

**2016-2019 Lane County Regional**

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**COMMUNITY  
HEALTH  
IMPROVEMENT  
PLAN**

*Working together to create a caring community  
where all people can live a healthier life*



## Health

*“A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”*

– World Health Organization

## Healthy Community

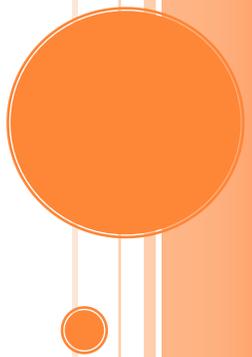
*“One that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.”*

– World Health Organization



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Dear Community Partner,

I am pleased to present the **2016-2019 Community Health Improvement Plan**. This plan is the product of a collaborative effort by community members, the 100% Health Community Coalition Executive Committee (serving as the Steering Committee), United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan. In order to collaboratively develop this Community Health Improvement Plan, an extensive Community Health Needs Assessment and Community Health Improvement Planning process was conducted over the last 15 months (March 2015-June 2016). Please see the companion document, the **2015-2016 Community Health Needs Assessment**, for further details on the process and data collected.

This Community Health Improvement Plan was designed to mobilize critical areas where collaborative action is needed to improve health and well-being. The plan illustrates where our community will work together over the next three years to improve the mental, physical and social health and overall well-being of our community.

**One of our region's greatest assets is our people: we are passionate about our community, committed to improvement, and determined to see the vision of health become a reality.** The drive, diligence, and support from the community made planning and completing this improvement plan possible. Thank you for all of your ongoing contributions and support for this remarkable community health improvement process.

Our challenges are great, but so is our community. We invite you to use this plan to help inform and enhance your knowledge of the work currently underway to improve community health. We also encourage you to review the priorities and goals, reflect on the suggested strategies, and consider how you can participate in this effort. By working together, we can create a caring community where all people can live a healthier life. We look forward to embarking on this journey together.

Sincerely,

A handwritten signature in black ink, appearing to read "Rick Kincade".

Rick Kincade, MD  
Chair, 100% Health Community Coalition



## Executive Summary

### We all want our community to be a healthy place to live and learn, work and play.

Our region has a strong foundation for a healthy community; it is built around abundant natural resources, has a history of collaboration across organizations, hardworking residents, caring neighborhoods, and innovative opportunities. While we are proud of these assets, we recognize there are still barriers to overcome.

The **2016-2019 Community Health Improvement Plan** (CHIP) is the product of a 15-month long community health improvement planning process led by the Live Healthy Lane partnership – United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, Trillium Community Health Plan and many community partners. The purpose of this process has been to develop a health improvement plan that partners from different sectors (e.g. health, education, housing, transportation) can use as a framework to improve the health of our community over the next three years. This plan contains strategies intended to make measurable improvements in two areas that the community voted to make our priority: **social and economic opportunities** and **healthy behaviors**.

The CHIP is informed by the **2015-2016 Community Health Needs Assessment** (CHNA), a report describing the health status of people in our community and the conditions that contribute to health. It also integrates significant input received from community members and stakeholders. The report is available online at: [www.LiveHealthyLane.org](http://www.LiveHealthyLane.org).

The purpose of the assessment and health improvement effort is to reduce health disparities, promote health equity and improve overall population health. There are education and economic implications for poor health and addressing these issues successfully requires resources, effort, innovations and most importantly, participation from the entire community. The CHIP provides a common vision and shared approach for local partners to build strategic partnerships as we work toward creating a healthy and vibrant community.

To date, this community-driven process has **engaged over 2,500 individuals and 200 organizations**. By continuing to work together, we can create a caring community where everyone can have the opportunity to live a healthier life.





## Overview of Our Region

For the purposes of this 2016-2019 Community Health Improvement Plan, our community’s region includes Lane County and Reedsport, Oregon.

Reedsport, Oregon is located in Douglas County on the central Oregon coast and is 87 miles southwest of Eugene, Oregon and has 4,090 residents (97% urban, 3% rural).

Extending from the Pacific Ocean to the Cascade mountain range, Lane County is a vibrant mix of communities and people. Lane County is the fourth most populous county in Oregon, with a population just over 350,000 residents. The Eugene-Springfield area contains over 60% of the county’s population and is the third-largest Metropolitan Statistical Area in Oregon. Outside of the metro area, Lane County is largely rural and unincorporated. The concentrated population, yet large geographic area of the county creates disparities in access to health and human services, as well as resources.

The 2016 County Health Rankings and Roadmaps rank Lane County 12<sup>th</sup> out of 36 counties in Oregon for overall health outcomes (length of life and quality of life) and 9<sup>th</sup> for health factors (health behaviors, clinical care, social and economic factors, and physical environment). Our region is a moderately healthy community with well-educated and active residents. The population is increasing, living longer, and becoming more diverse. Although good health outcomes and behaviors are prominent, there are still gaps to be addressed. Disparities exist between racial, geographic, and socioeconomic groups. For some issues, the gap is markedly wide.





## Vision & Values

### Vision Statement

**Live Healthy Lane:** Working together to create a caring community where all people can live a healthier life.

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### Community Values

- **Compassion** – We are creating a community where all people are treated with dignity and respect.
- **Equity** – We believe everyone should have the opportunity to live a healthy life.
- **Inclusion** – We strive to embrace our differences and treat the whole person.
- **Collaboration** – We have committed our collective resources to innovation, coordination, and integration of services.





## Goals & Strategies

### Goals

Increase **economic and social opportunities** that promote healthy behaviors.

Increase **healthy behaviors** to improve health and well-being.

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### Strategies

- ❖ Support **economic development** through investing in workforce strategies that provide sustainable family wage jobs in our communities.
- ❖ Encourage a range of safe and affordable **housing** opportunities, including the development of integrated and supportive housing.
- ❖ Assure availability of affordable **healthy food** and beverages in every community.
- ❖ Strengthen cross-sector **collaborations** and align resource to improve the physical, behavioral, and oral health and well-being of our communities.
- ❖ Encourage organizations across multiple sectors to integrate **health criteria** into decision making, as appropriate.
- ❖ Encourage the implementation of programs to promote positive **early childhood development** and safe/nurturing environments.
- ❖ Support the implementation of evidence -based **preventive screening** and referral policies and services by physical, behavioral, and oral healthcare and social service providers.



## Equity Considerations

### Equity Value Statement:

*We believe everyone should have the opportunity to live a healthy life.*

**When making decisions, problem solving and taking action, it is important for us to consider equity and the impact on everyone in in our community, especially those in underserved demographic groups and protected classes.**

**Health Equity** - Health equity is achieved when every person has the opportunity to "*attain his or her full health potential*" and no one is "*disadvantaged from achieving this potential because of social position or other socially determined circumstances.*" - Centers for Disease Control and Prevention.

**Health Disparities** - "*Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by*" people who have historically made vulnerable by policies set by local, state, and Federal institutions. "*Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), gender identity, or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.*" - Centers for Disease Control and Prevention

**Social Determinants** - "*Social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices.*" - World Health Organization

This community health improvement effort offers providers, planners, decision makers, policy makers, funders, and community leaders an opportunity to intentionally apply an equity framework into collective action and impact. A key element to successfully addressing the prioritized strategic issues will be to address all social, economic and environmental factors that provide everyone in our region an opportunity to live a healthy life. In order to fully realize health equity, all factors contributing to health must be addressed. Therefore, the Community Health Improvement Plan will use an equity lens to identify those factors that may have significant impacts on each priority area. An equity lens process is an intentional method for identifying and addressing health inequities by making more informed decisions to move toward the goal of achieving health equity. By adhering to such a framework, we can work on addressing the underlying factors that have led to consistently poorer health outcomes for disadvantaged groups.

Formed from the 2013-2016 Community Health Improvement Plan's Equity Workgroup, the Lane Equity Coalition Steering Committee will help ensure equitable implementation of the 2016-2019 Community Health Improvement Plan and monitor its progress toward improving health equity.



## What Makes Us Healthy?

Risk factors that influence health such as age, genetics and race cannot be changed; these risk factors determine about 30% of an individual’s health. The other 70% of risk factors that influence health are factors such as social and economic conditions, health behaviors, clinical care, and the physical environment, that can be changed through individual actions, policy changes or environmental modification. These two types of risk factors interact over the lifespan to influence an individual’s overall health.

Research demonstrates that **social and economic conditions** contribute to the largest percentage of our health status, followed by **health behaviors**, **clinical care**, and the **physical environment**. Social and economic conditions encompass community safety, education, employment and income. Health behaviors include alcohol and drug use, diet and exercise, tobacco use, and sexual activity. Clinical care comprises access to health insurance and a consistent source of quality care that will meet the needs of the people. Lastly, the physical environment covers housing, air quality, and transportation.



### Social Determinants of Health

A person’s health is determined largely by social and economic factors, rather than by the health care he or she receives. This “social determinants of health” model explains why certain segments of the population experience better health outcomes, while for other populations, external factors in their lives make health difficult to achieve. Parts of our community experience significantly worse health than others. Narrowing the health disparities, and improving overall population health, requires solutions to address the social determinants of poor health. Understanding how these factors influence health is critical for developing the best strategies to address them.

The conditions in which we live, work, study, and play all influence health; achieving healthy communities will require the active engagement of many sectors. Working toward better health is not just the job of the individual, but the job of the community and organizations as well. Community and organizational support will ensure that residents who decide to live healthier will have the support and encouragement needed to be successful.

*“The biggest obstacle to making fundamental societal changes is often not a shortage of funds but lack of political will; the health sector is well positioned to build the support and develop the partnerships required for change.”*

- Dr. Thomas Frieden, CDC Director

# Planning Process

This Community Health Improvement Plan (CHIP) is the culmination of a community health improvement planning process that began with a Community Health Needs Assessment (CHNA), a comprehensive report of the state of health in our region. This CHIP was derived from CHNA findings of the health needs, conditions, and disparities between populations and regions in our community.

The process followed the Mobilizing for Action through Planning and Partnerships (MAPP) framework, a community-driven strategic planning model for improving community health. Developed by the National Association of County and City Health Officials (NACCHO), MAPP outlines the framework to conduct a CHNA and CHIP.

MAPP is made up of four assessments that are the foundation of the planning process, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action.



## Organize for Success and Partner Development

The assembly of the Live Healthy Lane partnership completed **PHASE ONE** of the process in the spring of 2015. United Way of Lane County, Lane County Public Health, Trillium Community Health Plan, and PeaceHealth collaborated with members of the local public health system to form the organizational structure for the MAPP process. To develop a plan for improved community health and help sustain implementation efforts, the assessment and planning process engaged community members and local public health system partners through the following avenues:

- Steering Committee: provided guidance and direction for CHNA and CHIP.
- Core Team: conducted the CHNA, implement the CHIP, and will provide the overall management of the process.
- CHIP Action Teams: developed and will implement CHIP action plans.
- Additionally, community members and local public health system partners provided input and direction throughout the process.

## Visioning

**PHASE TWO:** The visioning phase was a community-based process where more than 135 people from across the region participated in a multi-site simulcast community brainstorming session on June 25, 2015. The community vision and values that were selected are:

*Working together to create a caring community where all people can live a healthier life.  
Compassion ♦ Equity ♦ Inclusion ♦ Collaboration*



## Four MAPP Assessments

**PHASE THREE:** The four MAPP assessments included for the collection of quantitative and qualitative data. These data offered critical insights into the challenges and opportunities for our community. Phase Three was conducted from May through December 2015.

- *The Community Health Status Assessment* provided quantitative information on the community's health. To complete this assessment, a subcommittee was formed to focus on identifying and analyzing key issues from over 200 broad indicators.
- *The Community Themes and Strengths Assessment* gathered the thoughts, opinions, and perceptions of thousands of community members and consumers in order to understand which issues are important to the community. Three methods of data collection were utilized: 2,295 surveys were gathered, 50 focus groups conducted (with 500 participants), and 53 key informants were interviewed.
- *The Local Public Health System Assessment* evaluated the components, activities, competencies, and capacities of our local public health system and how well the 10 Essential Services of Public Health are being provided. To complete this assessment, members of the local public health system met to assess the system's performance.
- *The Forces of Change Assessment* identified the trends, factors, and events that were likely to influence community health and quality of life, or impact the work of the local public health system. To complete this assessment, the Core Team and Steering Committee worked together to form a comprehensive picture of the region's strengths, weaknesses, opportunities, and threats.

## Identify Strategic Issues

**PHASE FOUR:** Strategic issues are critical challenges to be addressed, as well as significant opportunities to be leveraged, in order for a community to achieve its vision. Phase Four was conducted between December 2015 and February 2016, concluding with a multi-site community event to present the CHNA findings and vote on the strategic issues. While many areas are significant, identifying priority areas creates opportunities for collective impact. Two strategic issues were prioritized by over 260 people in our community to mark the end of the CHNA and form the foundation for the CHIP. The 2015-2016 CHNA report is available online at [www.LiveHealthyLane.org](http://www.LiveHealthyLane.org).

## Formulate Goals and Strategies

**PHASE FIVE:** This phase involved the formation of goals related to each strategic issue and identifying strategies for achieving each goal. Phase Five was conducted between February and April 2016, during which time meetings were held with the Core Team, Steering Committee, previous CHIP Workgroups, and stakeholders to evaluate potential strategies on various criteria (potential for cross-sector collaboration, health and equity impact, alignment with current work, available resources, and community support). In April 2016, the Steering Committee approved two goals and seven strategies for the 2016-2019 CHIP.

## Action Cycle

**PHASE SIX:** The action cycle is a continuous cycle of planning, implementation, and evaluation that seeks to move the needle on key health priorities over the course of the three year plan. Implementation of Phase Six began in April 2016 with the identification of objectives and the development of this CHIP report. The action cycle will continue through 2019.



# Strategic Direction

In collaboration with community members, consumers, and stakeholders, two strategic issues and goals were identified to guide actions toward demonstrably improving health and well-being in our community. The multi-level, multi-sectoral strategic approach demonstrates that the CHIP is a bold effort to harness the collective impact of our region’s communities and local public health system partners.

## Strategic Issues

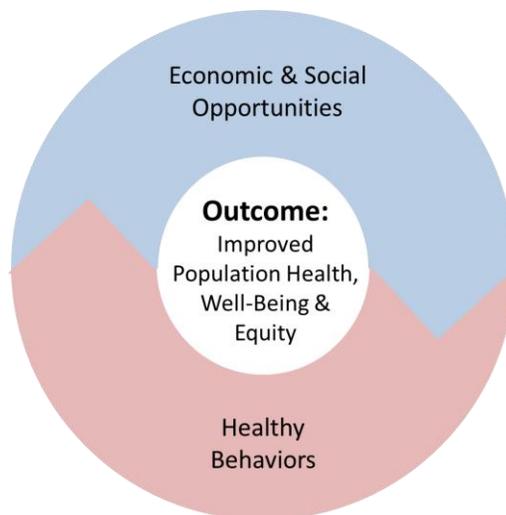
- ❖ *How can we promote access to economic and social opportunities necessary to live a healthy life?*
- ❖ *How can we promote healthy behaviors and engage the community in healthy living?*

## Goals

- ❖ *Increase economic and social opportunities that promote healthy behaviors.*
- ❖ *Increase healthy behaviors to improve health and well-being.*

Creating a healthy community requires action within and across sectors, because progress in one area will advance progress in another. To achieve lasting change, our community cannot continue doing more of the same. We must embrace a more integrated, comprehensive approach to health. This new perspective on health must become an essential part of our community, achieved by weaving together the threads of physical, mental, economic and social well-being.

These priorities were chosen based on which accomplishments would offer the greatest improvements in lifelong health, advance health equity, and promote equal access to conditions that allow people to be healthy. This plan outlines seven strategies intended to serve as the roadmap to addressing these areas and advancing toward our vision of a healthy community.





## Economic and Social Opportunities

Health starts in our homes, schools, workplaces, neighborhoods, and communities. Good health is far more than the absence of illness; social and economic opportunities strongly affect the ability to lead healthy lives. Health status and quality of life are intimately tied to numerous factors including income, poverty, race/ethnicity, education level, geographic location, and employment status. Unfortunately, too many in our community still do not have access to equal choices and opportunities that enable them to pursue healthy behaviors. By working to positively influence social and economic conditions that support changes in behavior, we can improve health in ways that can be sustained over time. Improving the conditions in which we live, learn, work, and play takes a unified approach to create a healthier community.

*“It is so important to address the social determinants of health: poverty, access, education, and housing, which are root causes of so many chronic diseases.”*

– Community Member

The “Economic and Social Opportunities” priority highlights the need for improving the conditions in which we live, learn, work, and play in order to create a healthier community.

## Healthy Behaviors

To create positive health outcomes, we must foster individual and community actions that promote good health from the start of life until its end. Community leaders, individuals, and representatives from healthcare, businesses, government and education must forge powerful partnerships and must support the desire of people to live healthier lives and engage in healthy behaviors. Personal choice and responsibility play a key role in attaining and maintaining health. Daily practices like eating a healthy diet, getting regular exercise, refraining from risky behaviors, and managing stress is linked to reduced negative health conditions such as heart disease, diabetes, and cancer. However, the choices people make depend on the choices they are given. The healthy choice is not always the “easy” choice – particularly for our community’s more vulnerable residents – as was repeatedly voiced by community members and consumers throughout the CHNA/CHIP development process. Socioeconomic factors – such as whether people can afford to buy nutritious foods and safely engage in exercise in their neighborhoods – and environmental factors – such as whether healthy food options are locally available – impact an individual’s health behaviors. By empowering the community to embrace healthy behaviors, individual and overall health outcomes will be positively impacted.

*“We have to make the healthy choice the easy choice!”*

- Community Member

The “Healthy Behaviors” priority strives to demonstrate the link between health behaviors and chronic disease and to help our region create environments that make healthy choices the easy choices.



## Statement of Need

As part of the 2015-2016 Community Health Needs Assessment (CHNA), assessments were conducted to capture comprehensive snapshot of the current community health condition of our region, including the specific health needs and opportunities. Please view the full report online at [www.LiveHealthyLane.org](http://www.LiveHealthyLane.org) for the detailed findings and data citations.

As voiced by the community and supported by publically available data, our community is, overall, a moderately healthy and safe community. Our population is increasing, living longer, and becoming more diverse. Our community strengths include our availability of parks and recreational areas, strong collaboration and sense of community, public awareness of the social determinants of health, local healthy food, clean environment, increased access to health care coverage, and healthy living as a value. Collaborative partnerships and community engagement are strong and should serve as the foundation for planning and implementing initiatives to improve health.

Although good health outcomes and behaviors are prominent in our region, there are still gaps to be addressed. Disparities were identified between racial, geographic, and socioeconomic groups. The overarching theme of the CHNA data reflects a community divided between a high quality of life and limited resources for those in need. Not everyone in our region has the opportunity to be healthy and thriving. Some communities, for example, have great access to affordable grocery stores, public transit, health and human services, and other resources that benefit health and wellness. Other communities – often low-income and/or rural – are closer to fast food and alcohol retail outlets, freeways, industrial pollutants, and other factors that contribute to high rates of disease, death, injury, and violence.

### *Employment and Income*

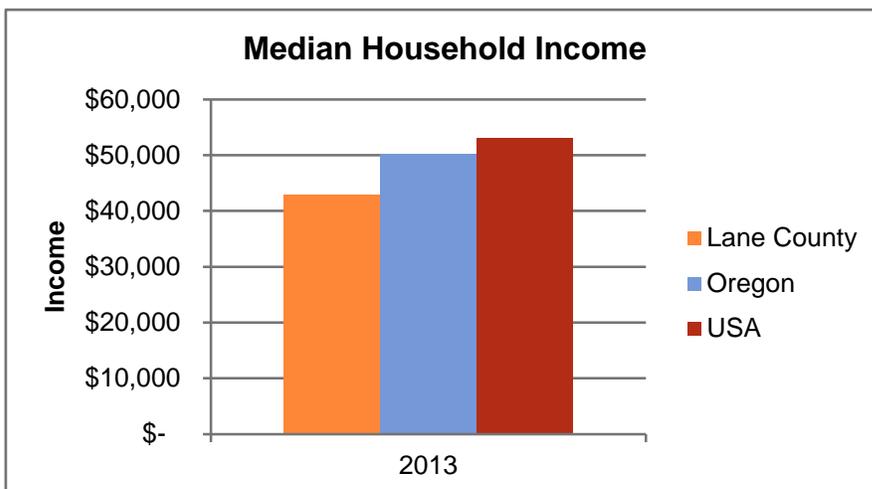
Creating conditions for economic growth adds to the health and vitality of a community. Investing in sustainable local businesses has many community benefits, including economic development (provides new jobs and keeps money in the local economy), environmental sustainability, and food security.

Community members who completed the survey identified good jobs and a healthy economy to be the third most important factor in creating a healthy community. Higher employment rates lead to better access to healthcare and better health outcomes. Lane County's current unemployment rate of 6.9% is similar to the state rate (U.S. Bureau of Labor Statistics, 2014). Overall, black/African-Americans, Latinos, youth and adults with less than a high school diploma are more likely to be unemployed. Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, and lead to an increase in unhealthy behaviors.

Income can affect the ability of a household to have access to quality housing and childcare, health care, higher education opportunities, and nutritious food. Areas with higher median household incomes are likely to have more educated residents and lower unemployment rates. As income increases, so does life expectancy.



The median income of all Lane County households consistently lags when compared to the state of Oregon as whole and the rest of the United States. In 2013, the median household income of all households in Lane County was \$42,931 (ACS, 2013).



Far too many people in Lane County live in poverty. Approximately 20% of residents live below poverty level, which is more than the state as a whole and the nation (ACS, 2013).

Poverty can result in negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. Key informants who were interviewed mentioned poverty as a critical health and quality of life issues in our region. Income and poverty disparities are evident between racial, geographic, and socioeconomic groups.

ALICE (an acronym that stands for Asset Limited, Income Constrained, Employed) households are households that earn more than the federal poverty level, but less than the basic cost of living for the county where they are located. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs in a given area. In Lane County in 2013, 43% of households fell below the ALICE Threshold, compared with 38% of Oregon households (ALICE, 2013). Community members and stakeholders participating in focus groups highlighted the lack of family wage jobs in our region.

*“I think having a livable wage takes so much stress off people, so then they are able to live a healthy life and make healthy choices.”*

– CHNA Focus Group Participant

**Housing**

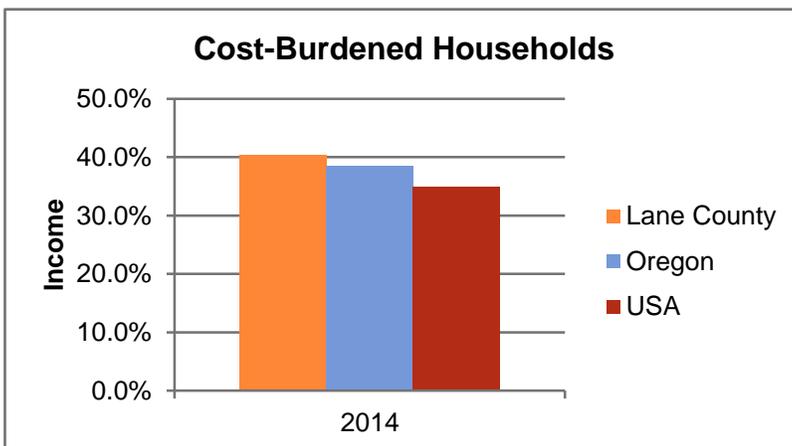
The availability of safe and affordable housing can serve as an indicator of the overall social, economic, health, and demographic state of the community. Spending a high percentage of household income on housing can create financial hardship, especially for renters with lower income. With a limited income, paying a high rent may not leave enough money for other expenses, such as food, transportation and medical care.

*“The cost of adequate housing in relation to wages here is very difficult.”*

– CHNA Focus Group Participant



In Lane County, 40.4% of our households are cost burdened, meaning they pay more than 30% of their income for housing (ACS, 2014). Surveyed community members identified the lack of affordable housing and poverty in the top five problems that impact health in the community. Focus group participants and key informants highlighted the vital importance of affordable, quality, and safe housing, especially with integrated services, to provide the foundation for community members to be healthy and thriving.



