
# *Douglas County Community Health Improvement Plan (CHIP) 2019*

# *Contents*

# *Umpqua Health Alliance Community Health Improvement Plan (CHIP) 2019*

| *Big Rock/Focus Area & Strategies* | *Indicators / Metrics* |
|---|---|
| ***Social Determinants of Health***<br><br>***Housing & Homelessness***<br>Support efforts to increase accessibility, availability and affordability of quality housing<br><br>Support programs and efforts that address homelessness<br><br>***Economic Drivers***<br>Increase education & knowledge about the effects of poverty on health and support programs that address economic drivers of health | Homeless students by district<br><br>Homeless count<br><br>Poverty rate by county |
| ***Behavioral Health & Addictions***<br><br>Support efforts & programs that improve access, integration and delivery of behavioral health and addiction services | CCO metrics<br><br>Adults with 1 or more poor mental health days<br><br>Access to mental health providers |
| ***Healthy Lifestyles***<br>***Food & Nutrition***<br>Increase the availability of nutrition education and healthy, nutritious food<br><br>***Prevention***<br>Support prevention services, including but not limited to early detection and screening, health behavior education and built environment projects.<br><br>***Oral Health***<br>Support increased access to oral health services and oral health prevention education | Preventive screenings<br><br>CCO metrics<br><br>Biometric markers such as cholesterol, A1c stabilization<br><br>Food insecurity<br><br>Adults consuming at least 5 fruits/vegetables a day<br><br>SMILE survey<br><br>Access to dental providers |
| ***Families & Children***<br>Support efforts and programs that mitigate trauma and increase resilience<br>Promote programs that address child & youth health and wellness<br>Support programs and projects that address maternal health and wellness<br>Continue to engage with Early Learning Hub to promote early learning programs | Child abuse reports<br><br>Children in foster care<br><br>% of infants who are breastfed |

# *Introduction*

The 2019-2022 Umpqua Health Alliance (UHA) Community Health Improvement Plan (CHIP) is a plan that aims to improve the health of individuals, families and the community at-large. The plan is community informed and focused on making meaningful changes. It is intended to address significant issues that influence overall health in the UHA service area, specifically Douglas County. The CHIP is based on data reviewed, collected and analyzed from the 2018 Community Health Assessment (CHA).

The 2018 CHA was led by UHA's Community Advisory Council (CAC). The CAC began the CHIP process by reviewing the CHA. They then gathered and reviewed community input with both surveys and a large community partner meeting. The CAC also reviewed the 2019-2024 State Health Improvement Plan priorities, past UHA funded CHIP projects and the 2013 UHA CHIP. Four broad focus areas (big rocks) were identified. The CAC also discussed and agreed that the concept of health equity would be woven into all four of the broad categories to ensure that it was being addressed in all areas of CHIP work.

*Focus areas*

| | | | |
|---|---|---|---|
| ***Social Determinants of Health*** | ***Behavioral Health & Addictions*** | ***Healthy Lifestyles*** | ***Families & Children*** |

These four areas coincide well with the state health improvement plan, covering all of the five 2020-2024 State Health Improvement Plan (SHIP) priorities.

*CCO CHIP Alignment with State Health Improvement Plan*

| *SHIP Priority* | *Coinciding UHA CHIP priority* |
|---|---|
| Economic drivers of health (including issues related to housing, living wage, food security and transportation) | Social Determinants of Health focus area |
| Access to equitable preventive health care | Healthy Lifestyles focus area |
| Behavioral health (including mental health and substance abuse) | Behavioral Health & Addictions focus area |
| Adversity, trauma and toxic stress | Families and Children and Healthy Lifestyles focus areas |
| Institutional Bias | Healthy Equity lens across all focus areas |

## *Planning Process*

The Douglas CHA collaborative began the CHIP process in early 2019.

