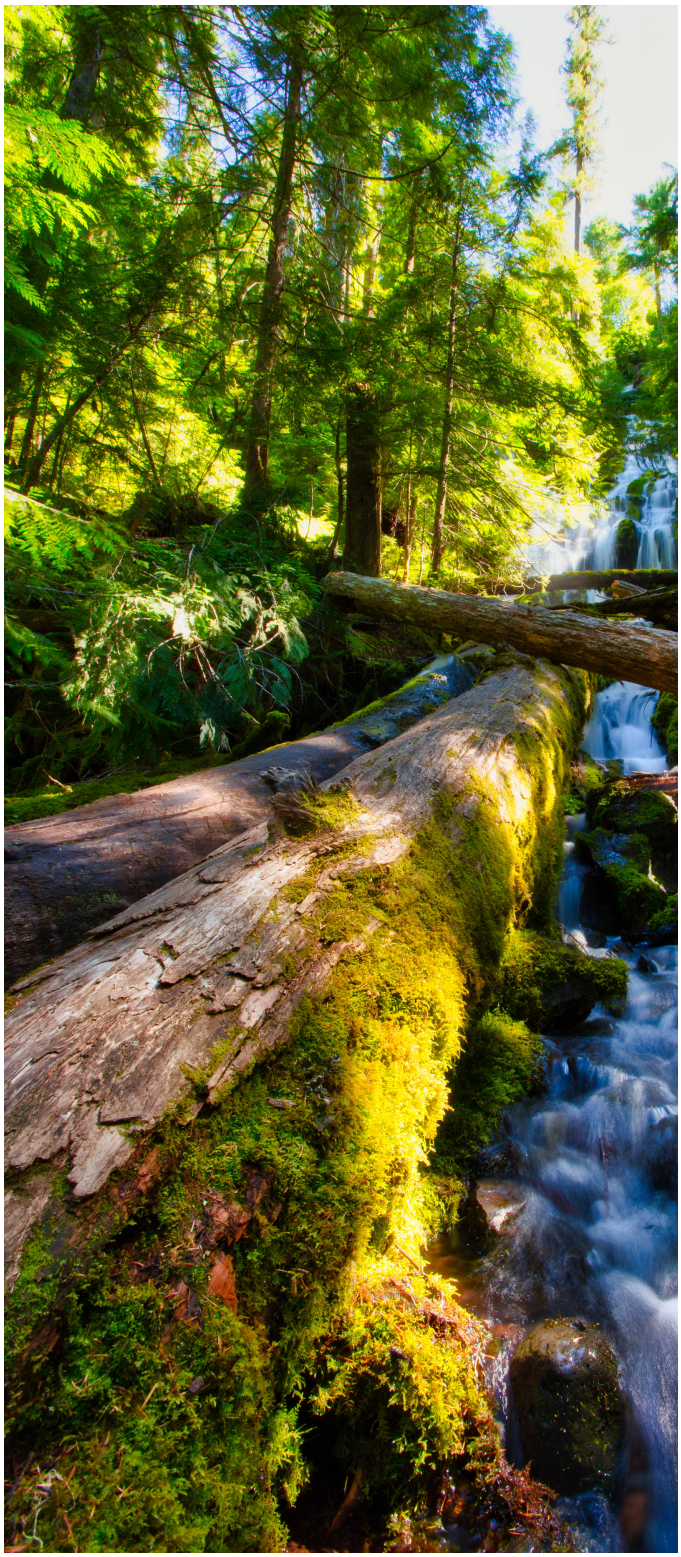

Partnership for Community Health

Linn, Benton & Lincoln Counties

Regional Community Health Improvement Plan

2024-2028

Regional Community Health Improvement Plan

Linn, Benton & Lincoln Counties

2024–2028

Published January 2, 2025

To access this document in an alternate format
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Community Partner Acknowledgements

The Partnership for Community Health would like to thank the numerous community partners of the Linn-Benton-Lincoln region for their invaluable contributions to the development of the regional Community Health Improvement Plan (CHIP). The partners are presented in alphabetical order:

Affordable Housing Partners of Lincoln County

Alsea Community Action Collaborative

Arcoíris Cultural

Atonement Lutheran Church

Benton County Behavioral Health

Benton County Coordinated Homeless Response Office

Benton County Health Navigation

Benton County Home, Opportunity, Planning & Equity (HOPE)

Benton County Public Health

Building Blocks Mental Health

Casa Latinos Unidos

Center Against Rape and Domestic Violence (CARDV)

Child Development Network

Coast to the Cascades Community Wellness Network

College of Osteopathic Medicine of the Pacific-Northwest (COMP-NW)

Communities Helping Addicts Negotiate Change Effectively (C.H.A.N.C.E.)

Community Harm Reduction Mentors & Allies

Community Health Centers of Benton and Linn Counties

Community Outreach Inc (COI)

Community Services Consortium

Conexión Fénix

Confederated Tribes of Siletz Indians

Corvallis Daytime Drop-in Center

Corvallis Multicultural Literacy Center

Crossroads Communities

Exodus Recovery

Faith Community Health Network

Faith Hope & Charity

Family Assistance and Resource Center Group

Family Tree Relief Nursery

Farmworker Housing Development Corporation

Growing Ancestral Roots

Integrated Services Network Support Services

Intercommunity Health Network Coordinated Care Organization (IHN-CCO)

IHN-CCO Behavioral Health Strategy Committee

IHN-CCO Community Advisory Council

International Moms Group

Lincoln County Behavioral Health

Lincoln County Community Health Center

Lincoln County Health & Human Services

Lincoln County Health & Human Services, Behavioral Health

Lincoln County Homeless Advisory Board

Lincoln County Housing Authority

Community Partner Acknowledgements (continued)

Lincoln County Public Health

Linn County Public Health, Health Promotion

Linn Benton Hispanic Advisory Council

Linn Benton Lincoln Health Equity Alliance

Linn Benton National Association for the Advancement of Colored People (NAACP)

Linn County Maternal Child Health Programs

Linn County Multi-Agency Coordination Group

Linn County Public Health

Mid-Willamette Trans Support Network

Northwest Coastal Housing

Old Mill Center for Families & Children

Oregon Coast Bank

Oregon Health Authority

Oregon Public Health Association

Oregon State University

Oregon State University College of Health

Oregon State University Extension Service

OSU Student Health Services

ReConnections Counseling

Regional Health Education Hub

Roundhouse Foundation

Samaritan Family Medicine, Samaritan Health Services

Samaritan Treatment & Recovery Services

Siletz Community Health Clinic

South Benton Food Pantry

Strengthening Rural Families

Systems of Care

United Way of Linn, Benton & Lincoln Counties

Unity Shelter

Weaving Fala

Young Roots Oregon

Contents

Executive Summary

Background

The 2024-2028 regional Community Health Improvement Plan (CHIP) was developed by the Partnership for Community Health (PCH) in collaboration with the communities of Linn, Benton, and Lincoln Counties. The PCH is a multiagency collaborative with a shared vision to improve the health and well-being of all people within the region. The current PCH members are:

- Benton County Public Health
- Community Advisory Council (CAC) for the InterCommunity Health Network Coordinated Care Organization (IHN-CCO)
- Community Health at Confederated Tribes of Siletz Indians
- Lincoln County Public Health
- Linn Benton Lincoln Health Equity Alliance
- Linn County Public Health
- InterCommunity Health Network Coordinated Care Organization (IHN-CCO)
- Samaritan Health Services
- United Way of Linn, Benton & Lincoln Counties

This is the first regional CHIP developed for Linn, Benton, and Lincoln counties. A regional approach enables communities to share information about health needs, collaborate with various partners, and develop health improvement strategies for impact across the region. This collaboration also elevates common health-related needs in Linn, Benton, and Lincoln Counties, intending to lessen the perceived geographic and social divides that impact the health of these communities. The PCH conducted a Regional Heath Assessment (RHA) for 2022-2026 that was published in Spring, 2023.

