Marion-Polk Community Health Improvement Plan

2021-2025

Marion County OREGON Health & Human Services

POLK COUNTY HEALTH SERVICES

PacificSource Community Solutions

willamette health council

Acknowledgements

- The Marion-Polk CHIP 2021-2025 is the product of a community driven process and reflects contributions from many partners across the community. The contents of this document are meant to serve as a guide for community health improvement work in Marion and Polk Counties. However, each organization supporting the shared CHIP has a unique mission, and separate values and priorities. This CHIP does not commit any organization to any future policy positions or new programs, unless otherwise indicated by an individual organization. We thank supporting organizations for their contributions to writing the CHIP, and look forward to continuing our collaborative work.

- The full Marion-Polk CHIP 2021-2025 document is available in other languages and alternative formats upon request. A summary of the CHA and CHIP is also available in English, other languages, and alternative formats upon request.

Dear Marion and Polk County Community Partners:

It is our pleasure to share with the community the 2021-2025 Marion-Polk Community Health Improvement Plan (CHIP). The contents of this plan were informed by the 2019 Community Health Assessment (CHA), updates to the CHA health data in 2020 and 2021, and input from community partners across the region. This CHIP builds on previous success to create a plan that reflects both Marion and Polk Counties, and reflects recent success in establishing new collaborative partnerships.

The priority areas for the CHIP are:

- Substance Use
- Behavioral Health Supports
- Housing

Our community led the way in choosing these priorities in 2019. However, the emergence of COVID-19 in 2020 delayed starting the process of developing actionable goals and strategies to address the three priority areas. We are extremely proud to see how our community partners came together after a difficult year to refocus on the future health of our community and the development of the CHIP.

The 2021-2025 CHIP represents the collaborative work of many community members and partners from both Marion and Polk Counties. Despite the barriers of working across virtual platforms for the past year, over 100 people participated in the different work groups to brainstorm aims, strategies, and measures to move the needle on the three priority areas that were identified by the 2019 CHA. This is remarkable, especially considering that the COVID-19 pandemic response has not slowed down.

The primary collaborative partners ensuring the development and implementation of the CHIP are organizations from the local public health and health care system, but we can't do this alone. COVID-19 demonstrated how health impacts every aspect of our lives and how protecting our health requires community-wide action. Our CHIP will be no different.

With the understanding that building community partnerships is essential to improving population health, we followed the Mobilizing for Action through Partnership and Planning (MAPP) framework by the National Association of City and County Officials (NACCHO) to write this CHIP. We emphasized the importance of community engagement at every step of the process, and followed the lead of Priority Area Work Groups made up of partners from Marion and Polk Counties in choosing our aims and strategies.

Thank you to all the community partners who shared their expertise and lived experience in the process of developing this CHIP. We faced unprecedented challenges this last year, and learned that together we can make a difference in our community.

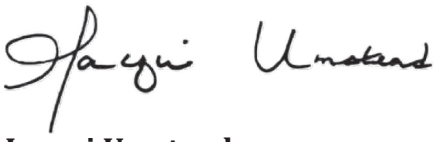
Katrina Rothenberger
Marion County Health and Human Services

Jacqui Umstead
Polk County Public Health

Core Executive Committee

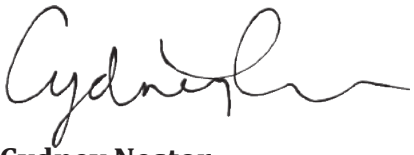
Katrina Rothenberger
Marion County Health and Human Services
Public Health Division

Justin Hopkins
Willamette Health Council



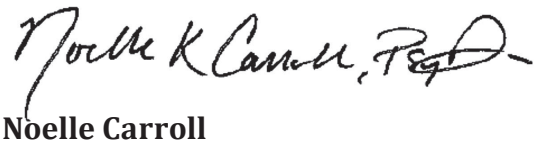
Jacqui Umstead
Polk County Public Health

Cyndi Leinassar
Salem Health



Cydney Nestor
Marion County Health and Human Services
Behavioral Health Division

Diana Netter
Legacy Silverton Medical Center



Noelle Carroll
Polk County Health Services

Lauren Benjamin
Santiam Hospital

Josie Silverman-Méndez
PacificSource Community Solutions,
Marion County and Polk County
Coordinated Care Organization (CCO)

Jennifer Jordan
Kaiser Permanente

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Executive Summary

In 2019, Marion and Polk Counties continued their partnership to assess and improve the health of their populations by renewing their shared **Community Health Assessment (CHA)**. To assess and plan for health in our community, Marion and Polk Counties use the nationally recognized Mobilizing for Action through Partnership and Planning (MAPP) framework. The framework provides structure for public health leaders to work with partners to prioritize public health issues and develop a strategic plan to address those issues. MAPP emphasizes community engagement at every step of the framework.

Through the year-long CHA process, community partners identified three strategic priority health issues for the next **Community Health Improvement Plan (CHIP)**. Community partners that participated in the CHA considered factors such as data on health conditions, **social determinants of health**, and other forces driving health outcomes like **Adverse Childhood Experiences (ACEs)**, and trends over time. The final priority areas that informed this CHIP are: Substance Use, Behavioral Health Supports, and Housing.

The CHA and CHIP are guided by a shared vision:

A diverse and inclusive community with a physical environment that facilitates optimal physical and social health, infrastructure that supports economic growth and stability, and an integrated health care system that promotes equitable access to whole person care.

The core partners supporting the 2021-2025 CHIP are: Marion County Health and Human Services, Polk County Public Health, PacificSource Community Solutions Marion County and Polk County CCO (PacificSource Marion-Polk CCO), Willamette Health Council, Salem Health, Legacy Silverton Medical Center, Santiam Hospital, and Kaiser Permanente.

The core partners understand that improving population health requires community-wide effort. For that reason, the core partners convened Priority Area Work Groups made up of diverse community partners with expertise and experience in each of the strategic priority health issues. Based on the assessment data from the 2019 CHA and complementary data from community partners, the Work Groups provided direction for writing the aims and strategies of this CHIP.

3 Priorities	**9 Aims**
11 Measures	**59 Strategies**

For questions or more information, contact:
Marion County Health and Human Services
Public Health Division, Prevention Team
mchdprevention@co.marion.or.us

CHIP Background for Marion and Polk Counties

A Regional Plan

Marion and Polk Counties have worked together on a shared CHA and CHIP since 2015. As partners, the Marion and Polk County public health departments used the MAPP framework to assess community health across both counties. The most recent CHIP guided the two counties from 2016-2018. Working together, Marion and Polk Counties achieved improvements in increasing prenatal care access; increasing immunization rates for 2-year olds; decreasing tobacco use in adults and teens; decreasing adult binge drinking and teen alcohol use; and decreasing opioid-related deaths and hospitalizations.

Improving health takes time. While the CHIP partners made progress in improving the 2016-2018 CHIP priority health issues, there are still concerning health trends that require the community's attention and action. At the conclusion of the 2016-2018 CHIP, the Marion and Polk public health departments and the **Coordinated Care Organization (CCO)** agreed to switch to a 5-year timeline to provide more time for the CHIP to make a difference in the community's health.

In 2018, following the most recent CHIP, the core partners at Marion County, Polk County, and the previous CCO from 2015-2019, Willamette Valley Community Health, revisited the CHA. After examining data and gathering community feedback, the CHA process led to choosing three strategic priority health issues for the new CHIP. Some of the priorities overlap with the previous CHIP indicating that the community wants to see more improvements building off the progress made in previous years.

The 2019 CHA priorities that guide this 2021-2025 CHIP are: Substance Use, Behavioral Health Supports, and Housing.

Planning During Change and Adversity

Since writing the 2019 Marion-Polk CHA, our community has experienced significant changes that affected our next step in the MAPP framework: writing a collaborative CHIP. The Oregon Legislature created new laws that increased expectations for local health departments, hospitals, and CCOs to work together on a shared CHA and CHIP. Marion and Polk Counties welcomed a new CCO to the region, PacificSource Marion-Polk CCO, and their community governance body, the Willamette Health Council. However, the most radical change was the COVID-19 pandemic.

Marion County was an early hotspot in Oregon during the ongoing COVID-19 pandemic. The local public health and health care systems in both Marion and Polk Counties had to quickly respond and build community partnerships to increase testing, contact tracing, and, most recently, organize vaccination efforts to protect county residents. Community response to the pandemic caused a delay in writing this CHIP. At the same time, there was broad recognition that COVID-19 likely worsened health issues related to substance use, behavioral health, and housing in our community.

As the pandemic continued, the community also experienced devastating wildfires in the fall of 2020 and

a damaging ice storm in early 2021. Through this adversity, our community partners have expressed heightened awareness of the importance of population health and commitment to the shared vision of the Marion-Polk CHA and CHIP.

Aligning Community and Statewide Efforts

Through recent and ongoing adversity, Marion and Polk Counties have established stronger community partnerships based on concern for the public's health. As a result, the CHIP process was able to build on community momentum for active health emergencies to call attention to the need for planning proactive prevention. Community members are aware that COVID-19 has likely exacerbated health disparities and related issues pertaining to substance use, behavioral health, and housing.

Over 100 individuals from a variety of local organizations and boards volunteered to participate on the CHIP Priority Area Work Groups. These community partners helped to identify gaps, support existing work, avoid duplicative efforts, and provide direction for collective action. For the first time, the Marion-Polk County CHIP explicitly aligns with local planning efforts that originated outside of the public health or health care sectors.

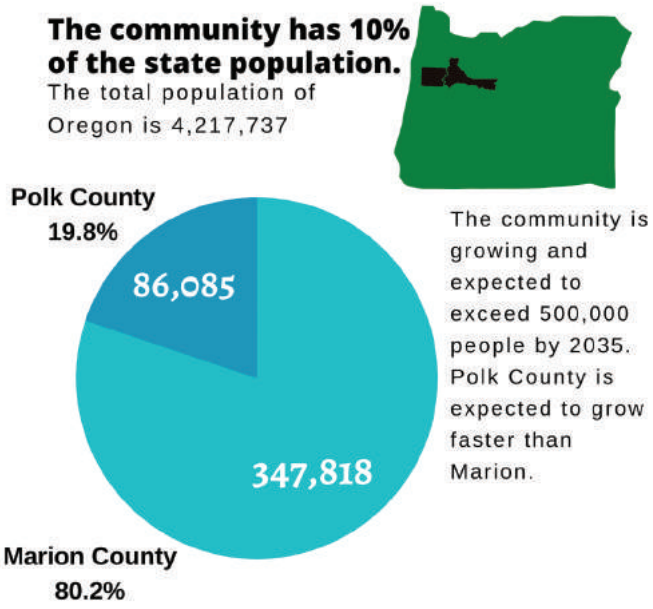
The Mid-Willamette Valley Homeless Alliance (MWVHA), which is the regional **Continuum of Care (CoC)**, released a Strategic Plan in 2020 that closely aligns with the CHA priority areas. With this in mind, the CHIP Housing Priority Area Work Group advised aligning with the CoC Strategic Plan instead of creating new, potentially redundant goals. Aligning with local planning efforts for housing further builds on community momentum to address population health issues and the social determinants of health.