### *CHIP Process*


The CHA process followed a modified Mobilizing for Action through Planning and Partnerships (MAPP) model and continued this national best practice for health planning as the collaborative moved into the CHIP process. The CHIP process was rooted in the planning vision and values established in the beginning of the CHA. An additional assessment to the MAPP process was the Integration Assessment. UHA invited dozens of community partners to the table to assess where integration was happening currently in the community and identified opportunities for improved integration. Specific partners included dental organizations, K-12, relief nursery, addictions and mental health, food bank, domestic violence and child abuse agencies, early learning organizations and health care providers. CAC membership also participated in that meeting and later reviewed notes and data when setting the CHIP priorities.

# *Focus Areas & Strategies*

## *Focus Area: Social Determinants of Health*

### *Community Health Assessment data supporting this priority*

The 2018 Douglas Community Health Assessment (CHA) highlighted the perspective that health is more than health care, more than what happens in the health care provider office and more than individual health outcomes of disease and death. The CHA stated that multiple factors in a community impact the health of individuals, families and community. These are often called the Social Determinants of Health. As one UHA CAC member articulated during the prioritization of this focus area:

> ***"The social determinants of health big rock focus area encompasses economic drivers and other things that affect wellness." —CAC member***

For the purpose of this CHIP, the issues of living wage and economic drivers such as poverty, housing and homelessness were highlighted as strategy areas.

People experiencing homelessness was listed a significant concern in the 2018 CHA focus groups and surveys. Housing availability and quality was also a very common concern listed in the CHA. A few notable data points in the CHA related to homelessness and housing are as follows:

- ***The number of homeless adults is increasing in the annual point in time count***
- ***Availability of housing was listed as the second biggest concern for focus group and survey participants in the 2018 CHA***

Economic drivers of health, specifically poverty, is higher in Douglas County than the state overall.

- ***Close to one in three children (28.6%) are living in poverty in the county***
- ***Over 20% of all of the county residents are living in poverty***

Poverty was listed as a significant concern by 2018 CHA focus group and survey participants

| *Focus area* | *Strategy priority area* | *Strategy* | *Indicators/outcomes to track progress* |
|---|---|---|---|
| Social Determinants of Health | Housing & Homelessness | Support efforts to increase accessibility, availability and affordability of quality housing<br><br>Support programs and efforts that address homelessness | Homeless students by district<br><br>Homeless count |
| | Economic Drivers & Poverty | Increase education & knowledge about the effects of poverty on health and support programs that address economic drivers of health | Poverty rate by county |

# *Focus Areas & Strategies*

## *Focus Area: Healthy Lifestyles*

### *Community Health Assessment data supporting this priority*

Access to food, including availability and affordability is historically an issue in Douglas County. Food insecurity, as defined by the USDA, is a lack of access to enough food for all members in a household and a limited or uncertain availability of nutritionally adequate food.

### *15.4% of all residents in the county and over one in four children in the county were food insecure in 2016*

Prevention includes upstream efforts to contribute to overall well-being, screening to detect disease earlier and education to address health behaviors. Notable data in the CHA that relates to prevention include:

- ***Nearly 60% of the adults in Douglas County have one or more chronic condition, higher than the state as a whole***
- ***Cancer is the leading cause of death in Douglas County, followed by heart disease***
- ***Tobacco use is a modifiable health behavior and remains high in the county, one in four adults smoke cigarettes in the county***
- ***The percentage of the population in the county that is considered obese has been increasing for decades, 30% of the adults living in the county are considered obese***

Oral health and accessibility of oral health services remains an issue for patients and providers in the county. Oral disease is on the rise in Oregon and Douglas County.

### *Youth in Douglas County are less likely to have seen a dentist or dental hygienist for a check-up in the last year than youth statewide.*

| *Focus area* | *Strategy priority area* | *Strategy* | *Indicators/outcomes to track progress* |
|---|---|---|---|
| Healthy Lifestyles | Food & Nutrition | Increase the availability of nutrition education and healthy, nutritious food | Adults consuming at least 5 fruits/vegetables a day<br><br>Food insecurity |
| | Prevention | Support prevention services, including but not limited to early detection and screening, health behavior education and built environment projects | Preventive screenings<br><br>CCO metrics<br><br>Biometric markers such as cholesterol, A1c stabilization<br><br>Obesity rates |
| | Oral Health | Support increased access to oral health services and oral health prevention education | SMILE survey<br><br>Access to dental providers |