Public Health Foundation

Public health is defined by three core functions: **assessment**, **policy development**, and **assurance**. These functions provide a framework for local health departments and healthcare systems to promote optimal health and remove systemic inequities. The goals and strategies in the CHIP address these functions and guide resources to meet the communities' needs.

Key public health concepts that guide the development and implementation of the CHIP include:

- Social determinants of health
- Health equity
- Public health modernization
- Mobilizing for Action through Planning and Partnerships (MAPP 2.0)

What is a Community Health Assessment?
A comprehensive picture of a community's current health status, factors contributing to higher health risks or poorer health outcomes, and community resources available to improve health.
What is a Community Health Improvement Plan?
A long-term, systematic effort to address public health problems based on the results of community health assessment activities. The process involves a collaborative, community-wide effort to identify health problems, assess data, develop measurable objectives, inventory community assets and resources, develop and implement coordinated strategies, and cultivate community ownership of the process.

Adapted from Public Health Accreditation Board Acronyms and Glossary of Terms Version 2022

CHIP development process

Community Health Improvement is a data-informed cycle that assesses community health needs and strengths, sets strategic priorities, and identifies processes for health improvement. The CHIP was developed from key themes in the RHA and community input on health challenges and opportunities. Four priority areas were set, and workgroups developed goals and strategies for each area. Workgroups included a balanced representation of counties, tribes, community-based organizations, and healthcare system members. The PCH Steering Committee finalized the CHIP based on the recommendations of the workgroups.

Priorities and goals

Each CHIP priority area has three goals and two to four strategies for each goal. Goals are long-term outcomes that set the direction for addressing the key health issues. Strategies are activities performed to reach a goal. All goals and strategies were developed with a focus on priority populations and inclusion, diversity, anti-racism, and equity (IDARE).

 **Access to Affordable Housing**	 **Access to Quality Care**	 **Behavioral Health**	 **Inclusion, Diversity, Anti-Racism, and Equity (IDARE)**
H1. Expand the availability of brick-and-mortar shelter, transitional, and/or permanent housing units by developing, acquiring, or securing properties across Linn, Benton, and Lincoln counties.	AQC1. Grow the regional healthcare workforce in innovative, supportive, and sustainable ways.	BH1. Use a person-centered, culturally responsive, and trauma-informed approach to behavioral health promotion and destigmatization through education, communication, and engagement.	IDARE1. Change systems, remove barriers, nurture equity, and improve well-being.
H2. Expand and sustainably fund supportive services for shelter, transitional, and/or permanent housing.	AQC2. Reduce barriers to Oregon Health Plan enrollment and the use of benefits.	BH2. Increase access to responsive, transformative behavioral health services and supports that are culturally and linguistically appropriate.	IDARE2. Increase inclusion, diversity, antiracism, and equity (IDARE) and gender justice education and accountability measures in the system of services.
H3. Improve data across the spectrum of shelter and housing providers to help create future progress measures and inform planning.	AQC3. Ensure that care is timely, local, and empowering.	BH3. Develop and improve a comprehensive continuum of care that integrates regional behavioral health systems and community-based organizations (CBOs) using a person-centered and community-focused approach.	IDARE3. Improve the process of collecting, using, owning, and sharing data by creating a data task force.

Introduction

Partnership for Community Health

The Partnership for Community Health of Linn, Benton & Lincoln Counties (PCH) is a multiagency collaborative of local public health authorities, health systems, and key partners committed to improving community health in the region. The PCH produced the **Regional Health Assessment (RHA)**, 2022-2026 and this regional **Community Health Improvement Plan (CHIP)**, 2024-2028.

The Partnership for Community Health includes the following organizations, who co-created this CHIP with community input and share responsibility for implementation and evaluation.

- Benton County Public Health
- Community Advisory Council (CAC) for the InterCommunity Health Network Coordinated Care Organization (IHN-CCO)
- Community Health at Confederated Tribes of Siletz Indians
- Lincoln County Public Health
- Linn Benton Lincoln Health Equity Alliance
- Linn County Public Health
- InterCommunity Health Network Coordinated Care Organization (IHN-CCO)
- Samaritan Health Services
- United Way of Linn, Benton & Lincoln Counties

The PCH was established in 2021 to promote a shared vision for community health and positive change. PCH members represent large portions of the regional public health and healthcare systems and recognize that their full impact cannot be realized without further elevating voices and experiences across sectors and populations.

Collective Impact Model

The PCH is guided by a **collective impact framework** that encourages partners to solve complex social and systemic problems by focusing on a shared vision of positive change.[1] The core components of this framework include:

- Common agenda
- Shared measurement
- Mutually reinforcing activities
- Continuous communication
- Backbone support organizations

The goals and strategies in this CHIP function as the shared agenda and goals, with the PCH serving as the "backbone organization." Shared work plans for CHIP implementation and the PCH's commitment to long-term collaboration exemplify continuous communication and mutually reinforcing activities.

[1] https://collectiveimpactforum.org/what-is-collective-impact/

Regional Community Health Assessment and Improvement Plan

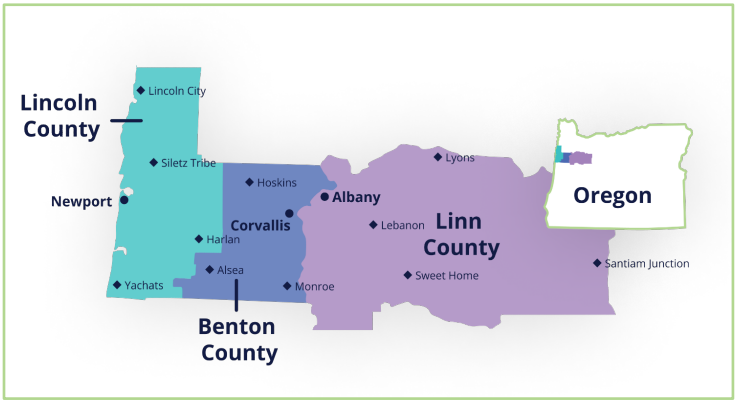
This is the first regional Community Health Improvement Plan developed for Linn, Benton, and Lincoln counties. A regional approach enables communities to share information about health needs, collaborate with various partners, and develop health improvement strategies for impact across the region. This collaboration also elevates common health-related needs in Linn, Benton, and Lincoln counties, intending to lessen the perceived geographic and social divides that impact the health of these communities.

Public Health is defined by three core functions: **assessment**, **policy development**, and **assurance**. These functions encompass essential public health services that provide a framework for agencies such as local health departments and hospital systems to promote optimal health and remove systemic inequities. The RHA and CHIP process enables the PCH to perform these essential services by collecting comprehensive information about the region's health status and directing resources to meet the communities' needs.

The People of Linn, Benton, and Lincoln Counties

All information in this section and the priority area sections (Housing, Access to Quality Care, Behavioral Health, IDARE) comes from the 2022–2026 Linn, Benton, and Lincoln County Regional Health Assessment (RHA) (English and Spanish) unless otherwise noted.

Approximately 268,700 people reside across the 3,900 square miles encompassing Linn, Benton, and Lincoln counties. The region contains diverse populations including families, migrant workers, immigrants, farmers, educators, and more. This area also has many younger residents and professionals, influenced by the presence of Oregon State University, Linn Benton Community College, and Samaritan Health Services.

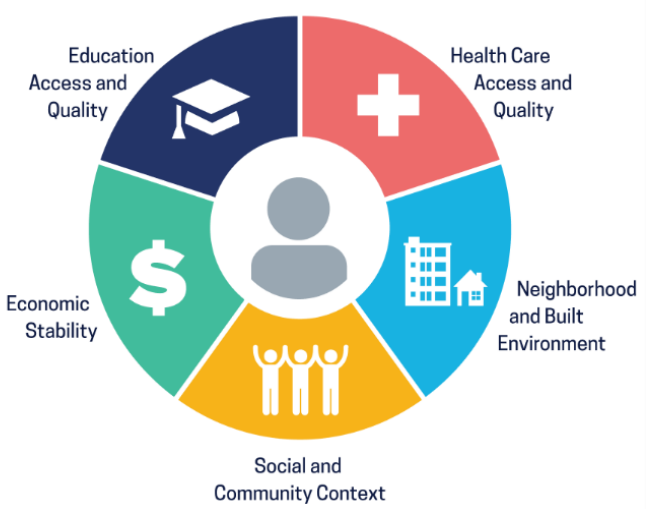


The region's mix of urban and rural areas and its diverse populations create varied and complex health and social needs. Disparities exist in housing availability, access to quality healthcare, and behavioral health resources. People with lower socioeconomic status often experience greater barriers. Significant differences are also evident between English- and non-English-speaking families, urban and rural residents, and white and non-white individuals.