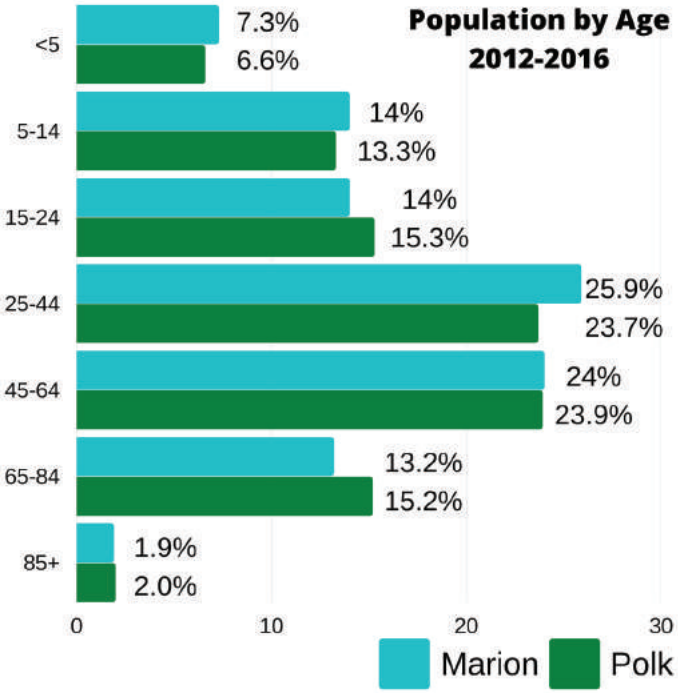
The **Oregon Health Authority (OHA)** is actively encouraging health partners to work together and align community health improvement efforts at the state and local level. After recent statute changes **(ORS 414.577)** requiring local public health authorities, coordinated care organizations (CCOs), and hospitals to collaborate on CHAs and CHIPs, OHA increased their expectations for local planning efforts. New requirements, primarily directed through CCOs, push for including a wide range of community partners, focusing on housing as a social determinant of health, and aligning with strategies from the State Health Improvement Plan (SHIP), known as *Healthier Together Oregon* (https://healthiertogetheroregon.org/).

Marion and Polk Counties completed the 2019 CHA at the same time that development of the SHIP was underway. Fortunately, the separate processes led to overlapping priorities: the Marion-Polk CHIP aligns with the SHIP.

Demographics

As of 2019 there were about 433,903 people living in Marion and Polk Counties.



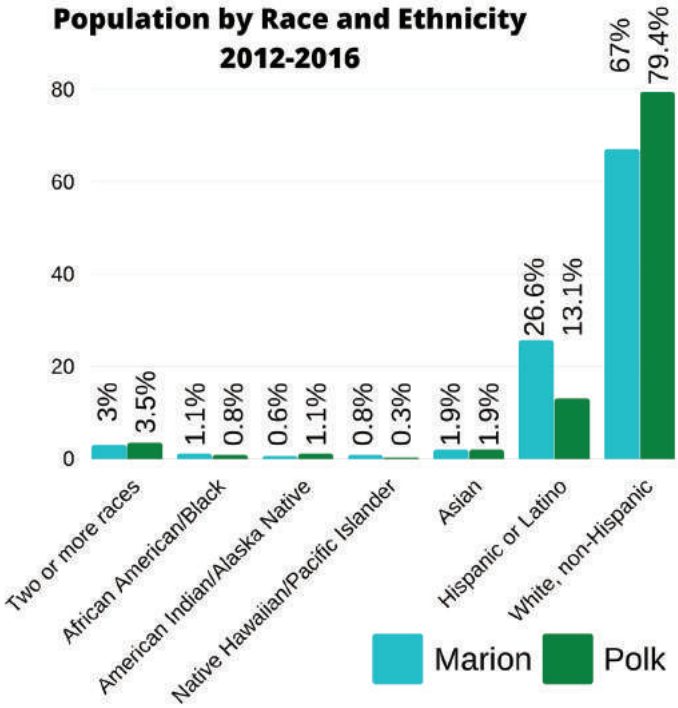


Marion County has larger Hispanic or Latino/a/x and Native Hawaiian/Pacific Islander populations than Polk County and the state.

Spanish, Asian or Pacific Islander languages, and Russian are most common languages after English.

Over 15% of the population in the community report living with a physical, mental, or emotional disability. The greatest proportion of people with a disability are over the age of 75.

For specific data sources, view the Marion-Polk CHA 2021 Update at co.marion.or.us



Social Determinants of Health

"Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Healthy People 2030).[i] Examples of SDOH include economic stability, access to quality education, access to quality health care, neighborhood affordability and safety, social community context, built environments, and environmental risks like polluted air and water.

SDOH influence health inequities. The fundamental root causes that create differences in SDOH are:

- Economic, environmental, and structural disparities;
- and the distribution of power and resources by race, gender, class, sexual orientation and other dimensions of identity across communities (National Academies of Sciences).[ii]

"Interpersonal, institutional, and systemic biases in policies and practices (structural inequities)" shape the distribution of power and resources in society (National Academies of Sciences). These root causes lead to unequal social economic and environmental conditions that create the social determinants of health, and lead to differences in health outcomes.

[Image Source: Centers for Disease Control and Prevention. Public Health Professionals Gateway. *Social Determinants of Health*. Accessed 12 April 2021. Retrieved from: https://www.cdc.gov/publichealthgateway/sdoh/index.html]

Some examples of how SDOH impact the community in Marion and Polk Counties include:

Poverty: From 2015-2019, about 14.2% of people in Marion County and 12.6% in Polk County were living below the federal poverty line. 1 in 4 children in Marion County live in poverty. All races and ethnicities had greater poverty rates than White, non-Hispanics. Poverty contributes to housing security issues and can make it more difficult to access and afford physical and behavioral health care.

Food Security: 1 out of 6 children are food insecure in the community. 41% of Marion County lives in a food desert, and 18% of Polk County. Food insecurity can create stress that impacts physical and mental health.

Housing: About half of community members who rent paid 30% or more of their gross household income on rent. In 2019, an estimated 1,095 community members were homeless, however this figure likely underestimates the total homeless population.

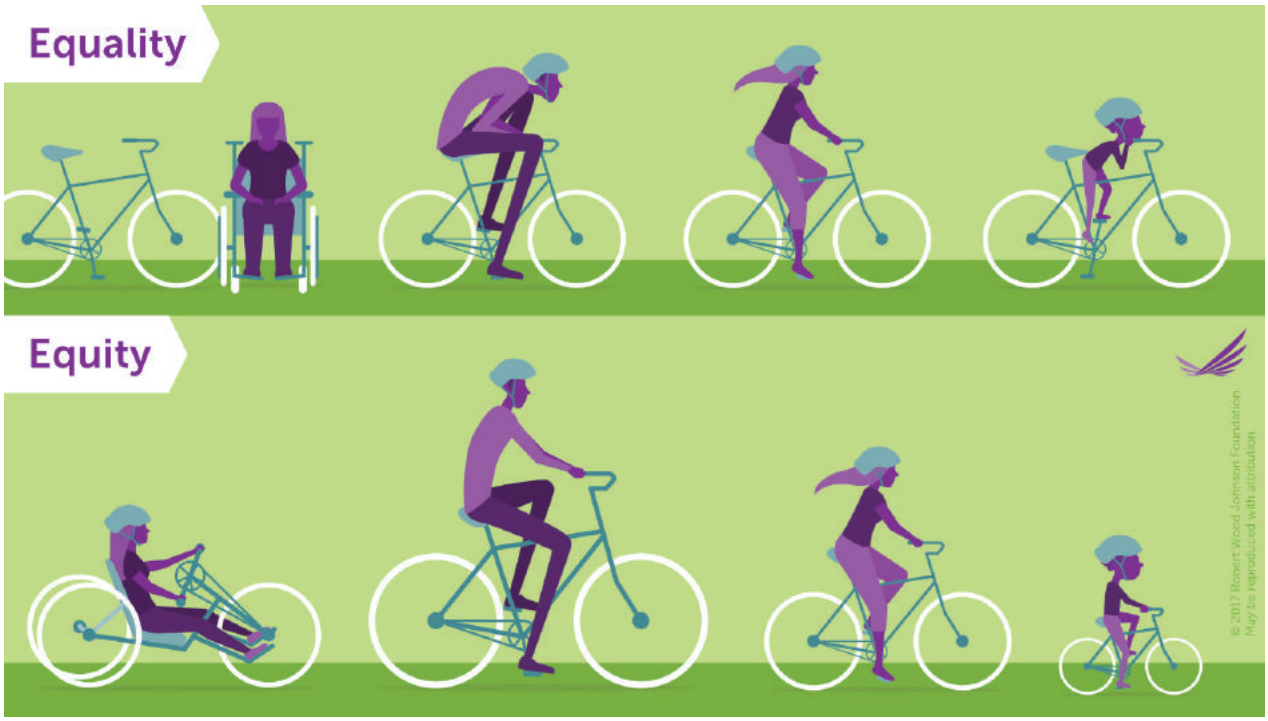
Education: 85% of adults over age 25 in Marion County, and 91% in Polk County, have a high school diploma or GED. From 2012-2016 the percentage for the Latino/a/x population was only 53% in Marion, and 61% in Polk. People who do not receive a diploma or GED are more likely to experience poverty.

Health Insurance: In 2017, 94% of the community had health insurance. 33% of the population in Marion County, and 26% in Polk County, were enrolled in the Oregon Health Plan. While health insurance is an important for accessing care, there are other costs and barriers to receiving physical and behavioral health care.

Health Equity

The community members that supported writing the 2019 CHA and 2021-2025 CHIP used a definition of health equity inspired by the World Health Organization (WHO).[iii] According to the WHO, health equity is defined as the absence of unfair, avoidable, or remediable differences in health among social groups. To achieve health equity, it's necessary to remove obstacles to health such as poverty, discrimination, and their resultant consequences. A state of health equity is said to exist when all people can reach their full potential regardless of social or economic status, race, ethnicity, religion, age, disability, gender identity, sexual orientation, or other socially determined circumstance.

Communities often observe health inequities when there are health disparities among people. Healthy People 2020 described health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically [and currently] linked to discrimination or exclusion."[iv]



[Image Source: Robert Wood Johnson Foundation. *Achieving Health Equity. Visualizing health Equity: One Size Does Not Fit All Infographic.* Accessed 12 April 2021. Retrieved from: https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html]

The Marion-Polk County CHIP applied a health equity lens.[1] Using a health equity lens requires considering equity during every step of the ongoing CHIP process.

[1] The health equity lens was adapted from the Oregon Department of Education (ODE) Equity Lens.

Actions that included an equity focus in the CHIP process included:

- Embedding health equity considerations in the "CHIP Handbook", which all Priority Area Work Group received as a tool to support their participation in the CHIP Process.
- Creating an Equity Subcommittee for the Marion-Polk CHIP Steering Committee.
- Actively recruiting leaders from community-based organizations that serve diverse populations to join Priority Area Work Groups.
- Asking for feedback from the Mid-Willamette Valley Health Equity Coalition.
- Creating opportunities for community leaders representing communities of color to review and provide feedback that was meaningfully incorporated into the final CHIP.

