2020-2024 Central Oregon Regional Health Improvement Plan
2021 Progress Report

Changes in community health priorities, goals, strategies, resources or assets.

The Central Oregon Regional Health Improvement Plan (RHIP) moved from a four-year to a five-year plan, which began January 2020, and ends December 2024. Each of the six priority areas will receive $2 million to invest back into communities within Central Oregon, totaling $12 million in investments.

The Central Oregon Health Council (COHC), with the review and guidance of RHIP workgroups and partners, invested almost $575,000 for COVID-related health disparities throughout the region (COVID-19 Final Report). These COVID mini-grants are influencing 21 of the 26 Future State Measures in the 2020-2024 RHIP.

A scoring protocol was developed, reviewed, and implemented for all potential investments. The scorecard asks voting partners from RHIP priority area workgroups to score a proposed project based on: (1.) the details of the project, (2.) diversity, equity, and inclusion, (3.) evaluation and sustainability, (4.) project supports and partnerships, and (5.) budget. The scorecard is shared with all potential applicants for consideration when completing their letter of interest or full application. Standard Grant Scorecard.

In September of 2020, the COHC launched the Central Oregon Health Data site. This site continuously updates its data (qualitative and quantitative) repository to track health-related aspects of the communities within Central Oregon. In addition to publishing a health assessment every five years, this site has been made available to anyone who wants the most up-to-date information available on more than 250 demographic elements and over 340 health-related indicators. These indicators, or data points, are available at the regional, county, community, zip code, and neighborhood-level depending on the data source. Highlighting the RHIP and its six priority areas, the site tracks progress toward indicators and projects that have been or are funded currently in support of the priority area (What We're Learning).

The site has local, state, national, and federal funding opportunities, promising practices, a community calendar, and a growing resource library. Individuals and organizations can contact the COHC to add data elements that they would like to share with the region (example). Users can build their dashboard and share the link with partners or other community members.

Strategies used to address the CHP health priorities.

The COHC provided backbone support to develop workgroups for each RHIP priority area to impact Future State Measures. Participants involved in workgroups include subject matter experts, partner organizations, Community Advisory Council (CAC) members, and community members. To implement the RHIP, the COHC used a structured and participatory strategic planning process developed by the Institute of Cultural Affairs. The methodology is grounded in collaborative strategies that draw upon human assets and build social capital to facilitate sustainable community development. The workgroups began investing funds to implement these strategies in 2021.

The following Future State Measures have projects and strategies currently receiving funding:

- Improve graduation rates among students experiencing economic disadvantage
- Decrease severely rent and mortgage burdened households
- Increase the percentage of Housing Choice Vouchers (HCV) holders that can find and lease a housing unit
- Develop and utilize a comprehensive system to accurately capture the extent of Central Oregonians experiencing homelessness

- Increase letter name recognition and kindergarten readiness among youth experiencing economic disadvantage and among underserved races
- Increase third-grade reading proficiency among youth experiencing economic disadvantage and among underserved races

In addition to funding, numerous strategies are being considered based on our structured problem-solving work in each of the six priority area workgroups. RHIP workgroups are considering the following to move indicators towards future state measures:

<u>Address Poverty and Enhance Self-Sufficiency:</u>

- Invest in programs addressing social determinants of health (e.g. TRACEs, Families Forward)
- Offer Cultural Humility training with topics that include diversity, language access, and Culturally and Linguistically Appropriate Services (CLAS) standards
- Enhance community messaging on self-sufficiency supports
- Raise awareness and expand access to low-cost exercise opportunities in each community
- Expand access to primary care clinics (e.g. locations, night/weekend appointments, school-based health centers)
- Invest in and expand Traditional Health Worker programs (e.g. training, increase the workforce, task-specific roles)
- Expand access to health insurance enrollment and insurance benefits education services
- Increase access to qualified/certified interpreters for limited English proficient populations
- Simplify or create a universal form for financial assistance programs regionally (e.g. social service programs, healthcare programs)
- Expand access to and increase the affordability of healthy, nutritious foods
- Reduce transportation barriers to health services (e.g. Uber Health)
- Promote and expand telemedicine options for medical, mental health, dental care, and substance abuse treatment
- Create peer recovery support programs for individuals who are high utilizers of the system and/or are engaged in Medication Assisted Treatment (MAT)
- Advocate for affordable housing tax increment financing
- Advocate for changes to policy regarding Single Dwelling Units (SDU) and tiny homes in Central Oregon
- Advocate for the creation of a shared living program that would pair individuals seeking affordable housing with those who have spare rooms and need assistance with daily living (e.g. elderly and people with disabilities)

- Encourage the utilization of Community Benefits Agreements (CBA) to ensure development projects create meaningful opportunities for the community and local workforce
- Advocate for policies addressing the social determinants of health and health inequities (e.g. early child development, nutrition/food access, social protection, the living environment, fair employment, and decent work)
- Increase family-friendly work policies
- Strengthen economic supports for families
- Advocate for and incentivize affordable childcare
- Expand access to vocational training programs, apprenticeship programs, and pre-apprenticeship programs
- Increase co-location and proximity of health and social services
- Leverage anchor institutions and social enterprise that benefit marginalized populations
- Expand access to high-quality childcare and pre-school programs within the workplace
- Partner with local community colleges and universities to increase access and promote higher education
- Develop/expand access to programs and activities that increase high school completion (e.g. ninth-grade retention initiatives, bridge programming, first-generation post-secondary programs, vocational programs)
- Increase exposure to career pathway programs for high growth and high wage jobs (e.g. trades, technology, health careers)
- Expand access to asset development programs such as Individual Development Accounts (IDA) and Child Savings Accounts (CSA)
- Explore how to develop a system of diversion (https://www.naco.org/resources/data-driven-justice-playbook)
- Offer training on working with individuals in poverty (e.g. Bridges out of Poverty Training)
- Increase the voices of those served within program planning and process improvement conversations (e.g. advisory council)
- Develop a housing barrier removal fund (e.g. rental assistance, deposit assistance, utility assistance, property debt forgiveness)