# *Focus Areas & Strategies*

## *Focus Area: Behavioral Health & Addictions*

*Community Health Assessment data supporting this priority*

Mental health, depression and substance use were top concerns in the 2018 CHA focus groups and surveys of community members. A few notable data points in the CHA related to behavioral health and addictions are as follows:

- ***Depression in youth has been steadily increasing for 8th and 11th graders in the county with 40% of 8th and 11th graders reporting feeling sad or hopeless every day for two weeks***
- ***The suicide rate for all ages has been on a solid increase trend since 2000 and considerably higher than the state rate***
- ***Douglas County has higher rates of binge drinking and opioid prescribing rates than state averages***

| *Focus area* | *Strategy* | *Indicators/outcomes to track progress* |
|---|---|---|
| Behavioral Health & Addictions | Support efforts & programs that improve access, integration and delivery of behavioral health and addiction services | CCO metrics<br><br>Adults with 1 or more poor mental health days<br><br>Access to mental health providers |

## *Focus Areas & Strategies*

## *Focus Area: Families & Children*

The Families and Children focus area aligns with the state SHIP and includes adversity, trauma and toxic stress, including abuse and neglect, living in poverty, incarceration, family separation and exposure to racism and discrimination. Events such as these have a lifelong effect on the health of individuals. The CAC prioritized work around ACEs and trauma to be of high priority.

The CAC also prioritized supporting programs and services related to health and wellness of maternal and child health, including the promotion of breastfeeding.

| *Focus area* | *Strategy* | *Indicators/outcomes to track progress* |
|---|---|---|
| Families & Children | Support efforts and programs that mitigate trauma and increase resilience<br><br>Promote programs that address child & youth health and wellness<br><br>Continue to engage with Early Learning Hub to promote early learning programs | ACE's metrics<br><br>Number of organizations with Trauma Informed Policies/ Procedures<br><br>Child abuse reports<br><br>Children in foster care<br><br>% of infants who are breastfed |

## *Next Steps*

The 2018 Community Health Assessment and 2019 Community Health Improvement Plan draw attention to many challenges and opportunities for positive change in Douglas County. These documents are one another as companion documents, to both paint a picture of health in Douglas County as well formulate a plan to address the needs identified in the snapshot of health. The process and these documents are considered to be living, meaning they will be updated and changed as the community health and needs change. UHA's Community Advisory Council members will continue to provide vital oversight of the Community Health Improvement Plan, with input from community partners. These community partners include but are not limited to the Early Learning Hub, school health providers, relief nurseries, community health centers, oral health care providers, community mental health providers, the area hospital, administrators of county health department programs that offer preventive services to children, partners coordinating the effective and efficient delivery of health care to children and adolescents, and any partners who are working to improve the health and wellbeing of individuals, families and the community at large in UHA's service area.

Umpqua Health Alliance and the Community Advisory Council recognizes that there are many organizations already working to improve health and wellness in our service area. Connecting with current efforts will help strengthen this work and provide stronger outcomes. This document will guide CAC members and UHA in identifying community benefit initiatives that will have the greatest positive impact in Douglas County.

# *Appendix*

## *UHA Community Health Improvement Plan (CHIP) Care Integration Assessment| April 2019*

The UHA Community Health Improvement Plan (CHIP) began in the spring of 2019. The care integration assessment was added as a required component of the Community Health Assessment (CHA) and CHIP processes during the 2017 legislative process with House Bill 2675 and subsequent ORS 414.627. UHA convened a meeting on April 15th, 2019 where a large group of community members came together to conduct the care integration assessment.

The **purpose** of the care integration assessment is to identify the service areas with opportunities for integration that will influence the health and quality of life in the community assessed. The care integration assessment is designed to inform the CHIP, which shall include plans and strategies for integrating physical, behavioral and oral health services.