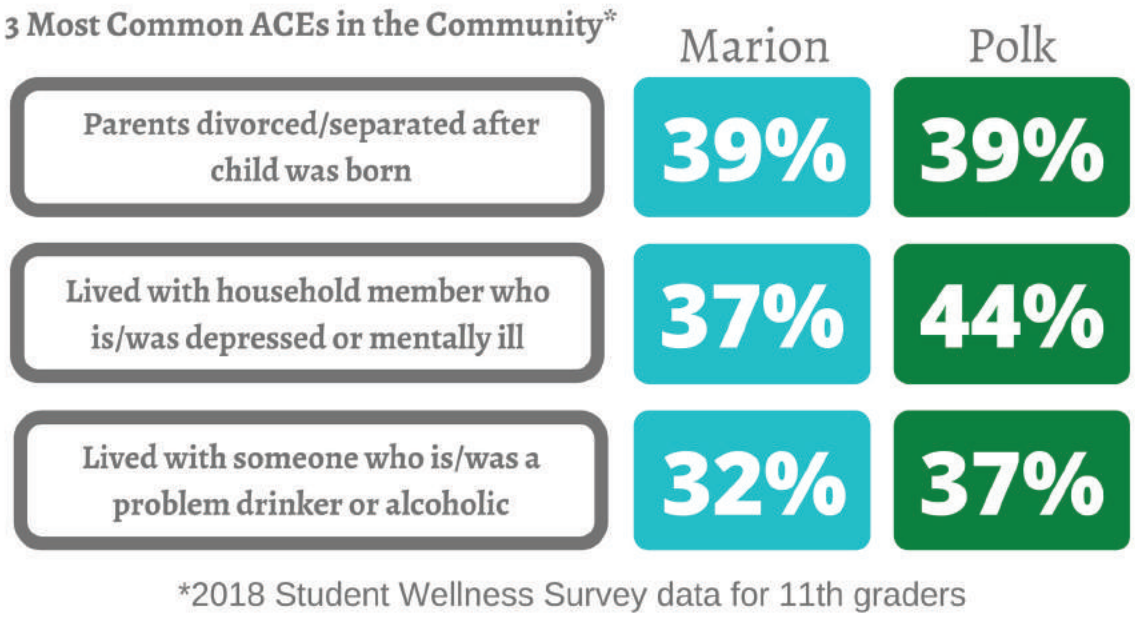
Partners leading the CHIP faced multiple barriers to creating an inclusive, representative, and accessible process. Social distancing requirements due to COVID-19 led to all planning meetings being virtual. Attending virtual meetings can be challenging for community members who lack access to necessary technology or face other barriers. Many local organizations that serve marginalized populations had limited capacity to participate in the CHIP process because they were focused on supporting communities they serve in the COVID-19 response.

The CHIP core partners will seek to improve outreach to partners who offer essential perspectives for advancing health equity and to improve collaboration. This strategic plan for improving health will be a living document that will be periodically reviewed and updated, and the core partners will aim to address gaps over the next five years.

Adverse Childhood Experiences

The 2019 CHA identified Adverse Childhood Experiences (ACEs) as a significant force of change in the community that impacts substance use, behavioral health, and housing issues. Adverse Childhood Experiences (ACEs) are events that cause adversity and/or trauma during sensitive childhood development periods. ACEs can include things like abuse, neglect, substance use in the home, living with a person experiencing mental illness, divorce, household member incarceration, and exposure to domestic violence. Other examples include discrimination, community violence, bullying, poverty, food insecurity, and homelessness.[vi]

A growing body of evidence supports that ACEs can lead to increased incidence of adult health risk behaviors, mental illness, chronic disease, disability, and premature mortality. Exposure to ACEs and the associated adversity and trauma can lead to toxic stress that negatively impacts child development. Studies suggest that children exposed to four or more ACEs are two to five times more likely to develop behavioral health issues and chronic health conditions.[vii] In Oregon 22% of adults over 18 had four or more ACEs. Minority populations also experience a greater number of ACEs. 37% of American Indian/ Alaska Natives had four or more ACEs along with 28% of Pacific Islanders, and 25% of African Americans/Blacks (2016 BRFSS).



Many children in foster care have experienced ACEs. In 2019, there was about 686 children in foster care in the community.[viii] A 2019 research report for Marion County from the Oregon Department of Human Services Office of Reporting, Research, Analytics and Implementation found that for parental factors drug involvement was a leading barrier to permanently reuniting foster children with their parents.[ix]

For specific data sources, view the Marion-Polk CHA 2021 Update at co.marion.or.us

COVID-19

The COVID-19 pandemic demonstrated how health impacts every aspect of our community. In 2020, 16,081 community members were infected with COVID-19. Of those 262 people passed away.

14,083 cases and 228 deaths in Marion County

1,998 cases and 34 deaths in Polk County

COVID-19 was the third leading cause of death in the United States in 2020.[x]

Rates of COVID-19 have varied across community groups by factors, such as age, race, and ethnicity, with communities of color experiencing higher rates of illness. Populations with chronic health conditions (e.g. heart disease, asthma, diabetes, and obesity) were at greater risk of a poor outcome from COVID-19, as well. These disparities highlight systemic issues that contribute to differences in health outcomes and barriers to achieving health equity.

In addition to devastating health, social, and economic impacts on our community, the COVID-19 pandemic exposed weaknesses and gaps in our public health infrastructure. Establishing new and improving existing community relationships was critical to scaling up the public health response to COVID-19. Enhancing these relationships will be an important part of improving community health now and moving forward. While the response to the pandemic is ongoing, community members demonstrated that they are ready to resume upstream work on health issues to improve overall resilience.

Community members that participated in the CHIP process are concerned about the impacts COVID-19 likely had on the priority areas of Substance Use, Behavioral Health Supports, and Housing. Preliminary data suggests that COVID-19 and the pandemic response may have exacerbated pre-existing problems in these areas. CHIP leadership will remain open to adjusting our goals and strategies as more data about the impacts of the pandemic becomes available. However, our community will begin work to address current concerns and will adapt our health improvement work as needed.

CHIP Structure and Process

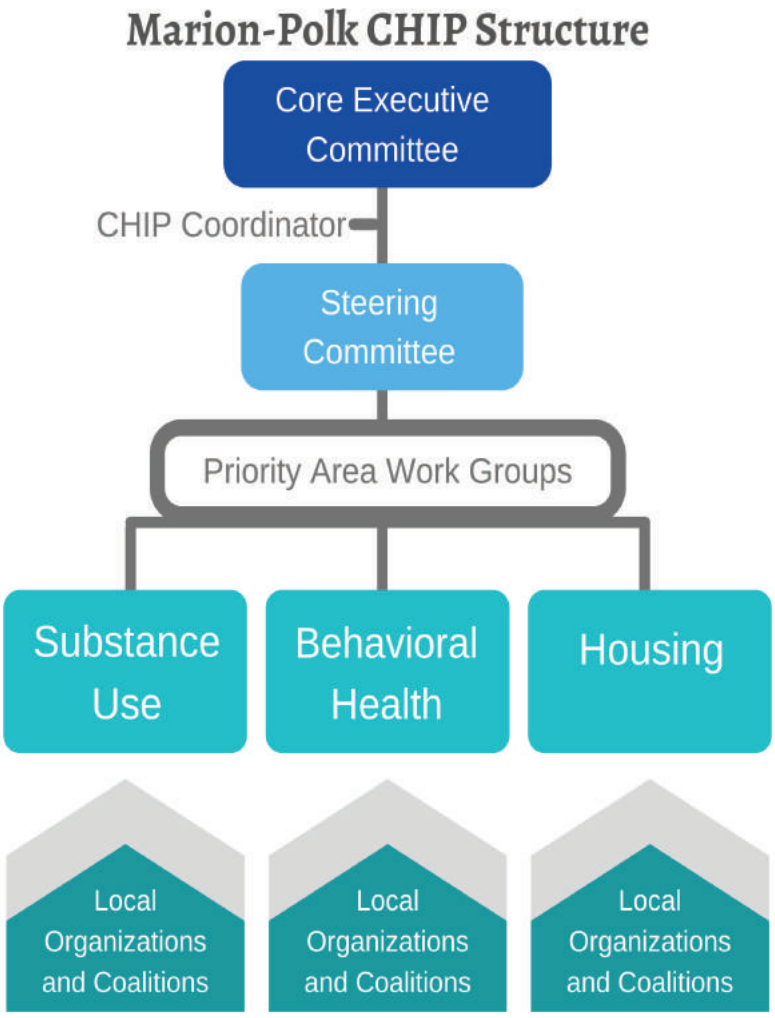
Structure

Core Executive Committee
The Core Executive Committee provides leadership that ensures the overall success of the CHIP partnership and process. This committee includes representatives from local health departments, hospitals, the Coordinated Care Organization (CCO), and the CCO community governance body in Marion and Polk Counties. These core partners are required to write a shared CHA and CHIP under Oregon statute. Together, they oversee the development of the CHIP. They will also work within their respective organizations to support implementation.

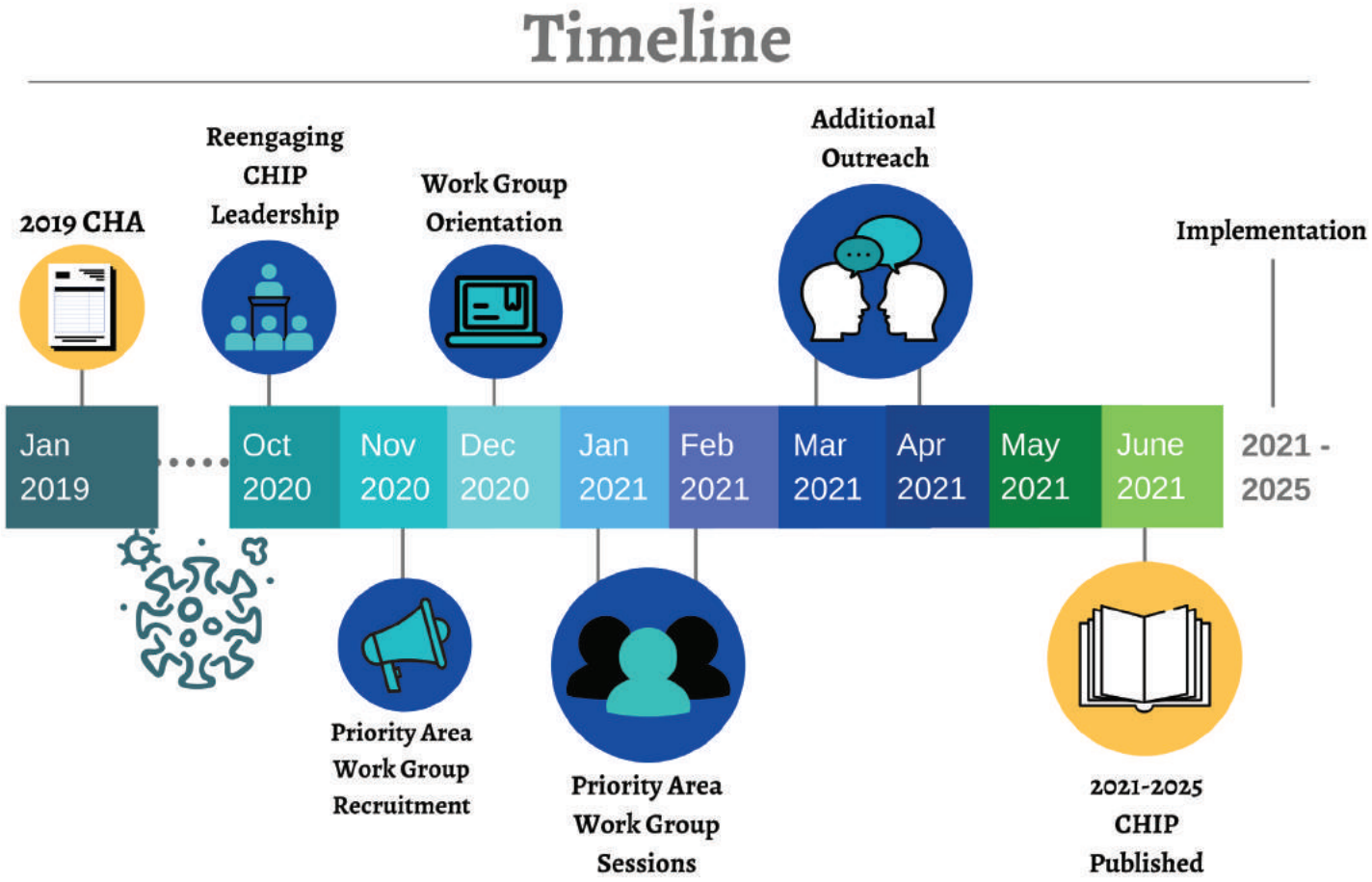
> **Members:** Marion County Health and Human Services, Polk County Public Health, Legacy Silverton Medical Center, Santiam Hospital, Salem Health, Kaiser Permanente, Willamette Health Council, PacificSource Marion-Polk CCO

Steering Committee
The Steering Committee responds to directions from the Core Executive Committee and works with the CHIP Coordinator by providing technical assistance during the CHA and CHIP process. The committee includes individuals from community organizations that are concerned with population health and the social determinants of health.