Behavioral Health: Increase Access and Coordination

- Promote mental health resources (Mind Your Mind Central Oregon)
- Educate medical providers and leadership on ways to address co-morbid behavioral health conditions as a way to reduce the total cost of care and improve outcomes

- Arrange education for providers and privacy officers addressing HIPAA myths minimizing regulatory obstacles while coordinating care
- Increase peer certification training in the region to boost the workforce and expedite the credentialing process
- Incorporate learning opportunities to increase primary care provider and behavioral health clinician confidence in addressing behavioral health conditions
- Provide networking opportunities between primary care providers and specialty behavioral health providers
- Expand intern and post-graduate training opportunities in rural areas
- Maximize sites that offer National Health Service Corps loan reimbursement to attract more mental health providers from across the nation to our region
- Establish and expand innovative strategies to increase the workforce and access to services (e.g. Collaborative Care Model (CoCM), Project ECHO)
- Incentivize providers to work in rural areas (e.g. recruitment incentives, financial incentives)
- Provide education and advocacy to federal legislators to align 42 CFR part 2 with HIPAA allowing Substance Use Disorder (SUD) services to be better coordinated
- Create value-based contracting that has metrics specifically tied to access, engagement, and outcomes
- Manage the provider panel as part of the array of services available to individuals with clear expectations about priority populations, the intensity of services, and lengths of stay appropriate to the level of care
- Encourage the development of value-based contracting with a specific focus on closed-loop referral process using a Health Information Exchange (HIE) that incentivizes coordination between specialty behavioral health and medical providers
- Implement a provider tool that directs individuals to the right level of care and contains provider resources to help meet individual care needs
- Embed and integrate behavioral health providers in specialty medical clinics, hospital medical-surgical units, emergency departments, intensive care units, and post-acute care settings
- Develop the integrated behavioral health model in rural primary care by increasing the number of Behavioral Health Consultants, Community Health Workers, and co-located behavioral health specialty care (e.g. psychiatric services)
- Develop a Collaborative Care Model (CoCM) of psychiatric systematic case review in primary care
- Improve bi-directional referrals from primary care to and from specialty behavioral health in rural areas by maintaining Building Bridges work

- Ensure that contract negotiations include medical and behavioral health providers so that reimbursement and contractual incentives acknowledge their interdependence on health outcomes and total costs of care
- Provide fiscal contract incentives for the utilization of Traditional Health Workers
- Conduct a pilot project that explores ways to employ Traditional Health Workers to work at specialty behavioral health organizations and be deployed within primary care clinics
- Develop more multi-provider, clinic-based practices offering fidelity treatment programs to target populations (e.g. Dialectical Behavior Therapy for Borderline Personality Disorder)
- Develop a method to measure timeliness and engagement with specialty behavioral health referred from primary care, including:
  - Defining the target to achieve based on risk and need
  - Develop a data system that tracks access to care across both community mental health and panel providers
  - Closed-loop referral process
  - Piloting this work with primary care and specialty behavioral health providers
- Develop a standardized screening process to assure clients receive the appropriate level of care and follow-up across various services, including:
  - Creating a community standard of care with a majority of providers
  - Standardized screening tools and workflows
  - Coordinated care networks
  - Closed-loop referral process
  - Electronic medical record technology that tracks referrals and care transitions
  - Piloting this work with primary care and specialty behavioral health providers
- Create a multi-stakeholder workgroup reflective of the community to monitor the development and implementation of the COHC Behavioral Health Increase Access and Coordination work to ensure equity, regional work scope, marginalized populations, and geographically diverse areas of Central Oregon
- Develop a clear understanding of rural area behavioral health needs and ensure that the strategies employed above are addressing these specific points
- Develop training strategies to increase the number of behavioral health providers specializing in under-served subpopulations (e.g. young children, seniors, diverse language and cultural groups such as Native Americans and Latinx)
- Bring behavioral health treatment to people in their homes through home visiting or telehealth
- Provide adequate funding for specialty behavioral health care services enabling experienced and licensed providers to be employed by multidisciplinary agencies to treat highly impaired patients with Medicaid/Medicare insurance
- Similar to House Bill 2611 that requires cultural competency training for primary care providers create a parallel requirement for behavioral health providers

- Use the National Standards for CLAS in Health and Health Care to drive the decision-making and value system of the workgroup in charge of overseeing this work

Promote Enhanced Physical Health Across Communities

- Hypertension/Heart Disease:
  - New blood pressure awareness campaign (www.knowmybp.org)
  - Increase awareness of the DASH (Dietary Approaches to Stop Hypertension) Diet (https://www.cdc.gov/salt/reduce_sodium_tips.htm)
  - Make blood pressure testing readily available in all communities throughout Central Oregon
- Obesity:
  - Promote worksite programs to improve diet and increase physical activity among employees
- Diabetes:
  - Develop a regional HbA1c awareness campaign
  - Ensure access to quality, evidence-based prevention, and self-management programs:
    - Lifestyle change programs to prevent type 2 diabetes among people at increased risk
    - Lifestyle change and self-management programs for adults with type 2 diabetes and other chronic conditions
- Physical Activity:
  - Implement community-wide campaigns to increase physical activity through social support, screening, and education
  - Partner with health care providers to prescribe appropriate exercise for youth and adults
  - Offer educational, social, and/or physical activities to older adults in group settings to encourage movement and community engagement
  - Support and expand safe walking routes to schools and bus stops in all Central Oregon communities
  - Implement pedestrian/ bicycle injury prevention programs (e.g. bicycle helmets, crosswalk safety, public education campaigns)
  - Encourage children to spend less time in front of screens
  - Create sustainable physical activity programs that connect primary care with community programs and opportunities
  - Implement health education campaigns across multiple media platforms that encourage/increase physical activity and support tobacco cessation
- Sexually Transmitted Infections (STI)