The care integration assessment brainstorming meeting began with a discussion of the purpose of the care integration assessment, followed by discussion of the definition of integration. Care integration was defined as the purposeful presence or coordination of services that maximally support a person or family at each opportunity for interaction with social and health systems.

The group then brainstormed and listed the best examples of integrated care in the county as well as the greatest opportunity. The specific questions asked were:

- ***Write down how and where you've seen the best examples of integrated care in Douglas County.***
- ***Write down where you see the greatest opportunity for care integration in Douglas County.***

*Best Examples of Integration Cited:*

- ***Food banks***
- ***Bailey's Clinic***
- ***Coordinated Clinic Services***
- ***No Clue!***
- ***CARES + Phoenix Charter School- Education w/mental health and social services provided to students in need***
- ***Co-located victim services***
- ***Mental health and substance abuse co located at Adapt Madrone Bldg***
- ***Substance abuse intervention at Phoenix School***
- ***UCAN***
- ***UCHC***
- ***Integrated care clinics UCHC and South River***
- ***UCHC***
- ***Behavioral Health & primary care***
- ***SBHC***
- ***CO-located advocate program w/BPA and healthcare***
- ***No true integration by definition***
- ***Co-located south river UCHC***
- ***Dental in schools and other locations***
- ***Dental, medical, foster child assessments and mental health all in one agency***
- ***Behavioral health integrated physical health clinics***

*Greatest opportunity for care integration in Douglas County cited:*

- ***Integrate prevention across/within systems, example schools like Phoenix***
- ***Integration in schools for kids and youth***
- ***PCP, MH, Sub, Housing Svcs all under one roof***
- ***Addressing food insecurity/hunger at doctor appts***
- ***DHS/law enforcement/mental health services/education***
- ***Link mental health to education***
- ***Further integration of physical primary health into Adapt Madrone building***
- ***Substance use and addiction services in primary care***
- ***Housing advocate***
- ***Mothers milk access, support, clinical reimbursement***
- ***Dental***
- ***Be more active in schools, proactive***
- ***Integration of behavioral health and substance abuse services***
- ***KIC-Multi agency coordination***

Individuals in the group then filled out the Integration Assessment Grid, which was designed to identify community value in integration and to identify the level of integration currently happening in several different service areas.

| Service Area | Integration Today | Value of Integration to Community |
|---|---|---|
| **Mental Health Services** | 32⋆ | **60** ♡ |
| **Food Availability & Access** | 27⋆ | 59 ♡ |
| **Housing Availability & Access** | 20⋆ | 57 ♡ |
| **Substance Use Treatment** | 30⋆ | 55 ♡ |
| **Public Health System** | 22⋆ | 51 ♡ |
| **Physical Health Services** | 30⋆ | 56 ♡ |
| **Oral Health Services** | 36⋆ | 54 ♡ |
| **Income/Poverty** | 26⋆ | 52 ♡ |
| **Education System** | 31⋆ | 54 ♡ |
| **Transportation** | 23⋆ | 51 ♡ |
| **Legal Services** | 14⋆ | 39 ♡ |

None or some integration happening= ⋆
Moderate integration happening=⋆⋆
Extensive integration happening= ⋆⋆⋆
Less important to community=♡
Moderate importance to community=♡♡
Very important to community=♡♡♡

After the individual assessment, the group then broke into small groups and identified and listed best practices, opportunities, challenges and resources needed in each domain. The groups then prioritized opportunities in each domain with dots.

