UMPQUA HEALTH ALLIANCE

Douglas County, Oregon
2025-2029 Community Health Improvement Plan

Toketee Falls in Umpqua National Forest

Contents

Land Acknowledgement

We want to respectfully acknowledge the Cow Creek Band of Umpqua Tribe of Indians ("Tribe" or "Cow Creek"), who have stewarded these lands since time immemorial.

We want to further acknowledge the Tribe's deep cultural and spiritual connection to these lands in addition to its entire interest and ancestral areas, which includes more than six million acres located within the Rogue and Umpqua River Watersheds. These lands and the vibrant resources within them have been important since time immemorial and will continue to be a vibrant part of Tribe's cultural identity for generations to come.

We recognize the preexisting and continued sovereignty of the Tribe and thank them for continuing to share their Indigenous knowledge and perspective on how we might work together to manage and care for these shared resources sustainably, with mutually beneficial outcomes.

We commit to engaging in a respectful, meaningful, and successful partnership as we explore shared stewardship of these lands.

Acknowledgements

The Board, leadership, and staff of Umpqua Health Alliance are grateful to the partners and stakeholders who devoted their leadership, dedication, professional expertise, and time to achieve this milestone for Douglas County.

A special thank you to:

- The UHA Community Advisory Council and CHP Steering Committee Members for dedicating their time and expertise to advising the CHP.
- Douglas County community members who participated in the CHP action planning events whose input helped shape the goals, objectives, and strategies found in the CHP.

Community Health Improvement Plan Leads

Kathryn Hart, Community Engagement Manager, Umpqua Health Alliance

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Community Advisory Council (CAC)

Community Advisory Councils (CACs) are a key component of the unique Oregon Coordinated Care Organization (CCO) model. CACs are governing bodies that include at least 51 percent Medicaid consumers and other stakeholder community members. They provide member voice and authority in our plan and are charged with:

- Ensuring CCO members receive the highest quality patient care and service possible
- Giving voice to member satisfaction and experience
- Participating in the development of the Community Health Assessment and Community Health Improvement Plan
- Administering innovation investments informed by the Community Health Improvement Plan
- Providing oversight for initiatives designed to increase health equity

Steering Committee

Thank you to the individuals and cross-sector partners serving on the CHP Steering Committee. Your time, resources, and expert counsel guided this process. The CHP Steering Committee convened monthly meetings, and we are grateful for their commitment and leadership in the community engagement and data review, which were fundamental to the success and completion of this report.

UHA CHP Steering Committee Members

While not every entity invited to participate in the CHP Steering Committee had the capacity to join in this process, we acknowledge and appreciate the input and guidance given at any level. In addition to the listed CHP Steering Committee Members, we also want to thank the Coquille Indian Tribe and the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians who were not able to participate in this process but whose ancestral lands partially lie within Umpqua Health Alliance service area.

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Juliet Rutter
Umpqua Valley Rainbow Collective
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Research and Design Partners

The Community Health Improvement Plan was conducted in partnership with Health Management Associates (HMA), an independent, national research and consulting firm specializing in publicly funded health care and human services policy, programs, financing, and evaluation. HMA's mission is to improve the health and well-being of individuals and communities by making publicly funded health care, and the social services that support it, more accessible, equitable, and effective.

About Umpqua Health Alliance

Umpqua Health is deeply rooted in Douglas County, and we are proud to call the Umpqua Valley our home. Our integrated network of skilled local providers delivers high-quality health care to Douglas County residents. Umpqua Health also collaborates closely with community partners to evaluate ongoing health care needs and issues while collaborating on local solutions.

Our subsidiary, the Umpqua Health Alliance (UHA), is one of 16 coordinated care organizations (CCOs) in Oregon that has served members of the Oregon Health Plan (OHP) since 2012. UHA connects more than 40,000 Douglas County OHP members to physical, behavioral, oral health care through an integrated network of providers. UHA is managed through a locally based board of directors and Community Advisory Council (CAC) that ensures local health care needs are met.

Umpqua Health also operates the Umpqua Health–Newton Creek Clinic, a certified rural health clinic in Douglas County that offers integrated whole-person care, including pediatric and adult primary care, urgent care, as well as behavioral health services. Local governance and oversight are at the center of the coordinated care model and the heart of the original vision of Gov. John Kitzhaber, MD, because people who live locally know how to best care for our communities.

Executive Summary

The Umpqua Health Alliance (UHA) Community Health Improvement Plan (CHP) envisions a Douglas County where everyone can achieve health and optimal well-being in an environment of access, equity, and resilience. To achieve this vision, Douglas County communities are working on eliminating health disparities by embracing community voice, establishing trusted partnerships, and implementing evidence-based strategies and best practices to achieve equitable health outcomes for all.

In 2023, collaborative efforts of community and organizational partners led by UHA created the Community Health Assessment (CHA), a comprehensive review of the current health status of our shared communities and our most pressing health needs. Background of the CHA can be found at: https://www.umpquahealth.com/wp-content/uploads/2024/01/uha-cha-2023.pdf

Health priorities were determined because the following were found to be true for Douglas County:

- Community members expressed concern about the priority
- Secondary data pointed to either significant differences in Douglas County compared to Oregon and/or indicated a concerning or worsening trend regarding the priority

Health priorities were selected using the following criteria:

- Can the partnership and/or a single organization influence the issue?
- Is there existing community will and/or opportunity to leverage or influence the issue?
- Is measurable change possible within five years?