Priority Area Work Groups
The Priority Area Work Groups include individuals with knowledge and professional or lived experience that connects to the priority health issues of Substance Use, Behavioral Health Supports, and Housing. Members of the Steering and Core Executive Committees also joined other community members in the Priority Area Work Groups. There were three work groups (one for each priority health issue). The work groups met for a series of work sessions to review local health data and give direction for writing the CHIP aims, strategies, and population health outcome measures.



Process



Reengaging: A key decision for getting back on track after being delayed by COVID-19 was hiring a project coordinator fully dedicated to the CHIP. Marion County Health and Human Services led hiring a CHIP Coordinator who started in the position in October 2020. That same month, the Core Executive Committee resumed monthly meetings to direct the CHIP process. The CHIP Coordinator worked with the Core Executive and Steering Committees to agree on a working timeline, organize the Priority Area Work Group structure, and recruit community members to participate on work groups. Ideally, the CHIP process would have been spread out over a year-long period to allow ample opportunities for community feedback. After considering the impact of delays, the Core Executive Committee adopted an accelerated timeline of seven months to develop and adopt the new CHIP.

Recruitment: Core Executive Committee members, Steering Committee members, and the Project Coordinator worked together to recruit work group members. Activities included publicizing "CHIP Leadership Orientation" sessions in e-blasts and newsletters, sending email invitations to local community groups and organizations, sending personalized invitations to key community leaders, and sharing "in-person" invitations during virtual meetings of local groups, such as Health Advisory Boards, the Mid-Willamette Valley Health Equity Coalition, Service Integration Teams, and others.

Orientation: In December 2020, Steering Committee members and new Priority Area Work Group members virtually attended "CHIP Leadership Orientation" sessions to learn about the CHA and CHIP and what to expect when participating in work sessions to help write the next CHIP. The CHIP Coordinator offered three opportunities to attend a session. Fifty-four people attended an orientation session. Orientation sessions were not priority area specific. The core partners continued work group recruitment through January 2021. All Priority Area Work Group members received a CHIP Handbook that covered the same material as the orientation sessions.

Work Group Sessions: In January and February of 2021, the Substance Use, Behavioral Health Supports, and Housing Priority Area Work Groups each met for two 2-hour work sessions. The work groups met using Cisco WebEx, and facilitators used the digital tool Poll Everywhere to manage participation. Each work group followed the same agenda for their work sessions:

Session 1

- Welcome and Logistics
- Community Agreements
- Community Partner Data Presentation
    - Substance Use: "Marion County Substance Abuse Prevention Needs Assessment 2019" by Susan McLauchlin B.S., CPS Marion County Health and Human Services
    - Behavioral Health Supports: "2019 Marion-Polk County Community Health Assessment" by Sierra Prior, MPH Marion County Health and Human Services
    - Housing: "Mid-Willamette Valley Homeless Alliance Gap Analysis and Community Action Coordinated Entry Data" by Ashley Hamilton, The ARCHES Project and Carla Munns, IMBA
- Review Current Initiatives, Resources, and Gaps
- Begin Process to Select Goals

After Session 1, staff from Marion County Health and Human Services, PacificSource Marion-Polk CCO, and Willamette Health Council reviewed work group responses for themes, and used the themes as categories for draft proposed goals. Each work group received at least 10 draft goal statements to discuss, revise, and rank for their top choices in the second work session.

Session 2

- Review New Community Agreements
- Discuss and Rank Proposed Draft Goals
- Begin Process to Set Population Outcome Measures
- Begin Process to Determine Strategies

By the end of the second work session for the Substance Use and Behavioral Health Supports Work Groups, each group had selected three goals. The work groups decided to meet for an additional joint session to review and revise the goals so that they would align with each other.

The Housing Work Group did not select goals. Instead, members used the time in the second work session to discuss aligning with the Mid-Willamette Valley Homeless Alliance (MWVHA) and Continuum of Care (CoC) 2020 Strategic Plan. The CHIP Coordinator brought the request for alignment to the Core Executive and Steering Committees for discussion and approval. Both leadership committees reached consensus to support alignment.

At the direction of the Housing Work Group and leadership committees, the CHIP Coordinator reviewed the CoC Strategic Plan and selected objectives that align with the health focus of the CHIP and objectives that mentioned organizational members of the CHIP Core Executive Committee. The CHIP Coordinator then met with the Housing Work Group for a third session to review the goals and strategies that describe how the CHIP aligns with the Strategic Plan, and actionable strategies the public health and health care systems can support.

Staff from Willamette Health Council and PacificSource Marion-Polk CCO provided technical assistance and facilitation support during all of the Priority Area Work Group work sessions.

Additional Outreach: In March 2021, PacificSource Marion-Polk CCO and Willamette Health Council organized additional outreach. This included key informant interviews and two group sessions to gather additional feedback on the draft goals that came from the Priority Area Work Groups. More information about this additional outreach is described on page 25.

Work Group Recruitment, Attendance, and Demographics

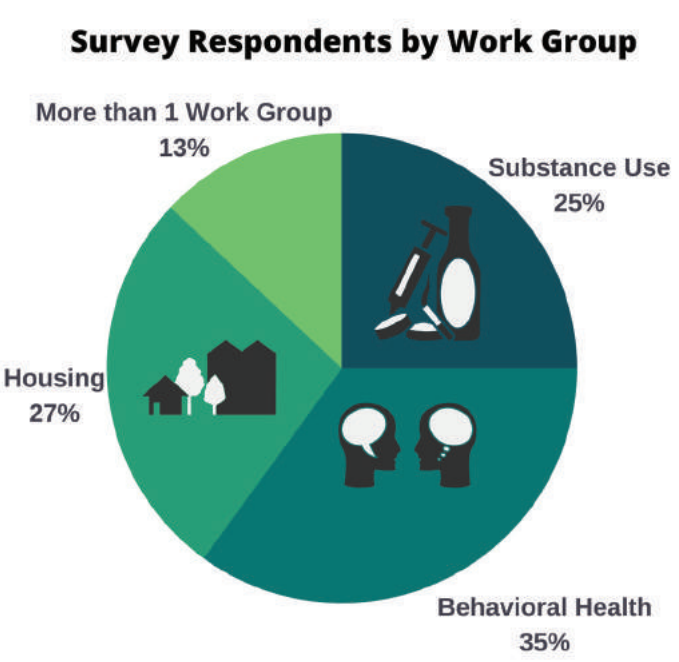
Recruitment and Attendance

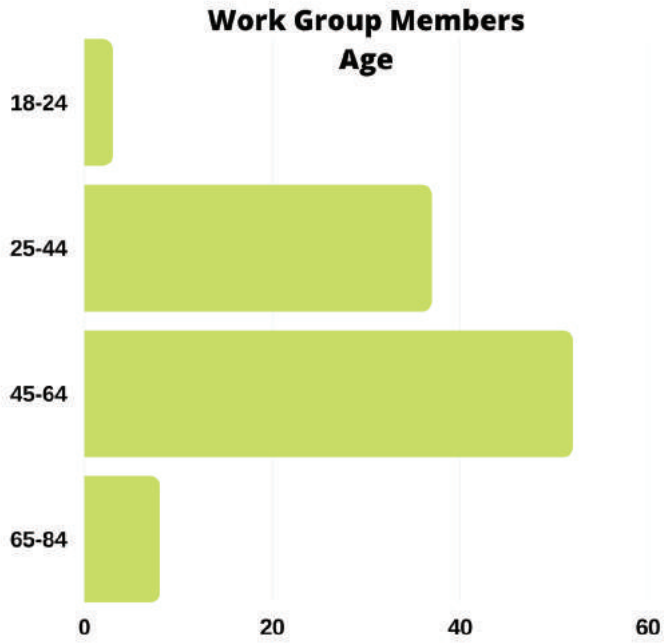
The Priority Area Work Group members shared their professional expertise and lived experience to provide guidance for writing the CHIP aims and strategies. The majority of members represented local organizations that strive to improve community health. There were 46 organizations with one or more representatives in the CHIP process. A full list of organizations that were represented in the Priority Area Work Groups is provided in the appendices.

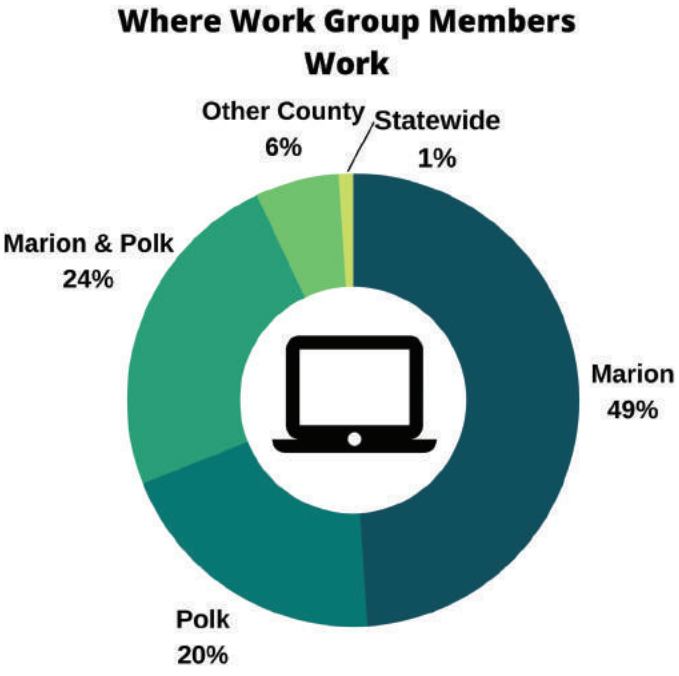
	Substance Use	Behavioral Health Supports	Housing
Volunteers Recruited	23	53	41
Present at 1st Work Session	17	41	26
Present at 2nd Work Session	16	29	24

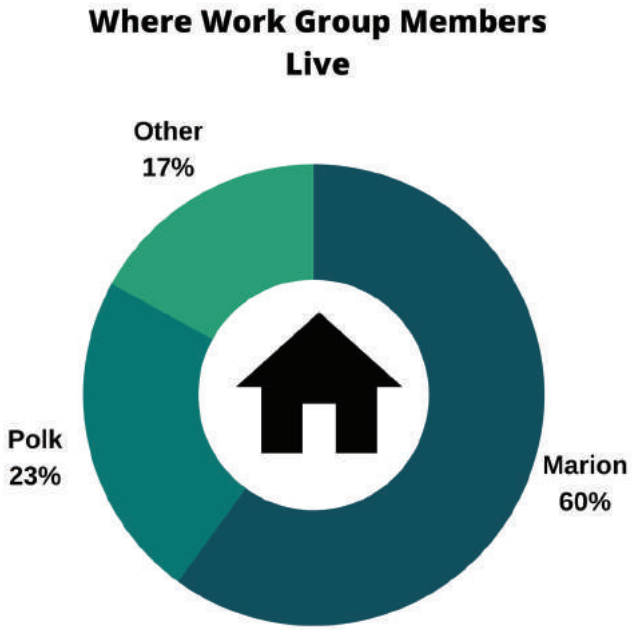
Demographics

67 Priority Area Work Group members answered the demographics survey.









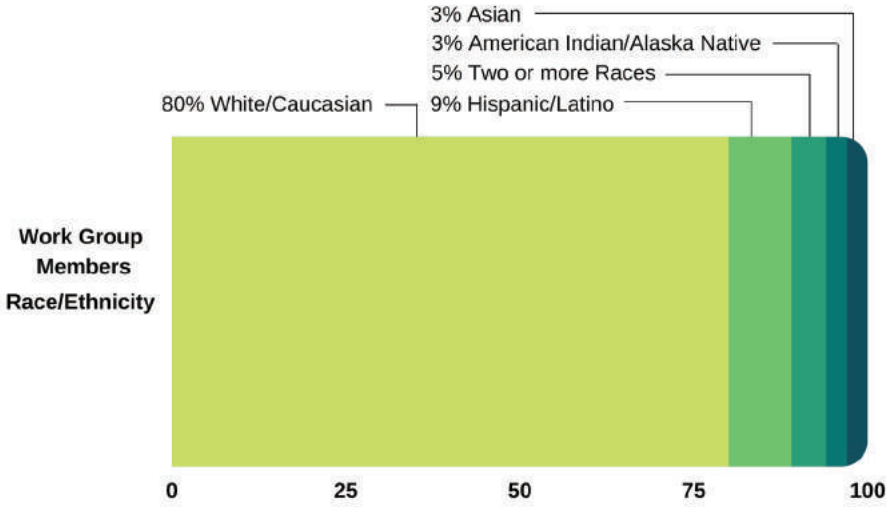
13%
Identify as Bilingual and Biculutural

78%
Identify as female*

16%
Live with a disability

58%
Have lived experience in the priority areas

*(This question was phrased to reflect how data categorized by sex is displayed in the 2019 CHA, where the American Census Bureau is the source. Survey respondents pointed out this question didn't provide options for other gender or gender non-conforming; intersex, or transgender individuals. The 2021 CHA Update includes new data on sex assigned at birth, gender, and sexuality for 11th graders based on the 2018 Student Wellness Survey.)