    - Protect against disease or injury by providing condoms/promoting barrier methods in conjunction with health education campaigns
    - Implement school education, sustain My Future, My Choice™, and other comprehensive risk reduction programs that are evidence-based
- Oral Health
    - Increase awareness of systemic concerns and potential complications of oral infections through integrated community education to achieve universal messaging across the health system
- Promote annual physical and oral well-care visits for adults and youth in both traditional (e.g. primary care office) and non-traditional settings (e.g. school-based health centers)
- Increase provider referrals to evidence-based programs such as the National Diabetes Prevention Program, Walk with Ease, and Living Well Self-Management
- Reduce STIs through early screening, contract tracing, and early treatment for all partners
- Increase physical activity in school settings:
    - Promote active semi-structured recess time, after school activity clubs, intramural and extramural sports, and physically active classroom breaks to increase activity among school-aged youth
    - Provide opportunities for classroom modification to accommodate increased movement (e.g. built environment, supplies)
- Increase physical activity in workplace settings:
    - Promote physical or policy changes that make healthy choices easier and target the entire workforce (e.g. adopt standards for healthy foods and beverages, allow more opportunities to be physically active, provide health club memberships)
- Increase physical activity in community settings:
    - Support the development of joint-use agreements so that community members can access indoor/outdoor facilities of schools, non-profits, and private organizations for exercise and play
- Increase access to and consumption of fresh, healthy foods:
    - Work with employers, schools, grocery stores, and other food retail outlets to make healthier foods less expensive than unhealthy foods (e.g. provide incentives, subsidies, or discounts on healthy foods, increase prices for unhealthy foods)
    - Expand SNAP benefits use at farmers markets and double their value when purchasing vegetables and fruit

        - Expand and support program participation and availability for cooking classes or farmer's market education with fresh food/vouchers (e.g. Veggie RX, Cooking Matters)
        - Increase the number of childcare facilities, schools, hospitals, senior facilities, and worksites that adopt nutrition standards
    - Tobacco Retail Licensing:
        - Limit retailer density and proximity to youth
        - Eliminate price promotions and flavors that entice initiation and make cessation more difficult
    - Increase the price of sugary drinks
    - Encourage the food industry to adopt guidelines for marketing to children voluntarily (https://www.publichealthlawcenter.org/topics/healthy-eating/food-marketing-kids)
    - Enact water fluoridation in Central Oregon communities
    - Built Environment:
        - Create or improve places for physical activity (e.g. built environment includes a focus on the outdoor environment with complete streets and mixed-use development, zoning regulations)
        - Incorporate Health Impact Assessments (HIA) as a process to evaluate potential health effects of a plan, project, or policy before construction or implementation
        - Incorporate pedestrian and bicycle master plans into general city plans and capital improvement programs
        - Ensure that children can walk and bicycle safely to school, including Safe Routes to School non-infrastructure activities and infrastructure improvements to provide sidewalks and bicycle paths
        - Connect roadways to complementary systems of trails and bicycle paths that provide safe places to walk and bicycle for children, seniors, and the general public
        - Increase access to play areas for children to be active (e.g. public places, parks, school playgrounds)
        - Increase safety infrastructure to encourage active transportation (e.g. sidewalks, lighting, crossing signals, crosswalks)
    - Incorporate Traditional Health Workers in a team-based care model to improve key health indicators (e.g. health education, outreach, enrollment, and information agents to increase protective health behaviors) (https://www.thecommunityguide.org/)
    - Coordinate physical and oral health screenings at the dental office (e.g. blood glucose or HbA1c testing, closed-loop referrals to primary care)
    - Collective Impact model:

        - Address the built environment in local and transportation planning (regional and state)
        - Jointly promote built environments that encourage exercise and injury prevention (e.g. bike and walking routes separated from motor vehicle traffic)
    - Develop collaborations across worksites, coalitions, agencies, and communities to change local environments to create opportunities for physical activity (e.g. create or improve walking paths, build exercise facilities, provide access to existing facilities)
    - Support connections between school and community programs that include physical activity, nutrition education, tobacco prevention, and oral health that is accessible to all children
    - Work with local, state, and federal parks and recreation programs to offer and promote access to physical activity
    - Coordinate with insurance companies, human resource offices, and workplace wellness programs to offer and incentivize strategies that support nutrition, physical activity, preventive care, and tobacco cessation
    - Create and maintain a third-party electronic platform for closed-loop referrals between health systems and community programs and services
        - Identify pathways that directly link specialty care with resources for food, physical activity, and other social determinants of health needs.
    - Assist with or provide incentives for supermarkets or farmers' markets to establish their businesses in underserved areas (https://www.cdc.gov/obesity/strategies/healthy-food-env.html)
    - Increase number of American Indian/Alaska Natives participating in evidence-based lifestyle change programs (e.g. Diabetes Prevention Program)
    - Increase the number of Department of Human Services (DHS) and Oregon Health Authority (OHA) mental and behavioral health service providers that adopt standards for healthy food and beverages, physical activity, and breastfeeding support for employees and clients
    - Expand mobile food pantry (e.g. High Desert Food and Farm Alliance model/project)
    - Improve existing programs to be more culturally impactful/responsive to micro populations (e.g. modify Veggie Rx/Food Hero information and recipes to include and honor traditions of native people)

Stable Housing and Supports

- Develop partnerships between traditional health workers and housing providers to allow property-based health promotion and educational opportunities