## Behavioral Health/Mental Health Domain

| | |
|---|---|
| **Best Practices**<br>Trauma informed care<br>Panel care (team coordination) medical/ clinical<br>Cognitive Behavioral Therapy<br>Integration<br>School based therapist<br>Alternative programs<br>Cancer center | **Opportunities**<br>**Screenings – 4 dots**<br>**Parity – 3 dots**<br>**Increase % of funding to prevention- 2 dots**<br>**Skill building for self/emotional Reg – 2 dots**<br>**Suicide prevention education – 1 dot**<br>Education and training<br>Re-education of understanding mental health & mental health services<br>Anger management classes<br>Training needs |
| **Resources Needed**<br>**1 way in- 3 dots**<br>More clinicians- LMP at all levels<br>Residential treatment<br>Crisis/respite<br>More community-based treatment<br>PSA on where to go for needs you may have<br>Connections to social engagement and personal development<br>"Mental health lifeguards" needed | **Challenges**<br>Trust and collaboration across systems needs improvement<br>State mandates create barriers<br>SILO's<br>Burn out collaboration<br>Trauma stigma access<br>Transportation<br>Funding for non-traditional, alternative programs<br>Privacy laws-school/care provider<br>Health of community impacts recruitment of profession<br>Core community structures feel diminished: libraries, UCC, public health<br># of kids in foster care and lacking foster parents |

## Housing Availability & Access Domain

| | |
|---|---|
| **Best Practices**<br>Housing first model<br>Quality wrap-around services<br>Dream savers/IDA->first time home buying | **Opportunities**<br>**Tiny house movement (transitional resource)- 7 dots**<br>**Increase State $$$- 5 dots**<br>Engage with state of Oregon Initiatives<br>More collaboration across groups<br>2nd Chance Program |
| **Resources Needed**<br>Community will<br>Affordable housing<br>Support for special populations-those with cognitive delays<br>More housing units (renting/purchasing)<br>Responsible builders<br>Community investment | **Challenges**<br>Economics<br>Classism<br>Requiring sobriety before housing<br>Lack of housing<br>Housing affordability<br>Land mitigation<br>Maintenance costs of public housing<br>Not in my backyard mentality<br>Decrease fed. $<br>Long wait lists for public housing (UCAN)<br>crime |

**Food Availability & Access Domain**

| **Best Practices** | **Opportunities** |
|---|---|
| Meals on Wheels<br>Emergency food to the people<br>Nutrition education<br>Partnership with healthcare<br>Conceptually based on principles vs. places<br>Snack packs at schools<br>Consider food policy-that is the resource you refer to<br>Network-policy committee across sector work. Leadership, community will and advocacy<br>UC-VEG<br>Whole foods cradle to elder<br>Community gardens Stewart Park free lunches for kids<br>Dream Center does Breakfast every morning<br>School Food Programs/Green Bag Program | **Linking existing efforts and aligning- 4 dots**<br>**Education about nutrition information- 2 dots**<br>**Transformative change in addition to existing incremental change – 1 dot**<br>**People to understand the available network of food (agencies are unaware of providers)-1 dot**<br>CCO become more involved in nutrition<br>Mobile Food Pantry<br>More advertising for Green Bag and expand to business programs and restaurants<br>More community gardens<br>House bill to increase age of WIC<br>ADVOCACY!! |
| **Resources Needed** | **Challenges** |
| Network-policy committee across sector work. Leadership, community will and advocacy<br>Data tracking-initiation, exclusivity duration, breastfeeding<br>Coordinate-fully integrate to base program implementation<br>Fundraising efforts<br>Sustainability for school gardens | Understanding of local food system<br>Desire to focus only on children<br>Funding Sneak Peeks (types are expensive to obtain)<br>Getting the food to where the person is<br>Consider logistics & stigma<br>Avoid duplicating efforts<br>Competing-(Green Bag only helps one pantry)<br>Access to mothers milk support, promotion, protection, reimbursement for clinical lactation care<br>Transportation<br>Stigma!!!<br>Communication<br>Time pantries are open<br>Baby food<br>Fresh food |

**Substance Use/Abuse & Treatment Domain**

| **Best Practices** | **Opportunities** |
|---|---|
| Education-in the community & schools<br>Suboxone centers<br>ADAPT-MedAssist Treatment Services<br>HIV alliance<br>S.I.S. – Safe Injection Sites<br>Harm reduction models<br>Peer support<br>Oxford House<br>Salvation Army rehab program<br>AA - NA | Residential Treatment Center- 7 dots<br>Expand Services- 5 dots<br>Oxford House<br>More services<br>Certified Alcohol and Drug Counselor classes<br>More voluntary participants |
| **Resources Needed** | **Challenges** |
| More providers<br>More group support<br>Residential treatment<br>Partnerships<br>More Peer Support<br>Smoking prevention<br>Intensive Outpatient Program<br>Gaming addiction | Consumer choice<br>Availability & Access<br>Funding<br>Unmet need<br>Education / Knowledge of risks<br>Homeless population |