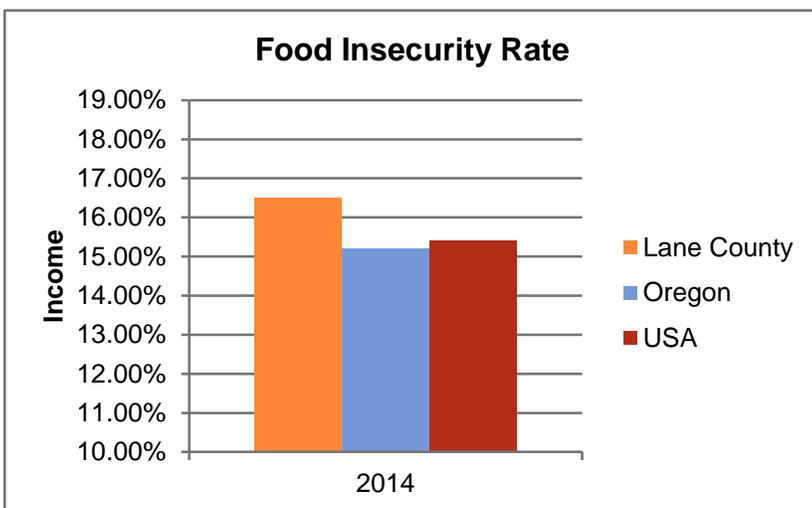
### Food Security

Far too many of residents in our community struggle with access to healthy nutritious foods and food security. The USDA defines food insecurity as “limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.” When it’s hard for people to access nutritious food it becomes difficult to prevent and manage chronic diseases like diabetes or other diet related diseases.

*“We need to step out of the food box, and we need more focus on jobs, job training, and more long term access to food.”*

– CHNA Focus Group Participant

Lane County’s food insecurity rate of 16.5% is higher than Oregon as a whole’s 15.2% (Mind the Meal Gap, 2014). Almost 22% of Lane County’s total population receives financial supports through the Supplemental Nutrition Assistance Program (SNAP) and ½ of all students are eligible for the Free and Reduced Lunch Program in Lane County (SNAP, 2012; Department of Education, 2015). Community residents echoed the need for increased accessibility to affordable healthy foods in survey responses, focus groups, and key informant interviews.





### Food and Nutrition

It is essential to eat a fresh, healthy and balanced diet in order to maintain a healthy weight and prevent chronic disease. Consuming healthy foods and beverages is associated with lower risk of overweight and obesity and lower rates of numerous chronic diseases. Due to a combination of behavioral, social, economic, and environmental factors, many people do not eat the recommended levels of fruits and vegetables.

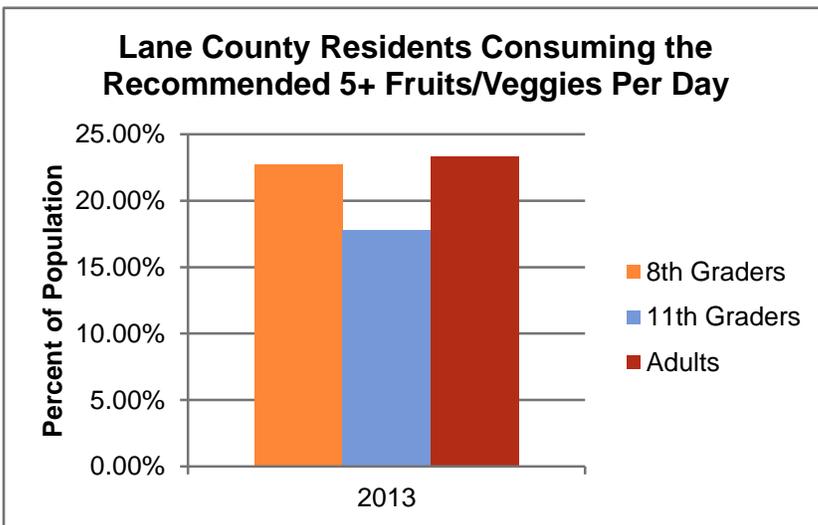
Only one in four Lane County adults and youth (8<sup>th</sup> and 11<sup>th</sup> graders) consume the recommended five or more servings of fruits and vegetables per day, a proportion that has not changed significantly over time (Oregon Behavioral Risk Factor Survey, 2013; Oregon Healthy Teens Survey, 2013).

The availability and affordability of healthy and varied food options in a community increase the likelihood that residents will have a balanced and nutritious diet. Unfortunately, fast food is accessible across Lane County, while access to full service grocers and farm stands varies throughout the county and “food deserts” exist both in metro and rural areas. The USDA defines food deserts as “parts of the country void of fresh fruit, vegetables, and other healthful whole foods, usually found in impoverished areas. This is largely due to a lack of grocery stores, farmers' markets, and healthy food providers.”

In 2010, an estimated 39% of Lane County residents lived within close proximity to a full service grocer or a farm stand (USDA, 2010). While residents of Lane County have slightly better access to supermarkets or grocery stores when compared to the state of Oregon as a whole, there are huge disparities across the county. Low-income and underserved areas in Lane County have limited numbers of stores that sell healthy foods, especially fresh fruits and vegetables. Rural communities have a high number of convenience stores, where healthy and fresh foods are less available than in larger, retail food markets. Public transit is readily available in the metro area, but is limited or lacking in outlying and rural areas, creating more of a barrier to accessing healthy foods.

### Early Childhood Development

Community members and stakeholders identified positive early childhood development as one of the key indicators of creating a healthy and thriving community. Experiences in early childhood are extremely important for a child’s healthy development and lifelong learning. How a child develops during this time affects future



*“We need better early education so kids have the best possible chance of doing well later in school and in life.”*  
 – CHNA Focus Group Participant



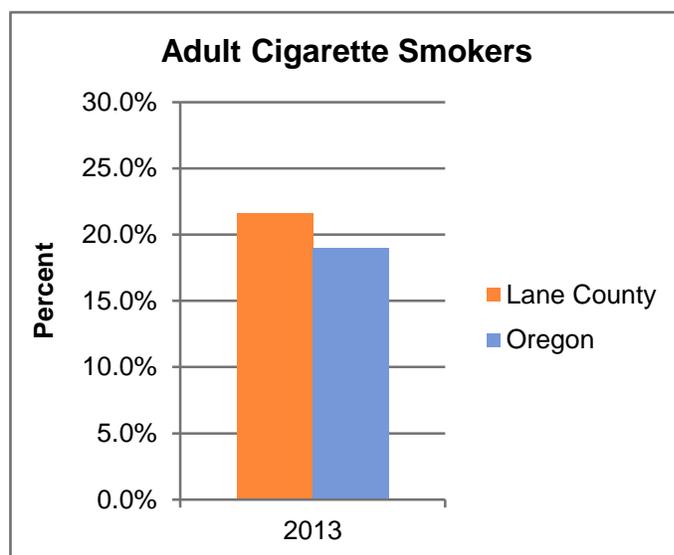
cognitive, social, emotional, language, and physical development, which in turn influences school readiness and later success in life. Failure to mitigate adverse early childhood experiences, such as poverty, abuse, or neglect, can impair healthy brain development, increasing social costs by exposing children to greater risk of academic failure and physical and mental health problems (Drotar, 1992).

Early education greatly influences health by improving access to more opportunities for secure employment and housing, better living conditions, and opportunities to live a healthy lifestyle. Oregon has the 4th worst four-year high school graduation rate in the nation, with Lane County continuously falling below the state average. In 2014, only 7 out of every 10 students had graduated from high school in four years (Dept. of Education, 2014).

***Tobacco, Alcohol, and Drug Use***

Alcohol, tobacco use, and drug use issues are concerns in our region that impact many lives. Community members who were surveyed and key leaders who were interviewed identified drug and alcohol abuse issues as having a big impact on health in the community.

Tobacco use remains the leading preventable cause of death. With nearly one out of every five people smoking, tobacco use is higher in Lane County than in Oregon overall (BRFFS, 2013). The burden of tobacco use falls hardest on lower-income residents. Tobacco use kills approximately two people a day in Lane County. Tobacco use causes lung cancer, cardiovascular disease and chronic obstructive pulmonary disorder, as well as increases the chances that a person will develop asthma, arthritis, diabetes, stroke, and various cancers, and worsens the ability to manage existing chronic diseases.



Binge drinking alcoholic beverages is associated with greater risk for injury, violence, substance abuse and alcoholism. Adult binge drinking has trended upward for more than a decade and has remained consistently higher in Lane County than the state Average. One in five adults report binge drinking in the past month. Likewise, alcohol induced deaths have also continued to increase. 74 people in Lane County died from causes directly attributable to alcohol use and an estimated 90 or so more people died from alcohol related causes including chronic diseases, injury and other (Oregon Center for Health Statistics, 2013).

Despite regulation by federal and state agencies, misuse, abuse, addiction and overdose of prescription drugs continues to occur in Lane County. Drug poisonings after a period of decline in end of the 2000’s is on the rise again, and is 1.5 times higher than it was a decade ago (OCHS, 2013). On average, one person died from a drug poisoning each week in Lane County last year, more than half of those deaths were from Opioids. Opioids such as heroin and prescription pain medications are the leading contributor to drug-induced deaths.

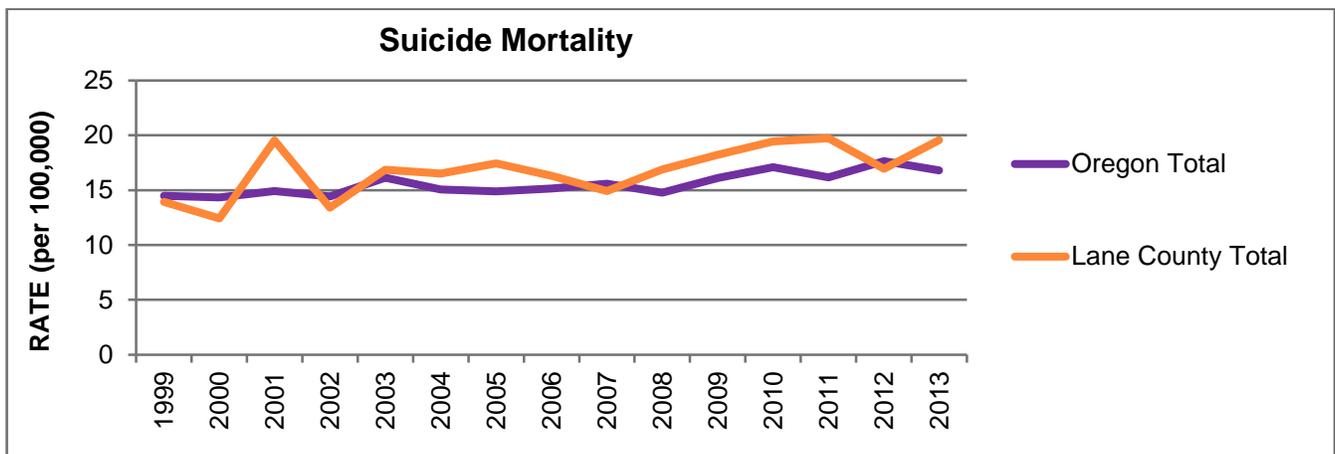


### Mental Health

According to the World Health Organization, mental health is defined as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” Focus group participants and key informants identified mental health as a critical health and quality of life issue affecting our community. Suicides and severe depression have devastating long-lasting impacts on Lane County communities at rates far higher than much of the nation. Suicide rates have slowly increased over the last decade in Lane County and in the state as a whole and suicide is one of the five leading causes of death for people in Lane County aged 10-54 years. More than one person dies from suicide in Lane County every week (Oregon Center for Health Statistics, 2013).

*“We need to make mental health services more accessible.”*

– CHNA Survey Respondent



### Sexually Transmitted Infections

Sexually transmitted infections are a significant health problem in Lane County. These infections pose a threat to an individual’s immediate and long term health and well-being. They can lead to severe reproductive health complications such as infertility and ectopic pregnancy. Rates of some sexually transmitted infections are the highest they’ve been in 15 years. Sexually Transmitted Infections such as Chlamydia, Gonorrhea, and Syphilis have steadily risen and more than doubled over the last decade, and rate has accelerated in the past 5 years, roughly half of all infections occur among young people age 15-24 years of age (OR Office of Disease Prevention and Epidemiology, 2000-13).

### Preventive Care

Preventative screenings and other services are essential for both children and adults in preventing illness, promoting wellness, and fostering vibrant communities. Use of preventative screening and health services is generally lower in Lane County than in Oregon overall.

*“Prevention is the key to a healthier community.”*

– CHNA Key Informant



Well-child visits allow doctors and nurses to have regular contact with children; this helps to monitor the child's health and development through periodic developmental screening. Among children served by Trillium who received developmental screening in the first 36 months of life, 57.1% completed developmental screening during the first six months of 2015, compared to 28.3% in 2013 and 45% in 2014. Nearly 30% of adolescents served by Trillium had well-child visits in 2015 (mid-year), an approximate 10% improvement over 2013.

Screening for alcohol and drug misuse is critical to the prevention of or early intervention in addiction. Among Trillium Medicaid members, alcohol and drug screening has nearly tripled since 2013 and was completed for 8.8% of members ages 12 and older during the first six months of 2015, compared to 3% in 2013.

Oral health has been shown to impact overall health and well-being. Professional dental care helps to maintain the overall health of the teeth and mouth, and provides for early detection of pre-cancerous or cancerous lesions. People living in areas with low rates of dentists, such as our rural communities, have more difficulty accessing the dental care they need. In Lane County, 64.1% of adults had a dental care visit in the past year, based on 2010-2013 data. This was slightly lower than Oregon's 66% (BRFSS, 2013). About 75% of Lane County 8<sup>th</sup> and 11<sup>th</sup> graders had seen a dentist in the past year (Oregon Healthy Teens Survey, 2013).

### *Access to Care*

Community members and stakeholders indicated that it is necessary to increase the availability of integrated primary care and behavioral health services, including School Based Health Centers. While we have greatly expanded the availability of health insurance, having health insurance is most effective when it also facilitates access to a consistent source of care. Access to a consistent healthcare provider results in increased use of preventive services, better health (physical, behavioral, oral) outcomes, reduced health disparities, and lower health care expenditures.

*“Access to healthcare is still an issue.”*

– CHNA Key Informant

As of Mid-Year 2015, 69% of Medicaid enrollees in Lane County were assigned to Primary Care Providers practicing out of recognized Patient Centered Primary Care Homes (PCPCH). This is up from just over 60% in 2014, due to Medicaid expansion. (Trillium Report, 2014, 15).

Access varies greatly throughout the county and some rural areas have the highest unmet need in the state. Lane County is ranked in the middle as far as the number physicians are available to the population overall, 80% or more of local physicians are concentrated in Eugene/ Springfield. Communities in the Coastal Range and foothills and along the Highway 58 corridor have some of the highest unmet needs in the state. Surveyed community members identified the lack of access to physical, mental, and oral as the third biggest problem impacting the health in our community and that there is a shortage of health and social services, especially in rural communities and for vulnerable populations (i.e. rural, racial and ethnic minorities, homeless, LGBTQ+, children and families, seniors, etc.).



### *Collaboration, Coordination, and Navigation*

Our health is determined in part by the resources and supports available in our homes, neighborhoods, and communities. Community members stressed that the current system remains too difficult to navigate for many people. There is a need to improve communication between organizations and the public about available resources, and improve access to appropriate services for vulnerable populations. Many in Lane County – ranging from low-income persons to non-native English speakers seeking culturally responsive care in their primary language – struggle to get the services they need to be healthy and well. Community members and stakeholders identified services for vulnerable populations as one of the highest priorities for the community and its members to be healthy and thriving. Residents appreciate the organizations that provide critical services and resources in Lane County. However, there are still not enough health and social services to meet the growing needs of Lane County’s most vulnerable populations. When community members are linked with appropriate services, complex health and socioeconomic factors can be better addressed.

*“We need more culturally and linguistically appropriate health care and human services.”*

– CHNA Focus Group Participant

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### Community Assets

- ❖ Successful organizational collaborations and community partnerships.
- ❖ Social connectedness and community involvement.
- ❖ Community awareness of the social determinants of health and the broad perspective of health.
- ❖ An increased focus on prevention.
- ❖ The involvement of community organizations in service delivery.
- ❖ Solid interest and support for strengthening the local public health system.
- ❖ Healthy environments and recreational opportunities.
- ❖ Increased access to healthcare coverage.

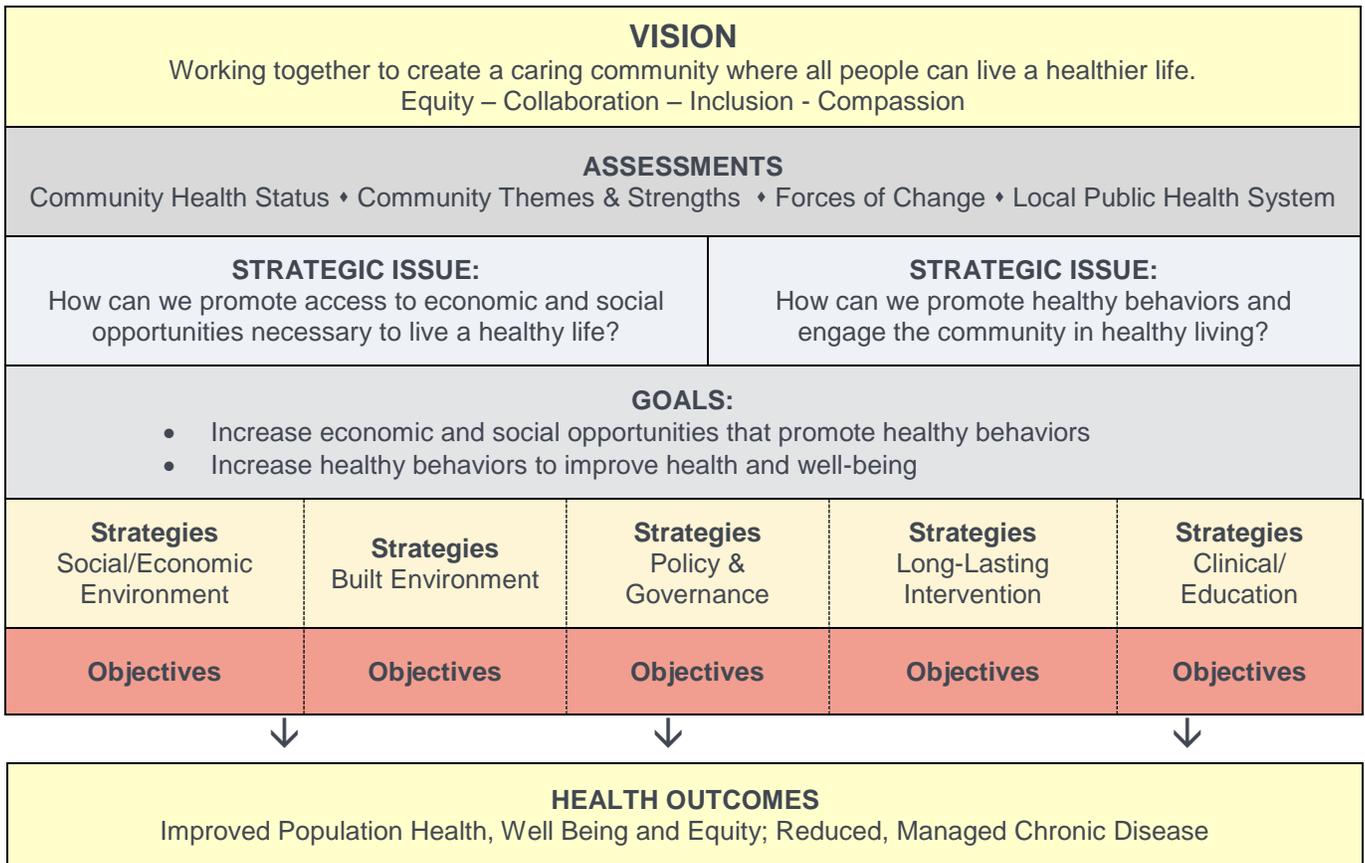
*“There is a lot of collaboration between organizations and community members in our community.”*

- CHNA Focus Group Participant



# Action Framework

This CHIP Action Framework reflects our vision of health and well-being as the sum of many parts, and our belief that combining these components is essential to improving population health and motivating community change. This framework demonstrates the interdependence of factors affecting health and is intended to focus efforts and mobilize an integrated course of action.



We know it will take many partners to improve the health of Lane County, and it is our hope that this CHIP will help join individuals, organizations, and communities together to create a healthier place for everyone. As we make progress with the strategic issues outline in this CHIP, we believe Lane County will approach an outcome of improved population health, well-being and health equity. Achieving this will require sectors of the community to come together in new ways.



## Strategies and Objectives

### Strategies

Decades of research and practice have built an evidence base that point to effective approaches to improve the health of our community. Improving socioeconomic factors (e.g., poverty, education) and providing healthful environments (e.g., designing communities to promote access to healthy food) reinforce health across the community. Broad-based changes that benefit everyone should be supplemented by clinical services that meet individual health needs (e.g., mental health screening). Through health promotion, education, and counseling, we can provide people with the knowledge, tools, and options they need to make healthy choices.

The strategies and objectives described in this CHIP are based on information gathered from interviews and surveys conducted with key stakeholders and content experts, case study and evidence-based research, and local quantitative and qualitative data. These implementation strategies and objectives were selected based on their feasibility within the focus areas and their potential for adoption by the project partners and community.

This CHIP outlines seven multi-level, multi-sectoral, evidence-based strategies designed to improve the health and wellness of our community. The five-tier pyramid, shown on the following page, illustrates the impact of different types of strategies that will be implemented. The strategies addressing the socioeconomic factors that affect health make up the top of the pyramid. They have the greatest potential to affect health because they reach the entire population by making health resources readily available, ensuring the health care system is equipped to address health needs, and enacting policy that makes the healthy choice the default choice for the entire population. The strategies in the bottom two tiers of the pyramid commonly occur in a healthcare or social service setting. These interventions are essential to protect and improve an individual's health, but they typically have a lesser impact on the entire population's ability to achieve optimal health. Together, the strategies weave the web to help support community members in leading healthier lives.

### Measuring Progress

The strategies are accompanied by a mix of measurable objectives, which were selected to illustrate progress and spark dialogue about the factors that influence and improve health. While the objectives set measurable targets for our region as a whole, it is critical that the activities and tactics carried out ultimately lead to a reduction of disparities. Historically underserved and disproportionately impacted communities will be prioritized when resource decisions are being made and when strategies are being designed.

The performance measures that have been identified have the evidence base necessary to lead to improved health and well-being. The measures are not meant to delineate every indicator of population health, but rather to represent key elements of possible change. These indicators will be used to measure progress toward creating a healthy community and to plan and implement future efforts. Key indicators will be reported for the overall population and by subgroups as data becomes available. Indicators and targets are drawn from existing measurement efforts. As data sources and metrics are developed or enhanced, key measures/indicators and targets will be updated.



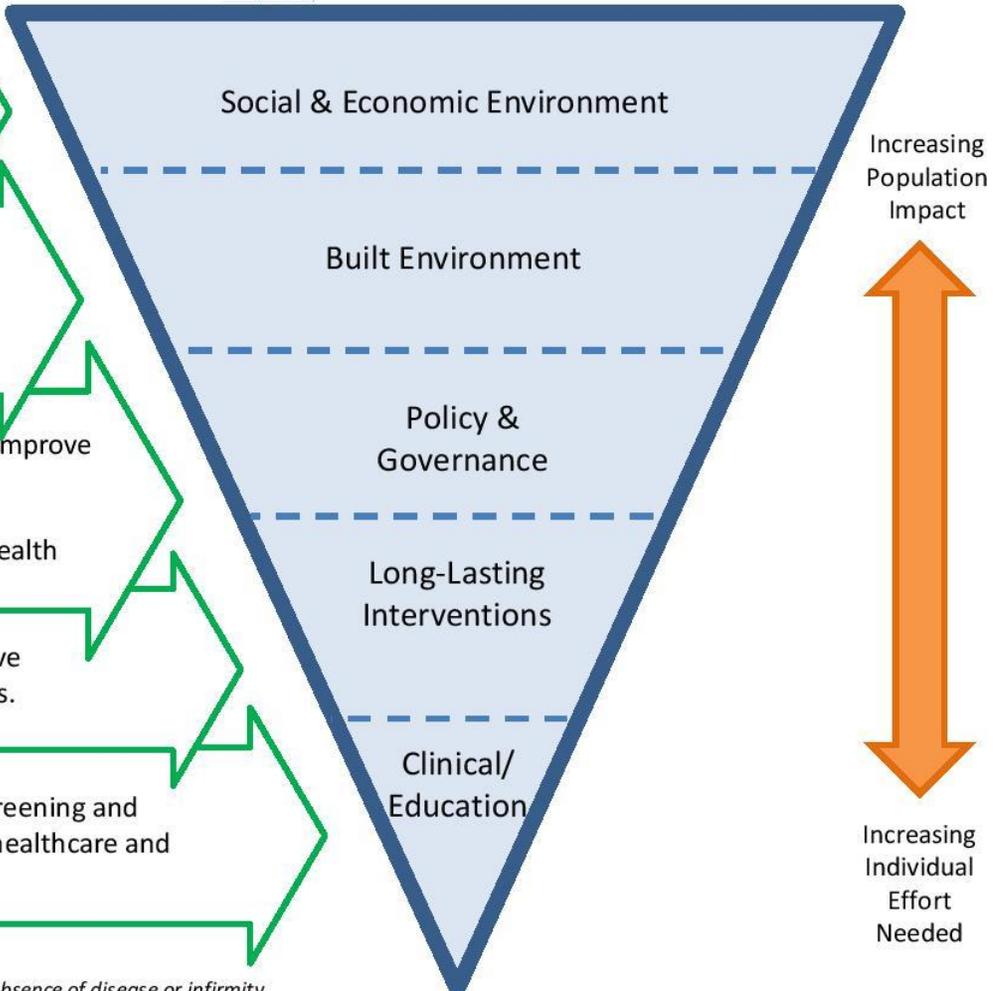
# 2016-2019 Lane County Regional Community Health Improvement Plan

## GOALS

Increase **economic and social opportunities** that promote healthy behaviors.  
 Increase **healthy behaviors** to improve health and well-being.