- Develop educational opportunities for housing providers and housing advocates on mitigating circumstances such as mental health or substance use disorders during the applicant screening process
- Develop and support a “Ready to Rent” education program in the region to support rental acquisition for those near the poverty level
- Develop forums and other opportunities to educate elected officials and other decision-makers on the housing crisis and the nexus between insecure housing and health disparities
- Promote free/low-cost preventive health services to those that are experiencing rent and mortgage burden
- Provide OHP enrollment assistance at affordable housing units
- Provide integrated preventive health services at affordable housing units
- Integrate wrap-around services for permanent supportive housing
- Enact a comprehensive strategy to amend local jurisdiction zoning ordinances to allow for a variety of housing types
- Construct all new housing developments close to transportation networks, walkable areas, and food access
- Ensure supportive relocation plans for individuals living on public lands or public rights of way
- Enforce existing tenant rights regulations
- Develop policies that allow supportive services for those experiencing homelessness to be reimbursed by the medical system
- Develop and implement a better process for transitional housing that leads to permanent housing
- Support a more robust regional Continuum of Care (CoCM) program, including shared data, coordination, and prioritization of needs and services
- Support housing barrier removal and landlord mitigation funds (e.g. rental assistance, first-month deposit, utility assistance, property debt forgiveness)
- Ensure support for collaborative efforts in building and staffing permanent supportive housing units
- Incorporate trauma-informed care practices into RHIP housing strategies
- Develop affordable housing units with medical, mental health, and/or drug and alcohol treatment provider partnerships that help individuals maintain stable housing
- Prioritize hospital collaboration with housing advocates that highlight the impact of housing instability on ED usage, hospitalization, and discharge plans
- Work with schools to break the cycle of generational poverty by utilizing existing partnerships at School-Based Health Centers and the Family Access Network (FAN) Advocates embedded in schools

- Prioritize law enforcement collaboration with housing and service providers to ensure critical connection for outreach to individuals experiencing homelessness
- Create a Regional Housing Council that emphasizes collaboration across systems
- Ensure that all housing-related outreach materials and educational opportunities are available in Spanish and other languages of preference
- Provide culturally appropriate training, engagement, and education for landlords and housing service providers
- Develop partnerships with agencies that serve marginalized homeless populations

<u>Substance and Alcohol Misuse: Prevention and Treatment</u>

- Use existing local campaigns and develop new campaigns as needed to raise awareness and educate the general public, including:
  - "Count on It: 0-1-2-3 Low-Risk Drinking Guide" for young adults
  - "Take Meds Seriously Oregon"
  - "Heal Safely"
  - "Reverse Overdose"
  - "Start the Conversation"
  - Awareness and education about DUII High Visibility Enforcement events
- Implement youth-focused campaign regarding negative effects of alcohol and drugs on the body and brain
- Provide Central Oregon Family Resource Center classes and other opportunities for parents that increase knowledge around substance abuse prevention
- Strengthen prevention education opportunities within school settings
- Implement Good Behavior Game at elementary schools
- Teach evidence-based curricula at middle and high schools
- Provide education for providers on SBIRT highlighting specialty referrals to treatment workflows
- Support continuing education for medical providers regarding the adoption of acute and chronic opioid safe prescribing guidelines
- Provide continuing education for behavioral health providers on evolving evidence-based medication-assisted treatment (MAT) for opioid disorder and alcohol use disorder
- Implement training for alcohol servers regarding responsible beverage service and ID checking
- Give training and technical support to law enforcement agencies to conduct DUII High Visibility Enforcement activities and awareness campaigns

- Increase awareness and education within the legal system about judicial approaches to impaired driving
- Increase the number of certified drug recognition experts working in law enforcement
- Identify contributing factors and explore solutions for traffic fatalities related to impaired driving
- Utilize “Bright Futures” Adolescent well-checks for every adolescent, which includes substance use screening
- Increase the number of board-certified adolescent medicine providers in Central Oregon (e.g. internal medicine, family medicine, pediatric medicine)
- Pre-conception and pre-natal care for women to mitigate risks of premature birth, substance use exposure, and other high-risk behaviors
- Adopt universal drug screening for all pregnant women as a standard of care
- Expand peer support services for pregnant women who screen positive for substance use disorder
- Adopt safe prescribing guidelines accompanied by appropriate risk mitigation for acute and chronic pain prevention
- Implement universal patient education regarding secure storage and disposal of medications to prevent diversion and non-medical use of illicit substances
- Provide or expand syringe exchange services
- Increase school-based access to substance abuse screening, early intervention, and treatment services as opposed to school suspension
- Provide “Teen Intervene” curriculum for early intervention on substance misuse among middle and high school youth
- Increase barriers to accessing substances
- Increase alcohol taxes
- Decrease alcohol outlet density and promotion
- Decrease tobacco retail density and promotion
- Initiate proactive policies to create tobacco/cannabis-free public spaces
- Reduce alcohol and cannabis sponsorship of community events
- Increase availability of sober housing and low-barrier housing
- Require cultural humility training for all service providers
- Strengthen and increase youth treatment services
- Advocate for funding and program expectations that would allow for the implementation at all levels of care of the National Institutes of Drug Abuse “Principles of Adolescent Substance Use Disorder Treatment”
- Empower Prevention Specialists/Public Health Educators to deliver alcohol, tobacco, and other drugs (ATOD) evidence-based curricula with fidelity in every middle and high school in Central Oregon
- Expand the use of alternatives to opioids for effective and safe pain management