The Oregon Office of Rural Health defines **rural** as any geographic area in Oregon ten or more miles from a population center of 40,000 people or more. Based on this definition, all cities and towns in Lincoln County are rural. Approximately half the population of Linn County and two-thirds of the population of Benton County reside in rural areas. Some communities in the region have state and federal designations for health care needs, which qualify them for additional resources for facilities and providers.

Public Health Foundations

Social Determinants of HealthSocial Determinants of Health (SDOH) are the non-medical factors that cause health inequities. Access to care, housing, and behavioral health services depends on social and economic factors. Differences in ease of access—or even the ability to access—exist due to differences in race, ethnicity, culture, language, and location (for example, urban and rural communities). The SDOH were a high priority for all partners in the CHIP development process. Focusing on the SDOH enables this CHIP to impact upstream factors in community health and root causes of health inequities.



https://odphp.health.gov/healthypeople/objectives-and-data/social-determinants-health

Public Health Modernization

https://oregonclho.org/local-health-departments/public-health-modernization

The state of Oregon adopted an equity-focused public health system that combats contemporary public health challenges. Modernization aims to ensure that the public health system operates efficiently, is aligned with health system transformation, and provides critical protections for every person in the state. These protections include protection from communicable diseases and environmental risks, health promotion, and prevention of disease and injury. In 2017 the Oregon State Legislature began funding local public health authorities (LPHAs) and regional partnerships to increase their capacity around key functions to achieve a high standard of overall health for all Oregonians.[2] This CHIP is a regional Modernization project that aligns with the LHPAs' goals for health outcomes and equity.

Public Health Accreditation

The Public Health Accreditation Board (PHAB) is the national accreditation body for public health departments in the U.S., which supports the improvement of their quality, accountability, and performance. Accreditation helps support local health agencies through opportunities for funding and resources, as well as systemic improvements to the national public health infrastructure. Current accreditation standards are aligned with the ten essential public health services and emphasize health equity across all domains.

[2] https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf

State Health Improvement Plan

This CHIP is aligned with *Healthier Together Oregon*, the 2020-2024 State Health Improvement Plan (SHIP).[3] The vision of the SHIP is:

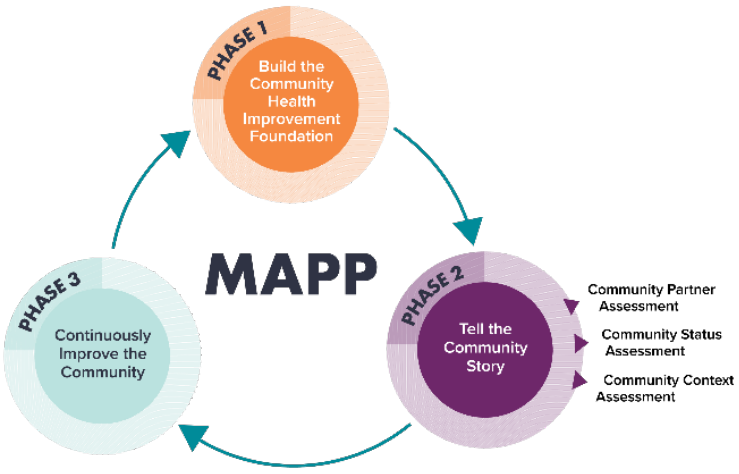
> Oregon will be a place where health and well-being are achieved across the lifespan for people of all races, ethnicities, disabilities, genders, sexual orientations, socioeconomic status, nationalities, and geographic locations.

The overarching goal of the SHIP is to achieve health equity, naming the following groups as priority populations that experience persistent barriers to health access and outcomes in the state:

- Black, Indigenous, people of color, American Indian/Alaska Native People (BIPOC-AI/AN)
- People with low incomes
- People who identify as lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+)
- People with disabilities
- People living in rural areas

MAPP 2.0

The planning process of this CHIP is partly adapted from Mobilizing for Action through Planning and Partnerships (MAPP 2.0). This framework was developed by the National Association of County & City Health Officials (NACCHO) and is recognized as a best practice for aligning community resources to achieve health equity and address health issues. Engagement partners across sectors and authentically representing the status of communities is foundational to this model. While MAPP 2.0 covers the entire cycle of community assessment and improvement, the handbook was used most in the process of prioritizing CHIP goals and designing implementation plans. The PCH is likely to continue to use MAPP 2.0 in future cycles.



MAPP 2.0 User's Handbook https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

[3] https://www.oregon.gov/oha/ph/about/pages/healthimprovement.aspx

Regional CHIP Development

Community Health Assessment

Key Themes from the 2022-2026 RHA:

- Access to affordable housing and homelessness
- Access to quality care
- Equity, diversity, and inclusion
- Food insecurity and access
- Healthy youth and families
- Mental health
- Substance use and misuse

The regional Community Health Improvement Plan (CHIP) is one component of a data-informed cycle that assesses community health needs and strengths, sets strategic priorities, and identifies processes for health improvement. The PCH conducted a Regional Health Assessment (RHA) to better understand the health-related issues impacting Linn, Benton, and Lincoln Counties.

The 2022-2026 RHA was published in Spring, 2023. Data in the RHA is compiled from the following sources:

- Secondary sources such as the U.S. Census, state and federal government reports, and private-sector research
- Previous community health assessments and topics identified by public health agencies
- Community Health Survey distributed on paper and electronically in seven languages throughout Linn, Benton, and Lincoln Counties
- Virtual and in-person focus groups representing a broad range of communities and under-represented populations
- Key informant interview with diverse partners representing community-based organizations and cultural organizations

Following the development of the RHA, the PCH Steering Committee analyzed the data to identify priorities for the CHIP. This included a community engagement campaign to share RHA findings and ask community members to rank their priorities among the key themes. Engagement activities included community meetings, tabling events, and presentations to community-based organizations and schools. A prioritization survey was also distributed throughout the region. This feedback was analyzed via the SWOT method (Strengths, Weaknesses, Opportunities, and Threats)[4] to identify the four priority areas for the CHIP:

Workgroups

The PCH convened four workgroups to develop goals and strategies for each priority area. Workgroups included leaders from prior community engagement and equity partners from across the region. Care was taken to include a balanced representation of counties, tribes, community-based organizations, and healthcare system members. Their work was grounded in consideration for health outcomes, social determinants of health, and systems of power, privilege, and oppression.

[4] https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/swot.html

Workgroups met an average of four times between January and April 2024. Each workgroup was co-led by key partners with subject matter expertise and knowledge of the regional public health and healthcare systems. They were supported by planning team members (5-15 people) and support staff who coordinated meetings, facilitated discussions, and drafted recommendations. Workgroup members (30-40 people) included community partner organization representatives, individuals with lived experience, and equity experts. All workgroup participants were invited to participate in crafting and revising the goals and strategies. The PCH Steering Committee finalized the goals and strategies for each priority area based on the recommendations of the workgroups.

Health Equity Focus

Each CHIP priority area includes a component of health equity and inclusion, diversity, anti-racism, and equity (IDARE). The PCH uses the following definitions for these terms:

Health Equity	No individual, group, or person experiences worse health outcomes or unequal access to health support because of factors that are beyond their control or result from injustice. **Embodying** health equity means valuing everyone equally. **Achieving** health equity requires taking action to prevent inequalities, address injustice, and eliminate health disparities.
Inclusion	Creating spaces where all people are valued and empowered
Diversity	Celebrating human differences
Anti-racism	Actively confronts and transforms systems of oppression and discrimination based on race
Equity	Addresses systemic barriers and provides access to opportunities and resources.