## STRATEGIES

- Support economic development by investing in workforce strategies that provide sustainable family wage jobs.
- Encourage a range of safe and affordable housing opportunities, including the development of integrated and supportive housing.
- Assure availability of affordable healthy food and beverages in every community.
- Strengthen cross-sector collaborations and align resources to improve the physical, behavioral, and oral health and well-being of our communities.
- Encourage organizations across multiple sectors to integrate health criteria into decision making, as appropriate.
- Encourage the implementation of programs to promote positive early childhood development and safe/nurturing environments.
- Support the implementation of evidence -based preventive screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers.



*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*



# Community Health Improvement Plan

## STRATEGIC ISSUES

- ❖ *How can we promote access to economic and social opportunities necessary to live a healthy life?*
- ❖ *How can we promote healthy behaviors and engage the community in healthy living?*

## GOALS

- ❖ *Increase economic and social opportunities that promote healthy behaviors.*
- ❖ *Increase healthy behaviors to improve health and well-being.*

## EQUITY FOCUS

Ensure that activities are prioritized to positively impact underserved demographic groups and reduce health disparities. When making decisions, problem solving and taking action, it is important for us to consider equity and the impact on everyone in our community, especially those in underserved demographic groups.

## LONG-TERM OUTCOMES

### Improved:

- Mental/behavioral health
- Physical health
- Oral health
- Living wage jobs
- High school graduation rate
- Affordable housing

### Reduced:

- Food insecurity
- Poverty
- Chronic disease
- Preventable death and disease
- Obesity and obesity-related disease
- Adverse Childhood Experiences
- Substance abuse
- Tobacco use and tobacco-related disease
- Suicide and depression
- Health disparities



## INITIATIVE #1: SOCIAL AND ECONOMIC OPPORTUNITIES

### STRATEGIES:

- ❖ Support economic development through investing in workforce strategies that provide sustainable family wage jobs in our communities.
- ❖ Encourage a range of safe and affordable housing opportunities, including the development of integrated and supportive housing.
- ❖ Promote availability of affordable healthy food and beverages in every community.

### JUSTIFICATION

Investing in workforce strategies that support sustainable local businesses has many community benefits, including economic development (by providing new jobs and keeping money in the local economy), environmental sustainability, and food security. Specifically, the growth and re-localization of the food system has health, social, economic, and environmental impacts.

Safe and affordable housing serves as a platform for positive health, education and economic outcomes and is a crucial base in supporting resilient neighborhoods. Service-enriched housing helps the most vulnerable members of our communities to live a healthier life in a more stable environment.

As our community seeks to grow a more sustainable and equitable economy with healthy residents, ensuring that healthy food is accessible to all is crucial. Without access to healthy foods, a nutritious diet and good health are out of reach. Likewise, without grocery stores and other fresh food retailers, communities are also missing the commercial vitality that makes neighborhoods livable and helps local economies thrive.

OBJECTIVES	PERFORMANCE MEASURE	BASELINE	2019 TARGET	DATA SOURCE
Increase the percent of families with living wage jobs	Percent of families with incomes below the living wage	46% (2010-2014)	44%	ACS; MIT Living Wage Calculator
Increase the median household income	Median household income	\$42,931 (2008-2013)	\$43,779	ACS
Decrease the proportion of low-income households that spend more than 30% on housing	Proportion of cost burdened low-income households (household income less-than or equal to 30% Housing Urban Development Area Median Family Income)	76% (2012)	75%	Comprehensive Housing Affordability Strategy data



OBJECTIVES	PERFORMANCE MEASURE	BASELINE	2019 TARGET	DATA SOURCE
Increase the number of supportive housing units (integrating behavioral health and primary care services)	Number of supportive housing units	537	553	HUD CoC Housing Inventory County Reports
Increase the number of services (e.g. nutrition, employment/ training, physical activity, screening/ healthcare) provided in supportive housing units	Number of services provided in supportive housing units	TBD	TBD	TBD
Increase the percent of our collective food budget that is spent on foods grown, raised, and processed in our communities	Proportion of school district's food budget spent on local foods	29.6% (2013-2014)	36%	USDA Farm to School Census
	Percentage of producers participating in farm direct marketing (farms selling directly to the consumer)	22.9% (2012)	23.6%	USDA Census of Agriculture
	Percent of total agricultural sales that are farm direct marketing sales	4.0% (2012)	4.5%	Oregon Dept. of Ag.
Increase the proportion of the population that lives within close proximity to healthy food retail outlet	Percent of population within close proximity to healthy food retail outlets	38.6% (2013)	39.8%	Lane County Health Mapping
	Percent of low income (income below poverty threshold) population with low access to a supermarket, supercenter, or large grocery store. (>1 mile urban, >10 mile rural)	29% (2010) [4.9% of total population; 17,141 people]	28%	USDA Food Environment Atlas
	Farmers' markets/1,000 population	0.045 (2013) [count=16 markets]	0.05 [~18 markets]	USDA Food Environment Atlas
Increase the proportion of adults and youth that consume at least five fruits/veggies per day	Percent of youth and adults who consume at least five servings of fruits/ veggies per day	8 <sup>th</sup> graders: 22.7% 11 <sup>th</sup> graders: 17.8% Adults: 23.3% (2013)	8 <sup>th</sup> graders: 23.4% 11 <sup>th</sup> graders: 19.3% Adults: 25%	Oregon Healthy Teens Survey; BRFFS



## INITIATIVE #2: HEALTHY BEHAVIORS

### STRATEGIES:

- ❖ Encourage the implementation of programs to promote positive early childhood development and safe/nurturing environments.
- ❖ Support the implementation of evidence-based preventive screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers.

### JUSTIFICATION

Experiences in early childhood are extremely important for a child’s healthy cognitive, social, emotional and physical development. Failure to prevent early adverse childhood experiences, such as poverty, abuse, or neglect, can impair healthy brain development, increasing social costs by exposing children to greater risk of academic failure and physical and mental health problems. Communities can promote positive early childhood development and safe/nurturing environments by making a variety of services and programs available.

Preventive screening and services can help improve the health of infants, children, and adults and promote healthy behaviors. By encouraging patients to take advantage of appropriate preventive services, diseases can be found early, when treatment works best.

OBJECTIVES	PERFORMANCE MEASURE	BASELINE	2019 TARGET	DATA SOURCE
Increase the proportion of children who are ready for school in the following domains of healthy development: social-emotional development, approaches to learning, language, and cognitive development	Kindergarten Assessment average scores (self-regulation and interpersonal skills)	Self-Reg: 3.5/5 Interpersonal Skills: 3.9/5 (2015-2016)	Self-Reg: 3.7 Interpersonal Skills: 4.0	Oregon Dept. of Education
Increase the availability of integrated primary care and behavioral health services, including School Based Health Centers (SBHCs)	Number of Tier 2 and 3 Primary Care Patient Centered Medical Homes (PCPCH)	30 Tier 3 PCPCH (based on Q3 2016 PCPCH data)	33	Trillium
	Percentage of Medicaid members enrolled in a recognized PCPCH	82.4% (2015 performance)	90%	Trillium



OBJECTIVES	PERFORMANCE MEASURE	BASELINE	2019 TARGET	DATA SOURCE
	Utilization of School Based Health Centers	TBD	TBD	National Census of School Based Health Centers and OHA Public Health SBHC Program
	Percent of SBHCs that are integrated	TBD	TBD	National Census of School Based Health Centers and OHA Public Health SBHC Program
Increase the number of individuals who receive screenings/ referrals/ services (e.g. developmental, SBIRT, well-care, oral care, tobacco cessation, mental health/suicide, BMI, food security, reproductive sexual health)	Percent of children served by Trillium who receive developmental screening in the first 36 months of life	67.2% (2015)	73%	Trillium; Oregon Health Authority
	Percent of Trillium members (ages 12 and older) who had appropriate screening and intervention for alcohol or other substance abuse (SBIRT)	12.7% (2015)	12.7%	Trillium; Oregon Health Authority
	Percent of Trillium members (ages 12 and older) who had depression screening (PHQ9 or PHQ2)	23.5% (2015)	25%	Trillium; Oregon Health Authority
	Percent of adolescents (ages 12-21) served by Trillium who had at least one well-care visit in the past year.	37.8% (2015)	41.5%	Trillium; Oregon Health Authority
	Percent of population who had a dental care visit in the last year	8 <sup>th</sup> Graders: 74% 11 <sup>th</sup> Graders: 72.7% Adults: 64.1% (2013)	8 <sup>th</sup> Graders: 76.2% 11 <sup>th</sup> Graders: 74.8% Adults: 65.3%	Oregon Healthy Teens Survey; BRFSS



OBJECTIVES	PERFORMANCE MEASURE	BASELINE	2019 TARGET	DATA SOURCE
	Percentage of adult Trillium member tobacco users advised to quit by their doctor	51.3% (2014)	56.4%	Trillium; Oregon Health Authority
	Effective contraceptive use percentage among Trillium women members at risk of unintended pregnancy	36.6% (2015)	42.2%	Trillium; Oregon Health Authority



## INITIATIVE #3: COLLABORATIVE INFRASTRUCTURE

### STRATEGIES:

- ❖ **Strengthen cross-sector collaborations and align resources to improve the physical, behavioral, and oral health and well-being of our communities.**
- ❖ **Encourage organizations across multiple sectors to integrate health criteria into decision making, as appropriate.**

### JUSTIFICATION

Creating a healthy community is a team effort and calls for mobilizing effective partnerships in order to identify and solve health problems. Collaboration across sectors such as education, business, transportation, and community development can play an essential role in the process. Cross-sector collaborations and aligning resources have the power to directly influence our community's health.

A 'Health in All Policies' approach infuses health considerations and criteria into policy, planning, and program decisions. It also encourages collaboration with partners outside of the health care sector.

OBJECTIVES	PERFORMANCE MEASURE	BASELINE	2019 TARGET	DATA SOURCE
Increase the number of entities across a range of sectors contributing (e.g. staff, financial, other resources) to the CHIP	Number of hours and dollars contributed to the CHIP	Orgs that contributed to the 2013-2016 CHIP (Steering Committee or Workgroup): 31 (2016)	Orgs that contribute to the 2016-2019 CHIP: 50	Internal; Annual CHIP Survey
Increase the dollars to support common agenda goals	Dollars supporting common agenda goals: - External grants that align with the CHIP - Leveraged grants - Funds made available for community projects - Partner expenditures on CHIP initiatives	TBD	TBD	Internal; Annual CHIP Survey



OBJECTIVES	PERFORMANCE MEASURE	BASELINE	2019 TARGET	DATA SOURCE
Establish a shared measurement system for the CHIP	Creation of a CHIP shared measurement system	0 (2016)	1	Internal
Improve the performance of the local public health system in delivering the ten Essential Public Health Services	Essential Public Health Services (EPHS) and Model Standards Scores	Average overall performance score: 50.3%  EPHS #4 (mobilizing community partnerships): 55.5% (2015)	Average score: 55.6%  EPHS #4: 61%	National Public Health Perf Standards Program: Local Public Health System Asses.
Increase the number of organizations across a range of sectors that formally adopt a “health in all policies” approach to decision making	Number of organizations that have a formally adopted “health in all policies” approach to decision making	1 (2016)	6 orgs across 3 sectors	Annual CHIP Survey
Increase the number of policies that support tobacco- and smoke-free environments and address the main drivers of youth tobacco use	Number of tobacco- and smoke-free environments	48 (2016)	53	Lane County Public Health
	Number of policies that address the main drivers of youth tobacco use	56 (2016)	61	Lane County Public Health



## Alignment

During the community health improvement planning process, the need for greater alignment of efforts was determined to be necessary in order to have the greatest impact on health. As such, this plan defines “alignment” as shared priorities, partnerships, and collaborative effort to reach goals. Alignment brings together a number of intersecting initiatives, all of which share common aims.

Based on the review of local public health data, it was determined that there are more similarities than differences in the health of our residents and that of the rest of the state. For this reason, and in order to align efforts at the state and local level to increase impact, the Live Healthy Lane team has worked to align our CHIP’s priorities and strategies with the Oregon State Health Improvement Plan, Healthy People 2020, and National Prevention Strategy. We would like to thank these health improvement planning teams for their leadership in this work.

The chart below demonstrates the alignment of the 2016-2019 Lane County Regional Community Health Improvement Plan strategies with local, state, and national health improvement priorities.

Strategy	Local Plans	Oregon State Health Improvement Plan	Healthy People 2020	National Prevention Strategy
Support economic development through investing in workforce strategies that provide sustainable family wage jobs in our communities.	X		X	
Encourage a range of safe and affordable housing opportunities, including the development of integrated and supportive housing.	X		X	X
Assure availability of affordable healthy food and beverages in every community.	X	X	X	X
Strengthen cross-sector collaborations and align resource to improve the physical, behavioral, and oral health and well-being of our communities.	X	X	X	X
Encourage organizations across multiple sectors to integrate health criteria into decision making, as appropriate.	X	X	X	X
Encourage the implementation of programs to promote positive early childhood development and safe/nurturing environments.	X	X	X	X
Support the implementation of evidence - based preventive screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers.	X	X	X	X



## Next Steps

To oversee the CHIP's implementation process, the Live Healthy Lane partnership will develop an implementation plan. The plan will be developed in collaboration with community members, consumers, and stakeholders and will outline the activities and a timeline to accomplish the goals in the CHIP. United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan will take the lead on implementing and tracking progress. The 100% Health Executive Committee will serve as the Steering Committee for the Community Health Improvement Plan and provide guidance and direction for its implementation. Along with the collaboration of community stakeholders, the four partnering organizations will:

- Track and evaluate progress made implementing the strategies.
- Periodically review the plan and propose changes when greater impact can be achieved by modifying approaches.
- Help form strategic new partnerships to carry out the CHIP.
- Create connections between this plan and other key plans and initiatives that have similar goals.

A key initial step in the implementation plan will be to identify partners with whom to collaborate in each of the plan's priority areas. CHIP Action Teams focusing on particular initiatives will be established to complete more in-depth planning and to ensure successful implementation of strategies. Action Team members will have significant expertise on a specific issue and will include a mix of community partners and staff. When needed and as recommended, additional Task Forces will be established.

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing for the desired future, and a clear evaluation of whether the efforts are making a difference. The health of the community is ever changing, as are the priorities of its members. In response to the changing needs of the community, action plans will be annually reviewed and will be updated as needed to meet current needs and trends. This will allow us to track progress, celebrate achievements and change course when desired outcomes are not being met. We will produce an annual report, beginning in 2017.

While participating in the CHIP's development, current and new partners demonstrated a great deal of enthusiasm for collaborating with United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan. This enthusiasm relates not only to the important goals outlined in the CHIP, but also to the spirit of partnership that is required to work together across sectors to improve the health and well-being of the community. We acknowledge that we cannot begin to do this work alone and we invite you to join us. We invite you to visit the Live Healthy Lane website at [www.LiveHealthyLane.org](http://www.LiveHealthyLane.org) to view updates about the work and learn more about participating.

Lastly, it is important to note that the CHIP priorities are not the only priorities that United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan will pursue. While each organization's internal strategic plans contain key activities and programs that will be implemented to help achieve the CHIP goals, they also include many other important projects and priorities.



## Summary

This Community Health Improvement Plan is the product of 15 months of collaboration between United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan, along with our partners and the communities we serve. The strategies and objectives outlined in this document are only the beginning stages of improving the health of the region. The community's health is ever changing, as are the priorities of its members. In response to the changing needs, action plans will be annually reviewed and will be updated as needed to meet current needs and trends. We will produce an annual report, beginning in 2017, to share any successes or challenges we have encountered.

Community and organizational engagement is the most critical component of the community health improvement planning process. We are thankful to the thousands of community members and hundreds of organizations across our region who shared their time and expertise by attending the Community Health Visioning Session, the Live Healthy Lane: Defining Our Future event, participating in a focus groups, key informant interviews, completing the Community Health Survey, or evaluating potential strategies and otherwise providing input on the plan development. This health improvement planning process has only been possible because of the amazing participation from local organizations and the community. **Thank you!**

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## How Can You Help Improve Community Health?

Community health improvement is not a static process. We promote a cross-sector approach to community health planning and are therefore are looking for a variety of agencies interested in partnering across the region to help develop recommendations, implement programs, and evaluate efforts. If you, or your organization, are one of the missing partners in the Lane County Regional CHIP please contact us to get more information about how you can help support our efforts to improve community health. *We look forward to working together to create a caring community where all people can live a healthier life!*



### CONTACT

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# Acknowledgements

Thousands of community members and hundreds of organizations representing public, private and nonprofit groups contributed to the 2015/2016 Community Health Needs Assessment and development of the 2016-2019 Community Health Improvement Plan. The complete list of contributors can be found on Page 36. Their time, dedication and efforts are greatly appreciated. The following is a list of key contributors:

## *100% Health Community Coalition Executive Committee*

- Rick Kincade, MD**  
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PacificSource Health Plans
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Lane County Health and Human Services  
PeaceHealth
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- David Parker**  
Trillium Community Health Plan
- Jocelyn Warren**  
Lane County Health and Human Services
- Rick Yecny**  
Trillium Rural Advisory Council



**100% Health**  
Community Coalition



United Way of Lane County



**PeaceHealth**



Trillium  
Community Health Plan  
It's beautiful what we cover





## Community Partners

*Thank you to all who participated in the 2015-2016 Community Health Needs Assessment and helped develop the 2016-2019 Community Health Improvement Plan. Thank you!*

### HEALTH SYSTEM

Advantage Dental  
 Bethel Health Center  
 Cascade Health Solutions  
 Community Health Centers of Lane County  
 Cottage Grove Physical Therapy  
 Emergency Veterinary Hospital  
 Eugene Health Centers  
 Healing Spirit Integrative Health Center  
 Health Care For ALL Oregon  
 Health Security Preparedness and Response  
 Hope Family Health Clinic  
 Kaiser Permanente  
 Lane Community College Health Clinic  
 Lane County Maternal and Child Health Programs  
 Lane County Health and Human Services  
 McKenzie Surgery Center  
 McKenzie-Willamette Medical Center  
 Occupy Medical  
 Oregon Health Authority  
 Oregon Heart and Vascular Rehab Program  
 Oregon Home Care Commission  
 Oregon Imaging Center  
 Oregon Medical Group  
 Oregon Research Institute  
 PacificSource Health Plans  
 PeaceHealth  
 Planned Parenthood of Southwestern Oregon  
 Rural Oregon Accessible Medicine  
 Simard Chiropractic  
 Slocum Center for Orthopedics & Sports Medicine  
 Taylored Benefits  
 Trillium Community Health Plan  
 University of Oregon Health Center  
 Volunteers in Medicine  
 White Bird Clinic  
 Willamette Dental Group

### BEHAVIORAL AND MENTAL HEALTH

Center for Family Development  
 Direction Service  
 HIV Alliance  
 Lane County Behavioral Health  
 Laurel Hill Center  
 Lifestyle Changes  
 Looking Glass Community Services  
 National Alliance on Mental Illness (NAMI) of Lane County  
 Options Counseling and Family Services  
 Oregon Family Support Network  
 Oregon Research Behavioral Intervention Strategies  
 Serenity Lane  
 Siuslaw Area Partnership to Prevent Substance Abuse  
 Solutions Therapy, Consulting and Training  
 South Lane Mental Health  
 Trauma Healing Project  
 Willamette Family Inc.

### GOVERNMENT

Board of County Commissioners  
 City of Creswell  
 City of Eugene  
 City of Eugene Adaptive Recreation  
 City of Eugene Planning & Development Department  
 City of Eugene Public Works  
 City of Eugene Senior Services  
 City of Eugene: Recreation Services  
 City of Florence  
 City of Oakridge  
 City of Springfield  
 City of Veneta  
 Community Health Centers of Lane County  
 Congressman Peter DeFazio  
 Department of Human Services  
 Eugene City Council  
 Lane Council of Governments (LCOG)  
 Lane County Behavioral Health  
 Lane County Government  
 Lane County Health & Human Services  
 Lane County Maternal and Child Health Programs  
 Lane County Public Health  
 Lane County Public Works  
 Oregon Health Authority  
 Oregon State Legislature  
 Oregon's 4th Congressional District  
 US Forest Services, Willamette National Forest



**HUMAN SERVICES AND COMMUNITY ORGANIZATIONS**

211 Info  
 90by30  
 A Community Together  
 Bethel Family Center  
 Brattain House Community Family Center  
 Centro Latino Americano  
 City of Eugene Adaptive Recreation  
 City of Eugene Senior Services  
 City of Eugene: Recreation Services  
 Coaching Parents  
 Cottage Grove Family Resource Center  
 Court Appointed Special Advocates (CASA)  
 CrossCultural Now  
 CrossFit Kin  
 Daisy CHAIN Mothering  
 Department of Human Services  
 Downtown Languages  
 Eugene Civic Alliance  
 Eugene Family YMCA  
 Eugene Public Library  
 Family Forward Oregon  
 Family Relief Nursery  
 Fern Ridge Community Dinner  
 FOOD for Lane County  
 Goodwill Industries  
 HealthFirst Financial  
 Healthy Moves  
 Hearing Loss Association of America  
 Huerto de la Familia  
 Institute for Patient- and Family-Centered Care  
 Kids' FIRST Center  
 Lane County Commission for the Advancement of Human Rights  
 Lane Independent Living Alliance (LILA)  
 Lane Workforce Partnership  
 League of United Latin American Citizens  
 Marcola Family Resource Center  
 Mohawk-McKenzie Grange  
 NAACP - Eugene/Springfield Oregon  
 Oakridge Family Resource Center  
 Oakridge Kiwanis Club  
 Ophelia's Place  
 Oregon Food Bank  
 Oregonians for Gambling Awareness Organization  
 Parent Partnership Comprehensive Programs  
 Parenting Now!  
 Pearl Buck Center  
 Pilas! Family Literacy Program  
 Planned Parenthood REvolution  
 Relief Nursery  
 School Garden Project of Lane County  
 Senior and Disability Services  
 ShelterCare  
 South Lane Family Resource Center  
 Sponsors

Springfield Public Library  
 St. Vincent de Paul  
 Stand For Children  
 Sustainable Cottage Grove  
 United Way of Lane County  
 Walterville Grange  
 Willamalane Park and Recreation District  
 Willamette Farm and Food Coalition  
 WomenSpace  
 Youth MOVE Oregon

**EDUCATION**

4J Eugene School District  
 Bethel School District  
 Creswell School District  
 Early Childhood CARES  
 Early Learning Alliance  
 Head Start of Lane County  
 Junction City School District  
 Lane Community College  
 Lane Community College Health Professions Division  
 Northwest Christian University  
 Northwest Youth Corps  
 Oregon Health and Science University  
 Oregon State University Extension  
 Siuslaw School District  
 South Lane School District  
 Springfield Public Schools  
 University of Oregon  
 Wilagillespie Elementary School

**HOUSING**

Cornerstone Community Housing  
 Housing and Community Services Agency (HACSA)  
 Housing Policy Board  
 Lane County Land Use Planning & Zoning  
 Oregon Housing and Community Services  
 Oregon Housing Alliance  
 Springfield/Eugene Habitat for Humanity  
 Viridian Management  
 Windermere

**TRANSPORTATION**

City of Eugene Transportation Options  
 Eugene and Springfield Safe Routes to School  
 Lane Transit District (LTD)

**ECONOMIC DEVELOPMENT**

Eugene Chamber of Commerce  
 Lane County Economic Development  
 Lane Workforce Partnership  
 Neighborhood Economic Development Corp. (NEDCO)  
 Upper Willamette Community Development Corporation  
 WorkSource Lane

**FOUNDATIONS & PHILANTHROPY**

AmeriCorps VISTA  
 Children's Institute  
 Oregon Community Foundation  
 Slocum Research and Education Foundation  
 Taubert Foundation  
 United Way of Lane County



**BUSINESSES**

Banner Bank  
Cross Cultural Now  
Dean/Ross Associates  
Emerald Aquatics  
Eugene Water and Electric Board  
Hawes Financial Group  
Hershner Hunter  
Lourdes Sanchez Attorneys at Law  
Lunar Logic  
Moss Adams LLP  
Ninkasi Brewing Company  
Pacific Continental Bank  
Royal Caribbean Cruises Ltd  
Sapient Private Wealth Management  
Smith and Associates  
US Bank

**MEDIA**

Rick Dancer Media Services  
KEZI 9 News  
KLCC  
KMTR

**CRIMINAL JUSTICE AND PUBLIC SAFETY/EMERGENCY SERVICES**

Eugene Police Department  
Eugene Springfield Fire Department  
Johnson Johnson & Schaller, PC  
Juvenile Recovery and Progress Court  
Lane County Circuit Court  
Lane County District Attorney's Office  
Lane County Legal Aid & Advocacy Center  
Lane County Sheriff's Office  
Lane County Youth Services  
Oregon Department of Corrections  
Public Defender Services of Lane County Inc.  
Springfield Police Department  
US District Court, District of Oregon

**FAITH**

Centro de fe Community Church  
Community Service Center  
Discover the Power of Choice  
First Christian Church  
Power House Worship Center

**COALITIONS & COMMITTEES**

100% Health Community Coalition  
100% Health Safety Net Committee  
Alliance for Healthy Families  
Be Your Best Cottage Grove  
Bicycle and Pedestrian Advisory Committee  
CHIP Equity Workgroup  
CHIP Mental Health and Addictions Workgroup  
CHIP Obesity Prevention Workgroup  
CHIP Tobacco Prevention Workgroup  
Coalition of Local Health Offices  
Community Resource Network  
DHS District 5 Advisory Committee  
Early Childhood Mental Health Team  
Early Learning Alliance  
Early Learning Alliance Pediatric Advisory Group  
Early Learning Stakeholders  
Eugene Springfield Prevention Coalition  
Family Resource Center Managers  
Lane County Mental Health Promotion Steering Committee  
Lane Equity Coalition  
Mental Health Advisory/Local Alcohol and Drug Planning Committee  
Patient and Family Advisory Council  
PeaceHealth Health and Wellness Committee  
Pediatric Advisory Group  
Public Safety Coordinating Council - Adult Committee  
Public Safety Coordinating Council - Youth Committee  
Trillium Community Advisory Council  
Trillium Rural Advisory Council  
United Way Emerging Leaders  
United Way Human Service Providers Forum

**LANE COUNTY AND REEDSPORT COMMUNITY MEMBERS AND CONSUMERS**





## Glossary

### *10 ESSENTIAL PUBLIC HEALTH SERVICES*

The 10 Essential Public Health Services, developed by representatives from federal agencies and national organizations, describe what public health seeks to accomplish and how it will carry out its basic responsibilities. The list of 10 services defines the practice of public health:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

### *ACCESS/ACCESS TO CARE*

This is the extent to which a public health service is readily available to the community's individuals in need, including the capacity of the agency to provide service in a way that honors the social and cultural characteristics of the community. It also focuses on agency efforts to reduce barriers to service utilization. "Access to care" refers to access in a medical setting.