**Public Health Domain**

| **Best Practices** | **Opportunities** |
|---|---|
| DPHN<br>Communicable diseases tracking & treatment<br>Integrating policy and prevention into existing systems to align them not fragment them<br>Consumer voice/consumer driven<br>Positive messaging<br>Local example: toilets downtown consider cost effective, health & safety<br>Focus on housing first<br>Uplift resource & referral, through ESD | Public Health Modernization Informed & engaged community (big arrow down to) address the barriers to having community involved, such as location and transportation-5 dots<br>Identify gaps in public health<br>Visible leadership and operations |
| **Resources Needed** | **Challenges** |
| Visible leadership and operations<br>Public Awareness- 1 star<br>Events<br>Reference sheet of all county resources available at all non-profits | It's a mystery!! What still exists and where is it? – a star and an arrow<br>Accessing data (local)-arrow points down to lead efforts on strategies-arrow points down to evaluating strategies with consumer voice |

## Physical Health Services Domain

| Best Practices | Opportunities |
|---|---|
| Integration of physical/oral/mental<br>Kickstart Y<br>PE in schools<br>Blue Zones<br>Total Health Improvement Plan<br>Funding for prevention Integrating Adverse Childhood Experiences and Trauma Informed | **Education on cheap healthy eating-4 dots**<br>**More gender specific services and expertise- 3 dots**<br>**Support kids in playing sports more-2 votes**<br>**THIP in more doctor offices-2 votes**<br>**Parents understanding importance of physical health of children-1 vote**<br>Embed Catch Program in schools<br>Consumer health voice-make it fun<br>Mercy Foundation Grant for sports participation |
| **Resources Needed** | **Challenges** |
| Parks with adult access equipment<br>Sidewalks, trails and pathways<br>Safe routes for bikes and walking<br>Public Service Announcement about physical health and mental health | Cost of gym memberships<br>Punishment for kids by taking away recess/physical activity<br>PCP wait list<br>MH concerns<br>More opportunities for equipment to make user friendly for all needs<br>Funds to support healthy eating and activity<br>Understanding |

## Oral Health Domain

| Best Practices | Opportunities |
|---|---|
| In schools<br>First tooth first visit<br>Dental care pregnant moms Advantage & Healthy Kids Outreach Program<br>School Screenings<br>Integrating mental/physical/oral<br>WIC<br>FDC-screening 3x/year<br>Advantage & So. River & Douglas Cares integration<br>Head Start<br>Family Development Center<br>WIC Dental Days | **Increase OHP benefits-3 dots**<br>**PSA early dental care-1 dot**<br>Dental organizations partner with OHP on preventative<br>Education through schools/prevention<br>Single-payer health care<br>Integrated health care-has improved in the last ten years<br>Tele-Health in group homes |
| **Resources Needed** | **Challenges** |
| Staff needs to be trained in OHP/poverty<br>Equality regardless of insurance<br>Rural access<br>Fluoride<br>Silver Diamine Fluoride – check mark | Equality regardless of insurance or without insurance<br>Limited care opportunities with OHP<br>Cost of OHP oral health-type of care is limited (quality + procedures done)<br>Rural access<br>#1 pediatric illness/disease<br>Emergent case & dentures (hinders employment)<br>Gap in service for veterans (group homes and rest homes), uninsured, seniors, working class<br>Not prioritized-perceived as a luxury<br>Hours |