The workgroup for the priority area of Inclusion, Diversity, Anti-Racism, and Equity (IDARE) sought to provide an equity lens that could be used in all the regional CHIP priority areas. The CHIP includes IDARE-specific strategies, but the entire project team will ensure equity across all priority areas.

Goals and Strategies

The four priority areas selected for the 2024-2028 regional Community Health Improvement plan are:

 Access to Affordable Housing	 Access to Quality Care	 Behavioral Health	 Inclusion, Diversity, Anti-Racism, and Equity (IDARE)
H1. Expand housing units	AQC1. Grow and sustain the workforce	BH1. Build community resilience	IDARE1. Improve equity and well-being
H2. Expand supportive services	AQC2. Increase Oregon Health Plan access and use	BH2. Grow a healthy workforce	IDARE2. Increase education and accountability
H3. Improve housing data	AQC3. Timely, local, and empowering care	BH3. Improve care coordination	IDARE3. Improve data quality

Goals are long-term outcomes that set the direction for addressing priority issues. Within the collective impact framework, the goals reflect the shared values of all partners, who are all committed to the systemic changes needed to achieve them. According to MAPP 2.0, goals and measurable indicators broadly describe what will be achieved by successfully addressing this priority issue.

Strategies are action plans performed to reach a goal. Each strategy in the CHIP was developed to uplift priority populations and address root causes of health inequities. The strategies in this CHIP represent improvements to existing or planned initiatives and novel approaches to public health issues in the region.

In public health, effective goals and strategies are often developed with **SMARTIE** objectives. This framework helps make the objectives clear and facilitates communication and accountability. MAPP 2.0 defines SMARTIE as:

- **S**pecific: Names a goal of the community partner who is implementing the strategy
- **M**easurable: Provides a way to assess the goal's progress
- **A**chievable: Can be attained, doable
- **R**ealistic: Is relevant based on the program's plan
- **T**imely: Includes a clear deadline
- **I**nclusion: Ensures that underrepresented voices are heard and share power
- **E**quity: Seeks to address injustices, inequality, and oppression within the system

The SMARTIE measures in this CHIP will include a specific time frame and identify the people responsible for completing the strategy action steps. Although MAPP 2.0 recommends setting SMARTIE objectives as the goals and strategies are being developed, staffing limitations in the PCH during that phase meant that some SMARTIE objectives will be established during CHIP implementation.

Implementation and Progress Measures

Progress measures

The PCH progress measures team developed the initial measurable outcomes for the CHIP goals. For most goals, the measurable components include outputs (direct results of the activities) and short- and longer-term outcomes relating to population health and health disparities. Progress measures are based on RHA data and input from workgroups. Where applicable, the progress measures team also identified baseline and improvement objectives.

The progress measures will continue to be refined in collaboration with PCH data experts and the implementation teams. As more detailed action plans are developed for the CHIP strategies, the expected outcomes and theories of change will evolve.

Implementation Plans

The Partnership will share responsibility for implementing the CHIP across the region. The collective impact model will support health agencies and community partners to contribute resources that are best matched to their skills and capacities while having a positive impact beyond the historical organizational and geographic silos. Implementation (action) plans are being developed for the CHIP goals and strategies. To promote collective impact and a shared measurement system, the PCH project coordination team is guiding community partners in writing action plans and tracking long- and short-term outcomes.

The core components of the implementation plans include:

- Specific activities for each strategy
- Timeframes for implementation steps
- People or groups responsible for implementation
- Outcome indicators and the reporting frequency
- Additional collaborators
- Resources needed and special considerations

Updated implementation plans will be published on the PCH website as they are available.

Evaluation

The PCH project coordination team is responsible for monitoring and evaluating the CHIP. Sustained engagement among the partners, implementation groups, and community will ensure that the CHIP is monitored continuously and that everyone is responsive when adjustments are needed. Evaluation plans for each strategy are being developed during implementation planning. The evaluation approaches to determine success and impact are:

- **Process**: How the activities are implemented; measuring the quantity and quality of CHIP activities and implementation steps
- **Outcome**: Assessment of short- and long-term program objectives; measuring the changes in health conditions, behaviors, and indicators

Questions that will guide CHIP evaluation include:

- Are activities being implemented as intended?
- Will the activities lead to the best possible outcomes for all populations?
- Are progress measures being collected? Do they reflect the impact of the strategies?
- Does the CHIP implementation reflect the health equity principles of the PCH?

To promote transparency and accountability, the PCH will share evaluation findings with community partners and collaborate on quality improvement. Evaluation and progress reports will also be published on the PCH website. Additional evaluation will take place through reporting required by the Oregon Health Authority, Public Health Accreditation Board, and other statutes covering the coordinated care organization and hospital systems

Priority Area:
Access to Affordable Housing

Overview

Access to safe, quality, and affordable housing is a basic necessity for healthy people and communities. Housing and the neighborhood environment are major social determinants of both physical and mental health. Improving equitable access to affordable housing has downstream impacts on health factors including physical safety, financial stability, consistent education and employment, supportive services, and resiliency to climate events.

Housing access and affordability present many challenges to community health in Linn, Benton, and Lincoln Counties. Among homeowners and renters in the region, a high percentage of household income is spent on mortgage/rent, insurance, and utilities. Community members noted the need for more housing units, including shelters, migrant/seasonal worker housing, and living spaces close to public transportation.

Homelessness and housing instability are also experienced in the region, and over one-third of unhoused people are considered chronically homeless while experiencing disabling conditions. Youth in K-12 schools are considered homeless according to the McKinney-Vento Act if they are unhoused, are doubled up with others due to hardship, or do not have a consistent nighttime place of residence. Lincoln County disproportionately experiences homelessness (14% of K-12 enrollment) compared to Benton (3%) and Linn (5%) Counties.

Housing efforts in Linn, Benton, and Lincoln Counties are managed by a network of municipalities, county and state agencies, federal programs, and community-based organizations (CBOs). In January 2023 Oregon Governor Tina Kotek declared a State of Emergency in response to a 63% increase in statewide homelessness since 2016. The accompanying Executive Order 23-20 and subsequent legislation increased investments in shelters, rehousing, and coordination of state and local housing priorities. House Bill (HB) 2019 requires locally driven two-year plans for attaining rapid rehousing and sheltering goals. The CHIP housing strategies align with these plans and draw on their community engagement processes.

The intersection of housing access and health is also recognized by Oregon's Medicaid program, which uses a Medicaid 1115 Waiver to support social needs through Oregon Health Plan (OPH) coverage. Beginning in Fall 2024, OPH members experiencing health-related social needs may qualify for housing benefits including rental assistance and home modifications. The regional Coordinated Care Organization's (IHN-CCO) Transformation Plan to improve health outcomes and quality of care has funded numerous housing pilot programs. The SHARE Initiative (Supporting Health for All Through Reinvestment) is a mechanism for CCOs to invest net income in addressing social determinants of health and equity. Housing is a top SHARE priority statewide and in the region. Most SHARE projects fund housing services and supports, transitional housing, affordable housing, emergency shelter, and permanent supportive housing.

Partners

Community partners within Access to Affordable Housing have been essential to the historical progress of housing initiatives in the region. Partners establish memoranda of understanding and provide wraparound services. Coordinating with these community partners will be a key part of the implementation process.