### *ACCOUNTABILITY*

Accountability is an obligation or willingness to be assessed on the basis of appropriate measures of actions and outcomes with regard to the achievement of workgroup/program/organization or policy purposes.

### *ACTION CYCLE*

During Phase Six, Action Cycle, the community implements and evaluates action plans to meet goals, address strategic issues, and achieve the community's vision.

### *BEHAVIORAL RISK FACTORS*

Risk factors in this category include behaviors that are believed to cause, or to be contributing factors to most accidents, injuries, disease, and death during youth and adolescence as well as significant morbidity and mortality in later life.

### *CHRONIC DISEASES*

These are diseases of long duration, generally slow progression, and can be multisymptomatic.

### *COMMUNITY*

Broad community participation is vital to a successful MAPP process. Activities for each phase include specific consideration of ways to gain broader community member participation. This will ensure that the community's input is a driving factor. For this CHIP, 'community' refers to all those who live, learn, work, or play in Lane County, Oregon and Reedsport, Oregon.



**COMMUNITY ASSETS**

Contributions made by individuals, citizen associations, and local institutions that individually or collectively build the community’s capacity to assure the health, well-being, and quality of life for the community and all its members.

**COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)**

A community health improvement plan is a three-year, systematic effort to address public health problems on the basis of the results of community health needs assessment activities and the community health improvement process.

**COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)**

A Community Health Assessment engages community members and local public health system partners to collect and analyze health-related data from many sources.

**COMMUNITY MEMBER**

This is anyone who works, learns, lives, or plays in Lane County, Oregon or Reedsport, Oregon.

**CONSUMER**

This is anyone who is the recipient of services or commodities.

**DEMOGRAPHIC CHARACTERISTICS**

Demographic characteristics of a jurisdiction include measures of total population as well as percent of total population by age group, gender, race and ethnicity, where these populations and sub-populations are located, and the rate of change in population density over time, due to births, deaths, and migration patterns.

**ENVIRONMENTAL HEALTH INDICATORS**

The physical environment directly impacts health and quality of life. Clean air, water, and safely prepared food are essential to physical health.

**EVIDENCE-BASED**

Supported by the current peer-reviewed scientific literature.

**FORMULATE GOALS AND STRATEGIES**

In Phase Five, Formulate Goals and Strategies, goals that the community wants to achieve are identified that relate to the strategic issues. Strategies are then identified to be implemented.

**FOUR MAPP ASSESSMENTS**

During Phase Three, Four MAPP Assessments, qualitative and quantitative data are gathered to provide a comprehensive picture of health in the community.

**GOALS**

Goals are broad, long-term aims that define the desired result associated with identified strategic issues.

**HEALTH**

This is a dynamic state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity.



### *HEALTH DISPARITY*

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by people who have historically made vulnerable by policies set by local, state, and Federal institutions. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), gender identity, or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.

### *HEALTH EQUITY*

Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

### *HEALTH INEQUITY*

Health inequities are differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.

### *HEALTH RISK*

This is a condition of humans that can be represented in terms of measurable health status or quality-of-life indicators.

### *HEALTH STATUS*

This is the current state of a given population using various indices, including morbidity, mortality, and available health resources.

### *IDENTIFY STRATEGIC ISSUES*

In Phase Four, Identify Strategic Issues, the data are analyzed to uncover the underlying themes that need to be addressed in order for a community to achieve its vision.

### *INCIDENCE*

This is the measure of the frequency with which new cases of illness, injury, or other health condition occur among a population during a specified period.

### *INDICATOR*

This is a measure of health status or health outcome such as the number of people who contract a respiratory disease or the number of people who die from a particular chronic disease. Measures/data that describe community conditions (e.g., poverty rate, homelessness rate, number of food stamp recipients, life expectancy at birth, heart disease mortality rate) currently and over time.

### *INTERVENTION*

An intervention is an action intended to improve a specific public health issue.

### *LOCAL PUBLIC HEALTH SYSTEM*

This is the collection of public, private and voluntary entities, as well as individuals and informal associations, that contribute to the public's health within a jurisdiction.



### **OBJECTIVES**

An objective is a measurable target that describes specific end results that a service or program is expected to accomplish within a given time period. Objectives are time-bound and quantifiable or verifiable. They are action-oriented and focus on results. They help you track progress toward achieving your goals and carrying out your mission.

### **STAKEHOLDER**

A stakeholder is anybody who can affect or is affected by an organization, strategy or project. Stakeholders can be internal or external.

### **STEERING COMMITTEE**

This is the group that gives the MAPP process direction. The Steering Committee serves in a similar function as a board of directors and is representative of the local public health system. For this CHIP, the Steering Committee is the 100% Health Community Coalition Executive Committee.

### **STRATEGIES**

Strategies are patterns of action, decisions, and policies that guide a local public health system toward a vision or goal.

### **STRATEGIC PLANNING**

Strategic planning is continuous and systematic process whereby an organization or coalition makes decisions about its future, develops the necessary procedures and operations to achieve that future, and determines how success is to be measured.

### **MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)**

This is a community-wide strategic planning process for improving public health.

### **NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS (NACCHO)**

NACCHO's vision is health, equity, and security for all people in their communities through public health policies and services. NACCHO's mission is to be a leader, partner, catalyst, and voice for local health departments in order to ensure the conditions that promote health and equity, combat disease, and improve the quality and length of all lives.

### **OUTCOME**

Outcome means a change, or lack of change, in the health of a defined population that is related to a public health intervention. A health status outcome is a change, or lack of change, in physical or mental status.

### **PERFORMANCE MEASURE**

A performance measure is the specific quantitative representation of a capacity, process, or outcome deemed relevant to the assessment of performance.

### **PUBLIC HEALTH**

This is the science and the art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease; and the development of the social machinery to ensure to every individual in the community a standard of living adequate for the maintenance of health.



### *QUALITY OF LIFE*

While some dimensions of quality of life can be quantified using indicators that research has shown to be related to determinants of health and community wellbeing, other valid dimensions of quality of life include the perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life.

### *SOCIAL DETERMINANTS OF HEALTH*

Social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. They include the social environment, physical environment, and health services.

### *SOCIOECONOMIC CHARACTERISTICS*

Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education, and employment, and the proportion of the population represented by various levels of these variables.

### *STAKEHOLDERS*

All persons, agencies, and organizations with an investment or “stake” in the health of the community and the local public health system. This broad definition includes persons and organizations that benefit from and/or participate in the delivery of services that promote the public’s health and overall wellbeing.

### *STRATEGIC ISSUE*

Strategic issues are those fundamental policy choices or critical challenges that must be addressed for a community to achieve its vision.

### *STRATEGIC PLAN*

This is a plan resulting from a deliberate decision-making process that defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward.

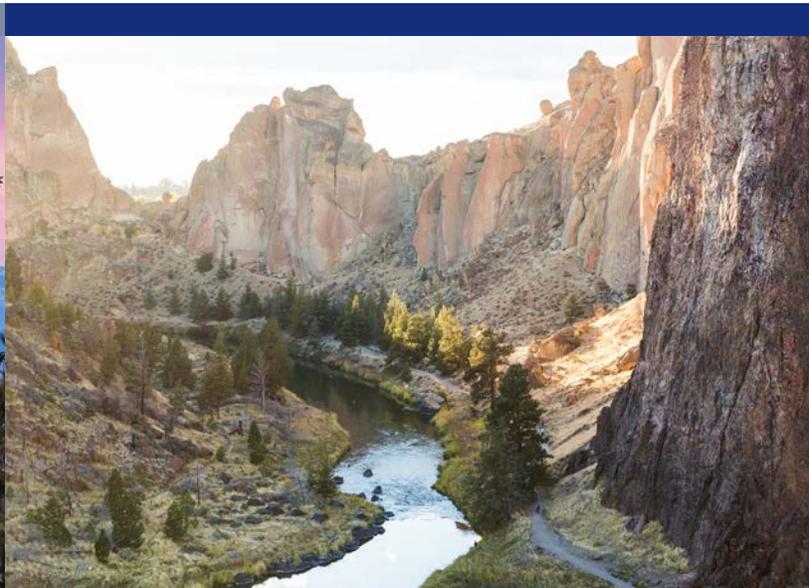
### *VISIONING*

During Phase Two, Visioning, those who work, learn, live, and play in the MAPP community (Lane County, Oregon) create a common understanding of what it would like to achieve. The community decides the vision, which is the focus of the MAPP process.



# 2016-2019

## CENTRAL OREGON REGIONAL HEALTH IMPROVEMENT PLAN



# A Message from the Central Oregon Health Council Board of Directors

Central Oregon health system partners are making important strides to improve the health of residents. These strides will continue to be facilitated by partnerships among healthcare providers, local governments, educators, community-based and non-profit organizations, citizen groups and other entities in the region. To further our vision of a healthier Central Oregon, regional partners have collaborated to create the Central Oregon Regional Health Improvement Plan (RHIP).

The nature of Central Oregon's economy varies among and within communities and the region is sensitive to fluctuations in the state and national economic conditions. In Central Oregon, many people enjoy an elevated quality of life, experience the natural beauty of the great outdoors, and pursue their dreams. Creating a healthier Central Oregon is critical to our region's continued success. This plan offers a roadmap through which this can be achieved.

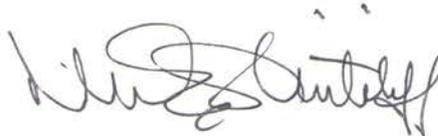
As the Central Oregon Health Council (COHC) Board of Directors, we are committed to the following:

- Pursuing the priorities, goals and strategies described in this plan.
- Continuing to build a health system that supports these priorities and meets the needs of our region.
- Aligning plans of our respective organizations with the priorities and goals of the RHIP.
- Facilitating partnerships to achieve these goals.

To the extent these goals are achieved, there will be a healthier Central Oregon and healthier citizens to enjoy the special place in which we live, work, and play!



Tammy Baney, Chair  
Commissioner, Deschutes County



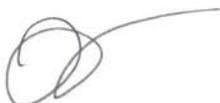
Mike Shirtcliff, DMD, Vice Chair  
President, Advantage Dental



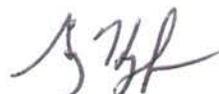
Mike Ahern  
Commissioner, Jefferson County



Ken Fahlgren  
Commissioner, Crook County



Megan Haase, FNP  
CEO, Mosaic Medical



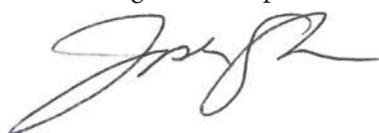
Greg Hagfors  
Chair Finance Committee  
CEO, Bend Memorial Clinic



Stephen Mann, DO  
Chair, Provider Engagement Panel  
Central Oregon IPA Representative



Linda McCoy  
Chair, Community Advisory Council



Joseph Sluka  
CEO, St. Charles Health System



Dan Stevens  
Executive VP, PacificSource Health Plans

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<b>Christine Pierson</b>	Medical Director (PEP Member)	Mosaic Medical
<b>Christy McLeod</b>	Chief Operating Officer (OPs Member)	Bend Memorial Clinic
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<b>Heather Simmons</b>	Dental Services Program Manager	PacificSource Community Solutions
<b>Jane Smilie</b>	Director (OPs Member)	Deschutes County Health Services
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<b>Jeff White</b>	(CAC Member)	Community Advisory Council
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<b>Joseph Sluka</b>	President and Chief Executive Officer (Board Member)	St. Charles Health System
<b>Julie Rychard</b>	Personal Agent (CAC Member)	Full Access High Desert
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<b>Megan Haase</b>	Chief Executive Officer (Board Member)	Mosaic Medical
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<b>Mike Ahern</b>	Commissioner (Board Member)	Jefferson County
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<b>Mike Shirtcliff</b>	President (Board Member)	Advantage Dental
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<b>Nikole Zogg</b>	Central Oregon Regional Manager (OPs Member)	Advantage Dental
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<b>Paul Andrews</b>	Deputy Superintendent (OPs Member)	High Desert Education Service District
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<b>Rebeckah Berry</b>	Operations and Project Manager	Central Oregon Health Council
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<b>Rick Koch</b>	Director of Echocardiography	Bend Memorial Clinic
<b>Rick Treleaven</b>	Executive Director (OPs Co-Chair)	BestCare Treatment Services
<b>Robert Ross</b>	Medical Director of Community Health Strategy (PEP Member)	St. Charles Medical Group
<b>Robin Henderson</b>	Chief Behavioral Health Officer & Vice-President of Strategic Integration (OPs Member)	St. Charles Health System
<b>Sarah Worthington</b>	Chronic Disease Program Manager	Deschutes County Health Services
<b>Scott Willard</b>	Executive Director (OPs Member)	Lutheran Social Services
<b>Sean Ferrell</b>	Program Manager (CAC Member)	Forest Service
<b>Sharity Ludwig</b>	Director of Community Dental Programs (PEP Member)	Advantage Dental
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<b>Tom Machala</b>	Public Health Director (OPs Member)	Jefferson County Health Department
<b>Wade Miller</b>	Chief Executive Officer (OPs Member)	COPA

# Introduction

## What is a Health Improvement Plan?

The Centers for Disease Control and Prevention defines a health improvement plan as “a long-term, systematic effort to address public health problems on the basis of the results of health assessment activities and the health improvement process.” System partners to address priorities coordinate efforts and target resources will use the Central Oregon Regional Health Improvement Plan (RHIP). A health improvement plan is critical for developing policies and taking actions that promote health. It defines the vision for the health of the community through a collaborative process and offers strategies to improve the health status of that community.

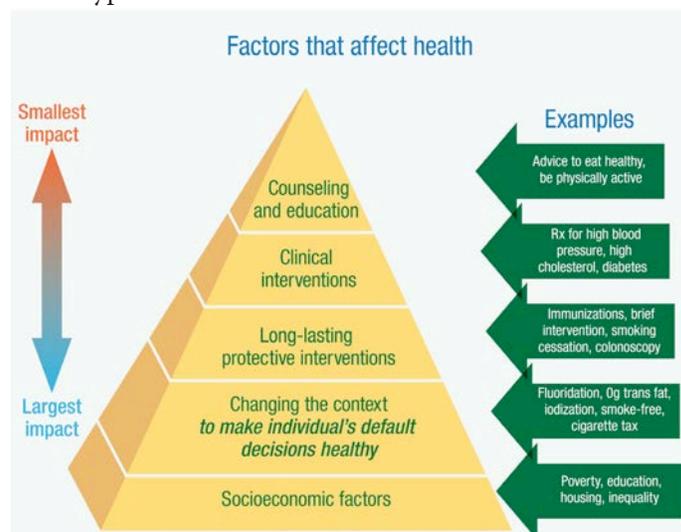
In 2015, Central Oregon health system partners created the Central Oregon Regional Health Assessment (RHA). A health assessment gives organizations comprehensive information about the community’s current health status, needs, and issues. This information provided the central guidance for creation of this health improvement plan.

Benefits of a health assessment and improvement process and plan include:

- Improved organizational and community coordination and collaboration
- Increased knowledge about health and the interconnectedness of activities
- Strengthened partnerships within local health systems
- Identified strengths, weaknesses, and gaps to address quality improvement efforts
- Measured benchmarks for public health and healthcare practice improvement

## Factors that Affect Health

A person’s health is determined largely by social and economic factors, although prevention and healthcare services contribute substantially to maintaining health. According to the World Health Organization (1948), “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” Where we live, go to school, and work affects our overall health, as does the safety and livability of our communities, whether we are economically stable or struggling to get by, and whether we have strong social connections. These factors are called social determinants of health and help explain why certain segments of the population experience better health outcomes than others. They also explain how external factors influence our ability to live healthy. The public health and healthcare systems implement strategies on multiple levels to improve the health of individuals and families, as well as the population at large. The five-tier pyramid, shown below, illustrates how different types of interventions affect health.



Source: Thomas R. Frieden, MD, MPH. A Framework for Public Health Action: The Health Impact Period. American Journal of Public Health. 2010 April; 100(4): 509-595. Doi:10.2105/ALPH.2009.185652 PMCCID: PMC2836340

# Introduction

## Factors that Affect Health (continued)

The Central Oregon RHIP necessarily incorporates strategies from all levels of the pyramid. Interventions in the top two tiers of the pyramid commonly occur in a healthcare setting. These interventions are essential to protect and improve an individual's health, but they often have a limited impact on the population's achievement of optimal health.

Interventions in the middle and at the base of the pyramid are geared toward improving the health of the entire population by focusing on prevention, making health resources readily available, ensuring the healthcare system is equipped to address health needs, and enacting policy that makes healthy choices the default and addressing socioeconomic factors that affect health. These interventions can have the greatest potential to affect health because they influence the entire population, in contrast to focusing on one individual at a time. However, it may take generations to see the effects of interventions designed to change socioeconomic factors.

## Clinical-Community Linkages

Clinical-community linkages receive special attention because they are required to ensure the success of strategies identified in the RHIP. The Agency for Healthcare Research and Quality (AHRQ) recommends clinical-community linkages that help to connect healthcare providers, community organizations, and public health agencies. Creating sustainable, effective linkages between the clinical and community settings can improve patients' access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live. These linkages connect clinical providers, community organizations, and public health agencies.

The goals of clinical-community linkages include:

- Coordinating healthcare delivery, public health, and community-based activities to promote healthy behavior.
- Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services.
- Promoting patient, family, and community involvement in strategic planning and improvement activities

Strategies that improve access to clinical preventive services (such as screening and counseling), community-level activities, and appropriate medical treatment have been shown to reduce and prevent disease in communities.

# Introduction

## Community Input

The Operations Council of the Central Oregon Health Council (COHC) used a community driven strategic planning process, “Mobilizing for Action through Planning and Partnership (MAPP),” to guide creation of the Central Oregon RHA and RHIP. The RHA includes data and information that describes the health status of Central Oregon residents. Input on the assessment was solicited from the COHC’s Board of Directors, Community Advisory Council, Provider Engagement Panel, county and regional health-related advisory boards and groups, and during community meetings in Crook, Deschutes, and Jefferson counties. During June through August 2015, partners completed a series of regional community and professional meetings to understand community, partner, and stakeholder perceptions related to health issues and forces of change that influence Central Oregon. The input and information gathered from these meetings established the RHIP priority areas and laid the foundation for the plan.

Two documents summarize results of the RHA: the “2015 Central Oregon Regional Health Assessment” and “Community Conversations: Creating the Regional Health Assessment and Health Improvement Plan, 2015.” Both of these documents can be found at this link: <http://cohealthcouncil.org/regional-assessments/>.

From September through December 2015, the Operations Council developed the RHIP with input solicited from local experts, the COHC’s Board of Directors, Community Advisory Council, Provider Engagement Panel, and health-related advisory boards and groups in Crook, Deschutes, and Jefferson counties. Evidence-based goals and strategies to address the priority areas were developed with input from Operations Council members, and with external expert guidance and support. These priorities, goals, and strategies became the outline for the RHIP. To ensure new information aligns with community perception, community input and collaboration will be an ongoing activity.

## How This Plan Is Organized

The health issues addressed in this plan were identified by a number of processes. Healthcare professionals and community stakeholders from the Operations Council completed the initial process with a scoring method using assessment data and information. The second process was completed by members of the Community Advisory Council using selection criteria based on intimate knowledge of communities and the region. The third process was a combined meeting with members of the COHC Board of Directors, Community Advisory Council, and the Operations Council. During this meeting these members reviewed the highest priorities from the Operations Council and the Community Advisory Council meetings. The health improvement priorities that surfaced during the joint meeting were:

- Behavioral Health (Identification & Awareness/Substance Use & Chronic Pain)
- Cardiovascular Disease
- Diabetes
- Oral Health
- Reproductive and Maternal/Child Health
- Social Determinants of Health

# Introduction

## How this Plan is Organized (continued)

The plan includes evidence-based strategies to address the health improvement priorities arranged as follows:

- Prevention/health promotion
- Clinical
- Policy
- Health equity
- Health system/access
- Childhood health

This plan has the requisite focus to ensure efforts are not so diluted as to become ineffective, but also attends to the interrelationships among the health improvement priorities selected. Arranging the plan as described above highlights where strategies impact more than one health condition and where addressing one health behavior can impact more than one health condition. For example, a prevention and health promotion strategy in Behavioral Health Identification and Awareness is alcohol, tobacco, and other drug health curriculum consistently and accurately being taught in schools to align with Oregon Department of Education (ODE) standards for health and evidence-based practice. This strategy aligns with prevention and health promotion efforts for cardiovascular disease as well, due to the linkages between tobacco and cardiovascular disease. Furthermore, while the plan focuses on specific priorities, the final chapter emphasizes the need to address the broader social determinants of health, where we have the greatest potential to impact the health of the entire population and “whole person” health.

Implementation of the plan will require further integration of public health, healthcare, behavioral health and human services at the individual, provider, system, community and regional levels. It is also intended to encourage positive change in our delivery systems to improve access, encourage efficiency, improve quality, and achieve measurable improvements in health outcomes.