- Integrate primary medical care into behavioral health settings
- Integrate SUD treatment providers into primary medical care settings
- Incorporate Peer Recovery Specialists into medical and SUD treatment settings
- Increase the number of providers offering MAT for both opioid and alcohol use disorder in medical settings
- Establish connectivity between universal maternal/child home visiting programs and prevention strategies for older children, adolescents, and young adults
- Provide closed-loop referrals for SUD screening and treatment
- Increase the number of Peer Support Specialists working with adolescents
- Expand nicotine insurance codes to be inclusive of SUD and Behavioral Health providers
- Strengthen evidence-based substance use disorder services within the judicial system
- Provide MAT to incarcerated individuals with opioid use disorder
- Strengthen training, enforcement, and community support for the prevention of alcohol sales to minors and over-service of alcohol to adults
- Address the effects of ACEs and trauma
- Implement Communities Mobilizing for Change on Alcohol
- Collaborate with the Oregon Dept. of Transportation regarding strategies to reduce DUII rates and increase justice system capacity to address DUII and DUII prevention
- Provide regional training regarding substance abuse prevention topics of shared interest/value for coalition partners
- Coordinate planning and response among diverse stakeholders to drug overdoses and overdose cluster events
- Support increased capacity of state-level toxicology investigations and reporting at the State Crime and Medical Examiners laboratories
- Increase access to behavioral health and SUD services at school-based health centers
- Increase coordination with outpatient specialty treatment providers
- Strengthen youth engagement and leadership/resiliency building
- Engage youth in prevention strategies in every community
- Provide adolescent recovery groups at every high school to reduce transportation barriers and increase autonomy
- Provide sober housing/low-barrier housing for youth in all communities
- Increase effectiveness and availability of services that use appropriate language and cultural context
- Expand Spanish-language specific services by native speakers
- Use screening tools that are validated and culturally relevant

- Use patient/client's preferred language for both oral and written communication and provide interpreting services at no cost to patient/client
- Provide patient-facing documents, office signs, and directories in the languages of highest diffusion in this region (English and Spanish)
- Support culturally-specific practices, such as "Many Pathways to Follow: Tribal-based Practices Overview"
- Increase availability of LGBTQ+ specific services
- Hire professionals who reflect the communities served
- Assure SUD providers have access to trained, qualified/certified interpreters following OHA guidelines and interpreter services provided at no cost to the patient/client
- Increase participation among populations experiencing substance use-related health disparities in substance abuse prevention coalitions

<u>Upstream Prevention: Promotion of Individual Well-Being</u>

- Increase awareness of the broad impacts of historical oppression, generational poverty, and trauma through a comprehensive awareness campaign
- Increase awareness of the positive outcomes of healthy pregnancies and early childhood surrounded by caring adults through an awareness campaign
- Expand and promote strategies that increase health literacy for children, youth, and families/caregivers
- Implement Central Oregon Regional Immunization Rate Improvement Project in Deschutes, Crook, Jefferson, and northern Klamath Counties to increase two-year-old immunization rates (using the AFIX Model)
- Screen for pregnancy intention and ensure timely access to contraceptives, long-acting reversible contraceptives (LARCs), and STI treatment
- Promote well-child and adolescent visits with appropriate screenings that include referrals to follow-up services, including specialized medical, behavioral, social/emotional, and dental
- Address the impact transportation barriers have on people's ability to obtain health care and other services
- Promote the inclusion of age-appropriate, medically accurate sexual health education in Central Oregon Schools (ODE, HB 2509 – ORS336.455)
- Promote the BOOST Program and the Immunization Quality Improvement for Providers (IQIP) program
- Promote reproductive health access through all community providers
- Implement Universally Offered Home Visiting legislative direction in Central Oregon (SB526), with availability throughout the region to all births by 2024

- Ensure all health care, behavioral health, public health, education, social service, childcare providers, first responders, law enforcement, community justice, and elected officials will receive four hours of trauma-informed care training
- Increase parent/caregiver input and review of service design, delivery, and responsiveness in their health and early learning needs
- Expand culturally responsive home visiting programs for prenatal and postnatal women in Central Oregon that includes screening for medical, dental, behavioral, and social services
    - Leverage peer support specialists, community health workers, and traditional health workers in implementation planning, nurse home visiting programs, and other in-home programs such as Healthy Families of the High Desert
- Expand and sustain Early Care and Educational resources that are accessible and affordable for families that include best practice business supports and local professional developmental opportunities
- Apply 2GEN tools and approaches that provide opportunities for and strive to meet the needs of children and families with low incomes to create educational success and economic stability
- Deliver preventive dental services to children and pregnant women in a non-traditional setting
- Establish a baseline for a metric such as the Child/Youth/Adult Resilience Measure (CYARM) that will measure a sense of belonging and identify drivers as a community
- Ensure every child in Central Oregon participates in developmental screenings at AMA recommended intervals and has access to indicated physical, oral, and behavioral health that include therapy and social/emotional services and support
- Ensure that households have their basic needs met through community resources, supports, and connections to needed services to eliminate disparities

Responsible partners who have been involved creating and implementing strategies to address CHP health priorities.

Individuals representing the following organizations have helped create the Regional Health Assessment (RHA), Regional Health Improvement Plan (RHIP), or provide input and expertise on one of our RHIP priority area workgroups. These organizations represent industries in health (e.g. hospital, primary care, behavioral health, dental, surgeons, pharmacy, public health), education (e.g. K-12, early learning, post-secondary, community), infrastructure (e.g. public works, transportation, utilities), justice (e.g. law enforcement, jail, parole, lawyers), government (e.g. elected officials, county, city, state offices), and non-profits/social services (e.g. WIC, Boys and Girls Club, Partners in Care). We also have representatives from the Community Advisory Council, Provider Engagement Panel, Operations Council, Central Oregon Diversity Equity and Inclusion (CODEI), Board of Directors, and the community.