The community partners supporting the CHIP for the Access to Affordable Housing priority area include:

- Affordable Housing Partners of Lincoln County
- Albany H.E.A.R.T. Board, Community Services Consortium
- Arcoíris Cultural
- Benton County Behavioral Health
- Benton County Coordinated Homeless Response Office
- Center Against Rape and Domestic Violence (CARDV)
- Casa Latinos Unidos
- Coast to the Cascades Community Wellness Network (CCCWN)
- Communities Helping Addicts Negotiate Change Effectively (C.H.A.N.C.E.)
- Community Services Consortium
- Corvallis Daytime Drop-in Center
- Corvallis Multicultural Literacy Center
- Faith Hope & Charity
- Family Assistance and Resource Center Group
- Farmworker Housing Development Corporation (FDHC)
- IHN-CCO Community Advisory Council (CAC)
- InterCommunity Health Network Coordinated Care Organization (IHN-CCO)
- IHN-CCO Delivery System Transformation Committee (DST)
- Lincoln County Homeless Advisory Board
- Mid Willamette Transgender Support Network (MWTSN)
- Oregon Coast Bank
- Northwest Coastal Housing
- Siletz Community Health Clinic
- Unity Shelter
- Young Roots Oregon

Goals for Access to Affordable Housing

The long-term vision of these goals is to ensure that all Linn-Benton-Lincoln residents have safe, affordable housing with a focus on priority populations who have been economically and socially marginalized.

	**Goal 1**	Expand the availability of brick-and-mortar shelter, transitional, and/or permanent housing units by developing, acquiring, or securing properties across Linn, Benton, and Lincoln counties.
	Goal 2	Expand and sustainably fund supportive services for shelter, transitional, and/or permanent housing.
	Goal 3	Improve data across the spectrum of shelter and housing providers to help create future progress measures and inform planning.

Strategies for Access to Affordable Housing

Goal area 1: Expanding housing units

This goal focuses on expanding a variety of housing units. Examples of priority housing units and emergency shelter options include:

- farmworker and workforce housing
- affordable family housing
- multi-generational housing
- smaller housing for seniors (e.g., shared housing and co-ops)
- medically related transitional housing
- housing for people experiencing neurodiversity, developmental diversity, or severe and persistent mental illness

Components to consider when expanding the availability of shelter, transitional, and/or permanent housing units include access to transportation, food, services, and accessibility.

Strategy 1.1	Increase access to existing units through landlord engagement and relationship building.
Strategy 1.2	Build brick-and-mortar units to expand housing availability.
Strategy 1.3	Create or expand accessible emergency shelter options that reflect community and cultural needs and address systemic barriers to shelter.
Local outputs (strategy)	Number of people rehoused (1.1, 1.2)
	CCO members with 1115 waivers (1.1, 1.2)
	Number of shelter beds added (1.1, 1.2)
	Number of safe and sober housing units (1.1, 1.2)
	Annual point-in-time homeless counts (1.2, 1.3)
	Identification of affordable housing data sources in addition to Oregon Housing & Community Services (OHCS) (1.3)
State or national evidence	Number of housing units in the Linn-Benton-Lincoln region

Goal area 2: Expand supportive services

This goal focuses on services including culturally and linguistically appropriate peer supports, street outreach, housing navigators, case managers, personal care attendants, mental health professionals, and operational staff.

Necessary components to consider for adding staffing capacity include:

- transportation to locations
- culturally and linguistically specific services to serve different populations
- trauma-informed care
- harm reduction support

Strategy 2.1	Partner with InterCommunity Health Network Coordinated Care Organization (IHN-CCO) to fund supportive services positions that are culturally and linguistically appropriate (e.g., Delivery System Transformation Committee, SHARE initiative, and direct contract).
Strategy 2.2	Partner with existing workforce at housing and shelter locations
Strategy 2.3	Identify and apply for sustainable grant opportunities at state, federal, and private levels to strengthen shelter, transitional, and/or permanent housing support services
Local outputs (strategy)	Number of organizations with supportive services (2.1, 2.2)
	Number of grants submitted and funds awarded (2.3)

Goal area 3: Improve housing data

Data quality and equity are severely lacking across the spectrum of shelter and housing providers. To be useful and actionable, data should reflect the makeup, diversity, and characteristics of the populations. It will be important to establish a baseline for actionable data that can then be used throughout this CHIP's five-year cycle and going forward.

Strategy 3.1	Work toward a tri-county continuum of care and withdrawal from the Rural Oregon Continuum of Care (2025).
Strategy 3.2	Research, expand, and adopt a culturally specific, situationally reflective, multi-tiered coordinated entry assessment tool that includes data for Race, Ethnicity, Language, and Disability (REALD) and Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics (SOGIES).
Strategy 3.3	Improve Continuum of Care's information technology system to improve data collection that meets the needs of shelter providers and is more culturally specific and situationally reflective.
Strategy 3.4	Align data management and sharing policies and training across organizations within the tri-county region.
Local outputs (strategy)	Creation of the Linn-Benton-Lincoln Continuum of Care; inclusion of equitable and justice-based policies in new COC (3.1, 3.3)
	Adoption of a coordinated entry assessment tool (3.2)
	McKinney Vento data (U.S. Department of Education, Education for Homeless Children and Youths Program) (3.4)
	United Way ALICE data (3.4)

Policy Changes

The Access to Affordable Housing priority area includes two recommendations for policy changes.

- **Strategy 3.1. Work toward a tri-county continuum of care and withdrawal from the Rural Oregon Continuum of Care (2025).** The creation of a new tri-county continuum of care (COC) requires the creation of policies that are inclusive, equitable, and justice-based. A tri-county COC for the Linn-Benton-Lincoln region would alleviate health inequities by improving access to resources that are better tailored to this region's population. This improved access to quality care would directly affect the regional **social determinants of health**.
- **Strategy 3.4. Align data management and sharing policies and training across organizations within the tri-county region.** This strategy seeks to improve the quality of data gathered and used by organizations serving the Linn-Benton-Lincoln region. Improving how needs and services are quantified will lead to better decision-making on positively impacting social determinants of health.

Priority Area:
Access to Quality Care

Overview

Access to care is defined as the "timely use of personal health services to achieve the best possible health outcomes."[5] The priority area includes clinical healthcare services and supportive services related to wellness and social determinants of health. This CHIP intentionally includes *Quality* in this goal to emphasize health equity and the health needs of priority populations.

In Linn, Benton, and Lincoln Counties, about 90% of residents are covered by health insurance (including private insurance, Medicaid, and Medicare). Insurance disparities by age, socioeconomic status, race/ethnicity, and geography highlight persistent inequities. The Oregon Health Plan (OHP), the state's Medicaid program, is available to eligible adults and children regardless of immigration status. Oregon adopted the Affordable Care Act's (ACA) Medicaid Expansion in 2014, so adults with incomes up to 138% of the Federal Poverty Level (FPL) are generally eligible. Adults earning 138% to 200% FPL may obtain no-cost health coverage through OHP Bridge. Oregon Senate Bill 558 expands Medicaid access and eligibility to children younger than age 19 in families earning up to 305% FPL.

The OHP is delivered through Coordinated Care Organizations (CCOs) – managed care organizations that provide integrated care that focuses on prevention, person-centered approaches, and management of chronic conditions. InterCommunity Health Network (IHN-CCO) is the CCO for Linn, Benton, and Lincoln counties. Community and consumer engagement is integral to CCOs. The Community Advisory Council (CAC) and county-level advisory groups advise on strategic planning, community benefit initiatives, care quality and service navigation, and the development of RHA and CHIP. CCOs participate in an annual Consumer Assessment of Healthcare Providers Survey (CAHPS) to measure the accessibility of healthcare services. CAHPS informs quality improvement and prioritization of community health services.

Access to quality care impacts people of all health insurance statuses. Out-of-pocket medical costs and insurance premiums may be a barrier to care for anybody, especially people facing growing costs of living and financial pressures. Community members report delays in care due to traveling far distances to see providers and long wait times for appointments. Other weaknesses include access to specialized care, culturally specific and trauma-informed health services, and navigating complex systems.

The region, particularly rural and remote communities, is experiencing provider shortages in primary care, dental services, and mental health. Healthcare facilities are more commonly located within city limits and can be difficult to access by people with transportation or mobility challenges. Following the COVID-19 pandemic many providers left the healthcare workforce and experienced significant burnout. Traditional Health Workers (THWs) can address gaps in care access and quality by providing community-based care and peer support under the direction of a licensed health provider. The Oregon Health Authority is expanding resources for THW certification, integration into health systems, and insurance reimbursement.