The COHC did not identify workforce development as a priority area of the RHIP—largely because it is implicit in all of the work outlined in this guiding document. The COHC acknowledges that none of the work proposed in the RHIP to address regional health improvement priorities or address social determinants of health will be possible without the work conducted by community partners to recruit, train, and educate employees. The COHC, working by and through its community partners, is eager to participate in efforts to expand workforce development opportunities. It is not possible to overstate the connection between stable and living wage jobs for a well-developed workforce and a healthier Central Oregon.

## Implementation and Accountability

The RHIP includes specific measurable health indicators for each of the priority areas that will be addressed from 2016 through 2019. This will allow us to track our progress, celebrate achievements, and change course when desired outcomes are not being met.

- 9 Work plans with specific timelines will guide implementation of strategies and will document progress made. The COHC and its committees will take the lead on implementing and tracking progress and will provide updates to the community. Further, regional health system partners have committed to use the RHIP as a guiding document for developing their organization-specific strategic plans.

# Behavioral Health Identification and Awareness

## The Problem

Stigma and the lack of integrated care pathways lead to a dramatic under-assessment and treatment of behavioral health issues in primary care settings.

There is considerable overlap between poor outcomes for chronic diseases and significant mental health and substance use problems. Approaches for preventing or treating chronic diseases need to address the whole person and their environment, particularly targeting screenings and support for mental health and substance use issues. Per capita costs among Medicaid-only beneficiaries with disabilities for coronary heart disease is nearly triple for people who also have co-occurring mental health and substance use disorders (SUDs) compared with people without either (Boyd, et al., 2010). Per capita costs are 3.8 times higher for diabetics with co-occurring mental health and substance use disorders than for diabetics with neither mental health nor substance use disorders (Boyd, et al., 2010). Individuals with depression average twice as many visits to their primary care doctor than do non-depressed patients and have nearly twice the annual healthcare costs. (Mauer & Jarvis, 2010).

The risk factors for depression and chronic diseases are bi-directional, with chronic diseases increasing the risk of depression, and conversely, depression increasing the risk of chronic diseases. Depression and unhealthy alcohol use is present in a significant percentage of people with diabetes and cardiovascular disorders. Depression has been proven to be such a risk factor in cardiac disease that the American Heart Association has recommended that all cardiac patients be screened for depression (AHA 2008). The presence of Type 2 diabetes nearly doubles an individual's risk of depression and an estimated 28.5% of diabetic patients meet criteria for clinical depression (Mauer & Jarvis, 2010). People with mental illness, substance use disorders (SUDs), or both are at increased risk for developing diabetes. Untreated behavioral health disorders can exacerbate diabetes symptoms and complications. In addition, companion features of behavioral health disorders – such as poor self-care, improper nutrition, reduced physical activity, and increased barriers to preventive or primary care – can adversely affect management of co-occurring diabetes (SAMHSA Advisory, 2013).

The majority of people who use alcohol at levels that impact their physical health and behavioral health do not meet dependency criteria and are inappropriate for specialty treatment programs. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice that targets patients in primary care with nondependent substance use. It is a strategy for intervention prior to the need for more extensive or specialized treatment. The utilization rate of SBIRT in Central Oregon remains at a fraction of the State benchmark, blunting the impact of this evidence-based practice. When primary care practitioners do identify a severe substance use disorder in a patient, the rate of successful referral to specialty SUD care remains very low, mainly due to low readiness-to-change in the patient, no system to develop the motivation, and close collaboration necessary for a successful treatment referral.

# Behavioral Health Identification and Awareness

## Goals

### Clinical Goals

1. Increase screenings for depression, anxiety, suicidal ideation, and substance use disorders.
2. When screenings are positive, increase and improve primary care-based interventions, and, when appropriate, referrals and successful engagement in specialty services.

### Prevention Goal

Normalize the public's perception of accessing resources for depression, anxiety, suicidal ideation, and substance use.

Health Indicators by 2019	QIM Measure	State Measure	HP 2020
1. Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015).	✓		
2. Number of Depression screenings and follow-up care provided in healthcare settings shall exceed 25% (Oregon Health Authority, 2015).	✓		
3. First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement benchmarks.			

## Action Area Strategy

### Prevention and Health Promotion

- Implement a program like the “Mind Your Mind” campaign.
- Social/emotional health curriculum taught in schools aligned with Oregon Department of Education (ODE) standards for health and evidence based practice.
- Alcohol, tobacco, and other drug health curriculum taught in schools aligned with ODE standards for health and evidence based practice.
- Implement a low risk drinking guideline (compliment to SBIRT) in the community.

# Behavioral Health Identification and Awareness

## Action Area Strategy

### Clinical

- Create a comprehensive identification and response system that is reflective of the entire primary care practice (from appointment scheduling to office visit).
- Use SBIRT/CRAFFT, PHQ 2 & 9, GAD-7, and other evidence-based screening tools within healthcare settings.
- Create a common response matrix that clinics could adopt, including physician intervention, BHC intervention, short-term BH intervention at PCP clinic, and referral to specialty BH services.
- Create pathway/mapping for referral to specialty care.
- Create clear referral and communication protocols.
- Health information shared with primary care coordination team for review and provider follow up.
- Ongoing regional trainings in screening tools and brief intervention response.

### Policy

- Promote policies that support routine screening and follow-up care for Substance Use, depression and anxiety.
- Promote policies that support public awareness and acceptance of mental health and substance use wellness strategies.

### Health Equity

- Screenings, interventions, and specialty services need to be culturally and linguistically specific in order to be successful.
- Please refer to the chapter on social determinants of health for additional strategies.

### Health System/ Access

- The creation of a common response matrix to screenings (i.e., brief provider intervention, BHC, or referral to specialty clinic) will improve the number of screenings and spread the cost-effective utilization of behavioral health interventions in healthcare settings.
- Increased public awareness of the role of behavioral health wellness in overall wellness will improve patient acceptance of behavioral health screenings.
- Assessment of resource needs within the community that will be addressed in partnership through multiple organizations, such as payees, public health, hospital, etc.

# Behavioral Health Identification and Awareness

## Action Area Strategy

### Childhood Health

- Substance use and depression are significant contributors to poor childhood health. Regular screening and follow-up care will increase childhood health outcomes.

## Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School boards
- Places of worship
- Employers
- Colleges
- Addictions and treatment centers
- State health promotion and prevention programs



# Behavioral Health

## Substance Use and Chronic Pain

### The Problem

People with severe Substance Use Disorders (SUDs) also carry a high medical burden and respond poorly to medical interventions, leading to extremely high utilization rates. The current disjointed practice pattern between medical care and specialty SUD services actually contributes to poor medical and behavioral health outcomes and increases the number of people with Opioid Use Disorder.

In a large-scale review of adult Medicaid beneficiaries in six states in 1999, between 16% and 40% of beneficiaries had diagnoses of moderate to severe substance use disorders (SUDs). In all states SUDs, were associated with higher rates of hospitalization for inpatient psychiatric and medical care. Importantly, beginning at age 50, medical costs for persons with SUDs almost doubled (Clark, Samnaliev, & McGovern, 2009). People with moderate-to-severe SUDs have nine times greater risk of congestive heart failure (Mertons, et al., 2003), likely due to poor nutrition, little exercise, and high rates of smoking in combination with the impact of their substance use. The comorbid combination of alcohol abuse, depression, and diabetes is often common in homeless and Native American populations (Am Indian Alsk Native Mental Health Rev, 2007). According to a 2008 study by the Oregon Division of Addiction and Mental Health, people with co-occurring mental health and SUDs have an average age at death of 45 years. Providing SUD treatment to those who need it has been shown to slow disease progression and growth in medical costs (Mancuso & Felver, 2010).

There has been a dramatic increase in opioid prescription drug availability over the past 15 years, which has resulted in an equally dramatic increase in prescription drug abuse and the related increase in heroin use in Central Oregon. In this manner, prescription practices by physicians can have serious public health consequences. The opioid-related unintentional prescription drug mortality rate has tripled in Oregon since 2000. The 5-year average age-adjusted opioid-related unintentional prescription drug mortality rate in Central Oregon was 3.6/100,000 population (95% CI 2.5-5.1) (CDC Wonder, 2009-2013). The 5-year average rate in Oregon during this time period was 4.1/100,000 population (95% CI 3.8-4.4). Injection drug users are the largest single risk group for Hepatitis C (CDC Surveillance for Viral Hepatitis 2013). Surveys have indicated that within one year of use, 50-80% of injection drug users test positive for the Hepatitis C antibody. Nationally, there was a 151.5% increase in acute Hepatitis C cases from 2010 to 2013, largely attributed to drug use (CDC 2013). With Central Oregon experiencing a significant increase in prescription opiate and heroin use, the region can expect to see an increase in Hepatitis C rates. Finding alternative resources to opioids for people suffering from chronic, non-cancer pain is one of the highest priorities identified by local physicians. To decrease the chronic over-availability of prescription opiates in our community requires, in part, providing evidence-based holistic approaches to chronic, non-cancer pain.

# Behavioral Health Substance Use and Chronic Pain

## Goals

### Clinical Goal

Create a bi-directional integration approach for people with severe substance use disorders.

### Prevention Goal

Implement a community standard for appropriate and responsible prescribing of Opioids and Benzodiazepines.

Health Indicators by 2019	QIM Measure	State Measure	HP 2020
1. Increase the rate of successful referrals from medical settings to specialty SUD services of people with moderate-to-severe SUDs.			✓
2. First year develop a baseline on the pharmacy, hospital, acute psychiatric, and emergency department expense related to people with moderate-to-severe SUDs. Second year set performance improvement benchmarks.		✓	
3. First year develop a baseline for number of people receiving greater than 120 mg morphine equivalent for more than three months.		✓	

## Action Area Strategy

### Prevention and Health Promotion

- Expand Prescription Drug Monitoring Program (PDMP) use by primary care providers.
- Develop plan for implementing alternative & complimentary pain treatment therapy.
- Compassionate care education for community providers.
- Expand needle exchange programs.
- Expand the availability of Naloxone.
- Expand medication disposal programs.
- Develop a process and care path for affected family and children to impact ACEs and behavioral health factors.

# Behavioral Health Substance Use and Chronic Pain

## Action Area Strategy

### Clinical

- Develop high functioning patient pathways from hospital and primary care settings into SUD specialty care.
- Create a “Hub and Spoke” model for Medically Assisted Treatment (MAT) that links the MAT specialty provider with (a) other SUD and mental health providers, and (b) primary care providers.
- Create an efficient, effective, and coordinated system of outreach, engagement, and care coordination services to medically significant populations, including: pregnant women who still use drugs, people who use illicit IV drugs, identified high utilizers of medical and pharmacy services, identified utilizers of mental health acute care services, and identified hospital patients.
- Provision of cost-effective medical/nursing support and alternative chronic pain management/chronic disease management skills training in selected SUD specialty care programs.
- Implementation of an outcomes system for each of the above four strategies focused on engagement and retention in specialty SUD services and on patterns of healthcare utilization.

### Policy

- Support the efforts of the Chronic Pain Task Force to educate physicians to best practice standards and to support alternative pain management strategies.
- Advocate with OHA to make alternative and complimentary pain treatment therapy a reimbursable service.
- Support legislation to make Naloxone available through the pharmacy without a physician’s prescription.
- Expand needle exchange and harm reduction education for people injecting illicit drugs.
- Expand prescription drug return programs.

### Health Equity

- Cultural and language specific treatment strategies for Latino clients.
- Safe and sober housing availability.
- Intentional Peer Support outreach for severely disadvantaged people with SUDs, including people who are homeless, Native American public inebriates, IV drug users, and pregnant women who use drugs.
- Support employment strategies for people with criminal records.
- Please refer to the chapter on social determinants of health for additional strategies.

# Behavioral Health Substance Use and Chronic Pain

## Action Area Strategy

### Health System/ Access

- Make available SUD engagement services at hospitals and primary care clinics.
- Identification of clients in SUD services who have high medical burden and develop, with the PCP, a whole healthcare and support plan.
- Development of alternative and complementary pain programs widely available in the community.
- Develop a community care plan for impacted children and family.

### Childhood Health

- Substance use is a significant predictor to all of the Adverse Childhood Events (ACEs). Treating the parent, who has a severe substance use disorder, decreases the number of ACEs a child experiences and increases that child's resiliency, thus improving long-term health status.

## Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School boards
- Places of worship
- Employers
- Colleges
- Addictions and treatment centers
- State health promotion and prevention programs
- Sheriff and Police Departments in Central Oregon



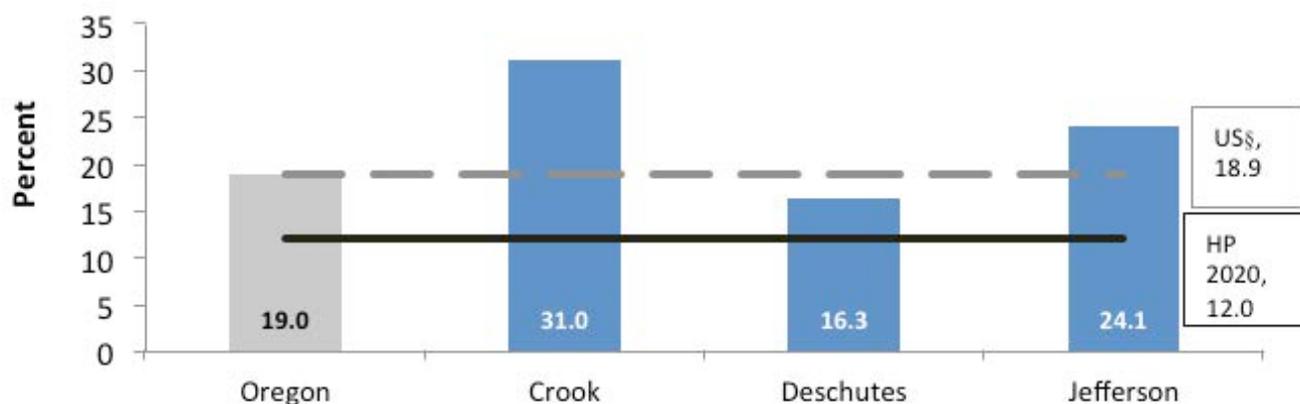
# Cardiovascular Disease

## The Problem

Cardiovascular disease (CVD) is a classification of diseases of the heart and blood vessels that includes chest pain, heart attack, and other conditions that affect the heart muscle, rhythm, or valves. Cardiovascular diseases are preventable with good nutrition and exercise, and by remaining tobacco free. People with cardiovascular disease or who are at high cardiovascular risk (due to the presence of one or more risk factors such as hypertension, diabetes or hyperlipidemia) need early detection and management using counseling and medications, as appropriate.

Smoking causes one of every three deaths from CVD, according to the 2014 Surgeon General’s Report on smoking and health. It is a leading cause of preventable death in the US and doubles a person’s risk for stroke (USDHHS, 2014). Nearly one in three adults in Crook County, one in six adults in Deschutes County, and one in four adults in Jefferson County report smoking tobacco.

Age-adjusted prevalence of adult current smokers (Oregon BRFSS, 2010-2013)



§National Health Interview Survey, 2011

The most common type of CVD in the United States is coronary artery disease, which affects the blood flow to the heart. It is one of the leading causes of death in Oregon and the US. In fact, among males and females admitted to St. Charles facilities in Central Oregon, 21% and 14%, respectively, were for CVD events (St. Charles Health System, 2014).

Cerebrovascular disease is another major form of CVD that affects blood flow in the brain. Stroke is one of the cerebrovascular diseases and is a leading cause of death and disability. A stroke is caused by a blood vessel breaking or an artery becoming clogged in the brain, which leads to reduced blood flow and brain damage. Knowing the signs and symptoms of stroke can save lives.

# Cardiovascular Disease

## Goals

### Clinical Goal

Improve hypertension control.

### Prevention Goal

Increase awareness of the risk factors for cardiovascular disease including tobacco use, uncontrolled hypertension, high cholesterol, obesity, physical inactivity, unhealthy diets, and diabetes.

Health Indicators by 2019	QIM Measure	State Measure	HP 2020
1. Increase the percentage of OHP participants with high blood pressure that is controlled (<140/90mmHg) from 64% to 68% (Baseline: QIM NQF 0018 - Controlling high blood pressure, 2014).	✓		✓
2. Decrease the prevalence of cigarette smoking among adults from 18% to 16% (Baseline: Oregon BRFSS, 2010-13; QIM Cigarette Smoking Prevalence).	✓		✓
3. Decrease the prevalence of smoking among 11th and 8th graders from 12% and 6%, respectively to 9% and 3%, respectively (Baseline: Oregon Healthy Teens Survey, 2013).			✓
4. Decrease the prevalence of adults who report no leisure time physical activity from 16% in Crook County, 14% in Deschutes County and 17% in Jefferson County to 14%, 12%, and 15 % respectively (Baseline: Oregon BRFSS, 2010-13).			
5. Decrease the prevalence of 11th graders and 8th graders who have zero days of physical activity from 11% and 6% to 10% and 5%, respectively (Baseline: Oregon Healthy Teens, 2013)			

## Action Area Strategy

### Prevention and Health Promotion

- Encourage healthcare providers to increase referrals, including electronic referrals, to the Oregon Tobacco Quit Line.
- Promote the Oregon Health Authority statewide Smokefree Oregon campaign for youth.
- Offer training and assistance to healthcare providers to implement “2As and R” or “5As” tobacco cessation counseling.
- Implement a community-based educational campaign on blood pressure control (i.e., Measure Up/Pressure Down).
- Engage community-based organizations (schools, dentists, colleges, employers, hospital, etc.) in an educational program/campaign around BP control and monitoring and CVD relationship.
- Engage employers to offer worksite health promotion programs that support improved employee weight status by targeting nutrition and physical activity

# Cardiovascular Health

## Action Area Strategy

### Clinical

- Implement evidence-based guidelines for the control of hypertension.
- Provide assistance to patients to self-monitor blood pressure, either alone or with additional support.
- Increase referrals to the Oregon Tobacco Quit Line.
- Implement “2As and R” or “5As” tobacco cessation counseling.

### Policy

- Implement a tobacco retail licensing program that will eliminate illegal sales to minors, prevent retailers from selling tobacco within 1000 feet of schools, raise the age of purchase to 21, and eliminate sales of flavored tobacco products.
- Increase the number of schools using the CDC School Health Index to improve their health policies and programs.
- Encourage healthy community design and policies that increase opportunities for physical activity, access to healthy foods, and other health-enhancing features.

### Health Equity

- Identify, develop and implement culturally competent materials and programs such as Smokefree Oregon ads for culturally disparate populations.
- Please refer to the chapter on social determinants of health for additional strategies.

### Childhood Health

- Engage schools to promote CVD prevention using best-practice, school-based model.

## Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School boards
- Places of worship
- Employers
- Colleges
- State health promotion and prevention programs
- Farmers markets
- Grocery stores

# Diabetes

## The Problem

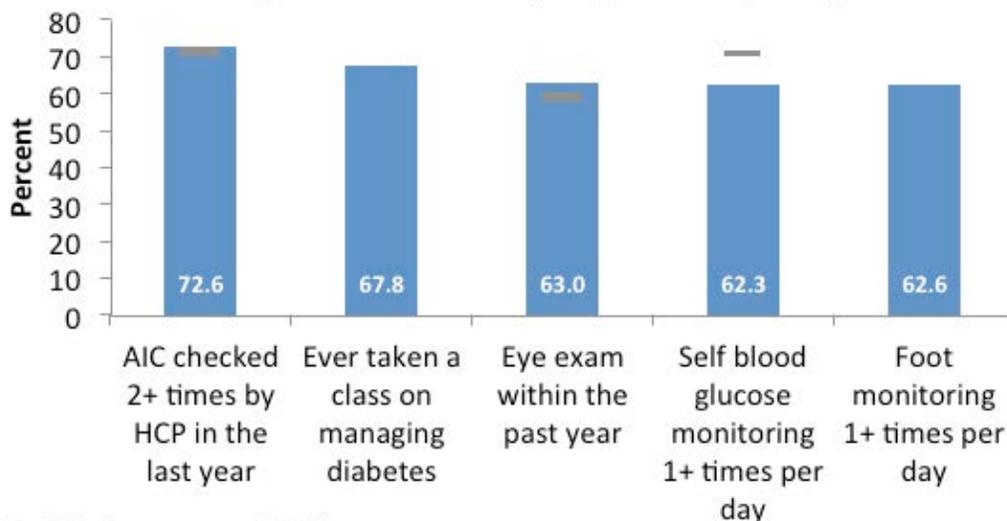
Diabetes is characterized by having high blood sugar levels and can lead to serious adverse outcomes if left untreated. There are several types of diabetes, including type 1, type 2, and gestational diabetes. Type 1 diabetes is an autoimmune disorder usually diagnosed at an early age. Type 2 diabetes, which makes up 95% of diabetes cases, is often diagnosed in adulthood (Lloyd-Jones D, et al., 2009). Gestational diabetes is a condition that affects pregnant women and often goes away once the baby is born. If left untreated, gestational diabetes may cause problems for the mother and baby. In addition, gestational diabetes puts women at increased risk for later developing type 2 diabetes. Prediabetes is a condition in which an individual has blood sugar levels that are elevated but not high enough to be considered diabetes.

In all cases, a diagnosis of diabetes has significant impacts on quality of life. If left untreated or poorly managed, diabetes can lead to major life-threatening and costly complications including kidney disease, blindness, cardiovascular disease and lower extremity amputations.

Many of the risk factors for prediabetes, diabetes and cardiovascular disease are the same and include physical inactivity, overweight/obesity, high blood pressure, tobacco use, and an unhealthy diet. This means that many individuals can focus on adopting the same healthy strategies to prevent the most common chronic health problems. Strong evidence shows that lifestyle interventions for persons at risk for developing diabetes significantly reduces risk of developing type 2 diabetes (DPP Research Group, 2009). These programs include coaching and counseling to maintain a healthy weight, increasing physical activity, eating healthy, and controlling hypertension, and can reduce the risk of developing type 2 diabetes as well as cardiovascular disease.

In Oregon, 9% of adults reported having diabetes in 2013, reflecting a doubling in prevalence over the past 20 years (Oregon Health Authority, 2015). For these adults, a key element of diabetes control is self-management education. Recent studies estimate that more than 1 out of 3 US adults (38%) – or 1 million Oregon adults have prediabetes; 9 out of 10 adults with prediabetes are not aware they have it (CDC, 2014). American Indians/Alaska Natives, African Americans and Latinos have a higher prevalence of diabetes than non-Latino Whites.

Percent of adults with diabetes who reported having received key diabetes self-management education (Oregon BRFSS, 2011)



Note: Not all measures match HP goals

— HP 2020 goal

# Diabetes

## Goals

### Clinical Goal

Improve control of type 2 diabetes.

### Prevention Goal

Decrease the proportion of adults and children at risk for developing type 2 diabetes.

Health Indicators by 2019	QIM Measure	State Measure	HP 2020
1. Decrease the prevalence of adults who are overweight (BMI 25 to 29.9) from 33% to 31% (Baseline: Oregon BRFSS 2010-13).			✓
2. Decrease the prevalence of 11th graders and 8th graders who are overweight from 14% and 16%, respectively, to 13% and 14%, respectively (Baseline: Oregon Healthy Teens, 2013).			✓
3. Decrease the percentage of OHP participants 18-75 years of age with diabetes who had HbA1c >9.0% from a baseline of 14.7% to 11% (Baseline: QIM NQF 0059 - Diabetes: HbA1c Poor Control, 2014).	✓		✓
4. Increase the percentage of OHP participants 18-75 years of age with diabetes who received an annual HbA1c test from a baseline of 77% to 87% (Baseline: NQF 0057 - Oregon State Performance Measure, 2014).	✓	✓	✓
5. Decrease the percentage of OHP participants with BMI greater than 30 from 31.5% to 30.9% (Baseline: Oregon State Core Performance Measure, MBRFSS 2014).		✓	✓

## Action Area Strategy

### Prevention and Health Promotion

- Implement a Diabetes Prevention Program (DPP).
- Increase availability of diabetes self-management programs.
- Engage employers to offer worksite health promotion programs that support improved employee weight status by targeting nutrition and physical activity.
- Partner with grocery stores and farmers markets to increase pre-diabetes and diabetes awareness programs.
- Develop targeted strategies to improve Diabetic Medication Adherence (i.e.: refrigeration, MedMinders, etc.).
- Create partnership with Parks and Recreation offices to offer peer led exercise sessions.

# Diabetes

## Action Area Strategy

### Clinical

- Increase referrals to diabetes self-management and prevention programs.
- Improve medication adherence among patients with diabetes.
- Increase postpartum screening and follow-up for patients with gestational diabetes.
- Increase the use of case management interventions for patients with diabetes with CCO support for clinic innovations.
- Improve coordination between medical and dental providers to provide the tools and education needed about the correlation between oral health and diabetes (i.e.: Dental Medical Integration (DMI) Project).