211Info
A Smile for Kids
Abilitree
Advantage Dental by DentaQuest
Bend Food is Medicine Coalition
Bend La Pine School District
Bend Parks and Recreation District
Bend Treatment Center
Bethlehem Inn
Better Together
BestCare Treatment Services (Crook and Jefferson County CMHP)
Big Brothers Big Sisters of Central Oregon
BOOST Oregon
Brightways Counseling
Camp Fire Central Oregon
Capitol Dental Care
Cascade Internal Medicine
Cascade Peer and Self-Help Center
CCO Board Members
CCO Community Advisory Council Members
CCO Operations Council Members
CCO Provider Engagement Panel Members
Central Oregon Community College
Central Oregon FUSE
Central Oregon Health Council
Central Oregon Homeless Leadership Coalition
Central Oregon Independent Practice Association
Central Oregon Intergovernmental Council
Central Oregon Pediatric Associates
Children's Forest of Central Oregon
City of Madras
Confederated Tribes of Warm Springs
Council on Aging of Central Oregon
Creach Consulting
Crook County Health Department
Crook County Veterans Services
Cultivaire, LLC
DAWNS House
Decoding Dyslexia Central Oregon
Deschutes County Health Services
Early Learning Hub
East Cascades Women's Group
Economic Development for Central Oregon
Elite Volleyball Academy
Epic Property Management
Every Kid Sports
Family Access Network
Family Resource Center
Friends of the Children Central Oregon
Gentle Dental
Gero Leadership Alliance
Habitat for Humanity Bend Redmond
Habitat for Humanity La Pine Sunriver
Haelan House
Healing Reins

High Desert Education Services District
High Desert Food and Farm Alliance
High Desert Healthy Families
Homeless Leadership Coalition
Homestead Family Medicine
Housing Works
Hunger Prevention Coalition
Ideal Option M.A.T.
Jefferson County Public Health
Jericho Road
Klamath County Health Department
La Pine Community Health Center (FQHC)
Latino Community Association
Let's Talk Diversity
Metolius City Council
Mosaic Medical (FQHC)
National Association of Mental Illness
NeighborImpact Community Services
ODS Community Dental
OHSU
Older Adult Behavioral Health Initiative
Oregon Health Authority
Oregon Liquor Control Commission
Oregon Pediatric Improvement Project
OSU Cascades
OSU Extension
PacificSource Community Solutions (CCO)
Partners in Care
Planned Parenthood
Praxis Health/High Lakes Healthcare
Redmond Senior Center
Rimrock Trails
Saving Grace
Seed To Table Oregon
SMART Reading
Summit Health
Sunstone Recovery
St. Charles Health System (Hospital)
Stroke Awareness Oregon
Teen Challenge
The Center Foundation
The Environmental Center
The Shield
TRACEs Central Oregon
Thrive Central Oregon
United Way of Central Oregon
Volunteers in Medicine
Weeks Family Medicine
Wellness Bend
Westside Church

Progress and efforts made (including services provided and activities undertaken) to date toward reaching the metrics or indicators for CHP health priorities.

- RHIP workgroups for each of the six priority areas launched in January of 2020. Over 250 individuals volunteer their time to participate in these workgroups. They represent communities throughout Central Oregon and various industries aimed at improving health and well-being. Below you can find workgroup information; including names of voting partners who consistently attend meetings, previous meeting packets, future meeting agendas, and staff supporting these workgroups:

  1. Address Poverty and Enhance Self-Sufficiency

a. The workgroup funded five programs/initiatives that will increase high school graduation rates among economically disadvantaged students
b. Developing a multi-phase project to conduct listening sessions among those who are Asset Limited Income Constrained and Employed (ALICE) to determine the unique needs of different communities
    i. The listening sessions will have an emphasis on housing and transportation costs
    ii. Results will inform diverse approaches for each community to improve outcomes and meet the Future State Measures

2. Behavioral Health: Increase Access and Coordination

a. Implementing a pilot program to test and champion coordinated use of a screening tool and method to measure the appropriate level of follow-up
b. Developing a shared vocabulary
c. Completing baseline research to identify timeliness and engagement measures, conduct a feasibility study, and develop recommendations for measurement
d. Investing in behavioral health professionals in rural areas

3. Promote Enhanced Physical Health Across Communities

a. Developing a request for Letters of Interest to address increasing youth fruit and vegetable consumption and physical activity
b. Developing a strategy to expand Connect Oregon as a way to increase partnerships between clinics and community-based organizations

4. Stable Housing and Supports

a. Invested $200,000 to develop a Regional Housing Council
b. Currently reviewing a proposal for permanent supportive housing

5. Substance and Alcohol Misuse: Prevention and Treatment

a. Enhancing SBIRT within clinics to address binge drinking
b. Assessment on what drives binge drinking for 18-34-year-olds
c. Provide best practice education to retailers on tobacco and alcohol product placement to help eliminate sales to minors
d. Leverage project activities to provide community education around harms of youth exposure to tobacco advertising
e. Invest in Peer Support Specialists and hire a consultant to work on sustainable ways to engage people in treatment and reduce ED utilization

6. Upstream Prevention: Promotion of Individual Well-Being

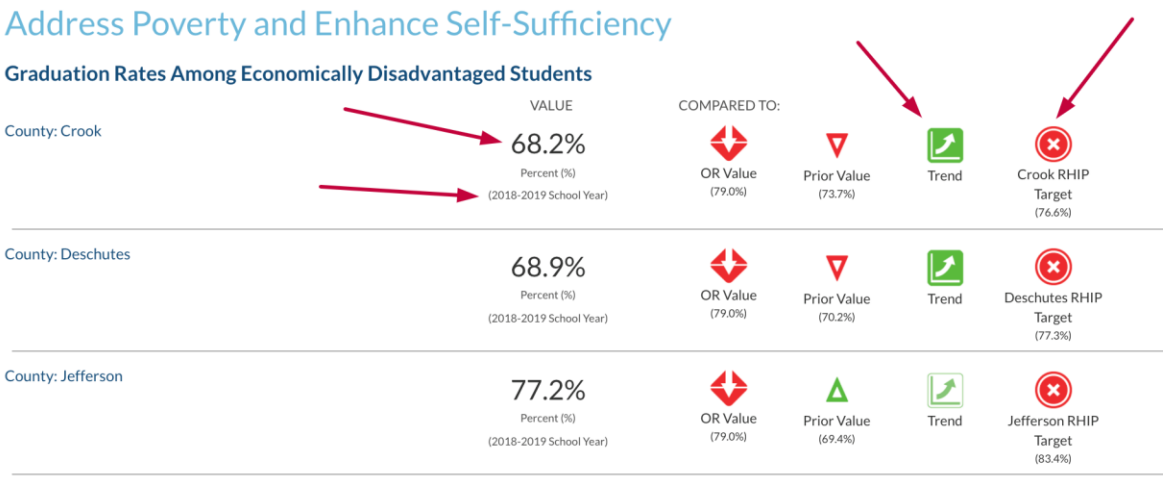
a. Investing in activities that support letter name recognition and reading
b. Developing and funding a shared organization immunization facilitator
c. Continuing already successful media campaign supporting planned pregnancy