The Core Executive and Steering Committees recognize that when we compare the survey results to local demographics data, the composition of the Priority Area Work Groups does not match our community as a whole. The CHIP leadership committees will strive to improve representation for the community we serve as we continue our shared CHIP work.

Values

The CHIP Coordinator facilitated three "CHIP Leadership Orientation" sessions in December 2020. Work group volunteers could choose any session to attend, and the sessions were not based on priority areas. During the orientation, the CHIP Coordinator reviewed data from the 2019 CHA and expectations for serving on a Priority Area Work Group. During the sessions, work group volunteers responded to the question: What do you think is most important in community health improvement work? Answers were collected in Poll Everywhere, and the platform generated a word cloud. The more a word was mentioned, the bigger it appeared in the word cloud. The following images are the final word cloud from each "CHIP Leadership Orientation" session. These word clouds demonstrate values that Priority Area Work Group members brought into their work sessions during the CHIP process.

*These word clouds do not correspond to Priority Area Work Groups. They were created in orientation sessions that were separate from the Priority Area Work Group sessions.

Work Group Themes

Each Priority Area Work Group met for two 2-hour work sessions. In the first work session, the work groups answered a series of questions in Poll Everywhere to perform an informal gap analysis. (A full list of questions is available in the appendices.) A small team, including subject matter experts, reviewed all the responses and compiled a list of themes on the most pressing issues within the broad priority areas to guide writing draft goal proposals for the work groups to review in their second work session. The review team also compiled a list of results the work group members want to see in the community to inform brainstorming possible population health outcomes. The table below summarizes the themes and desired results, and they are not listed in any particular order or ranking.

Priority Area Work Group	Substance Use	Behavioral Health Supports	Housing
Themes	• Youth Prevention • Access to Treatment • Recovery	• Prevention for At-Risk Populations • Social Isolation • Access to Care • Navigating and Coordinating the Behavioral Health System	• Preventing Homelessness • Housing Supply and Affordability • Homelessness
Desired results	• Decreased suicide • Fewer overdoses • Decreasing product sales • Decreased incarceration • Decreased recidivism • Decreased youth use • Mental health data • Increased life expectancy • Decreased consumption rates across lifespan • Decrease hospitalization	• Decrease in loneliness • Lower rates of depression • Fewer overdoses • Fewer behavioral health related ED visits	• Better school attendance • Fewer people spending 30% of income on rent • More affordable housing units • No homeless youth • Reduced chronic homelessness rates • Fewer people in shelters

Additional Outreach Results

PacificSource Marion-Polk CCO and Willamette Health Council led additional listening sessions with education and clinician community partners to further discuss opportunities and barriers in the CHIP priority areas. The two key informant group sessions took place in March 2021. A full list of participants is available in the "Community Partners" appendix.

Regional Health and Education Session

PacificSource Marion-Polk CCO facilitated this session with community partners from the education sector in Marion and Polk Counties. Participants discussed the three CHIP priority areas, as well as Electronic Medical Records (EMRs) and School-Based Health Centers. There were 29 participants.

Substance Use
It is common practice for schools to provide health education that includes substance use curriculum. Education partners find that presentations from outside partners help to reinforce messages about substance use. Some schools have youth peer support programs for supporting students with substance use and behavioral health challenges. For example, Salem-Keizer School District has worked with Youth Era, a peer run organization, in the past for suicide prevention education. They intend to expand partnerships with Traditional Health Worker (THW) organizations, but are in the beginning stages of planning. During the listening session, participants indicated that youth peer support programs could potentially help in tobacco cessation efforts.

Behavioral Health Supports
There are a variety of current initiatives and funding sources dedicated to supporting Socio-Emotional Learning and other behavioral health supports in the community. For example, the Willamette Education Service District (WESD) has recently increased their capacity to support local schools after receiving funding through the Student Success Act for mental and behavioral health training and Trauma Informed Care training. The Marion & Polk Early Learning Hub has multiple programs to provide support for childcare providers and children in their care, including their Care Connect Program. There is still a need for additional cross-sector collaboration and additional mental health and behavioral health supports in the K-12 and early learning systems.

Housing
Participants identified a barrier in addressing housing instability among students. Homeless students living with family members do not meet the United States Department of Housing and Urban Development definition of homeless, which prevents students from accessing support from the CoC. Participants indicated that there is a need to improve the community's ability to support students experiencing homelessness or housing insecurity.

Health Information Technology
None of the participants representing a local school indicated that their school uses an EMR system. Currently, any personal student information is stored in SIS (Student Information Systems) or a similar system. However, some schools use a performance management system to track behavioral health programs. For example, Salem-Keizer School District uses Panorama for documenting Socio-Emotional

Learning outcomes. This tool also helps with identifying high-risk children and providing support. WESD collects data related to behavioral health with DESSA (Devereux Student Strengths Assessment), and the Early Learning Hub collects the DECA (Devereux Early Childhood Assessment).

School-Based Health Centers (SBHCs)
There are two school-based health centers in the community based at Central School District (Polk County) and Chemawa Indian School (Marion County). Participants from Central School District provided positive testimony about access to care for students and students' families through their SBHC.

Clinician Session

Willamette Health Council facilitated this session with clinicians and other community partners from a variety of health specialties in Marion and Polk Counties. Participants focused on discussing the Substance Use and Behavioral Health Supports CHIP priorities. There were 18 participants. Willamette Health Council and PacificSource Marion-Polk CCO also met with a Dental Care Organization separately to discuss the CHIP goals.

Substance Use and Behavioral Health Supports
Willamette Health Council facilitated the conversation with a focus on service and payment integration of behavioral healthcare and substance use treatment. Other topics of discussion included preventive services, improving service delivery for patients with co-occurring disorders, and improving referrals. Currently, there are a limited number of clinics in Marion and Polk Counties that offer a substance use and behavioral health integrated service model. PacificSource Marion-Polk CCO offers value-based payment programs for Patient-Centered Primary Care Homes (PCPCHs) and Behavioral Health Integration. For example, Bridgeway Recovery Services provides integrated mental health and substance use disorder treatments with an OHA-PCPCH recognized primary care clinic. Another example that addresses both substance use and mental health is the local chapter of Dual Diagnosis Anonymous, which offers informal groups for people in recovery led by certified Peer Support Specialists. Various clinics reported different ways of addressing barriers to integrated care of behavioral health and substance use treatment.

Barriers shared include those related to integrating services (such as billing and confidentiality issues with HIPAA and CFR46-Part 2, which requires separate records systems for those experiencing substance use disorder). Clinicians view these barriers as limiting factors for efficient coordination of care. Potential solutions include braided funding opportunities that combine public and private funding, as well as more leniency in public funding that allows for integrated care and preventive services.

Local behavioral health treatment providers identified several barriers to improving service delivery in the community: finding substance abuse treatment providers with openings or beds available; a lack of certified substance abuse treatment providers (e.g. Certified Alcohol & Drug Counselors); a lack of incentive for providers to promote substance use and behavioral health; meeting needs of patients with dual or multiple diagnoses; and limited entry points for care.

Participants from Federally Qualified Health Centers (FQHCs) emphasized the role that primary care plays in accessing substance use treatment and behavioral healthcare. The two FQHCs in Marion and

Polk Counties are Northwest Human Services and Yakima Valley Farmworkers. Northwest Human Services employs behavioral health clinicians to work in their primary care clinics where they use SBIRT (Screening, Brief Intervention and Referral to Treatment) to assess patients for substance use-related disorders. These clinicians refer patients to treatment clinics that specialize in treating these disorders. Northwest Human Services and Yakima Valley Farmworkers agree that Traditional Health Workers (THWs) are important for helping people access appropriate care. A challenge with incorporating THWs is that it increases the number of decision makers before singular or co-occurring treatment even begins, and creates communication problems during care.

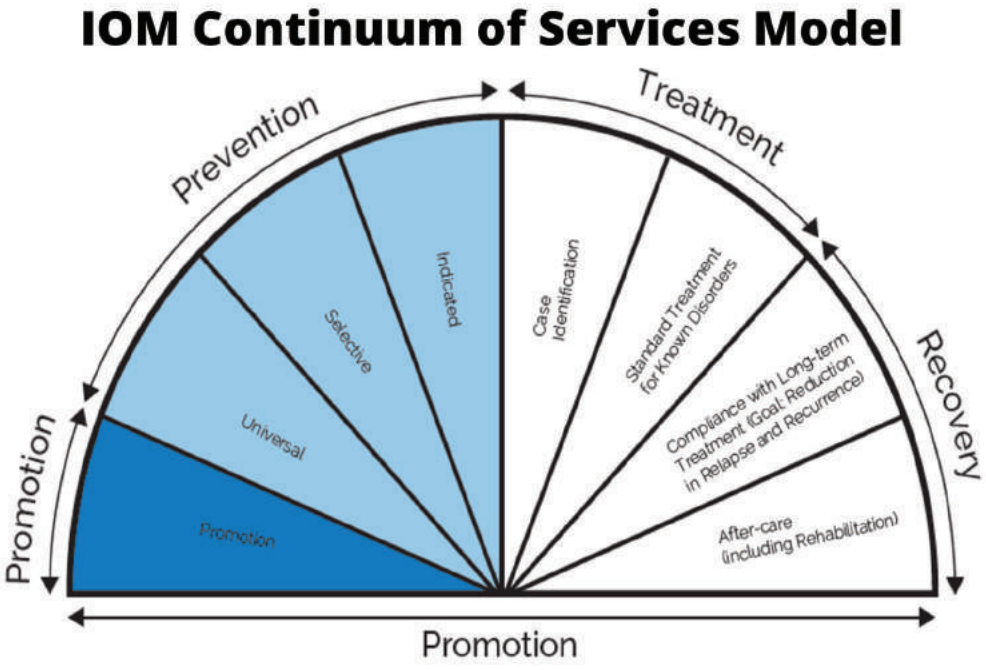
Oral Health

In a separate meeting, Willamette Health Council and PacificSource Marion-Polk CCO staff consulted representatives from Capitol Dental, one of the region's Dental Care Organizations, about supporting substance use and behavioral health prevention strategies. Their representatives affirmed that oral health plays a role in expanding prevention education regarding tobacco and prescription opioid use among youth. Relatedly, the providers expressed urgency in advocating for policies to co-prescribe naloxone with opioid medication in order to reduce overdose deaths, which can be an issue during wisdom teeth extraction aftercare. Concerning clinical oral health services in the Marion and Polk Counties, they discussed crossover between oral health and other health care services, and the need to improve integrated referral pathways between providers. Capitol Dental suggested integrating multidisciplinary health services onsite by co-locating physical, behavioral, and oral health services at low-income housing complexes and community centers. This would improve housing permanence by ensuring that basic health and safety needs are easily accessible and attainable for marginalized community members. Capitol Dental has successfully implemented this co-location model in other counties in Oregon.

