Community Health Improvement Plan for Linn, Benton, and Lincoln Counties 2024-2028: 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.

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.

Goal area 1: Expanding housing units

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

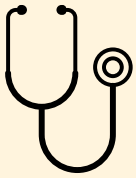
Strategy 2.1	Partner with InterCommunity Health Network Coordinated Care Organization (IHN-CCO) to fund supportive services positions that are culturally and linguistically appropriate (e.g., Delivery System Transformation Committee, SHARE initiative, and direct contract).
Strategy 2.2	Partner with existing 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

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)

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.

Goal area 1: Grow and sustain the regional healthcare workforce

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

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

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)

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.

Goal area 1: Build community resilience

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

Strategy 2.1	Grow and maintain a healthy behavioral health provider workforce by addressing retention strategies, burnout, and recruitment
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.
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 for community mental health programs (2.1)
	Regional 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; Healthcare Workforce Reporting (1, 2)

Goal area 3: Improve care coordination

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 & Disability (REALD);Sexual Orientation, Gender Identity, Gender Expression, & 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)

Inclusion, Diversity, Anti-Racism, and Equity (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

Goal area 1: Improve equity and well-being

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

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

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)