### Policy

- Increase the number of schools using the CDC School Health Index to improve their health policies and programs.

### Health Equity

- Increase provider and community referrals to the Spanish language Tomando Control chronic disease self-management program.
- Create diabetes awareness campaigns that are culturally aligned, health literate, and community specific.
- Encourage healthy community design and policies that increase opportunities for physical activity, access to healthy foods, and other health-enhancing features.
- Please refer to the chapter on social determinants of health for additional strategies.

### Health System/ Access

- Engage health systems to implement systematic EHR referrals to diabetes self-management and prevention programs.
- Improve provider and community awareness of diabetes self-management programs.

### Childhood Health

- Promote coordinated school health programs that prevent risk behaviors that contribute to heart disease and stroke:
  - Maintain or establish enhanced physical education classes.
  - Prohibit withholding recess as punishment.
- Engage schools to provide evidence-based interventions to promote physical activity and nutrition education in schools.

# Diabetes

## Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- Grocery stores
- Farmers markets
- Schools (policies around PE and physical activity during school hours)
- Parks and Recreation officials
- Pharmacies
- Employers
- Health clubs
- Places of worship
- Non-profit organizations



# Oral Health

## The Problem

The health of the mouth and surrounding structures is central to a person's overall health and well-being. Dental caries (cavities) is a communicable infectious disease most frequently caused by the bacterium *Streptococcus mutans*. Preventing the transmission from one person to another or controlling bacteria load in the mouth is possible and can eliminate or decrease tooth decay.

Dental caries is the most common chronic disease among children and is 5 times more common than asthma (American Academy of Pediatric Dentistry, n.d.). Untreated decay or other oral health problems in children can result in attention deficits, learning and behavior challenges in school, and problems speaking, sleeping and eating (The California Society of Pediatric Dentistry and California Dental Association, n.d.). In Central Oregon, one-quarter to one-half of first and second graders that were screened in selected Central Oregon schools had untreated tooth decay (Kemple Memorial Children's Dental Clinic, n.d.). Moreover, between 71.7% and 76.3% of Central Oregon 8th graders reported having at least one cavity, and between 4.8% and 6.4% missed one or more hours of school due to going to the dentist because of tooth or mouth pain (Oregon Health Authority, 2015).

Among adults, poor oral health may negatively affect a person's ability to obtain or keep a job and form relationships (National Institute of Dental and Craniofacial Research, 2000). In Central Oregon, one safety net clinic reported 40% of low-income patients seeking care for their physical health had dental issues that impacted their ability to eat or sleep (Volunteers in Medicine, 2013). Nationally, employed adults lose more than 164 million hours of work each year due to dental disease and dental visits (Centers for Disease Control and Prevention, 2006). Poor oral health is also associated with adverse pregnancy outcomes and other disease and conditions such as diabetes, cardiovascular disease, stroke and respiratory disease (National Institute of Dental and Craniofacial Research, 2000). Limited data exists regarding the older population but the 2014 Strategic Plan for Oral Health states that 33% of Oregonians ages 33-44 still have all of their teeth, while 37% of individuals age 65 and over have lost six or more teeth (Oregon Oral Health Coalition, 2014). Minorities and low-income populations are significantly more likely to report oral health problems (World Health Organization, 2012).

# Oral Health

## Goals

### Clinical Goal

Improve oral health for pre and post-natal women.

### Prevention Goal

Keep children cavity-free.

Health Indicators by 2019	QIM Measure	State Measure	HP 2020
1. By 2019, increase the percent of pre and postnatal women who had a dental visit from 55.2% to 60% (Baseline: PRAMS, 2011).			✓
2. By 2019, increase the percent of children 6-14 years who received a dental sealant to 20% (Baseline: Oregon Health Authority, 2015).	✓	✓	✓
3. By 2019, decrease the percent of 1st and 2nd graders with untreated dental decay in schools that participate in the School Dental Sealant Program by 5% (Baseline: School Dental Sealant Program, 2013-2014).			✓
4. By 2019, decrease the percent of 8th graders who missed one or more hours of school due to going to the dentist because of tooth or mouth pain by 0.5% (Baseline: Oregon Health Teens Survey, 2013).			
5. By 2019, increase the percent of children 0-5 years who received a dental service within the reporting year to 40% (Baseline: PRAMS, 2011).			✓

## Action Area Strategy

### Prevention and Health Promotion

- Partner Dental Care Organizations (DCOs) with pediatricians to provide post-natal moms with oral hygiene instruction and 90 day supply of xylitol at two-week post-natal visit.
- Provide education to providers asking the One Key Question® regarding importance of a dental visit prior to pregnancy.
- Decrease fear of the dentist by increasing provider awareness of Adverse Childhood Experiences (ACEs).
- Work with schools to ensure children receive toothbrush kits on a regular basis.
- Work with community-based entities to increase outreach, education, and intervention to underserved individuals.
- Assess oral health literacy.
- Implement Brush, Book, Bed (AAP).
- Provide nutrition counseling.
- Provide tobacco cessation resources.

# Oral Health

## Action Area Strategy

### Clinical

- Patients who indicate they plan to get pregnant in the next year get referred into dental care.
- Deliver preventive dental services to children and pregnant women in non-traditional settings.
- Primary care clinician prescribes oral fluoride supplementation starting at 6 months of age for children whose water supply is deficient in fluoride.
- Primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

### Policy

- Develop policies and practices to fast track pregnant women into dental care.
- Work with legislators to include fluoridated toothpaste in the SNAP benefits.
- Work with legislators to get fluoridated toothpaste to be covered as a prescription benefit for OHP members.
- Adopt trauma-informed care model policies within dental practices.
- Adopt a policy to see patients in the first year of life within dental practices.
- Establish optimally fluoridated community water systems.

### Health Equity

- Business practices and services will be culturally and linguistically competent in all dental locations.
- Please refer to the chapter on social determinants of health for additional strategies.

### Health System/ Access

- Integrate oral healthcare into the standard practice of care for all healthcare settings.
- All providers, including school-based health centers, shall adopt a minimum of two questions to assess oral health status and refer as appropriate.
- All primary care providers and primary care dentists shall adopt the One Key Question® and make appropriate referrals based on intent to become pregnant.
- All primary care providers, behavioral health professionals, and primary care dentists will administer or have knowledge of their patients' ACEs score.
- OB/GYN practices shall adopt policies/practices to assess oral health and refer to care.
- Expand comprehensive community-based oral health.
- Expand First Tooth program beyond clinic providers to include home visitors and lay persons such as licensed childcare workers and school nurses.

# Oral Health

## Action Area Strategy

### Childhood Health

- See previous Oral Health Action Areas and Strategies that address Childhood Health through their efforts.

## Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School boards
- Places of worship
- Employers
- Colleges
- State health promotion and prevention programs



# Reproductive & Maternal Child Health

## The Problem

Maternal and child health indicators describe the health and well-being of mothers, infants, children, and families. A mother's health and well-being before, during, and after pregnancy has direct and sometimes lifelong effects on the health of her child.

As a focus of maternal child health, low birth weight (LBW) is a serious public health challenge. Babies who have very LBW can be at higher risk of death and other complications as they grow up. LBW infants are more likely to die before their first birthday and more likely to suffer from cognitive development issues and chronic health conditions, such as high blood pressure and asthma. The problems associated with LBW also continue into adulthood: Compared to their peers, LBW individuals attain less education and earn less income. LBW is associated with tobacco, alcohol, and drug use; lack of early prenatal care, lack of maintaining a healthy weight.

In Central Oregon, 77.9% of infants received prenatal care in the first trimester as compared to 77.8% in Oregon (OHA – Performance Measures, 2015). Differences between the counties in 2014 show Deschutes at 81%, Crook at 70.4%, and Jefferson at 68.5% (OHA, 2014). Timeliness of prenatal care is a current quality incentive measure for the CCO.

The rate per 1000 for smoking during pregnancy was six times higher among women enrolled in OHP in Central Oregon than those with private insurance as demonstrated by the inset table.

**Table 1. Percent of women on OHP versus private insurance who smoked during pregnancy**

	Oregon	Crook	Deschutes	Jefferson	Central Oregon
OHP	19.1	28	17.7	14.4	17.9
Private	3.9	6.6	2.5	3.1	2.8

Cigarette smoking prevalence is a 2016 CCO quality incentive measure.

Unintended pregnancy refers to pregnancies that are mistimed, unplanned, or unwanted. About 51% of pregnancies in the United States are unintended (Guttmacher Institute, 2015). Measuring rates of unintended pregnancy helps gauge a population's needs for contraception and family planning. Unintended pregnancy is associated with increased risk of health problems for the baby as the mother may not be in good health or delay prenatal care upon learning of the pregnancy. Almost 50% of pregnancies in Oregon are unintended, and have been for more than three decades (Finer & Kost, 2011). In 2011, the most recent year for which there is state-level data on pregnancy intentions, there were 45,136 births, 37% of which were considered unintended. That year there were 9,567 elective abortions. Also in 2011, the unintended pregnancy rate was 36.6% for Oregon, 38.8% for Central Oregon, 37.7% for Deschutes County, and 35.3% for Jefferson County. The total unweighted denominator for Crook County was too small to report. (OHA, 2011; PRAMS, 2011).

A published study in 2013 found that Medicaid paid for approximately 63% of unintended births in Oregon (Sonfield & Kost, 2013). Among women ages 19 and younger, more than four out of five pregnancies were unintended. The proportion of unintended pregnancies is highest among teens younger than 15 years, with 98 percent of these pregnancies being unintended (Finer and Zolna, 2014).

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Immunizations are a key public health measure for preventing the spread of disease. A series of immunizations are delivered to children to ensure their immunity to many diseases. The trend over the past few years has shown a decrease in the immunization rates and there have been outbreaks throughout the nation. Central Oregon's rates have decreased to a point of concern. As noted in the 2015 Regional Health Assessment, two-year-olds in Jefferson County were more frequently up to date with immunizations than were two-year-olds in Crook and Deschutes County. Central Oregon practices and public health departments who provide vaccinations should assess and develop approaches to increase immunization rates in their practices to improve the health of Central Oregon children.

# Reproductive & Maternal Child Health

## Goals

### Clinical Goal

Reduce the prevalence of low birth weight among live-born infants by improving prenatal/postnatal care for mothers and infants.

### Prevention Goals

Prevent unintended pregnancies.

Improve immunization rates of children birth to two years.

Health Indicators by 2019	QIM Measure	State Measure	HP 2020
1. By 2019, increase the number of women in Central Oregon who receive prenatal care beginning in the first trimester from 86% to 90% (Baseline OHA: Performance Measures – Central Oregon Region – PS – May 2015; Oregon Health Authority 2013: Crook (77.8) Deschutes (81.0) Jefferson (66.3) (Baseline: Healthy 2020 – 70.8%).	✓	✓	✓
2. By 2019, decrease the percent of tobacco use among Central Oregon pregnant women from an average of 12.1% to 7.0% (Baseline: Oregon Health Authority Annual Report, 2013; Crook (15.0%) Deschutes (9.8%) Jefferson (11.4%) (Tobacco Smoking Prevalence – 2016 Metric).	✓		✓
3. By 2019, reduce low birth weight (LBW) (less than 2500 g {less than 5 lbs. 8 oz.}) to an incidence of no more than 5% of live-born infants in Central Oregon (Baseline: OHA, 2014; Healthy People 2020 - Goal).			✓
4. By 2019, increase effective contraceptive use among women of childbearing age in Central Oregon from 31.4% to 50% (Baseline OHA: Performance Measure – Central Oregon Region – PSCS – May 2015).	✓		✓
5. By 2019, increase the Central Oregon State Performance Measure – Child Immunization Status rate (0-24 months) (NQF 0038) from 62.1% to 80% (Baseline OHA: Performance Measure – Central Oregon Region – PS – May 2015; Immunization Rates, Oregon, 2014 (4.3.1.3.3.1.4) Crook (63%) Deschutes (60%) Jefferson (70%); Healthy People 2020 – 80%.	✓	✓	✓

# Reproductive & Maternal Child Health

## Action Area Strategy

### Prevention and Health Promotion

- Increase 2-year-old children immunization rates by implementing the Central Oregon Regional Immunization Rate Improvement Project (IRIP) in Deschutes, Crook and Jefferson County using the AFIX Program in Coordinated Care Organization (CCO) participating clinics.
- Expand prenatal and postnatal home visiting services to high-risk women in Central Oregon (NQF 1517).
- Provide home visits with the intent of educating on topics that include vaccinations, tobacco, alcohol, and key referrals for community resources.
- Screen women for their pregnancy intention on a routine basis by implementing “One Key Question® with all providers in Central Oregon.
- Support and promote contraception immediately following pregnancy.
- Provide referral to oral health services in pregnancy.
- Provide evidence-based community messaging and curricula to adolescents focusing on preventing unintended pregnancy, HIV/AIDS, and STIs.
- Ensure timely access to contraceptives and STI support.
- Support the initiation and sustainment of breastfeeding for new mothers with programs such as WIC, home visiting and “Baby-Friendly” hospitals.

### Clinical

- Screen 100% of pregnant women and refer them to appropriate medical, dental, behavioral and social services.
- Implement the “2As and R” and “5As” tobacco cessation and counseling in all healthcare settings.
- Increase referrals of pregnant women who use tobacco to the Oregon Tobacco Quit Line.

### Policy

- Promote the inclusion of age appropriate, medically accurate sexual health education in our schools (ODE, HB2509 – ORS336.455).
- Promote policies that support barrier free access to contraceptives.
- Promote policies that increase access to prenatal care with equity and rural concerns considered.
- Promote policies that support the use of LARC (long acting reversible contraceptives) as the most effective birth control option for women at highest risk for pregnancy.

- Please refer to the chapter on social determinants of health for additional strategies.

# Reproductive & Maternal Child Health

## Action Area Strategy

### Health System/ Access

- Implement universal nurse home visiting (Family Connects) as part of a regional perinatal continuum of care system in partnership with public health, primary care medical providers and the CCO.
- Expand access/marketing to improve effective contraceptive rates in primary care and public health.

### Childhood Health

- Reduce child maltreatment using evidence-based home visiting programs (i.e., Family Connects, Healthy Families) that work to improve family well-being and to reduce child maltreatment by coordinating services for high-risk families.
- Provide referrals that link clients to community services, resources and support (Early Learning Metric).

## Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School boards
- Places of worship
- Employers
- Colleges
- State health promotion and prevention programs



# Social Determinants of Health Part 1

## Education and Health

### The Problem

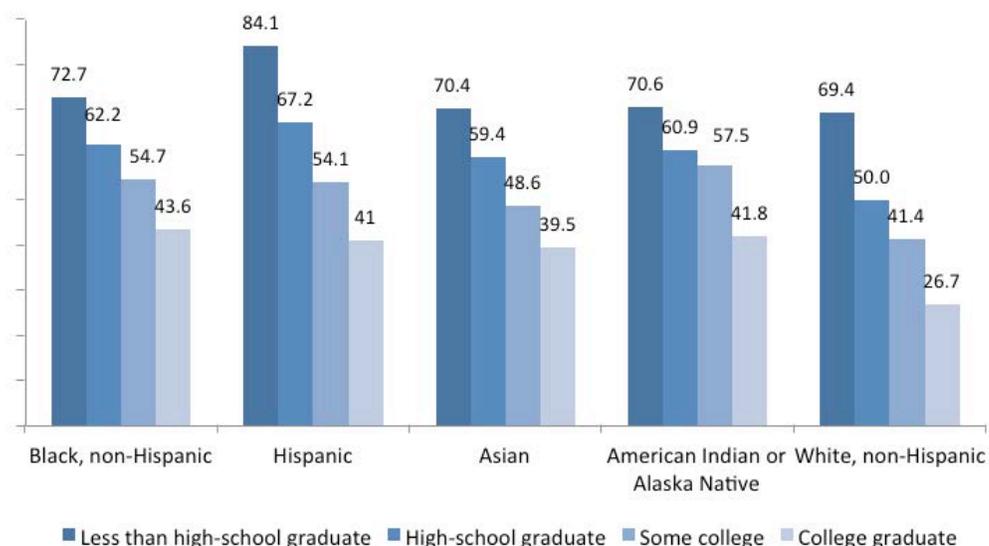
Healthy People 2020 highlights the importance of addressing the social determinants of health (SDOH) by including “create social and physical environments that promote good health for all” as one of its four overarching goals for the decade. The initiative has created a “place-based” organizing framework that categorizes SDOH into five (5) key areas:

- Economic Stability
- Education
- Social and Community Context
- Health and Healthcare
- Neighborhood and Built Environment

The SDOH span a wide range of complex and intertwined social conditions. Few, however, would argue that without a good education, people are significantly less likely to find stable employment with living-wage earnings. They are more likely to be living in poverty – which involves unstable/low-quality housing, unsafe neighborhoods, limited access to healthcare, transportation disadvantages and limited access to basic needs like affordable, healthy food (Low et al, 2005). While this is logical, what may be less intuitive is how strongly educational attainment is linked to health outcomes.

The Robert Wood Johnson Foundation, arguably the largest and most powerful think tank related to SDOH in the United States, commissioned a white paper in 2011 highlighting strong evidence that consistently connects educational attainment and health, even when other SDOH factors, such as income, are taken into account (Mirkowsky et al, 1999 and 2003). The study examined the interrelated pathways in which education is linked with health, including health knowledge and behaviors; employment and income; and social and psychological factors, including sense of control, social standing, familial context and social networks. One could conclude from this study that to impact SDOH at a population level, educational achievement should be a primary focus.

**Figure 1. Percent of adults, ages 25-74 years, in less than very good health\***

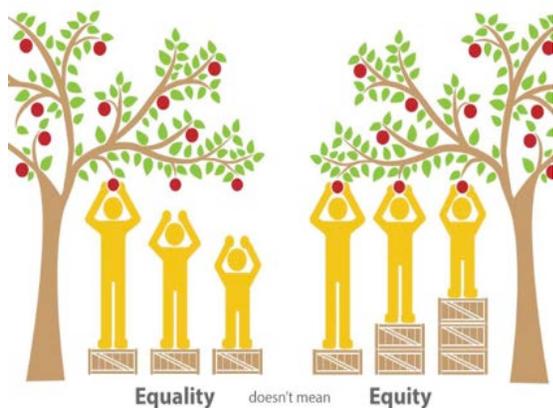


§ Source: Behavioral Risk Factor Surveillance System Survey Data, 2005-2007.  
 † Based on self-report and measured as poor, fair, good, very good or excellent.  
 \* Age-adjusted.

# Social Determinants of Health Part 1

## Education and Health

### Kindergarten Readiness and Third-grade Reading Scores



There are several early milestones that are closely linked to a child's future academic achievement. In elementary school, these include kindergarten readiness, third grade reading and fourth grade math. Data from across the states suggest that as a child's kindergarten readiness scores improve, the later milestone scores rise accordingly (Duncan et al, 2008). Furthermore, third grade reading level scores has been linked to high school graduation rates (Silver and Saunders, 2008). Both kindergarten readiness and third-grade reading are key indicators of future success because children with low scores at these milestones face a confounding learning disadvantage going forward (Maryland Department of Education, 2010).

### Equity, Disparities and Vulnerable Populations

There are a variety of SDOH factors that are barriers to educational achievement. These include adverse family context, food insecurity, culture and language differences and presence of childhood trauma (toxic stress). Though we know less education is linked with worse health across all racial and ethnic sub-groups (see Figure 1), there are populations that have different experiences and levels of exposure to these barriers.

Many school boards across Oregon struggle to meet the needs of students and families who have cultural or linguistic needs, special needs, live in poverty or have other barriers such as adverse family situations. Just as healthcare reform highlights the need for an equity lens as a key strategy, education reform has a similar calling. This focus on equity on both sides means that programs and policies aimed at outcomes such as increasing educational achievement should take all differences between and within subgroups into account and all programs should be tailored to address such differences.

In Central Oregon, geographic differences also need to be examined and any programs and efforts to address educational achievement need to be in balance with community needs and demographics. For example, the 501J School District in Jefferson County is one of the most diverse in the state. One-third of students are Latino, one-third White non-Hispanic, and one-third Native American.

### Early Childhood Adversity, Toxic Stress, and the Role of Community

Neuroscience is catching up with what we have long suspected about social determinants of health affecting children's learning and development. The original study on Adverse Childhood Experiences (ACEs) was published almost 20 years ago in collaboration between the CDC and Kaiser Permanente. Recently, growing understanding of the science behind toxic stress outcomes is generating renewed interest and investment, resulting in a push for strategies and practices that would prevent ACEs by targeting protective changes in the child's early life context. The American Academy of Pediatrics (AAP) calls these contexts "early childhood ecology." In their 2012 policy statement, the AAP states: "The effective reduction of toxic stress in young children could be advanced considerably by a broad-based, multi-sector commitment in which the profession of pediatrics plays an important role in designing, implementing, evaluating, refining, and advocating for a new generation of protective interventions."

# Social Determinants of Health Part 1

## Education and Health

### Opportunity-Connecting the Dots

Central Oregon has the right combination of state and local healthcare, community-based, public health and education system reform initiatives that if properly aligned, could have the potential to change health-shaping contexts for children and families. The following initiatives are either in development or being implemented regionally:

- Coordinated Care Organizations (CCO) – transformation of the Medicaid delivery system (60+% children, disproportionate poverty).
- Cradle to Career: Early Learning Hub/Regional Achievement Coalition (Better Together).
- Health and housing.
- Public health/primary care partnership (Perinatal Collaborative) to improve outcomes for at-risk moms, children and families.
- A growing interest in addressing Adverse Childhood Experiences (ACEs) and toxic stress (EL Hub, United Way of Deschutes County, Pacific-Source CCO).

Rather than coming at ACEs, child development and education from separate silos, what if all these stakeholders were to come together and adopt one, unified and powerful goal – that all children in Central Oregon enter kindergarten ready to learn, graduate from high school and go on to college? Given the strong and conclusive evidence that intertwines ACEs, educational achievement and long-term health, impact indicators, such as kindergarten readiness, could be easily tracked – with positive results giving us good confidence that we are removing SDOH barriers for both children and their families. Furthermore, if the perinatal population is targeted and children and their families are followed through their first 4-5 years with strong evaluation supports in place, the community will learn and improve upon how our multi-sectoral approach is performing with data and information as soon as the end of this RHIP cycle.

## COMMUNITY SPOTLIGHT

### United Way & ACES

United Way in Central Oregon is pursuing collective impact methods to heighten its impact on important social determinant needs and issues. As part of a long-term planning process, childhood trauma or Adverse Childhood Experiences (ACEs) has emerged as a critical issue of strategic importance to both United Way and its partnering agencies. The organization has initiated a broad-based effort to advance the prevention and treatment of childhood trauma. Goals include:

- Increasing awareness of ACEs and their negative impact on health and education outcomes
- Developing shared understanding and language for discussing ACEs, toxic stress, and resiliency
- Aligning agencies and programs around common goals
- Integrating trauma informed practices in programs and services
- Ensuring consistent, quality training and support for front-line workers

As a community-based organization, United Way is uniquely positioned to build the capacity of the community to address ACEs and trauma. They have a track record of community impact, as well as, competencies that include a broad-based network of partner agencies and donors, and a proven ability to raise and manage significant funds. For all these reasons, United Way will be a critical partner throughout implementation of the RHIP education and health strategy.

# Social Determinants of Health Part 1

## Education and Health

### Example Successful Cross-Sectoral Interventions

Fortunately, Central Oregon would not have to start from scratch in organizing and developing a strategy to change the early childhood ecology for vulnerable children and families. There is already momentum and planning taking place with healthcare representation through the work of the Early Learning Hub. There are also many best practices that could be studied to inform a community strategy that addresses ACEs by wrapping education, health and social supports (i.e. housing, transportation, employment) around families to impact children and youth educational achievement goals (Department of Vermont Health Access, 2015). Listed below are a few examples of multi-sectoral programs that are showing positive results nationally:

- **Child-Parent Education Centers (CPC):** CPC programs provide comprehensive educational, family support and healthcare services to economically disadvantaged children from ages 3-9. First developed in the 1960s, CPC initially launched in 25 sites in Chicago. The key goals were to improve school achievement, attendance, and parent engagement.
- **Northside Achievement Zone:** The Northside Achievement Zone (NAZ) exists to permanently close the achievement gap and end generational poverty for communities of color in North Minneapolis. Similar to Harlem's Children Zone, NAZ uses a family-centered, wraparound framework (housing, healthcare, parenting education supports) starting in the perinatal years, effectively supporting low-income families overtime so that their "scholars" will graduate from high school and be prepared for college. NAZ-enrolled families are making remarkable strides. Children are not only showing improved academic outcomes at key kindergarten and third grade benchmarks, but families are stabilizing their housing, employment, and health. A study by Wilder Research demonstrated that each dollar invested in NAZ provides more than a \$6 societal return.
- **Durham Connects:** Increases child well-being by bridging the gap between new parent needs and community resources. The project is a collaborative effort among the Center for Child & Family Health, The NC Department of Social Services, and the Durham County Health Department. Durham Connects hires and trains nurses to provide in-home health assessments of mothers and newborns, as well as to discuss the social conditions affecting the family. A study conducted between July 2009 and December 2010 showed increased positive parenting behaviors, father involvement, childcare selection, and reduced infant hospitalization among Medicaid recipients.
- **Center-Based Early Childhood Education:** Prepares children by providing skills development and readiness training, while also focusing on health and social development. ECE programs aim to improve the cognitive and social development of children ages 3 or 4 years.