[5] Definition from the National Academies of Sciences, Engineering, and Medicine (formerly known as the Institute of Medicine), cited from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services

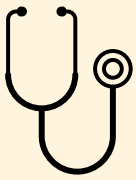
Partners

Community partners in the Access to Quality Care priority area include county-operated community health clinics; private, for-profit provider groups; small, independent providers; and nonprofit providers. Community partners currently supporting the regional CHIP for Access to Quality Care include:

- Alsea Community Action Collaborative
- Benton County Health Navigation
- Benton County Public Health
- Casa Latinos Unidos
- College of Osteopathic Medicine of the Pacific-Northwest (COMP-NW)
- Conexión Fénix
- Confederated Tribes of Siletz Indians (CTSI)
- Corvallis Daytime Drop-in Center
- Faith Community Health Network
- Federally Qualified Health Centers (FQHCs)
- InterCommunity Health Network Coordinated Care Organization (IHN-CCO)
- IHN-CCO Community Advisory Council (CAC)
- Lincoln County Community Health Center
- Lincoln County Public Health
- Linn County Public Health
- Mid Willamette Transgender Support Network (MWTSN)
- Oregon Public Health Association
- Oregon State University
- Samaritan Family Medicine
- Samaritan Health Services (SHS)
- SHS Regional Health Education Hub
- Yong Roots Oregon

Goals for Access to Quality Care

The long-term vision of these goals is to improve health equity and population-level health outcomes by ensuring that all Linn-Benton-Lincoln residents can access the right care at the right time and place. Community members and community-based providers will be empowered to share their perspectives with decision-makers to address the root causes of health inequities.



Goal 1	Grow the regional healthcare workforce in innovative, supportive, and sustainable ways.
Goal 2	Reduce barriers to Oregon Health Plan enrollment and the use of benefits.
Goal 3	Ensure that care is timely, local, and empowering.

Strategies for Access to Quality Care

Goal area 1: Grow and sustain the regional healthcare workforce

This goal addresses regional needs to expand the capacity of the regional healthcare workforce. The focus on capacity includes increasing the number of providers and adopting new models of care. Sustainable growth in the healthcare workforce will lead to stable employment at a livable wage. Providers need to be available in community and non-clinical settings in order to improve health equity.

Strategy 1.1	Sustainably increase the number of all levels and types of healthcare providers in the region (and particularly in rural areas). Focus areas include addressing institutional barriers, prioritizing meaningful strategies for recruitment and retention of diverse talent, and exploring innovative ideas to address provider burnout.
Strategy 1.2	Grow an electronic, closed-loop referral system between community and clinical services that supports community partners in accessing resources, meeting patient needs, gathering standardized data, and expanding community-based care.
Strategy 1.3	Create sustainable funding mechanisms for effective community-based care delivery. Examples include establishing reimbursement guidelines and fee schedules.
Local outputs (strategy)	Increased housing in the region (1.1)
	Number of referrals processed through Unite Us (1.1)
	Amount paid by IHN-CCO for community-based care (1.1)
State or national evidence	OHA Traditional Health Worker Registry (1.1)
	Licensed healthcare providers per capita from OHA Health Care Workforce reporting (1.1)

Goal area 2: Increase Oregon Health Plan access and use

This goal will increase the number of eligible individuals who enroll in the Oregon Health Plan. It is believed many people are unaware that they qualify for OPH or why health coverage is beneficial. The reasons for this may include:

- difficulty in completing the OHA enrollment paperwork
- lack of linguistically and culturally appropriate information
- unanswered questions about OHP and Medicaid
- temporary loss of coverage due to eligibility or disenrollment (Medicaid “churn”)

Strategy 2.1	Expand certified OHP Community Partnerships and increase OHP Assister attendance at community events. A focus area is to serve populations that have been economically and socially marginalized
Strategy 2.2	Increase awareness, accessibility, and satisfaction with IHN-CCO member resources.
Local outputs (strategy)	Number of Oregon Health Plan (OHP) Certified Community Partners in the Linn-Benton-Lincoln region (2.1)
	Number of expanded business hours in the OHP enrollment sector (2.2)
State or national evidence	Number of new IHN-CCO members (2.1)
	IHN-CCO Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey scores (2.1, 2.2)

Goal area 3: Timely, local, and empowering care

This goal captures a broad range of identified concerns related to quality of care. This includes:

- Logistic challenges to accessing care
- Care coordination and navigation challenges
- Long delays in available appointment times (particularly for establishing care with a new provider)

The need for care that is culturally/linguistically appropriate and trauma-informed is foundational to these strategies.

Strategy 3.1	Engage in meaningful collaboration with diverse community partners to explore innovative ways to provide the right care at the right time, including use of new technologies (such as telehealth
Strategy 3.2	Increase opportunities and financial support for communities that have been economically and socially marginalized to engage in evaluation and quality improvement work related to healthcare. An example is to improve the grievance and appeals processes in ways that allow systemic issues to be identified and addressed
Strategy 3.3	Share resources (such as best practices, policies, and training opportunities) among organizations across the region to improve the quality and consistency of care. Examples include providing gender-affirming care, language and interpreter access, and trauma-informed care and systems
Local outputs (strategy)	Assessment of regional access to specialists (3.1)
	"Secret shopper" model to gain insights into access to primary care (3.1)
	Access to traditional health worker (THW) training and sustainable billing models (3.1)
	Number of resources shared (3.3)

Policy Changes

The Access to Quality Care priority area includes the potential for policy changes**.** These policy changes would be part of Strategy 3.3.

- **Strategy 3.3. Share resources (such as best practices, policies, and training opportunities) among organizations across the region to improve the quality and consistency of care.** Strategy 3.3 is intended to improve information sharing and collaboration among organizations in the Linn-Benton-Lincoln region. Sharing best practices could lead to policy improvements to achieve health equity.

Priority Area:
Behavioral Health

Overview

Behavioral health is defined by the Centers for Disease Control and Prevention (CDC) as "a state of mental, emotional, and social well-being or behaviors and actions that effect wellness…The term also is used to describe the support systems that promote well-being, prevent mental distress, and provide access to treatments and services for mental health conditions." Behavioral health describes the connection between a person's behaviors and the health and well-being of the body and mind. Substance misuse and problem gambling are part of behavioral health. Although the term is often used interchangeably with **mental health**, mental health is a component of behavioral health relating to psychological well-being and conditions such as depression.

Identifying Behavioral Health as a priority area in CHIP represents a significant step towards recognizing mental health as a key component to overall health and reducing stigma around behavioral health and substance use. This step aligns with the Oregon State Health Improvement Plan (SHIP). Oregon has the highest prevalence of mental health conditions among youth and adults in the nation. Communities describe many barriers related to provider shortages, long wait times, transportation challenges, and difficulty finding a culturally and linguistically responsive provider. The COVID-19 pandemic exacerbated existing behavioral health challenges in children and adolescents. Youth reported poor overall mental health during the pandemic and are increasingly reporting feeling sad or hopeless in various health assessments.

Community members name substance use, youth mental health, comprehensive services for people with severe and persistent mental illness, and access to care as significant needs in the region. Rates of depression and other behavioral health indicators are generally comparable to state data, but some populations and geographic areas have specific challenges. Differences in suicide attempts and deaths, overdoses, and youth substance misuse between counties highlight how social and health factors impact behavioral health. It also demonstrates the need for community-driven and culturally appropriate interventions.

In the region, challenges in accessing providers and facilities are significant factors in behavioral health, particularly for some priority populations. Most providers are located within city limits, creating a barrier for many residents of remote areas, even if there is a high concentration of providers in the county overall. Equitably expanding access to behavioral health will require investments in workforce expansion and assuring that services provided are appropriate for the whole community. This includes gender-affirming care, peer support programs, and care coordination across medical and social services. The Oregon Health Plan (OHP) covers a range of behavioral health services without a referral, including peer-delivered and community-based services.