Priority Areas

- Substance Use
- Behavioral Health Supports
- Housing

Community partners participating in the 2019 CHA used data and a rigorous assessment process to select the priority areas of Substance Use, Behavioral Health Supports, and Housing. The CHIP Priority Area Work Groups reviewed CHA data and supplemental data from community partners relevant to the priority areas to inform aim and strategy development. Members of the Priority Area Work Groups performed an informal gap analysis in work sessions to discuss their perception of community trends and share information about current work. The Priority Area Work Groups then chose aims and strategies to move the needle on high level indicators related to issues that fall under the broad areas of Substance Use, Behavioral Health Supports, and Housing. The strategies include approaches that span the Institute of Medicine (IOM) Continuum of Services Model that ranges from promotion and prevention to treatment and recovery.[xi]



All work groups emphasized that COVID-19 has exacerbated issues in the priority areas. Implementing strategies will require considering how to respond now under social distancing limitations and in the future as restrictions are lifted. Each work group also discussed the importance of responding to

disparities in the priority areas with strategies that include collaborating with communities of color and improving data collection to better inform strategy implementation. These themes across work groups led to creating cross-cutting strategies that supporting organizations should aim to apply to the priority area specific strategies during CHIP implementation. There are many ways to fulfill the strategies that are not prescribed in this document. The CHIP Coordinator, along with members of the Core Executive and Steering Committees, will work with partners to interpret and implement the strategies.

Cross-cutting strategies:

- Collaborate with Black, Indigenous, Latino/a/x, Russian/Slavic, Asian, and Pacific Islander serving community-based organizations to improve health outcomes.
- Improve local data collection on health outcomes and social determinants of health for marginalized community members.
- Implement strategies in a manner that is culturally and linguistically responsive.

Finally, it is important to highlight current initiatives in the community that address Substance Use, Behavioral Health Supports, and Housing. As we move forward with implementing the CHIP strategies, we want to ensure strong alignment with efforts already in place so that we can leverage resources to further address gaps and take advantage of opportunities to improve community health. In the following sections, there is information about identified community initiatives that align with one or more CHIP priority area(s).

About the Population Outcome Measures and Goals

Population outcome measures were selected based on feedback from the Priority Area Work Groups and available data. Goals for the population outcome measures were developed in consultation with the Marion County Health and Human Services Public Health Division lead epidemiologist for the Marion-Polk Community Health Assessment.

Where possible, the goal targets are adapted from similar measures in Healthy People 2030. Population outcome measures that align with Healthy People 2030 are marked with (HP30). The targets were adapted to a 5-year timeline or modified to fit the community based on the most recent available data.

The remaining Population outcome measure target goals are generally based on a 10% improvement based on the data provided. Striving for a 10% improvement is common practice for public health goal setting and an achievable target.

Substance Use

Substance Use as a priority relates to decreasing the use of tobacco, alcohol, marijuana, and other drugs in the community. Marion and Polk Counties have consistently worked on programs to reduce the impact of a variety of substance use issues in this region. However, community members have determined that there are still unresolved issues where we can expand our efforts. Community members participating in the 2019 CHA and the CHIP Priority Area Work Groups in 2021 were specifically concerned about youth substance use. 24% of 11th graders in Marion and Polk Counties used alcohol in the last month according to the 2018 Student Wellness Survey. 19% of Marion County and 16% of Polk County 11th graders used marijuana in the last month. While not directly comparable, the Healthy People 2030 target for the proportion of adolescents aged 12- to 17-years reporting use of marijuana during the past 30 days is 5.8%.[xii]

Other concerns in the community include adult smoking and overdose. Adult smoking has been decreasing in recent years, but 17% of adults in Marion County and 14% of adults in Polk County were current smokers from 2012-2015. In 2016, 28.5% of current adult cigarette smokers had experienced four or more ACEs. Recent studies have found that LGBT individuals also have higher rates of smoking and e-cigarette use compared to heterosexual individuals.[xiii] The community and Oregon as a state failed to meet the Healthy People 2020 adult smoking goal of 12%, and the Healthy People 2030 goal has increased to 16.2%.

Opioid use remains a concern as well. Opioid-related overdose mortality rates peaked in the community from 2007-2011 and then decreased. There is reason to suspect that the community, which has had higher mortality rates than the state, experienced more overdose deaths in the past year due to the pandemic. The Centers for Disease Control and Prevention (CDC) reported that Oregon followed national trends in 2020 and saw an increase in drug overdose deaths. There were 40% more overdose death from January to June in 2020 compared to the same period in 2019. Most overdose deaths involved opioids, illicit fentanyl, and methamphetamines.[xiv] Marion and Polk Counties have programs specific to opioid use, and those programs should continue alongside expanded efforts in broader substance use prevention.

To address the variety of substance use concerns in the community, the Substance Use Priority Area Work group created goals and strategies that support prevention, treatment, and recovery. The following strategies reflect evidence-based strategies for substance use prevention recognized by the Community Anti-Drug Coalitions of America (CADCA) National Coalition Institute, but include specific direction from the Substance Use Priority Area Work Group members. While the first goal is specific to alcohol, tobacco, and marijuana use, the remaining goals are intentionally broad to encompass additional substances.

Work Group Insights:

What trends in substance use in our community are most concerning to you and/or the populations you work with?

- Opioid availability and use seem to be on the rise, particularly with the homeless population.

- Increasing alcohol and cannabis sales during COVID-19 is concerning.
- The lack of prevention in our community is concerning, especially with youth.

What are the results we want for populations in our community?

- Increased awareness of the links between alcohol and substance use to other health outcomes like cancer, diabetes, and obesity.
- A responsive system with adequate acute and long-term recovery supports and treatment.

Current community initiatives that align with this priority area include, but are not limited to:

- Peer Run Organizations
  - Iron Tribe
  - Project ABLE
  - Recovery Outreach Community Center
  - Youth Era
- Child, youth, and family serving initiatives
  - Marion & Polk System of Care
  - Children's Public Private Partnership (CP3)
  - Youth Advisory Boards/Councils (e.g. Central High School's Youth Advisory Council for their School Based Health Center)
  - Marion & Polk Early Learning Hub initiatives (e.g. Care Connect and Family Connects)
  - Boys & Girls Club Training Teens for Tomorrow (T3) program
  - Salem-Keizer School District contracted Behavioral Health services
  - Willamette Education Service District (WESD)
- Harm Reduction
  - Regional Opioid Overdose Prevention Coalition
  - HIV Alliance syringe exchange program
- Additional community initiatives
  - Great Circle Recovery opioid treatment program
  - Salem Health Community Health Education Center
  - Willamette Health Council Committee/Subcommittee work including the Clinical Advisory Panel and new Integration and Quality Incentive Measures Collaboratives
  - Community, Business and Education Leaders (CBEL)

Priority Area: Substance Use

Population Outcome Measures and Goals:

- Decrease the percentage of 11th graders in Marion and Polk Counties who drank alcohol in the last month by 3% by 2025.
  - Baseline: Marion 24.1%, Polk 23.6% (2018)
  - Target: Marion 21.1%, Polk 20.6%
  - Data Source: Student Wellness Survey
- Decrease the percentage of 11th graders in Marion and Polk Counties who used electronic cigarettes in the last months by 2% by 2025.
  - Baseline: Marion 12.5%, Polk 9.4% (2018)
  - Target: Marion 10.5%, Polk 7.4%
  - Data Source: Student Wellness Survey
- Decrease the percentage of 11th graders in Marion and Polk Counties who use marijuana in the last month by 2% by 2025.
  - Baseline: Marion 18.6%, Polk 16.3% (2018)
  - Target: Marion 16.6%, Polk 14.3%
  - Data Source: Student Wellness Survey
- Decrease the percentage of adults who use tobacco by 3% by 2025. (HP30)
  - Baseline: Percent of adults over 18 who are current cigarette smokers: Marion 16.0%, Polk 14.6% (2014-2017)
  - Target: Marion 13.0%, Polk 11.6%
- Decrease the opioid overdose death rate by 10% by 2025.
  - Baseline: Marion 10.36 per 100,000 (106 deaths), Polk 8.76 per 100,000 (22 deaths) (2016-2018)
  - Target: Marion 9.32 per 100,000, Polk 7.88 per 100,000
  - Data Source: Oregon Vital Statistics, Opioid Data Dashboard

Aim (A): Increase youth perception of harm of alcohol, tobacco, and marijuana to prevent substance use.

Strategies:

1. Provide culturally and linguistically specific information to youth that includes the consequences of alcohol and drug use and corrects misperceptions.
2. Collaborate with partners enforcing current alcohol, tobacco, and marijuana laws to promote retailer responsibility.
3. Disseminate information about substance use prevention that incorporates youth feedback.
4. Create opportunities to support youth by offering peer support services for prevention and cessation.
5. Collaborate with oral health providers to educate youth on substance use prevention.

Aim (B): Increase the community's ability to treat substance abuse by decreasing the gap in treatment service availability between rural and urban areas.

Strategies:

1. Increase the number of substance use treatment service providers.
2. Advocate for new treatment facilities in rural areas.
3. Advocate for more transportation options between rural and urban areas.
4. Build community partnerships with treatment centers, especially culturally specific ones.
5. Collaborate with local advisory boards or work groups on improving substance use treatment access for specific populations, such as community members with co-occurring disorders.
6. Provide training opportunities for the rural substance use treatment workforce to increase cultural and linguistic responsiveness and improve retention.
7. Expand use of telehealth services across the community.

Aim (C): Promote a community environment that supports the relationship between substance use disorder recovery and overall health and wellness.

Strategies:

1. Increase availability of culturally and linguistically specific recovery resources for youth and families in Marion and Polk Counties.
2. Promote providing alternative or alcohol-free activities in the community.
3. Reduce the availability of alcohol in the community to minors.
4. Promote treatment and recovery across the lifespan including emphasis on trauma informed care, addiction, and life skills after rehabilitation.
5. Improve community ability to connect people in recovery with Traditional Health Workers, which includes Community Health Workers, Peer Support Specialists, Peer Wellness Specialists, Personal Health Navigators, and Doulas.
6. Improve ability to connect people leaving incarceration with peer support services.
7. Promote the integration of physical, behavioral, and oral health care services to support wellness and individual social determinants of health.
8. Incorporate recovery into substance use education for youth.

Behavioral Health Supports

The 2019 CHA states that Behavioral Health often includes preventing or treating mental illnesses, such as anxiety and depression, and preventing and treating alcohol and drug abuse and other addictions. Navigating the health system, getting timely access to services, and matching with the appropriate workforce are all important factors in behavioral health care.

However, addressing the causes of mental health issues and substance abuse sometimes requires different strategies. The Marion and Polk County community has experienced concerning trends in the whole field of behavioral health. One of the primary data points that led the community to call out Behavioral Health Supports as a priority separate from Substance Use is the increasing prevalence of mental health risk factors for youth as they move up in grade levels. In addition, about 1 in 4 adults has been diagnosed with depression in the community.[xv]

The suicide mortality rate in Marion County has been increasing every year from 2013 to 2018. In 2018, the age-adjusted suicide mortality rate for Marion County was about 18 per 100,000. In Polk County, the 2019 rate was about 14 per 100,000. Neither county met the Healthy People 2020 goal of 10.2 per 100,000.