## Income & Poverty Domain

| Best Practices | Opportunities |
|---|---|
| OHA Workbook near home<br>Wrap around supportive services<br>Job training for clients to become staff<br>Vocational training | **Community angency provide childcare for staff and community -5 votes**<br>**Economic development-5 votes**<br>**Elevating status of women and income-3 votes**<br>Assuring quality education for all children<br>Upstream preventive health care<br>No wrong door programs<br>Understanding poverty tranings |
| **Resources Needed** | **Challenges** |
| Trauma informed supportive servicers<br>Reproductive health services, condoms with spermicide<br>Educate on budgeting<br>Child care subsidies<br>Vocation training<br>More living-wage employers<br>Child care providers | Multi-generational poverty<br>Limited work force training<br>10% of patients using 80% of resources<br>Lack of resources<br>Housing<br>Child care<br>Keeping college courses related to voc training |

## Education Domain

**Best Practices**

School-based services (Health Centers) Health and mental.
Comprehensive Care in one place Food boxes distribution
More early childhood education
Yoncalla Early Works, a parent led/ grassroots student success focus across all ages, wraparound model, supported by professionals
UCC providing community training to encourage local employment
Online education

**Opportunities**

**Satellite services in rural locations- 5 dots**
**Private partnerships/local businesses-1 dot**
School-based pantry/mobile pantry
Americorps Project as resource
People who understand the future of Douglas County and paring with business development people
Remove structural barriers
- Regulatory
- Sector
- Administrative
- Practice

**Resources Needed**

Volunteers and the structure to activate them
Strong workforce
Facilities/safe places to operate
Adequate on the job training
Voc ed programs focused on Douglas County jobs
Voc ed/trade in high school
Jobs that support higher ED
Support from the community
Increase parenting education near home

**Challenges**

Weekends/summer disconnection
Volunteer capacity
Stepping out of core mission (do we provide services as well?)
Turnover of staff/lack of qualified staff
Family distrust of schools
Keeping kids in school to graduation
Transportation

## Transportation Domain

| Best Practices | Opportunities |
|---|---|
| VA transportation<br>Bay Cities working with providers Dial-A-Ride-transport district connecting!<br>Utrans-transport district connecting!<br>Medicaid transport<br>Type 10 certification | **No Wrong Door how people can become connected- 6 dots**<br>**Revisit policies to change punitive rules/processes/policy- 3 dots**<br>**Court house 2 rides a month!-1 dot**<br>Knowledge of Medicaid transport-three arrows pointing to gym, grocery store and Non-car transportation (walkable, bikeable, consider strollers, wheelchairs, safe routes to school)<br>Trauma Informed needed<br>Transport for emergency food (rural folks medical transport)<br>Uber model for services |
| **Resources Needed** | **Challenges** |
| Information about comparable communities<br>Ability to sign up via an app, more routes and later routes to rural areas-(smiley face)<br>Car seats for resource transport. (Bay Cities doesn't have them.) | Cancellations/hurts service providers<br>Wait times/ride share, Medicare rides<br>logistics (e.g. Advanced notice Meeting individual needs: # of children, mobility, safety, cleanliness, #of bags, dogs)<br><br>48-hour rule<br>Times they run<br>Access to multiple non-medical stops<br>Accommodation (time) |

## Legal Services Domain

| Best Practices | Opportunities |
|---|---|
| Juvenile sex offender treatment<br>San Diego County- specialized courts<br>Crisis response training<br>Neighborhood Watch<br>Coalitions/task forces<br>Jail Diversion<br>Psychiatric Security Review Board<br>370<br>Legal Aid<br>Mental Health Court<br>Drug Court<br>Mobile Crisis | **Engage law enforcement in health and social services-2 dots**<br>**Changing the public defender's system-1 dot**<br>**Trauma informed- 1 dot**<br>Expand mental health provider ride alongs with law enforcement-happening<br>Trust building and dismantling fear (e.g. restorative Justice)<br>Legislation changes<br>Allowing lower level legal help |
| **Resources Needed** | **Challenges** |
| Supports for the newly un-incarcerated.<br>Education for judges, attorneys, etc on social and health issues<br>Navigator in systems to understand your rights/choices-specifically in child welfare<br>Sobering center-with qualified staff<br>Drop-in center-with qualified staff<br>Preventing illegal behavior<br>Resource list of legal resources<br>Referrals | Limited legal aid<br>Rotating judges<br>Support for judges & staff<br>Transportation<br>Child care<br>Felons getting jobs, housing etc.<br>Supports for the newly un-incarcerated. |

# **CCO Community Health Improvement Plan:** 2019 Supplemental Questionnaire

The purpose of this document is to support CCOs in meeting contractual requirements for the community health improvement plan (CHP) progress report submission per **Exhibit B, Part 1, #4**, **Oregon Revised Statutes 414.627 and 414.629**, **Oregon Administrative Rule 410-141-3145**.