Partners

The community partners supporting the regional CHIP for the Behavioral Health priority area include:

- Atonement Lutheran Church
- Benton County Behavioral Health
- Benton County Home, Opportunity, Planning & Equity (HOPE)
- Benton County Public Health
- Building Blocks Mental Health
- Casa Latinos Unidos
- College of Osteopathic Medicine of the Pacific-Northwest (COMP-NW)
- Communities Helping Addicts Negotiate Change Effectively (C.H.A.N.C.E.)
- Exodus Recovery
- Family Tree Relief Nursery
- Harm Reduction teams from local public health authorities
- Integrated Services Network Support Services
- Intercommunity Health Network Coordinated Care Organization (IHN-CCO)
- IHN-CCO Behavioral Health Strategy Committee
- IHN-CCO Community Advisory Council (CAC)
- IHN-CCO Delivery System Transformation Committee (DST)
- Lincoln County Behavioral Health
- Lincoln County Health & Human Services, Behavioral Health
- Lincoln County Public Health
- Linn Benton Lincoln Health Equity Alliance
- Linn County Public Health
- Linn County Public Health, Health Promotion
- Mid Willamette Trans Support Network (MWTSN)
- Old Mill Center for Families & Children
- Oregon State University (OSU)
- OSU Student Health Services
- ReConnections Counseling
- Samaritan Health Services (SHS)
- Samaritan Treatment & Recovery Services (STARS)
- Strengthening Rural Families
- Systems of Care

Goals for Behavioral Health

The long-term vision of these goals is to ensure that all Linn-Benton-Lincoln residents have equitable access to behavioral health support and treatments.

	**Goal 1**	Use a person-centered, culturally responsive, and trauma-informed approach to behavioral health promotion and destigmatization through education, communication, and engagement.
	Goal 2	Increase access to responsive, transformative behavioral health services and supports that are culturally and linguistically appropriate.
	Goal 3	Develop and improve a comprehensive continuum of care that integrates regional behavioral health systems and community-based organizations (CBOs) using a person-centered and community-focused approach.

Strategies for Behavioral Health

Goal area 1: Build community resilience

Community resilience is the ability of a community to adapt and maintain their well-being when faced with hardship. This goal uses education, communication, and engagement to destigmatize behavioral health and promote resilience. This includes clinical (medical) and non-clinical strategies (such as art, holistic or whole-person, and spiritual approaches). Three key characteristics of these strategies are:

- person-centered—care that focuses on a person and their needs and circumstances, instead of a condition, disability, or bias (prejudice or prejudgment) that may be present
- culturally responsive—understanding and adapting to a person's culture
- trauma-informed—care that recognizes the impact of trauma (an event that causes intense stress and has a lasting effect) on a person's life and well-being

Strategy 1.1	Connect physical, emotional, and social health and well-being by supporting individual and community tools that promote resilience and healthy coping.
Strategy 1.2	Encourage help-seeking by reducing barriers to access through outreach to specific populations (e.g., youth, veterans, tribal, and others)
Strategy 1.3	Create population-specific educational resources that increase community awareness of existing behavioral health services and destigmatize behavioral health and wellness.
Local outputs (strategy)	Number of resources created (1.1)
	Regional standardization of a social determinants of health screening tool (e.g., PRAPARE) (1.1)
	Increase FTE within the county Community Mental Health Programs (CMHPs), specific to health education, outreach, and prevention; and at local public health authorities (LPHAs) (1.2, 1.3)
State or national evidence	Oregon Areas of Unmet Health Needs and Healthcare Workforce Reporting (Goals 1, 2)

Goal area 2: Grow a healthy workforce

This goal focuses on increasing access to behavioral health services and support for the people who serve the community. This goal identifies four aspects of healthy workers:

- Responsive - the ability to understand and adapt as needed
- Transformative - making a lasting, positive change
- Culturally appropriate - respecting and responding to a person's cultural heritage, which can include ethnicity or religion
- Linguistically appropriate - respecting and responding to a person's need to interact in their language

Strategy 2.1	Grow and maintain a healthy behavioral health provider workforce by addressing retention strategies, burnout, and recruitment. Example: For retention and recruitment, support career development opportunities such as internships, mentorships, and culturally specific peer supports
Strategy 2.2	Reduce barriers to access to care including the physical barriers of transportation, rural and tribal needs, and culturally appropriate and gender-affirming treatment options. Example: Support funding for existing community service providers, CBOs, tribal organizations, and non-clinical settings.
Strategy 2.3	Create learning opportunities for providers that increase awareness around cultural competence and the unique behavioral health needs of communities that have been economically and socially marginalized.
Local outputs (strategy)	Decrease turnover and vacancy rates for community mental health programs (CMHPs) (2.1)
	Regional yearly financial investments in workforce development initiatives (2.1)
	Increase/improve early diagnosis, family resources and support, and wait times to access services (2.2)
	Number of substance use disorder beds (residential and detox) and psychiatric beds (mental health inpatient) (2.2)
	Number of providers trained in areas of community need (e.g., specialized services) and generalists (2.3)
State or national evidence	CCO Incentive Metric: Screening for Depression and Follow-Up Plan (2.1, 2.2)
	CCO Incentive Metric: Alcohol and Drug Misuse (SBIRT) (2.3)
	Oregon Areas of Unmet Health Needs and Healthcare Workforce Reporting (Goals 1, 2)

Goal area 3: Improve care coordination

This goal focuses first on the need to develop a **continuum of care**, a system of services that meet the varying needs of people throughout their lifespan. A comprehensive continuum of care means that all people can receive the right care at the right time from the right provider. An integrated network of regional behavioral health systems and community-based organizations (CBOs) is essential to achieving this goal.

This goal focuses on two types of approaches:

- Person-centered—care that focuses on a person and their needs and circumstances, instead of a condition, disability, or bias (prejudice or prejudgment) that may be present
- Community-focused—care that centers on the needs, environment, and circumstances of a community

Strategy 3.1	Create spaces to engage in collaborative discussions for relationship-building across systems.
Strategy 3.2	Identify and address insurance barriers to behavioral healthcare access.
Strategy 3.3	Streamline the client experience across organizations by establishing a flexible data collection and communication system adaptable to different organizational requirements, limitations, and needs.
Local outputs (strategy)	Annual regional symposium and interviews (3.1)
	Increase the number of enrolled OHP members; reduce the number of eligible uninsured (3.2)
	Adoption of coordinated entry assessment tool (3.3)
	Use of Race, Ethnicity, Language and Disability (REALD) and Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics (SOGIES) data (3.3)
State or national evidence	CCO Incentive Metric: Initiation and Engagement of Substance Use Disorder Treatment (3.1, 3.2)

Priority Area:
Inclusion, Diversity, Anti-Racism, and Equity (IDARE)

Overview

Inclusion, diversity, anti-racism, and equity are essential for fostering communities where everyone can thrive. Achieving health equity is a foundational goal of this CHIP. Local and national public health organizations recognize their direct impact on health outcomes and the social determinants of health. Systemic racism and historical disenfranchisement of marginalized groups contribute to disparities in life expectancy, seeking health care, maternal mortality, and other health indicators.[6] According to the CDC:

> Racism, both structural and interpersonal, are fundamental causes of health inequities, health disparities and disease. The impact of these inequities on the health of Americans is severe, far-reaching, and unacceptable.

The Oregon State Health Improvement Plan outlines the state's history of white supremacy and institutional biases that affect the current public health landscape. Key events include theft of land from Native American tribes; redlining (denying housing and mortgages based on race); internment of Japanese Americans during World War II; and laws forbidding Black Americans to settle in the state. These historical injustices continue to have an impact on groups that have faced and continue to face policies, practices, and systems that sustain oppression, exclusion, and injustice.

The priority area of Inclusion, Diversity, Anti-Racism, and Equity (IDARE) has specific goals and strategies. This is an addition to the health equity components of the entire CHIP. IDARE strategies address issues that affect health equity in the region and the concerns of the local communities. Limited county-level data on health disparities and indicators of equity and inclusion make it difficult to quantify the health equity challenges in the region. For this reason, several CHIP strategies seek to improve data quality and accountability for equity improvements in the health systems.