The statewide suicide rate increased again in 2019, which creates concern for Marion County as the local suicide rates tend to be similar to the state. Oregon had 20.4 deaths by suicide per 100,000 people in 2019. Oregon is ranked ninth highest in the nation for suicide rates. However, youth suicide deaths (ages 10-24) decreased in 2019 for the first time since 2015.[xvi] There is insufficient data yet to determine whether the pandemic led to higher suicide mortality rates in 2020. CHIP Priority Area Work Group members shared anecdotes expressing concern for increases in youth suicide attempts while students were unable to attend school in-person.

During the Forces of Change MAPP assessment, the community identified ACEs as an influential force that may present challenges and opportunities for behavioral health outcomes in our community over the next five years.

Work Group Insights:

What trends in behavioral health in our community are most concerning to you and/or the populations you work with?

- Barriers to education and positive educative experiences for BIPOC youth.
- There is a lack of coordination to our most vulnerable populations.
- Social isolation, particularly for older adults.

How can we bridge the gap between what we see now and our desired results?

- Better integration of Behavioral Health services in physical health spaces.
- A robust network of community, social, and informational services that ensure people feel heard and valued in our community.

Current community initiatives that align with this priority area include, but are not limited to:

- Education
  - Marion County Health and Human Services PAX Good Behavior Game program
  - Willamette Education Service District Regional Mental Health Community of Practice
  - Salem-Keizer School District contracted Behavioral Health services
- Peer Run Organizations/Peer Support Services
  - Iron Tribe
  - Northwest Senior and Disability Services' Health Opportunities for Personal Empowerment (H.O.P.E.) senior peer mentor program
  - Oregon Family Support Network
  - Project ABLE
  - Recovery Outreach Community Center
  - Youth Era
- Harm Reduction
  - Marion County Zero Suicide Initiative
  - Mid-Valley Suicide Prevention Coalition
  - United Way of the Mid-Willamette Valley Mobile Crisis Unit (CRU)
- Family and Community Supports
  - Capitol Dental Tooth Fairy project
  - Children's Public Private Partnership (CP3)
  - Community, Business and Education Leaders (CBEL) including the Fostering Hope Initiative led by Catholic Community Services, and Marion County Commission on Children & Families
  - Mano a Mano Polk County Family Wellness Project, and Youth Empowerment program
  - Marion & Polk Early Learning Hub initiatives (e.g. Care Connect and Family Connects)
  - Marion & Polk System of Care
- Additional community initiatives
  - Willamette Health Council Committee/Subcommittee work including the Clinical Advisory Panel and new Integration and Quality Incentive Measures Collaboratives

Priority Area: Behavioral Health Supports

Population Outcome Measures and Goals:

- Decrease the percentage of adults with depression by 3% by 2025.
  - Baseline: Chronic condition prevalence of depression in adults over 18: Marion 26.1%, Polk 27.8% (2014-2017)
  - Target: Marion 23.1%, Polk 24.8%
  - Data Source: Behavioral Risk Factors Surveillance Survey (BRFSS)
- Decrease the percentage of 11th graders experiencing symptoms of depression by 4% by 2025.
  - Baseline: Marion 35.2%, Polk 44.4% (2018)
  - Target: 31.2% Marion, 40.4% Polk
  - Data Source: Student Wellness Survey
- Decrease the suicide rate for Marion and Polk Counties by 5% by 2025. (HP30)
  - Baseline: Age-adjusted suicide rate: Marion 18.2 per 100,000 (63 suicides), Polk 14.6 per 100,000 (13 suicides) (2018)
  - Target: Marion 17.5 per 100,000, Polk 13.9 per 100,000
  - Data Source: Oregon Public Health Assessment Tool (OPHAT)
- Increase the rate of mental health providers per population by 10% in the community by 2025.
  - Baseline: Marion 343 per 100,00, Polk 276.5 per 100,000 (2020)
  - Target: Marion 377.2 per 100,000 (~119 providers added), Polk 304.2 per 100,000 (~24 providers added)
  - Data Source: County Health Rankings

Aim (D): Reduce depression rates across the lifespan.

Strategies:

1. Improve community partnerships between the health and education systems to collaboratively improve mental health supports with schools.
2. Connect distance learners in schools with mental health resources.
3. Improve outreach and education on community behavioral health services to youth transitioning out of foster care.
4. Improve outreach and collaboration between county behavioral health programs and organizations serving mental health needs of older adults.
5. Enable community-based organizations to destigmatize behavioral health by providing culturally responsive information to share with communities served.
6. Collaborate with tribes to address disproportionate depression and suicide rates, and contributing factors, in the community's Native American/Alaskan Native population.

Aim (E): Improve mental health resilience.

Strategies:

1. Implement resilience-informed practices.
2. Promote inter-generational programs to build social connections between community members of all ages.
3. Diversify the behavioral health workforce to reflect community demographics with bilingual and bicultural providers.
4. Adopt evidence-based practices for addressing loneliness in older adults to support senior community members.
5. Promote free and affordable behavioral health resources during community events.
6. Conduct a community assessment on social isolation and loneliness for at-risk populations.
7. Create a communications plan to promote mental health resilience in the community.
8. Develop policies and plans that support improving behavioral, physical, and oral health in LGBTQ+ populations in order to address health disparities.
9. Increase trauma-informed care training opportunities.

Aim (F): Improve access to behavioral health care.

Strategies:

1. Improve collaboration across systems to coordinate and target efforts related to improving the size, capabilities, and cultural and linguistic responsiveness of the behavioral health workforce.
2. Create a community work group to address poor access to behavioral health services for community members who have Medicare health insurance (either traditional Medicare or Medicare Advantage).
3. Improve recruitment, training, and retention of LCSWs serving older adults on Medicare in Behavioral Health organizations.
4. Support the Marion-Polk County Integration Collaborative.
5. Incentivize behavioral health integration in value-based payment program for providers participating in Patient Center Primary Care Homes.
6. Increase the number of Patient Centered Primary Care Homes.
7. Increase accessibility of behavioral health providers for residents in the community.
8. Increase the number of residents with health insurance focusing on ages 18-26.
9. Improve ability to link physical, behavioral, and oral health providers to improve referral processes.
10. Improve timely access to specialty behavioral health services.
11. Support health system alignment with the Integrated Care for Kids (InCK) initiative.
12. Increase number of free and/or low-cost behavioral health services in community.

Housing

Housing is a critical social determinant of health and the community, along with Oregon as a whole, is experiencing high rates of rental burden and a limited supply of housing. In 2018, residents of Independence, Salem, Stayton, and Woodburn identified "lack of affordable housing" as a key theme during all townhall sessions held to inform the 2019 CHA. About half of community members who rent experience rental burden, which means they pay 30% or more of their gross household income on rent. Community members believe that the lack of affordable housing is contributing to homelessness.[xvii]

In 2019, it was estimated that 1,095 community members were homeless. About 3% of K-12 students during the 2016-2017 school year were homeless or in an unstable housing situation. "The experience of housing-insecurity, defined as high housing costs, poor housing quality, unstable neighborhoods, overcrowding, and especially homelessness, places children at risk of ACE exposure" (National Health Care for the Homeless Council).[xviii] The four most common reasons why community members say they are homeless are "Unemployed" (41%), "Could not afford rent" (23%), "Homeless by choice" (17%), and "Mental or Emotional Disorder" (16%). Respondents believed that affordable housing or a job/source of income would improve their situation.

Housing problems in the community worsened at the onset of the COVID-19 pandemic. During the statewide "Stay at Home" order unemployment filings in Oregon peaked at the end of March in 2020 with over 88,000 filings.[xx] Without income, many Oregonians risked not being able to afford rent, which led Governor Kate Brown to enact a temporary moratorium on evictions due to non-payment in April of 2020.

211info is a nonprofit organization that helps people navigate local resources that address many individual needs connected to the social determinants of health. From February 2020 to December 2020, the top met service need for callers from Marion and Polk Counties combined was "Rent Payment Assistance" (1,507), and the top unmet need was "Homeless Motel Vouchers" (133). During the same period, the top needs community members called 211 to ask for assistance with included Health Care (29.76%), Housing (21.68%), Food/Meals (10.48%), and Utility Assistance (10.31%). The majority of callers during this period were White (3,032) followed by Hispanic/Latino/a/x (1,067) as the second largest group, and Black/African American (335) as the third largest group by race/ethnicity.[xxi]

Work Group Insights:

What trends in housing in our community are most concerning to you and/or the populations you work with?

- Underlying inequity in our economic system.
- Lack of affordable housing.
- The high number of unsheltered homeless people.

What are the results we want for populations in the community related to health and housing?

- More collaboration between community partners to take care of people with a holistic approach.
- Collective action.
- Sustainable housing for all and highly collaborative partners.

Current community initiatives that align with this priority area include, but are not limited to:

- Mid-Willamette Valley Homeless Alliance Continuum of Care, which includes the Board of Directors, Executive Committee, Collaborative Committee, Built for Zero Strategy Team, Coordinated Entry, Coordinated Outreach, Warming Shelters Subcommittee, Veteran Subcommittee, Youth & Young Adults Subcommittee
- Children's Public Private Partnership (CP3)
- City of Salem's Our Vision Plan
- Community, Business, and Education Leaders (CBEL)
- COVID-19 Response for Homeless and Houseless Communities
- Love INC of North Marion County
- Marion & Polk System of Care
- Mid-Willamette Valley Community Action Agency's Youth Empowerment Program
- Willamette Health Council Committee/Subcommittee work including the Clinical Advisory Panel and new Integration and Quality Incentive Measures Collaboratives

Priority Area: Housing

Population Outcome Measures and Goals:

- Decrease the rate of homelessness per 100,000 people by 10% by 2025.
  - Baseline: Marion 280.0 per 100,000, Polk 140.6 per 100,000 (2019)
  - Target: Marion 252.0 per 100,000, Polk 126.5 per 100,000
  - Data Source: US Census Bureau American Community Survey (ACS) and Oregon Housing and Community Services
- Decrease the percentage of renters who pay 30% or more of household income on rent in Marion and Polk Counties by 7% by 2025. (HP30)
  - Baseline: Marion 49.3%, Polk 50.5% (2015-2019)
  - Target: Marion 42.3%, Polk 43.5%
  - Data Source: ACS

Aim (G): Align the community health system with efforts to address health and safety issues relating to homelessness.

Strategies:

1. Align the local health system to support implementing the Mid-Willamette Valley Homeless Alliance Strategic Plan for Marion and Polk Counties.
2. Build relationships with the local health system and the Continuum of Care Collaborative Committee through establishing a Health and Safety Subcommittee.
3. Mitigate health safety issues associated with encampments.
4. Strengthen collaboration between the health system and street medical outreach teams that provide health assessments, vaccinations, TB testing, mental health assistances, and referrals.
5. Increase health care provider participation in Continuum of Care activities.
6. Improve data sharing to support ongoing health and safety as it relates to housing in future Community Health Assessment activities.

Aim (H): Reduce the risk of Marion and Polk County residents becoming homeless or returning to homelessness.

Strategies:

1. Improve community relationships with landlords and property managers to improve their ability to accept and retain tenants.
2. Promote housing and employment resources during health services (e.g. WIC).
3. Collaborate with senior and disability service organizations to identify actions to increase screening for housing accessibility, safety, and insecurity.

4. Support local health organizations, including physical, oral, and behavioral health providers to co-locate services and/or bring mobile services on-site to affordable housing complexes, senior care homes, recovery centers, and community centers.

Aim (I): Advocate for increasing the housing supply.

Strategies:

1. Support advocacy efforts to keep people housed during and after the COVID-19 pandemic.
2. Educate policy makers about housing as a social determinant of health and factors that impact the health and safety of the local housing supply.

Implementation and Accountability

Implementation
These aims, population outcomes measures, and strategies provide the CHIP framework for mobilizing community action through partnerships to improve the health of people in Marion and Polk Counties. No single person or organization can implement the entire framework alone to achieve our shared goals. Rather, everyone who helped write the CHIP framework now needs to decide the specific actions they will take. Our collective action will help us move the needle on our goals.