### COMMUNITY SPOTLIGHT: M.A. Lynch Elementary School

M.A. Lynch Elementary School had the highest percentage of students impacted by poverty in Deschutes County. After becoming a full-service Community School, it went from a "School in Improvement," status under No Child Left Behind to a "Champion School," within three years. At the time of the State Recognition, 93% of students met or exceeded the reading benchmark, and 88% met or exceeded the math benchmark.

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The Community School model expands before and after school programs for students and families and maximizes instructional time during the day. Enrichment and targeted academic support is provided for students and a wide range of services are provided to support parents such as GED programming, English language instruction, workshops on parenting and how to cope with stress, and financial preparation. To serve its growing Latino population, Lynch brought on a bilingual Community School Coordinator. Health was also a key support. Deschutes County Health Services and FQHC Mosaic Medical teamed up to open a school-based health clinic at Lynch to provide a range of physical and behavioral health services. More recently, the school has hosted a Head Start preschool program, creating a new bridge between early learning and the K-12 education system.

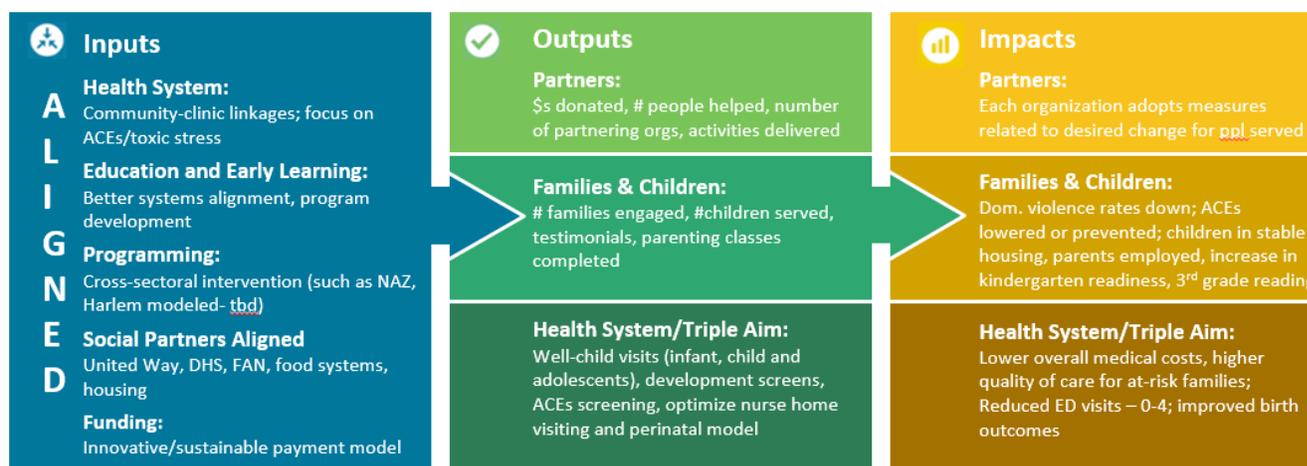
# Social Determinants of Health Part 1 Education and Health

## Education & Health Strategy Implementation Recommendations

1. There are five key strategies that the Central Oregon CCO and larger health system can take to advance educational achievement (i.e. kindergarten readiness) as a central SDOH goal (depicted as inputs in figure 2):
2. Inventory and understand the potential confluences that could be strengthened in partnership with community and education-based systems, such as the Early Learning Hub and public health nurse home visiting programs.
3. Align with and leverage the growing interest from healthcare, education and community-based organizations (i.e. United Way), in the prevention and treatment of early childhood trauma.
4. Support the formation of a workgroup that would bring together, education (Early Learning/Better Together), community-based and health system partners to identify achievement gaps “hot spots” and develop strategies to health, social service and education supports around children and families.
5. Intervene as early as possible to build resiliency in children and families, but also support youth whose lack of basic needs or poor health gets in the way of learning while already in school. The health system can support all children, youth and families by:
  - Promoting and providing annual well-child visit and conducting developmental screenings in the first 3 years of life
  - Promoting and providing annual adolescent well visits
  - Screening for ACEs (parents and children) and referring to treatment when appropriate
  - Meaningful and measurable collaboration with education, community and social support system
  - Develop innovative funding mechanisms to sustain outcome-producing models

The COHC, through the Operations Council, will develop a four-year work plan, in partnership with the above mentioned stakeholders, to implement strategies that pertain to the health system’s role, starting with Board adoption of kindergarten readiness as a system metric. This work plan should be vetted by numerous stakeholder groups and by the COHC, to be given final approval by no later than April 1, 2016.

**Figure 2. Education & Health Strategy At a Glance**



# Social Determinants of Health Part 2

## Housing

### The Problem

The home has deep cultural ties in America – a place where friends and families gather. The home is an anchor in the larger community, where connections and health-protective social networks flourish. As is the case with education, access to safe and stable housing constitutes one of the most basic and powerful social determinants of health. In addition to what we know intuitively about housing and health, there is growing scientific evidence that links access to safe and affordable housing with good health outcomes. Ensuring both housing stability and safety – i.e. free of health structural, bio-chemical health hazards, has become a public health priority worldwide. The World Health Organization recommends using the growing body of evidence linking housing and health to guide “primary preventive measures related to housing construction, renovation, use and maintenance, which can promote better overall health.”

The lack of safe and affordable housing has become a public health crisis in Central Oregon. Low-income families in all three counties struggle to find affordable housing. Even mid-income families, who do not normally struggle to find housing, are now finding it harder and harder to make ends meet as escalating rent and mortgage costs squeeze out room to budget for other living expenses. In Bend, Central Oregon’s largest city, affordable housing is not the only problem. Simply finding a place to live is also extremely difficult with low housing and apartment inventory and high market demand. Given all we know about the importance of housing to health, the current housing environment in this region has the potential to widen and exacerbate inequities and health disparities that impact people with fewer financial and support resources. This is particularly true for individuals and families trapped in a cycle of crisis and housing instability due to extreme poverty, trauma, violence, mental illness, addiction or other chronic health conditions.

### Promising Approach

The state of Massachusetts provides housing and supportive services to chronically homeless individuals through their Healthy and Home for Good (HHG) model. This has proven less costly and more effective overall than managing their homelessness and health problems on the street or in a shelter. As of their latest evaluation report, 766 chronically homeless individuals were placed in supportive housing. In the six months prior to housing, those participants accumulated 1,812 emergency department visits, 3,163 overnight hospital stays, 847 ambulance rides and 2,494 detox stays. The estimated total cost per person for measured services, including Medicaid (\$26,124), shelter (\$5,723) and incarceration (\$1,343) amounted to \$33,190 per year (Massachusetts Housing and Shelter Alliance, 2014). After one year in the program, the total per person costs for these same services fell to \$8,603. With the cost of housing and services through the HHG program amounting to \$15,468 per tenant, the total estimated return on investment to the state was \$9,118 per person. This is just one of dozens of studies that have shown health care and societal returns as a result of wrapping housing and supportive services around individuals with chronic, unstable housing conditions.

# Social Determinants of Health Part 2

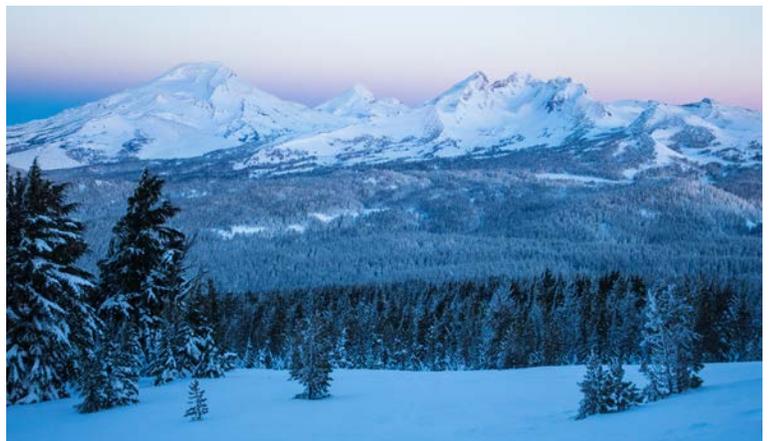
## Housing

### Implementation Recommendation

As part of its contract with the Oregon Health Authority, PacificSource Community Solutions, Central Oregon's Coordinated Care Organization, has outlined a plan to begin to address the housing crisis by bridging housing solutions with the health system (Transformation Plan Element 4.2). The COHC, through the Operations Council, will develop a four-year work plan around housing and health in alignment with the 2-year Transformation Plan deliverables as described below. Strategies that pertain to the health system's role will be endorsed by the COHC Board of Directors, with Board adoption of one or more housing related metrics to track and monitor performance toward this goal. This work plan should be vetted by numerous stakeholder groups and by the COHC, to be given final approval by no later than May 1, 2016.

Transformation Plan Milestone (July 30, 2016) and Benchmark (July 30, 2017):

- By July 30, 2016: Study promising and existing local, regional and national strategies. CCO, COHC and key partners secure funding for a pilot program that bridges housing and health care for those members who are homeless or at-risk for homeless and also have complex medical and behavioral health needs.
- By July 30, 2017: Partnerships are formalized (e.g. developer, property owner, housing agency). Pilot program begins implementation, dissemination of early findings provided to COHC and CAC.



# Appendix A: Acronyms

**Adverse Childhood Experiences (ACEs):** An adverse childhood experience (ACE) describes a traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult. The ACE score is a measure of cumulative exposure to adverse childhood conditions.

**Acquired Immunodeficiency Syndrome (AIDS):** A condition caused by a virus, in which lymphocytes are destroyed, resulting in a loss of the body's ability to protect itself against disease.

**Assessment, feedback, incentive, and exchange (AFIX):** A quality improvement program used to raise immunization coverage levels, reduce missed opportunities to vaccinate, and improve standards of practices at the provider level.

**American Academy of Pediatrics (AAP):** An organization dedicated to the health and well-being of infants, children, adolescents and young adults.

**American Heart Association (AHA):** A non-profit organization in the United States that fosters appropriate cardiac care in an effort to reduce disability and deaths caused by cardiovascular disease and stroke.

**Behavioral Health Consultants (BHC):** Behavioral health generalists who provide treatment within a healthcare setting for a wide variety of mental health, psychosocial, motivational, and medical concerns. BHCs also provide support and management for patients with severe and persistent mental illness and tend to be familiar with psychopharmacological interventions.

**Behavioral Risk Factor Surveillance System (BRFSS):** A phone survey conducted among randomly selected non-institutionalized adults that asks about a variety of health risks and behaviors.

**Blood Pressure (BP):** The pressure of the blood in the circulatory system.

**Body Mass Index (BMI):** Use both weight and height to determine the size of an individual. BMI is divided into four categories: underweight (<18.5), normal (18.5-24.9), overweight (25.0-29.9), obese (30.0 or greater).

**Cardiovascular Disease (CVD):** A classification of diseases of the heart and blood vessels that includes chest pain, heart attack, and other conditions that affect the heart muscle, rhythm, or valves.

**Centers for Disease Control and Prevention (CDC):** A federal organization that protects the health of the nation's residents and helps local communities do the same.

**Central Oregon Health Council (COHC):** The COHC is the governing body of our region's CCO. The COHC is dedicated to improving the health of the region and providing oversight of the Medicaid population and Coordinated Care Organization (CCO). The COHC's mission is to serve as the governing Board for the CCO and to connect the CCO, patients, providers, Central Oregon, and resources.

**Child-Parent Education Centers (CPC):** CPC programs provide comprehensive educational, family support and healthcare services to economically disadvantaged children from ages three to nine.

**Community Advisory Council (CAC):** The overarching purpose of the CAC is to ensure the CCO and COHC remains responsive to OHP consumer and community health needs. The CAC includes healthcare consumers of the CCO as well as representatives of public and private agencies that serve CCO members.

# Appendix A: Acronyms

**Coordinated Care Organization (CCO):** Is a network of all types of healthcare providers who have agreed to work together in their local communities for people who receive healthcare coverage under the Oregon Health Plan (Medicaid).

**Car, Relax, Alone, Forget, Friends, and Trouble (CRAFFT):** A short clinical assessment tool designed to screen for substance-related risks and problems in adolescents

**Dental Care Organizations (DCO):** There are eight DCOs in Oregon and they provide dental services to over 96 percent of the OHP clients eligible to receive dental benefits and services.

**Diabetes Prevention Program (DPP):** A prevention program aimed at improving Diabetes in a specified population. The program should be evidence-based.

**Dental Medical Integration (DMI):** Dental medical integration is the effort to improve coordination between medical and dental providers to improve client health.

**Early Childhood Education (ECE):** A program that prepares children by providing skills development and readiness training, while also focusing on health and social development.

**Electronic Health Record (EHR):** An electronic version of a patient's medical history.

**Generalized Anxiety Disorder-7 (GAD-7):** A concise self-administered screening and diagnostic tool for mental health disorders.

**Glycated hemoglobin (HbA1c):** A form of hemoglobin that is used to measure blood glucose concentration over time.

**Healthy Eating and Active Living (HEAL):** A coalition with diverse membership with the goal of health promotion.

**Healthy People 2020 (HP 2020):** National goals to meet by the year 2020.

**Human Immunodeficiency Virus (HIV):** A virus that causes HIV infection and over time acquired immunodeficiency syndrome.

**Intravenous drug (IV drug):** A drug that is administered into a vein or veins.

**Immunization Rate Improvement Project (IRIP):** A program to increase immunization rates in children.

**Low Birth Weight (LBW):** The birth weight of a live-born infant of less than 5 pounds 8 ounces regardless of gestational age.

**Long-Acting Reversible Contraception (LARC):** Birth control methods that provide effective, reversible contraception for extended periods of time without requiring user action.

**Medically Assisted Treatment (MAT):** A program that combines behavioral therapy and medications to treat substance use disorders.

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**Medically Assisted Treatment (MAT):** A program that combines behavioral therapy and medications to treat substance use disorders.

**Medicaid Behavioral Risk Factor Surveillance Survey (MBRFSS):** The BRFSS conducted among adults enrolled in Medicaid (OHP).

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**Northside Achievement Zone (NAZ):** Exists to permanently close the achievement gap and end generational poverty for communities of color in North Minneapolis.

**National Quality Forum (NQF):** A non-profit organization that works to improve quality of healthcare through several mediums, including the endorsement of evidence-based measures.

**Obstetrics/ gynecology (OB/GYN):** An obstetrician is a physician who delivers babies. A gynecologist is a physician who specializes in treating diseases of the female reproductive organs.

# Appendix A: Acronyms

**Operations Council (OPs):** OPs is housed within the COHC, and member promote and facilitate accessible, affordable, quality health services including mental, behavioral, oral, and physical health for Central Oregon residents. This group provides strategic, fiduciary, and operational advice to the COHC in a effort to design and implement key initiatives.

**Oregon Department of Education (ODE):** The Oregon Department of Education is responsible for implementing Oregon's public education policies, including academic standards and testing, credentials, and other matters not reserved to the local districts and boards.

**Oregon Health Plan (OHP):** Healthcare coverage program for low-income Oregonians.

**Patient Health Questionnaire (PHQ):** A concise, self-administered screening and diagnostic tools for mental health disorders.

**Performance Improvement Project (PIP):** The purpose of a PIP is to assess areas of need and develop a project intended to improve health outcomes. The Oregon Health Authority (OHA) contract requires Coordinated Care Organizations (CCO's) to conduct PIP's that are "designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have favorable effect on health outcomes and OHP Member satisfaction.

**Prescription Drug Monitoring Program (PDMP):** A state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients.

**Primary Care Provider (PCP):** A healthcare practitioner who sees people that have common medical problems.

**Pregnancy Risk and Monitoring Survey (PRAMS):** A survey of mothers who recently gave birth that addresses prenatal care, health behaviors and risks, and post-partum topics.

**Provider Engagement Panel (PEP):** This is a committee housed within the COHC, and provides a highly valued clinical perspective to the work the CCO and the COHC. Providers of the PEP represent a variety of healthcare organizations that serve the OHP population.

**Quality Improvement Measure (QIM):** State defined tolls that help measure and track the quality of healthcare services provided by eligible professionals and eligible providers of Medicaid within our healthcare systems.

**Screening, Brief Intervention and Referral to Treatment (SBIRT):** An evidence-based practice that targets patients in primary care with nondependent substance use.

**Social Determinants of Health (SDOH):** Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Substance Use and Mental Health Services Administration (SAMSHA):** The Substance Use and Mental Health Services Administration is a branch of the U. S. Department of Health and Human Services.

**Sexually Transmitted Infection (STI):** An infection transmitted through sexual contact, caused by bacteria, viruses, or parasites.

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**Supplemental Nutritional Assistance Program (SNAP):** Nutrition assistance program for low-income families.

**Substance Use Disorder (SUD):** A condition developed when the use of one or more substances leads to a clinically significant impairment or distress.

**To Be Determined (TBD):** Indicates the need to further develop a particular idea or strategy.

**Women, Infants, and Children (WIC):** A Federal program for low income and nutritionally at risk women, infants and children. Participants receive education, screening, and support in purchasing nutritious food.

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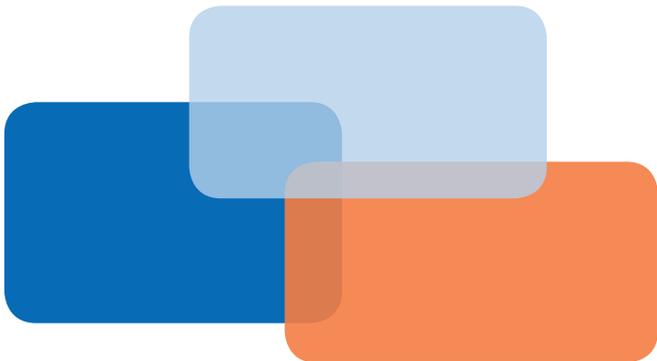
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# Jackson County

## *Community Health Improvement Plan*

# 2014



# Acknowledgements

*JCC Board of Directors*

*JCC Clinical Advisory Panel members*

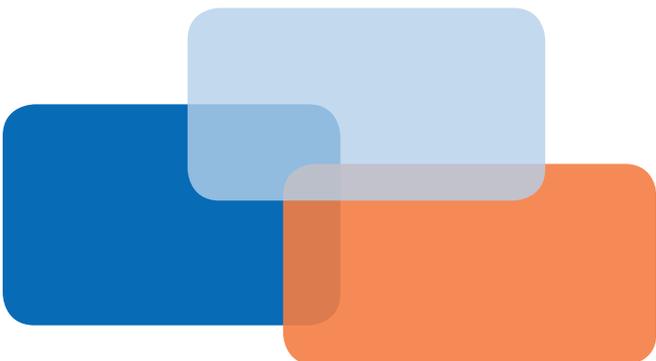
*JCC Community Advisory Council members*

*Jackson County Public Health*

*AllCare Health Plan CCO*

*PrimaryHealth of Josephine County CCO*

*Vanessa A. Becker, M.P.H., Principal. V Consulting & Associates Inc.*



# Summary

The health of individuals and our community is a very large topic. Measuring health and effectively addressing health problems is complex. Improving the health of a community requires resources, focused efforts, innovation and community engagement. The Community Health Improvement Plan (CHIP) is a plan that is based on the Community Health Assessment (CHA) data and prioritizes issues that participating Coordinated Care Organizations (CCOs) feel are important to address. In order to tackle such a large undertaking, several CCOs came together in 2013 to collaborate on a single, collective community health assessment for Jackson and Josephine Counties.

**Jackson Care Connect**, AllCare Health Plan and PrimaryHealth of Josephine County and their Community Advisory Councils (CACs) collaborated to create a single community health assessment (CHA) that was released December 2013. The process to create a Community Health Improvement Plan (CHIP) began in January 2014.

The three CCOs continued to collaborate on the CHIP, beginning with a collective process to identify three major topic areas for all three CCO CHIP documents to focus on. CAC members from all three CCOs reviewed data collected and highlighted in the 2013 Community Health Assessment. Three general focus areas were then identified as health priorities: **Healthy Beginnings, Healthy Living and Health Equity**.

## CHIP Process

Choose focus areas

Community input

Choose strategies

Write, share & submit plan

The next collaborative step involved the collection of extensive community input for strategies to address the collaborative health priority focus areas. Surveys and public meetings captured over 1000 unique comments and survey data from 628 community participants, both community members and individuals that provide health and social services in Jackson and Josephine County. All three CCOs provided resources for the data analysis of the community input part of the process.

Strategies were then chosen from the community input. Each CCO chose their own strategies based on their guiding philosophies, organization resources and priorities and input from their individual CACs. Each CCO drafted their own CHIP but continued to have shared health priority focus areas, format and design.

This CHIP includes strategies for enrollees and members of **Jackson Care Connect** and strategies for the community at large. Progress on the CHIP will be reviewed annually.

For a copy of the 2013 Jackson and Josephine County Community Health Assessment and full copies of the 2014 **Jackson Care Connect** Community Health Improvement Plan, please visit:

[www.jacksoncareconnect.org](http://www.jacksoncareconnect.org)

## What is a Community Health Improvement Plan?

A Community Health Improvement Plan or CHIP, is a process and a document that outlines strategies to support improved health of individuals and the community. This CHIP outlines prioritized health issues and ways to address them locally. This CHIP process included input from community members and people that provide health and social services in Jackson County. It is based on the Jackson and Josephine County Community Health Assessment that was completed in 2013.

## Useful Acronyms

CCO	Coordinated Care Organization
CHIP	Community Health Improvement Plan
CHA	Community Health Assessment
CAC	Community Advisory Council
JCC	Jackson Care Connect (a CCO)

# Community Health Improvement Plan (CHIP) 2014 High Level Strategies Map — Jackson Care Connect

## Healthy Beginnings

### *Perinatal Collaboration*

Participate in preconception health programs to improve birth outcomes, including reduction of substance use during pregnancy

### *Early Childhood Investment*

Support development of early learning HUB, with a focus on kindergarten readiness

### *Youth At-Risk*

Participate in multidisciplinary work improving basic needs for vulnerable youth including addictions, trauma, homelessness, food insecurity and mental health

## Healthy Living

### *Oral Health*

Evaluate and improve oral health experiences for members and community

### *Member Engagement in Health*

Increase member engagement, including wellness benefits

### *Healthy Communities*

Collaborate to reduce adverse affects of social determinants of health that increase risk of chronic disease

### *Tobacco*

Support policy development and individual interventions that reduce the burden of tobacco use

## Health Equity

### *Reduction of Health Disparities*

Collaborate with Regional Health Equity Coalition to identify data and opportunities to address health disparities in Jackson County

### *Social Determinants of Health*

Increase awareness of how poverty, adverse childhood events and trauma influence health, support community efforts to decrease poverty and build trauma-informed services

## Core Planning Principles

Through this process we strive to:

- Emphasize coordination and leverage local assets, programs and resources
- Choose strategies that are evidence-informed
- Incorporate voices of those we serve, including members of the Oregon Health Plan
- Engage the community advisory council members and provide activities for consumers to be involved in improving health
- Base work on the 2013 Community Health Assessment
- Create positive, measurable changes in the health of individuals and the community
- Build efforts over the 1-3 year timeline
- Meet Oregon Health Authority and Public Health Accreditation rules and mandates



*The purpose of the CHIP is to outline strategies and metrics that support improved health of individuals and the community*

# Jackson County

## Community Health Improvement Plan

2014

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# Introduction, Process and Methods

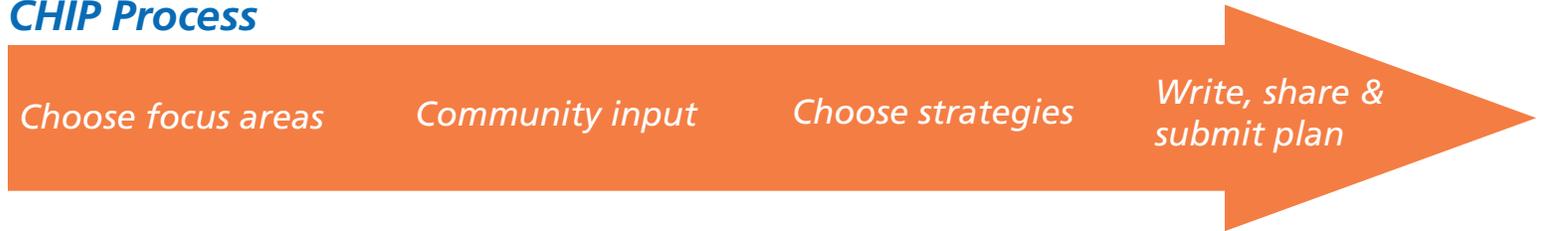
Understanding the picture of health in a community is the first step in planning to improve a community's health. The health of people who live in Jackson County and the causes of disease and disability has changed over the last several decades, with chronic diseases now being the major cause of premature death. Risk factors for chronic disease include tobacco use, obesity, limited access to healthy food and nutrition. Supporting people who live in Jackson County to have healthy lifestyles, promoting the health of our children and youth, and addressing health disparities are all factors in creating a healthier community.