A. The CHP is due to the Oregon Health Authority's Health Systems Division (CCO.MCODeliverableReports@state.or.us) by June 30, 2019.

B. Two documents are required to complete your annual progress report:

1) The full CHP; and
2) The completed questionnaire (this document).

## General

1. **Who is your CCO's primary contact for the community health improvement plan?**

CHP Primary Contact Name and Title: Kat Cooper, Director, Marketing & Communications
Email address: KCooper@umpquahealth.com

## Requirements

2. **Did the CAC oversee the CHA and adopt a CHP to serve as a strategic population health and health care system service plan for the community served by the CCO?** Oregon Administrative Rule 410-141-3145, Part 5.

☒ Yes ☐ No

3. **Did the CCO conduct the CHA and CHP so that they are transparent and public in process and outcomes?** CCO 2019 Contract: Exhibit B, SOW, Part 1, Governance; Section 4.c.

☒ Yes ☐ No

**Briefly describe how the CHA and CHP were transparent and public in process and outcomes:** UHA included public input in process and outcome of both the CHA and CHP. The CHA was created with primary data from two main sources: in-person focus groups and an online or physical personal survey. UHA's CAC helped organize 10 focus groups with different populations, with a total of 73 participants. UHA also organized a survey that was available online, as well as in physical copies. 298 people took the survey. The CAC utilized this data when developing the Community Health Improvement Plan. The CAC also discussed the CHP at CAC meetings that were held in public, and also invited community partners to a care integration meeting to discuss the CHP.

4. **Did the CCO provide opportunities for Indian Health Care Providers (IHCPs)[1] to contribute in the process to develop the CHA and CHP?** This includes, but is not limited to, the following actions: including tribes and IHCPs to contribute and gather health disparities data, identification of CHP priorities, and

[1] Indian Health Care Provider (IHCP), as defined in Oregon Administrative Rule 410-120-0000, means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603.

allowing IHCP feedback and review of the CHA and CHP. CCO 2019 Contract: Exhibit B, SOW, Part 1, Governance; Section 4.d.

☒ Yes ☐ No

**Briefly describe how and what opportunities the CCO provided:** UHA has tribal representation on the CAC itself. The CAC was integral in the creation of the CHA and CHIP and included tribal input in both the CHA and the CHIP.

**If no tribes or IHCPs are geographically represented in your service area, describe the outreach or other efforts taken to ensure representation of tribal populations living within your service area:** Click here to enter text.

5. **Did the CCO include representatives of populations experiencing health disparities in the CHA and CHP prioritization**? Oregon Administrative Rule 410-141-3145, Part 8; CCO 2019 Contract: Exhibit B, SOW, Part 1, Governance; Section 4.b.

☒ Yes ☐ No

**Briefly describe which populations were represented and how the CCO included them in the prioritization:**

UHA relied on it's Community Advisory Council members to help oversee the work on the CHA and CHP. UHA's CAC includes members who represent specific populations, including: seniors and people with disabilities, mental illness and addictions, children, tribal, and the faith community. While gathering input for the CHA, UHA's CAC organized 10 focus groups for individuals from specific target populations, including: Latino/Spanish-speaking individuals, CAC members, people with disabilities, geographic specific (Glide residents), people working in the service industry, people on Oregon Health Plan, retired people & seniors, people experiencing homelessness, behavioral health/mental health/addictions, and parents. The 10 focus groups had a total of 73 participants. Data from the CHA (including the focus groups) informed decisions made regarding the Community Health Improvement Plan.