Organizations will write **Action Plans**, or **logic models**, to implement the CHIP. Action Plans will include **organizational objectives** that describe the specific actions that an organization will take to support a CHIP strategy. The plans will also include process measures that track short- and medium-term outcomes and demonstrate progress in implementing the CHIP. Action Plans should include a timeframe, the responsible party, expected outcomes, and resources needed.

The following graphic is an example of how the priority areas, aims, measures, and organizational objectives align with each other.

This table is an example of how to describe an organizational objective in an Action Plan using a logic model.

Organization:				
CHIP Strategy:	Selected from Marion-Polk CHIP 2021-2025			
Objective:	Short- to intermediate-term outcome statements of organizational or collaborative activities			
People or Groups Receiving Services:				
Inputs	**Activities**	**Outputs**	**Outcomes**	
Resources	**Work/ Processes**	**Tangibles/ Services**	**Short Term - Takeaways**	**Long Term – Impact**
Staff, grants, in-kind support, supplies, etc.	Specific, measurable, achievable, realistic, and time-bond action steps to implement the strategy	Tangible and measurable results from the activities	Includes enhanced knowledge, understanding/perceptions/ attitudes, increased capacity, and changed behaviors	Long lasting conditions that support the desired outcome

To successfully set objectives, organizations that participate in implementing the CHIP will need to commit to:

- Pursuing the priorities, goals, and strategies described in this document.
- Sharing work and learning from other partners to inform collective action.
- Aligning plans and programs of our community's organizations with these goals.
- Leveraging partnerships and resources to achieve these goals.
- Continuing to build a public health system that supports our priority areas and meets the needs of our communities.

In July 2021, the CHIP Coordinator will begin work with members of the Core Executive Committee, Steering Committee, and Priority Area Work Groups to complete and compile Action Plans. Implementing the CHIP will involve everyone who helped create it. Additional organizations are welcome and encouraged to join the CHIP process during the implementation phase.

Accountability

The CHIP Coordinator will support tracking and evaluating CHIP implementation. Accountability steps will include collecting quarterly updates on organization Action Plans and publishing an annual evaluation report.

Intermediate progress will be shared with the Core Executive Committee, Steering Committee, and Priority Area Work Groups who will evaluate the overall success of CHIP strategies. Evaluating progress will include looking for gaps in strategies, finding opportunities for collaboration to strengthen community alignment, and promoting flexibility to meet community needs.

Evolution of MAPP

The National Association of City and County Health Officials (NACCHO) created MAPP, and is currently revising the framework.[xxii] MAPP was originally created to provide a structure that communities could follow for assessing population health and aligning community resources for collective action. The framework emphasized community engagement as means to advance policy, systems, and environmental change.

NACCHO recognizes that the practices in community health improvement planning are evolving. In response to community needs and to address challenges in the current framework, NACCHO is revising MAPP with an estimated launch of the revised framework between September 2022-August 2023.

The redesign will emphasize equity, inclusion, trusted relationships, strategic collaboration and alignment, data and community informed action, full spectrum action, flexibility, and continuous improvement. Features will include more technical assistance, simplified assessments, and a departure from planning cycles that produce stagnant documents. Marion and Polk Counties look forward to incorporating the revised MAPP phases into our local CHA and CHIP processes in the coming years.

Conclusion and Next Steps

This plan is supported by the Marion-Polk CHIP Core Executive and Steering Committees, as well as the PacificSource Marion-Polk CCO's/Willamette Health Council's Community Advisory Council. The next step to launch this plan is implementation. In the coming months, the CHIP Coordinator will collect Action Plans, or logic models, from CHIP partners that describe how these partners will advance the CHIP strategies. The CHIP Coordinator will also recruit organizations represented in the Priority Area Work Groups, and others, to write Action Plans. The CHIP Coordinator will use the Action Plans to track progress and compile annual evaluation reports.

The collaborative CHIP partners that form the Core Executive Committee will continue to support each other in meeting various reporting requirements that overlap with community health assessment and improvement planning work. This support will require continuing annual updates to the Marion-Polk CHA, and continually evaluating goals and improving strategies. Each update will provide an opportunity to reengage community partners who are essential for advancing this work in the community.

Many thanks to all the community partners who will support implementing this plan and improving substance use, behavioral health supports, and housing health related issues. This plan and our collective action are the springboard for changing the social determinants of health and improving health in Marion and Polk Counties.

Community Partners

Organizations Represented on CHIP Priority Area Work Groups

211info
Bridgeway Recovery Services
Catholic Community Services
Center for Hope & Safety
Centro de Servicios Para Campesinos
Cherriots- Salem-Keizer Transit
City of Salem
Community Action Head Start
Early Learning Hub
Fair Housing Council of Oregon
Kaiser Permanente
Latinos Unidos Siempre
Legacy Silverton Medical Center
Marion & Polk Early Learning Hub
Marion County

- Health & Human Services
    - Behavioral Health
    - Public Health
- Juvenile Department
- Sheriff's Office Law Enforcement Assisted Diversion (LEAD)

Marion County Health Advisory Board
Mid-Willamette Valley Health Equity Coalition
Mid-Willamette Valley Homeless Alliance
New Perspectives Center
Northwest Human Services
Northwest Senior and Disability Services
Oregon Health Authority
OHSU School of Nursing, Monmouth Campus
Oregon Marshallese Community Association
Prescription Drug Overdose Program Marion/Polk/Yamhill counties
Oregon Department of Human Services
Oregon Recovery
Pacific Stoa

PacificSource Marion-Polk CCO
Polk County
- Community Corrections
- Family and Community Outreach
- Health Services
    - Behavioral Health
    - Public Health

Polk County Health Advisory Board
Project Able
Recovery Outreach Community Center
Sable House
Salem Health
Salem Housing Authority
Salem Leadership Foundation
Salem-Keizer Public Schools
Silver Falls School District
Silverton Police
West Valley Hospital, Dallas
Western Oregon University, Division of Health & Exercise Science
Willamette Education Service District
Willamette Health Council
Willamette University
Youth Era

Organizations Represented in Key Informant Group Sessions

Regional Health and Education Session
Catholic Community Services
Central High School
Falls City School District
Legacy Silverton Medical Center
- Silverfalls and Mt. Angel School Districts School Nurse Consultant

Luckiamute Charter School
Marion County Health and Human Services
- Children's Behavioral Health
- Suicide Prevention

Marion & Polk Early Learning Hub
Mid-Willamette Valley Community Action (Head Start and Early Head Start)
Mid-Willamette Valley Health Equity Coalition
Perrydale School District
Salem-Keizer School District

- McKinney Vento Liaison
- Director of Socio-Emotional Learning
- Community School Outreach Coordinator for Marshallese Students
- Indigenous Education Program Academic Coach
- Community School Outreach Coordinator for Auburn Elementary School

Silver Falls School District

- School Nurse

Willamette Education Service District
Willamette University

Clinician Session

Bridgeway Recovery Services
Capitol Dental Care
Childhood Health Associates of Salem
Dual Diagnosis Association of Oregon
Marion County Health and Human Services
Mid-Valley Pain Clinic
Northwest Human Services
Oregon Family Support Network
PacificSource Marion-Polk CCO
Recovery Outreach Community Center
Salem-Keizer School District
Trillium Family Services
Willamette Health Council
Yakima Valley Farm Workers Clinic
Youth Era

Appendices

Glossary

Adverse Childhood Experiences (ACEs): Stressful and traumatic events occurring in childhood, including neglect, which can impact development and have lifelong consequences.

Behavioral Risk Factor Surveillance System (BRFSS): Random CDC phone survey that provides population estimates for various health conditions and exposures, which is weighted to reflect the population it was derived from with age-adjusted and crude rates.

Community Health Assessment (CHA): Assessment portion of the MAPP process that identifies key priority areas for the CHIP as informed by it supporting four assessments.

Community Health Improvement Plan (CHIP): Five year plan for improving the health of a community that's informed from the data and key priority area identified by the CHA.

Community Action Agency (CAA): Community based organization that identifies need and gathers resources to address local need, including the collection of local data such as the Homeless Point in Time Count.

Continuum of Care (CoC): A regional organization registered with the US Department of Housing and Urban Development to provide housing and homelessness services. The local CoC for Marion and Polk Counties is Mid-Willamette Valley Homeless Alliance (MWVHA).

County Health Rankings (CHR): Robert Wood Johnson Foundation program that compares and ranks counties across a wide variety of standard health measures.

Coordinated Care Organization (CCO): A coordinated care organization is a network of all types of health care providers (physical, behavioral, and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (i.e. Medicaid).

Health Disparity: A measurable difference in health or opportunities between groups of people, where one group is affected more than another. These differences are preventable and tend to be experienced by socially disadvantaged populations.

Healthy People 2020 and 2030: Healthy People provides science-based, ten year national objectives for improving the health of all Americans. These objectives are often used as benchmarks for setting goals at the local, state, and national level.

Oregon Health Authority (OHA): Oregon's state Medicaid agency. OHA oversees a majority of health-related progams including public health, the Oregon Health Plan, and the Oregon State Hospital.

ORS 414.577: Community health assessment and adoption of community health improvement plan; rules. (1) A coordinated care organization shall collaborate with local public health authorities and hospitals located in areas served by the coordinated care organization to conduct a community health assessment and adopt a community health improvement plan, shared with and endorsed by the

coordinated care organization, local public health authorities and hospitals, to serve as a strategic population health and health care services plan for the residents of the areas served by the coordinated care organization, local public health authorities and hospitals. The health improvement plan must include strategies for achieving shared priorities.

Social Determinants of Health (SDOH): Root causes responsible for the health of a community.

Student Wellness Survey (SWS): State survey administered at the local level every two years in schools to assess the health of teens including substance use and other factors. OHA is currently replacing SWS with a new Student Health Survey.

CHIP Terms

Action Plans: describes the activities an organization will complete accomplish an objective and support implementing a CHIP strategy

- Action Plans have specific timelines and assigned responsibility

Aims: long-term statements of desired change in the community to support improving health

Goals: long-term statements of desired population health outcomes

Logic Model: a graphic that shows the activities, inputs, outputs, and outcomes

Organizational objectives: short- to intermediate-term outcome statements of organizational or collaborative activities

- Objectives should be Specific, Measurable, Achievable, Relevant, and Time-based (SMART)

Population Outcome Measures: indicators that help to quantify the achievement of a goal

Priority Area: broad, health-related areas for CHIP work identified through the prioritization process using CHA data

Process Measures: indicators that help to quantify the achievement of an action step or organizational objective

Strategies: general approaches that will be utilized to achieve a goal

Work Session Gap Analysis Questions

Questions for Gap Analysis:

- What trends in [priority area] in our community are most concerning to you and/or the populations you work with?
- What are the unique needs for youth and families in relation to [priority area]?
- What are the unique needs for adult and elderly populations in relation to [priority area]?
- How has COVID-19 impacted [priority area] trends?
- What [priority area] initiatives or interventions work well in the community?
- What resources are available in the community for preventing [priority area] issues?
- If you are part of an organization that works with the community on [priority area] issues, what work are you currently doing or planning to do?
- What collaborative work is currently happening in the community around [priority area] issues?
- Are there gaps or barriers to coordinating [priority area] work in the community?
- Who benefits from current [priority area] initiatives in our community, and who is left out?
- What barriers are preventing more equitable outcomes in [priority area]?

Questions for Goal Setting:

- How would we describe, in general terms, the problems we are experiencing?
- Are there disparities in behavioral health that are connected to social, economic, or environmental factors?
- What are the results we want for populations in our community?
- How would we know if we achieve those results?
- How can we bridge the gap between what we see now and our desired results?
- What are your organization's goals related to [priority area]?

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Notes:

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