- Regional grant opportunities are released on a rolling basis here: https://cohealthcouncil.org/standard-grants/, as well as releasing information publicly through partners covering the region. We also ask partners to share funding opportunities with any organizations that might be a good fit.
- RFPs, LOIs, and funding for the following measures released to date:
  - Improve graduation rate among students experiencing economic disadvantage
  - Decrease severely rent and mortgage burdened households
  - Increase the percentage of Housing Choice Vouchers (HCV) holders that can find and lease a housing unit
  - Develop and utilize a comprehensive system for accurately capturing the extent of Central Oregonians experiencing homelessness
  - Increase letter name recognition at kindergarten readiness among youth experiencing economic disadvantage and among underserved races
  - Increase third-grade reading proficiency among youth experiencing economic disadvantage and among underserved races
- The workgroups have also funded $280,000 in mini-grants ($5,000 or less) to more than 80 projects. These projects serve areas in Deschutes, Crook, Jefferson, northern Klamath, and the Confederated Tribes of Warm Springs since launch in January 2020 (Q1 2020 RHIP Report). These mini-grants have influenced 23 of the 26 Future State Measures prioritized in the 2020-2024 RHIP (Mini-Grant Opportunities).
- In addition to these mini-grants funding, at least one more Future State Measure in the 2020-2024 RHIP, the workgroups also helped review and fund nearly $575,000 in COVID mini-grants region-wide focused on prioritized populations (N=124 projects) (COVID-19 Final Report). These COVID mini-grants have influenced 21 of the 26 Future State Measures in the 2020-2024 RHIP.

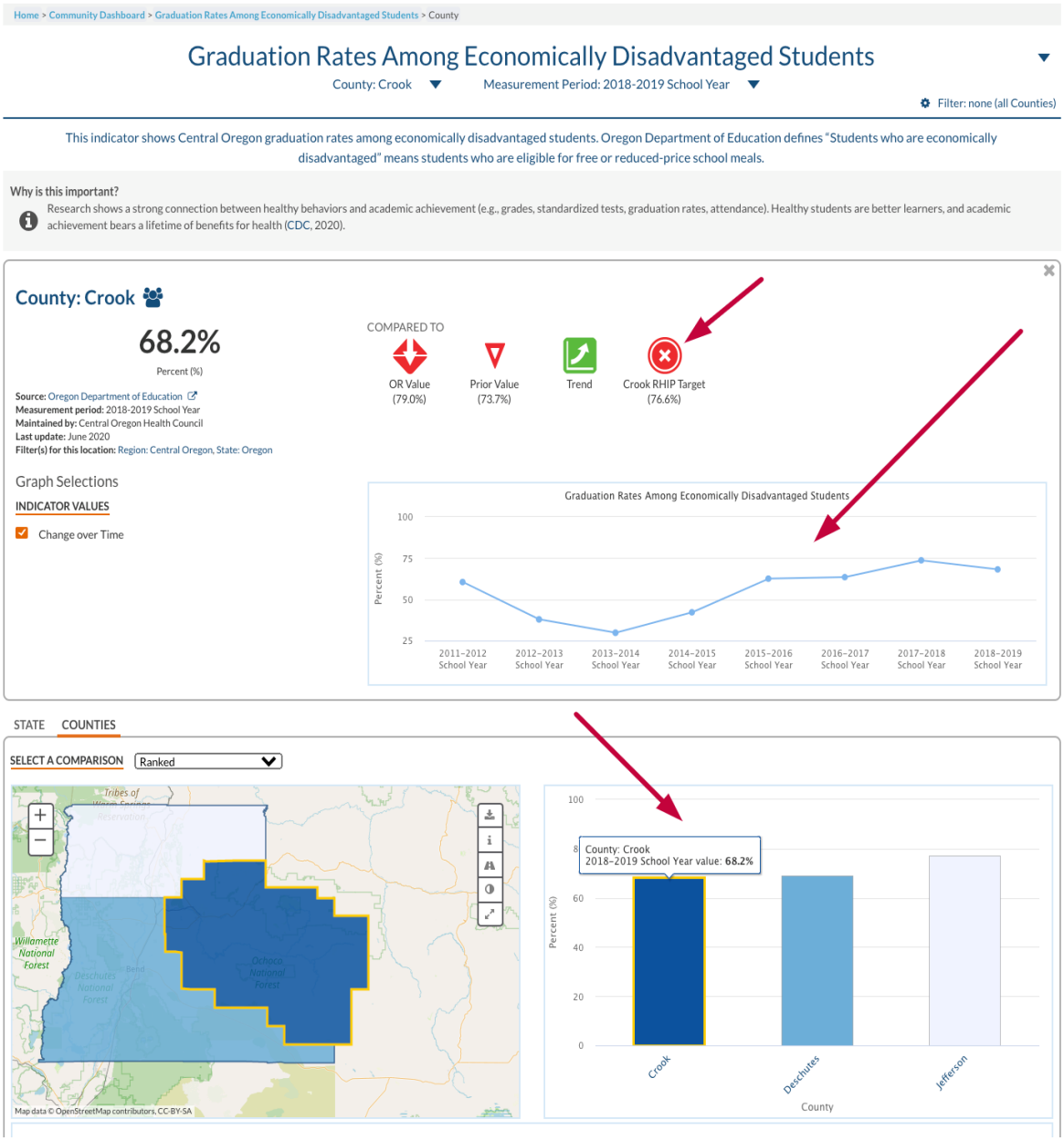
Identification of the data used, and the sources and methodology for obtaining such data, to evaluate and validate the progress made toward metrics or indicators identified in the CHP.