Measuring health and effectively improving the health of individuals and the community is complex and requires intentional planning. It begins by recognizing that health is beyond just the health care one receives and is influenced by many other factors such as health behaviors, environments that we live and work in, education and the health and social supports around us. Addressing these factors requires resources, effort, collaboration, innovation and community engagement.

The first step in improving health is to understand the state of health in a community. Three Coordinated Care Organizations (CCOs) came together in January of 2013 to collaborate on a single, collective community health assessment over two counties in Southwestern Oregon. Pooling resources, reducing duplication of effort and meeting mandates motivated the three organizations to secure a contract with a consultant to lead and facilitate a community health assessment. The Jackson and Josephine Community Health Assessment was completed to meet the needs of Jackson Care Connect, AllCare Health Plan, and PrimaryHealth. The document was released in December of 2013 and the next step, to create a Community Health Improvement Plan (CHIP) was started in January 2014. The CHIP is a plan that seeks to make sense of the data and prioritize strategies that the CCO and community stakeholders feel are important to improve community health.

**Focus Areas**  
*Healthy Beginnings*  
*Healthy Living*  
*Health Equity*

## CHIP Process



After completing the collective CHA the three CCOs continued to collaborate on the CHIP process, beginning with a collaborative process to identify three major topic areas. CAC members from all three CCOs reviewed data collected and highlighted in the 2013 Community Health Assessment and arrived at three general focus areas. The three focus areas were:

***Healthy Beginnings, Healthy Living and Health Equity.***

The next step in the CHIP involved the collection of extensive community input about possible strategies to address the health priority focus areas. Several methods were used to solicit feedback from the community. Methods included public meetings, and online and paper surveys. The public meetings utilized an audience response system that polled audiences for their ideas, allowing all participants an opportunity to provide their input anonymously. The public meetings also utilized a world café model where participants dialogued with other community members, eliciting many community-based ideas.

The surveys were written for easy reading and comprehension, resulting in a 97% completion rate. The questions asked in the public meetings and the surveys were organized around the three health priority areas and the goal was to gather ideas and solutions from community members, providers of health and human services and organizations. A summary of survey findings can be found in the appendix.

Significant outreach to recruit participants to the public meetings and for community members and providers to take the surveys (both paper and online versions) was completed by members of the Community Advisory Council and staff from all three CCOs. Surveys were distributed county wide and captured over 1000 unique comments from 628 participants.

The Community Advisory Council then worked with Jackson Care Connect staff to choose strategies for Jackson Care Connect's CHIP. Each CCO chose strategies based on their guiding principles, organization resources and priorities and individual CAC input. Although each CCO drafted their own CHIP they continued to have shared health priority focus areas, format and design. Jackson Care Connect worked closely with Jackson County Public Health to choose strategies and write the CHIP. The resulting CHIP includes strategies that will ultimately benefit members of Jackson Care Connect and strategies that will impact the community at large, and meets CCO requirements from the Oregon Health Authority (OHA).

Progress on the CHIP will be reviewed on an ongoing basis by the CAC and Board, with annual reports to the OHA.

### ***Core Planning Principles***

Through this process we strive to:

- Emphasize coordination and leverage local assets, programs and resources
- Choose strategies that are evidence-informed
- Incorporate voices of those we serve, including members of the Oregon Health Plan
- Engage the community advisory council members and provide activities for consumers to be involved in improving health
- Base work on the 2013 Community Health Assessment
- Create positive, measurable changes in the health of individuals and the community
- Build efforts over the 1-3 year timeline
- Meet Oregon Health Authority and Public Health Accreditation rules and mandates

## Priority Health Issue: Healthy Beginnings

**Goal: Engage in efforts to improve the health of children, adolescents and young adults from age 0 to 24**

### Overview

Adverse Childhood Events (ACEs), like exposure to domestic violence, substance abuse and homelessness, negatively affect the life long health and wellness outcomes of all persons. Jackson County residents are adversely affected by substance abuse, poverty and low graduation rates as noted in the 2013 Community Health Assessment.

### Perinatal

Nationally, nearly 50% of women become pregnant unintentionally. The risks of unintended pregnancies include exposure to substance abuse, including tobacco, low birth weight, and lack of prenatal care. Jackson and Josephine Counties have recently implemented a preconception health campaign to reduce unwanted pregnancies, and thereby reduce risks to the fetus. JCC will participate in the preconception campaign through attendance at meetings, support of data collection and information sharing and promotion of healthy activities to its members and community partners.

### Early Childhood

Youth affected by adverse childhood events (ACEs), as noted above, are less likely to be ready for kindergarten, less likely to meet grade level reading standards, and therefore perform lower overall in academics. Nearly one in four children in Jackson County live in poverty, creating significant challenges to their overall health and long-term development. JCC will collaborate to align Early Learning Services into a Regional Early Learning HUB, with the goal of improving the health and education outcomes of Jackson County's youth.

***“Out of 15 of my preschoolers—four were raised by grandparents last year. They aren’t always healthy [the grandparents] —and their health affects the kids and the grandparents. Plus, it’s stressful to raise your grand kids.” —2013 CHA Focus group participant***

### Youth At-Risk

High school graduation rates in Jackson County hover below the statewide average at around 60%. Youth depression rates, suicidal ideation rates and suicide attempts also exceed the State average. In fact, youth experiencing mental health crises is increasing in the County, as evidenced by an increase in ER visits and hospital admissions. In addition, youth report high levels of drug use, including increased use of tobacco, alcohol, marijuana and other illicit drugs from grades 6-11. Engagement in risky behaviors negatively affects the overall health and wellness of youth across their lifespan. JCC will continue to work with Southern Oregon Success, and other organizations to improve the educational and health outcomes for youth in our community.

JCC plans to work with several existing organizations focused on reducing risks to pregnant women and children, and preparing children to be ready for kindergarten, which is a measure of success over a lifetime. Organizations include: Health Care Coalition of Southern Oregon (HCCSO) and their Preconception Health Campaign; Southern Oregon Early Learning Services (SOELS) moving towards the creation of an Early Learning HUB; Southern Oregon Success focused on 100% high school graduation rates, and improved college and two-year degree rates.

JCC CAC recognizes the importance of a healthy, secure and supported early beginning to life for both its members and the community as a whole. The CAC will continue to be informed and participate in areas of work as available.

**Healthy Beginnings: 2014 CHIP Strategies and Objectives**

*Goal: Engage in efforts to improve the health of children, adolescents and young adults from age 0- 24*

High level strategy	Objective/work	Internal and community partners	When
<p><b>Perinatal Collaboration:</b> Participate in preconception health programs to improve birth outcomes, including reduction of substance use during pregnancy</p>	<p>Participate in the three year preconception health campaign including <b>One Key Question</b> integration into primary care, and other sites</p> <p>Focus on lowering high rates of addiction and tobacco use in the pregnancy population</p> <p>Ensure this population is screened for depression and connected with services</p>	<p><i>Heidi Hill, Belle Shepherd, Ginger Scott, CAC members as identified</i></p> <p><i>Jackson County Perinatal Task Force and Preconception Health Campaign steering members</i></p> <p><i>Health Care Coalition of Oregon (HCCSO) staff</i></p> <p><i>Provider Partners</i></p>	<p>2014-2017</p>
<p><b>Early Childhood Investment :</b> Support development of early learning HUB with a focus on kindergarten readiness</p>	<p>Participate in regionalization of early learning services through an early learning HUB and related family activities</p>	<p><i>Jennifer Lind, HUB Executive Board, Belle Shepherd, Blair Johnson (CAC member), HUB Agency Advisory Council Southern Oregon Early Learning Services (SOELS) and Southern Oregon Education Services District (HUB applicant)</i></p>	<p>2014-2017</p>

High level strategy	Objective/work CHP Handout #12	Internal and community partners	When
<p><b>Youth At-Risk:</b> Participate in multidisciplinary work</p> <p>improve basic needs for vulnerable youth</p>	<p>Participate in regional efforts to support adolescent and young adults during times of transition and vulnerability</p> <p>Represent healthcare in the multi-disciplinary work addressing: addictions, social determinants of health, food insecurity, homelessness, mental health</p> <p>Community partner for trainings and work related to poverty and Trauma Informed Care, partner with Jackson County's prevention coalition and other agencies serving that demographic</p>	<p><i>Staff Support: Heidi Hill, Board representation, Doug Mares</i></p> <p><i>Support the on going work of Southern Oregon Success</i></p> <p><i>Jackson County Public Health (will be doing prevention work)</i></p>	<p>2014-2017</p>

### Community Advisory Council learning opportunities and implementation role

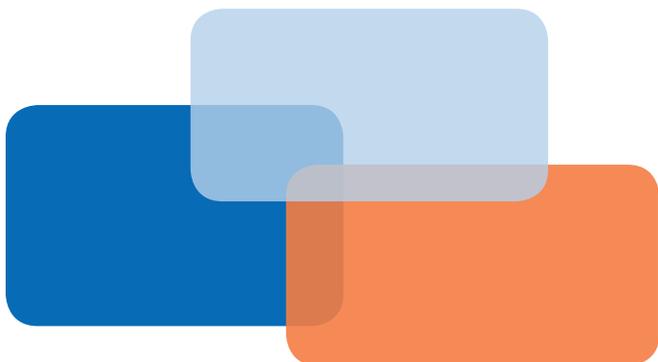
Presentation to CAC on Preconception Health work from HCCSO

Presentation to CAC on Early Learning work from SOELS and SOESD

Identification of Parent Advisory member (HUB subcommittee) to be on JCC CAC

Participate in ongoing trainings and learning opportunities as offered via HCCSO and the HUB

Presentation on prevention coalition work and possible partnership opportunities



**Goal: Promote Healthy Living and improve health outcomes**

Jackson Care Connect defines healthy living as participation in behaviors that improve overall health over the lifespan of an individual. Healthy Living addresses the full spectrum of physical, mental and social well-being.

**Oral Health**

The Community Health Assessment of 2013 found tooth decay to be five times more common than asthma in Oregon children. The community health assessment process also found that while focus group participants readily identified health problems related to obesity, they overlooked tobacco as a major community health issue. Rates of tobacco use are even higher for OHP members and other sub-populations such as those experiencing mental illness and pregnant mothers.

**Member Engagement**

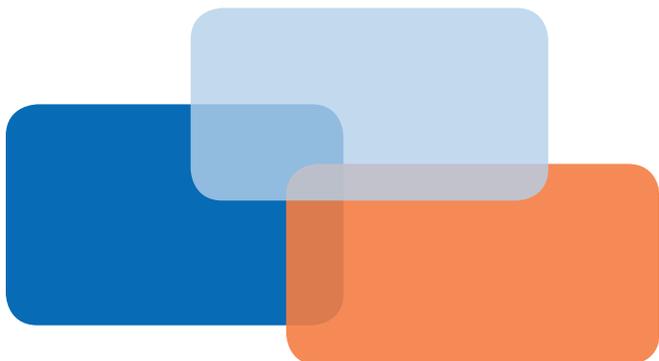
The Community Health Improvement Plan survey clearly demonstrated that people in Jackson County want to be engaged and empowered in their own health. A desire for low-cost and accessible fitness classes, along with access to nutritious foods was expressed. Self-management and peer-supported wellness programs were of interest to survey participants.

***“Part of the problem is the lack of real education around nutrition and disease prevention.” —2013 CHA Focus Group Participant***

**Healthy Communities/Tobacco**

The Jackson Care Connect CAC recognizes that there are many facets to Healthy Living in the community. Not all areas that affect Healthy Living can be addressed in this Community Health Improvement Plan. The Community Advisory Council also recognizes that there are many organizations already tackling problems that affect Healthy Living, and have identified opportunities to work with those organizations, including Jackson County Health and Human Services.

The Community Advisory Council chose four high-level strategy areas to focus on in the first year of the CHIP. Progress of these strategies and objectives will be charted and additional strategies will be evaluated and potentially added in 2015.



# Healthy Living: 2014 CHIP Strategies and Objectives

CHIP Handout #12

Goal: Promote Healthy Living and improve health outcomes

High level strategy	Objective/work	Internal and community partners	When
<p><b>Oral health:</b> Evaluate and improve oral health services for members and community</p>	<p>Develop Subcommittee who will partner with Clinical Advisory Panel to:</p> <ul style="list-style-type: none"> <li>• identify three oral health issues from member perspective</li> <li>• develop work plan to improve access, increase utilization and enhance members' experience of care</li> </ul>	<p><i>JCC's Dental Care Organizations</i></p> <p><i>Community Advisory Panel</i></p> <p><i>Community providers</i></p> <p><i>CAC members</i></p>	<p>2014-2017</p>
<p><b>Member engagement in health:</b> Engage and empower individuals to participate in self-management and healthy behaviors</p>	<p>Form CAC sub-committee to evaluate existing member programs focusing on healthy living</p> <p>Explore opportunities with identified sub-populations for possible member benefits and engagement</p> <p>Conduct member and community surveys with targeted populations to research impact of possible programs</p> <p>Support education and development of peer-delivered support programs that empower individuals to create a self-management program</p>	<p><i>Heidi Hill, Belle Shepherd, all CAC members and subcommittee as formed</i></p> <p><i>CAP and Board for approval and input</i></p> <p><i>JCC members at large</i></p>	<p>9/2014 12/2014</p>
<p><b>Healthy communities:</b> Collaborate to reduce adverse affects of social determinants of health</p>	<p>Develop and implement member incentive program for participating in evidence-based self-management programs available through partner agencies</p> <p>Support Jackson County Public Health in advocating for community-level policies aimed at chronic disease prevention and early detection/screenings</p> <p>Support Jackson County Public Health work around colorectal cancer screenings and other public health campaigns</p>	<p><i>JCC staff, Board and CAC members</i></p> <p><i>JC Public Health</i> <i>JCC Stakeholders</i></p> <p><i>Partner organizations to be identified by subcommittee work</i></p> <p><i>Jackson County Public Health</i></p>	<p>2014-2015</p>

High level strategy	CHP Handout #12 Objective/work	Internal and community partners	When
<p><b>Tobacco:</b> Support policy development and individual interventions that reduce the burden of tobacco use</p>	<p>Increase assessment and referral to tobacco cessation interventions for Jackson Care Connect members</p> <p>Support policies that promote tobacco free campuses at facilities serving Jackson Care Connect members</p> <p>Support Jackson County Public Health's Tobacco Prevention &amp; Education Program in advocating for community-level interventions aimed at reducing the burden of tobacco use in Jackson County</p>	<p><i>JCC Staff and stakeholders</i></p> <p><i>JC Public Health</i></p> <p><i>Provider networks</i></p>	<p><i>Ongoing 2014-2015</i></p>

**Community Advisory Council learning opportunities and implementation role**

Formation of sub-committees to focus on oral health and member engagement	<b>2014</b>
Inform and engage JCC CAC in Jackson County Public Health's work priorities	<b>2014 on going</b>
Evaluation of existing member benefits focusing on wellness	<b>2015</b>
Presentation from Rogue Valley Food System Network (RVFSN)	<b>2014</b>
Presentations on evidence-based "chronic care" self-management programs	<b>on going</b>

**Goal: Increase awareness of health equity issues in Southern Oregon and support efforts to address these issues**

Health Equity is a primary concern for Jackson Care Connect's CAC. Health disparities are influenced by factors such as place, race, and socioeconomic barriers. Jackson County struggles with poverty and those considered working poor. 15.8% of county residents live in poverty, with one-in-four children experiencing poverty and significant challenges to their overall health and long-term development.

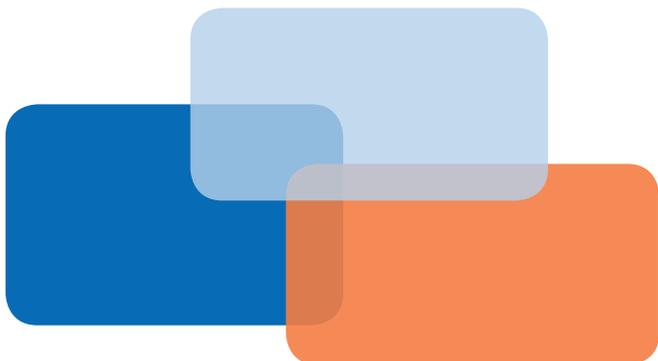
***“Without work there is no money. Without money we have to sell our house. Huge fear, we live in huge fear. Even though we have strong beliefs, I still can't provide.” —2013 CHA Focus Group Participant***

**Health Disparities and Social Determinants**

In addition to socioeconomic factors, race and ethnicity can play a part in determining health outcomes. Jackson County demographics for race and ethnicity are similar to state averages. 17% of Jackson County residents identify as a minority population, with 11.4% identifying as Latino. Jackson Care Connect membership is comprised of nearly 20% Latino. The Latino population continues to experience worse health outcomes, including nearly three times county averages for teen pregnancy.

**CHIP Priorities for 2014**

Jackson Care Connect has a responsibility to provide the best access and experience possible for all of its members. Health Equity work can encompass issues around geography, special populations, etc. The CAC has identified two areas of focus, informed by the 2013 Health Assessment. These two high level strategies will address health equity issues related to race, ethnicity and poverty and potential trauma caused by inequality.



## Health Equity: 2014 CHIP Strategies and Objectives

Goal: To increase awareness of health equity issues in Southern Oregon and to support efforts to address these issues

High level strategy	Objective/work	Internal and community partners	When
<p><b>Health Disparities</b> Diminish health disparities directly related to race and ethnicity</p>	<p>Develop baseline data of health disparities existing in region</p> <p>Identify ways to improve cultural competency for the regional services and JCC Providers</p> <p>Develop methods for increased engagement and involvement of priority population consumers in health care systems</p> <p>Support regional efforts to increase awareness of existing health disparities</p>	<p><i>Jackson County Public Health</i></p> <p><i>Southern Oregon Early Learning Services</i></p> <p><i>Care Oregon and Jackson Care Connect</i></p> <p><i>Stakeholders</i></p> <p><i>Oregon Health Authority's Office of Equity Inclusion and Transformation Center</i></p>	<p><b>2014</b>  <b>on going</b></p>
<p><b>Social determinants of health</b> Increase awareness of how poverty and trauma influence health and support community efforts to decrease poverty and build trauma-informed services</p>	<p>Facilitate community wide multi-disciplinary learning around the culture of poverty and organizational constraints contributing to poverty</p> <p>Support community efforts that address the effects of poverty. This includes potential programs, policies, outreach and education</p> <p>Provide education for community, CAC, and provider partners regarding the experience of poverty and how to offer appropriate services</p> <p>Build community alliances for future work addressing the social determinants of health</p> <p>Build community knowledge and capacity to provide Trauma Informed Care</p> <p>Jackson Care Connect CCO to collaborate with regional CCOs to facilitate staged learning collaborative to educate multidisciplinary team of service providers on Trauma Informed Care</p>	<p><i>Department of Human Services</i></p> <p><i>Jackson Care Connect CCO, other regional CCOs</i></p> <p><i>Other community partners identified through process</i></p>	<p><b>2014-2015</b>  <b>on going</b></p>

**Community Advisory Council learning opportunities and implementation role**

Review health disparities data identified by Regional Health Equity Coalition	<i>2015</i>
Participate in “cultural competency and implicit bias” training as identified by Coalition	<i>2015</i>
Frame the work of oral health and member engagement sub-committees through the Health Equity Lens	<i>2014</i>
Participate in learning sessions on Trauma Informed Care	<i>2014-2015</i>
Participate in education about poverty	<i>2015 and on going</i>

## Next Steps

*The 2013 Community Health Assessment and the 2014 Community Health Improvement Plan draw attention to many health challenges and opportunities for change. The documents and processes are designed to compliment one another, not stand on their own. These efforts mark the first step in an ongoing process of community health assessment, planning and improvement. The process and the documents will remain dynamic and will be added to and changed over the next several years as community health and perceptions of health change. Engagement of the CAC will continue to be instrumental in the process, as will listening to community members' priorities and concerns.*

*This JCC CHIP has been developed in alignment with requirements of the Transformation Plan and with consistent values and strategies outlined in the JCC Strategic Plan. Periodic assessment of the CHIP will be done to maintain this alignment and ensure appropriate use of resources.*

*For hard copies of this CHIP or the Community Health Assessment, please visit: [www.jacksoncareconnect.org](http://www.jacksoncareconnect.org)*



## Survey Summary

### Process & Methods

Several methods were used to solicit feedback from the community. The purpose of the survey and public meetings was to get ideas about how to improve health of community members and providers of health and human services in Jackson and Josephine Counties. Methods included public meetings, online and paper surveys.

The community survey was written for easy reading and comprehension, resulting in a 97% completion rate. Survey questions sought input on possible strategies and activities in the three focus areas of **Healthy Beginnings, Healthy Living and Health Equity**. Respondents were asked to choose three strategies from a list and provide additional options in open-ended questions. Surveys were available online, via surveymonkey and in paper/hard copy format.

The public meetings utilized an audience response system that polled audiences for their ideas, allowing all participants an opportunity to provide their input anonymously. The questions asked in the public meetings were the same as in the surveys. The public meetings also utilized a world café model where participants dialogued with other community members, eliciting many community-based ideas.

Significant outreach to recruit participants to the public meetings and for community members and providers to take the surveys (both paper and online versions) was completed by members of the Community Advisory Council and staff from all three CCOs. Surveys were distributed county wide and captured over 1000 unique comments from 628 participants.

Quantitative Excel data and all qualitative comments from the community survey, provider surveys and community meetings were reviewed for themes. Data and themes were then presented to the CCO executive staff and CAC. Categorized comments are available upon request to CCO staff.

## Summary Results and Themes

### Jackson Josephine County Community Health Improvement Plan 2014

#### Community Survey Statistics

*The highlighted responses below represent the top identified themes from the community surveys*

Total participants community survey	<b>554</b>
Total participants provider survey	<b>74</b>
Percent of total community surveys from Jackson County	<b>63%</b>
Total all surveys	<b>628</b>
Total participants public meetings	<b>60</b>
Total unique comments from surveys and public meetings	<b>1008</b>
Completion rate	<b>97%</b>
Survey open	<b>30 days</b>

## **Healthy Beginnings** *including: early childhood, children, teens and families*

- Parenting support and skill development
- Early intervention and home visiting programs
- Physical activities for youth
- Healthy food access for children and youth
- Sex education and pregnancy intention programs
- Homeless youth programs
- Family violence and affects of trauma on children
- Prenatal programs

## **Healthy Living** *including: healthy active living, alcohol, tobacco and other drugs, mental health*

- Assistance for low cost fitness events/memberships
- Nutrition/healthy eating classes
- Built Environment projects (sidewalks, walking paths, etc.)
- Worksite Wellness programs
- Youth alcohol, tobacco, and other drug prevention
- Increase treatment quality, volume, accessibility of mental health and addictions programs
- Chronic pain, prescription medication use and prescribing
- Tobacco policy and cessation benefits
- Provider training: mental health and trauma informed services

## **Health Equity** *including: access, special populations, social determinants of health*

- Benefits for alternative providers
- Navigators to help coordinate and navigate system
- Transportation
- Recruitment/retention of all providers
- Programs for seniors and the disabled
- Trauma/intimate partner violence (IPV)
- Language access and cultural competency
- Economic development
- College programs for youth
- Access to specific services such as dental

*\*Lists above are not ranked and are based on data from community survey, provider surveys and public meetings*