During data collection for the regional RHA and CHIP, community members frequently named IDARE components as public health challenges. This includes the availability of culturally appropriate services and biases experienced by people seeking care. Community groups stress that building trust and addressing power dynamics are essential to building more equitable systems. This is especially important in collecting and disaggregating health data, due to the history of harm experienced by communities of color through data misuse and unethical research.

The Oregon Health Authority established Regional Health Equity Coalitions (RHECs) as community-driven organizations that build on community strengths to reduce local health disparities. RHECs are based on a theoretical framework in which authentic community engagement and strengthened organizational capacity are the foundations for policy and system change.

[6] American Public Health Association, *Racial Equity and Public Health*. *https://www.apha.org/-/media/files/pdf/advocacy/speak/210825_racial_equity_fact_sheet.ashx*

Partners

Community partners currently working to address historical and current injustices by supporting the regional CHIP for the Inclusion, Diversity, Anti-Racism, and Equity (IDARE) priority area include:

- Benton County Home, Opportunity, Planning & Equity (HOPE)
- Benton County Public Health
- Casa Latinos Unidos
  - Conexión Fénix
- Confederated Tribes of Siletz Indians (CTSI)
- Corvallis Multicultural Literacy Center
- Growing Ancestral Roots (GAR)
- Integrated Services Network Support Services
- Intercommunity Health Network Coordinated Care Organization (IHN-CCO)
- IHN-CCO Community Advisory Council (CAC)
- International Moms Group (IMG)
- Lincoln County Public Health
- Linn Benton Hispanic Advisory Council (HAC)
- Linn Benton Lincoln Health Equity Alliance
- Linn Benton National Association for the Advancement of Colored People (NAACP)
- Linn County Maternal Child Health Programs
- Linn County Public Health
- Mid Willamette Trans Support Network (MWTSN)
- Oregon Health Authority
- Oregon State University (OSU)
- OSU Extension Service
- Samaritan Health Services (SHS)
- Strengthening Rural Families
- Weaving Fala
- Young Roots Oregon

Goals for IDARE

The long-term vision of these goals is to transform health and public health systems to increase inclusion, well-being, and community participation and engagement in the decision-making processes.

Goal 1	Change systems, remove barriers, nurture equity, and improve well-being
Goal 2	Increase inclusion, diversity, antiracism, and equity (IDARE) and gender justice education and accountability measures in the system of services
Goal 3	Improve the process of collecting, using, owning, and sharing data by creating a data task force

Strategies for IDARE

Goal area 1: Improve equity and well-being

This goal focuses on improving the well-being of individuals and the community through equitable health systems. Partners will make comprehensive and sustainable changes to promote individual and community health, well-being, and happiness. Care that is culturally/linguistically appropriate, gender affirming, and trauma informed is foundational to this goal.

Strategy 1.1	Develop community-driven practices that embed equity principles in the removal of institutional barriers
Strategy 1.2	Build accountability measures for providers and community members.
Strategy 1.3	Increase the number of culturally and linguistically appropriate service providers by removing institutional barriers and uplifting communities into these roles.
Local outputs (strategy)	Number and types of changes to policies and procedures (1.1)
	Number of culturally and linguistically appropriate services (CLAS) providers accessed and used (1.2, 1.3)
	Number of CLAS providers in the region (1.3)
State or national evidence	Oregon Health Authority (OHA) Health Care Interpreter Dashboard (1.2, 1.3)

Goal area 2: Increase education and accountability

This goal focuses on providers making positive system changes through education, community engagement, and action. Positive system changes can only happen when trust and healthy relationships exist between system providers and community members. Historical harm has been done to people who experience disadvantages. This goal seeks to start an ongoing process to connect system providers and community members in a way that honors and respects inclusion, diversity, antiracism, and equity (IDARE) and gender justice.

Strategy 2.1	Grow and maintain a healthy behavioral health provider workforce by addressing retention strategies, burnout, and recruitment. Example: For retention and recruitment, support career development opportunities such as internships, mentorships, and culturally specific peer supports.
Strategy 2.2	Improve equitable access to culturally and linguistically appropriate service (CLAS) providers.
Strategy 2.3	Provide resources (e.g., funding) and supports to community members around participation in decision-making bodies and advocacy.
Local outputs (strategy)	Number and types of changes to policies, processes, and service providers (2.1)
	Satisfaction surveys of perceptions of accountability, community, discrimination, and racial unity and tension (2.2)
	Number of trainings completed (2.3)
	Voter turnout (2.3)
State or national evidence	Coordinated Care Organization (CCO) incentive metric: Health Aspects of Kindergarten Readiness: CCO System-Level Social-Emotional Health (2.1, 2.2, 2.3)

Goal area 3: Improve data quality

This goal focuses on improving data collection systems through community engagement, transparency, and trauma-informed approaches. The strategies around collecting and using data will reflect best practices for

inclusion, diversity, antiracism, and gender justice. Both qualitative and quantitative data will be used to highlight specific details within data (e.g., gender, sexual identity, race) that are not always fully represented.

Strategy 3.1	Change strategies for gathering data to reflect inclusion, diversity, antiracism, and equity (IDARE) and gender justice.
Strategy 3.2	Centralize and coordinate data collection.
Strategy 3.3	Disaggregate data using a combination of quantitative (statistical) data and qualitative data (people's experiences).
Local outputs (strategy)	Surveys of perception of connectedness to policy makers, policy adoption, and decision-making (3.1)
	Adoption of standard definitions for equity data (3.2)
	Number of organizations with aligned policies and procedures for data equity (3.3)
State or national evidence	Establish a baseline for race, ethnicity, language, and disability (REALD) and sexual orientation or gender identity (SOGI) data (HB 3159) (3.1, 3.2, 3.3)

Policy Changes

The Inclusion, Diversity, Anti-Racism, and Equity (IDARE) priority area includes four recommendations for policy changes. Currently, there is a lack of equitable and representative data that accurately reflects the people of the Linn-Benton-Lincoln region and their needs. The tools and methods used to collect data are not universally accessible, culturally and linguistically appropriate, or gender affirming. It is very difficult to make decisions to alleviate health inequities in the region without accurate data.

- **Strategy 1.1: Develop community-driven practices that embed equity principles in the removal of institutional barriers.** The measurable outcomes for this strategy include updated or new policies at the county, state, and organizational levels.
- **Strategy 2.1. Educate and train providers and systems to commit to, continually engage with, and practice disability, gender (e.g., trans community), and racial justice.** The measurable outcomes for this strategy include updated or new policies at the county, state, and organizational levels.
- **Strategy 3.2. Centralize and coordinate data collection.** Coordination of data collection across county, state, and healthcare agencies will likely require policy changes. Collection of these data and sharing across systems is currently regulated by policy and statute.
- **Strategy 3.3. Disaggregate data using quantitative (statistical) data and qualitative data (people's experiences).**

Updates and Communication

This regional community health improvement plan (CHIP) contains the information available as of October 1, 2024. Additional data and resources will be incorporated in the implementation phase, including:

- Completed SMARTIE objectives for each goal and strategy
- Updated logic models
- Updated implementation plans
- Refined progress measures, progress indicators, and outcomes

The implementation data, evaluation plans, and all updates to the regional CHIP will be published on the Partnership for Community Health (PCH) website on an ongoing basis. The Partnership for Community Health website will be launched at the end of 2024. Features of the website will include:

- Dashboards: graphic summaries of the implementation and evaluation data
- Downloads: CHIP-related documents that are translated and accessible
- Frequently asked questions (FAQs): answers to the most common questions about the CHIP
- Stories of the community: testimonials on the impact and progress of CHIP initiatives from individuals and community-based organizations
- Voices of the community: feedback forms and opportunities to engage in conversations about the CHIP

The Communication Team will ensure that regular and timely information will be published on the PCH website. The Communication Team will also coordinate all communication for the regional CHIP, including press releases, community updates, and storytelling.