://jeffersonregionalhealthalliance.org/