A. For CHPs that did include quantifiable metrics or indicators for each health priority goal, the CCO should include the metric/indicator, data source, baseline data and year, and current year's data for each health priority goal. The CCO may include additional information to provide insight on data collection or context for why a metric/indicator has or has not madeprogress.

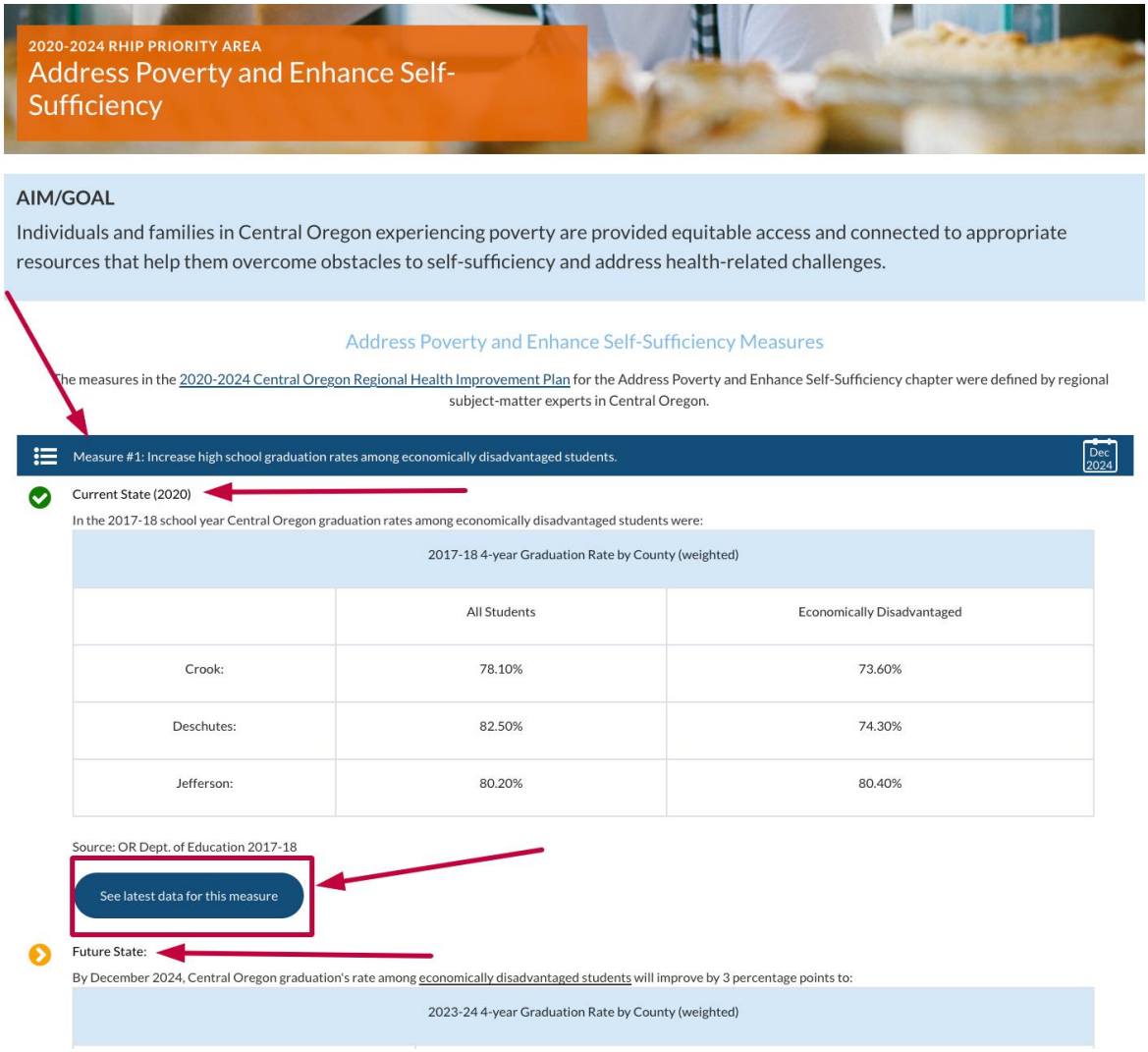
- Progress is tracked continuously by utilizing the dashboard in the link below. Every metric/indicator tracked shows its data source, current year's data, trends over time, and RHIP target achievements. These data are updated at least annually and referenced by the priority area workgroups monthly. 2020-2024 RHIP Dashboard Metrics Tracker: http://www.centraloregonhealthdata.org/indicators/index/dashboard?alias=rhip



- For example, if you click on Crook County in the above screenshot, you will get more detailed information about those data, including trend over time, as well as how data looks when compared to the other counties in the region:



- For baseline data, please view each of the priority area pages, which contain baseline data from the 2020-2024 RHIP, and a link to current data by indicator/metric, which shows source, trends over time, and RHIP target achievements:



1. Address Poverty and Enhance Self-Sufficiency
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- In addition to the six RHIP workgroups reviewing these data monthly, the Central Oregon Health Council Board of Directors, Community Advisory Council, Diversity, Equity and Inclusion Committee, Provider Engagement Panel, Operations Council, and various community-based webinars and learnings also review these data.