This CHA identified evidence that suggests it is important to continue focus on the four priority areas identified in UHA's 2019 CHP.

- Social Determinants of Health
- Behavioral Health and Addictions
- Families and Children
- Healthy Lifestyles

Once completed, the CHA provided a framework to gather structured feedback from subject matter experts, including individual community members, Community-Based Organizations, public health agencies, educators and education administrators, health care systems, and hospitals. This feedback was used to define the goals, objectives, strategies, and key results that will form the foundation for the ongoing work of the CHP.

This CHP is critical for creating a shared roadmap of strategies and actions to address the top health priorities for the region. It enables Douglas County to track progress, celebrate achievements, and modify course as the work unfolds to achieve greater and more equitable health for its communities.

The identified priorities in this document are the result of community input through two community action planning events and ongoing input from the CHP's steering committee members. The Governor's priorities for health improvement, the Oregon Health Authority's (OHA) 2020-2024 State Health Improvement Plan, the state's 1115 waiver and Supporting Health for All through REinvestment: the SHARE Initiative (SHARE) were also considered, and goals, objectives, and strategies were identified with that alignment in mind.

Through the unified commitment from multiple sectors across the county, we anticipate positive impacts on the issues the community finds relevant. We can and must do better collectively to improve the health of all who live, work, and play in Douglas County.

Priority Areas and Goals

Priority Area 1: Social Determinants of Health

Goal 1: Ensure that all people in Douglas County live, work and play in a safe and healthy environment and have equitable access to stable, safe, affordable housing, transportation, childcare, social services, and other essential infrastructure so that they may live a healthy resilient life.

Goal 2: Ensure Douglas County organizations create, and support opportunities aimed at fostering excellence and proficiency across all person-serving institutions.

Priority Area 2: Families & Children

Goal 1: Collaborate with education partners to build a community-wide understanding of the barriers to K-12 school attendance and the factors contributing to absenteeism rates.

Goal 2: Enhance resilience by fostering safe, connected, and strengths-based environments for individuals, families, caregivers, and communities.

Priority Area 3: Healthy Lifestyles

Goal 1: Create a culture of health in Douglas County.

Goal 2: Ensure all Douglas County residents have access to healthy, nutritious, and affordable food that meets their dietary and cultural needs.

Priority Area 4: Behavioral Health & Addiction

Goal 1: Provide more accessible and culturally aware behavioral health and addiction services in diverse locations.

Goal 2: Reduce stigma and increase community awareness that behavioral health and addiction issues are common and widely experienced.

Douglas County Profile

According to the 2020 US Census, 111,201 people reside in Douglas County. The county, situated in southwestern Oregon, covers 5,134 square miles, making it the fifth-largest county in Oregon and one of two counties that extend from the Pacific Ocean to the Cascade Range. Roseburg is the county seat and the largest city in the county, with a population of around 23,000.[1] In Douglas County, 29.8 percent of the people voted Democrat in the last presidential election, 67.3 percent voted for the Republican Party, and the remaining 2.9 percent voted Independent.[2]

Originally, the region was inhabited by the Umpqua Indians, now known as the Cow Creek Band of Umpqua Tribe of Indians, one of nine federally recognized Indian Tribal Governments in the State of Oregon. Today, the Tribe runs the Seven Feathers Casino and Hotel, named after the seven families who refused forced removal to the Grand Ronde Reservation. According to a 2016 report by ECONorthwest, the county's economic output was $188 million greater due to the jobs and activities provided by Tribal Government.[3]

Historically, the economy of Douglas County relied on the timber and logging industry. However, like many lumber-dependent areas, the county has faced economic challenges because of fluctuations in the timber market and environmental regulations. The county is known for its picturesque natural beauty, and it is renowned for its outdoor recreational opportunities, offering access to numerous parks, forests, and wilderness areas, making it a popular destination for outdoor enthusiasts. Efforts have been made to diversify the economy, with a focus on health care, tourism, manufacturing, and small businesses, including its emerging wine industry. The geology of the region is known for producing high-quality grapes, and several wineries and vineyards have been established in the area.

What is the Community Health Improvement Plan?

The CHP is a five-year plan to systematically address community health issues based on the Community Health Assessment (CHA) completed in 2023. This CHP analyzes the current state of community health, envisions a healthier future, and lays out strategic steps to achieve this vision. The plan will target the root causes of health inequities and social determinants of health (SDOH) such as economic stability, education access, health care availability, neighborhood environment, and social context. By prioritizing these foundational issues, the CHP aims to create sustainable, long-term improvements in health. The plan will involve continuous monitoring and evaluation to ensure that interventions are effective and that resources are allocated efficiently to areas of greatest need.

Why is the CHP important to Douglas County?

The CHP will function as a framework and strategic plan for community-wide action. Because the CHP is meant for the entire community, it can differ from the internal or departmental strategic plans of agencies or organizations. The CHP helps align the work of our diverse partners and specific plans around common priorities, supports coordinated work on these priorities, enhances collaborative relationships between partners, and sets and tracks common progress indicators.

[1] American Community Survey, Table B01001, 5-year estimate, 2017-2021

[2] https://www.bestplaces.net/voting/county/oregon/douglas

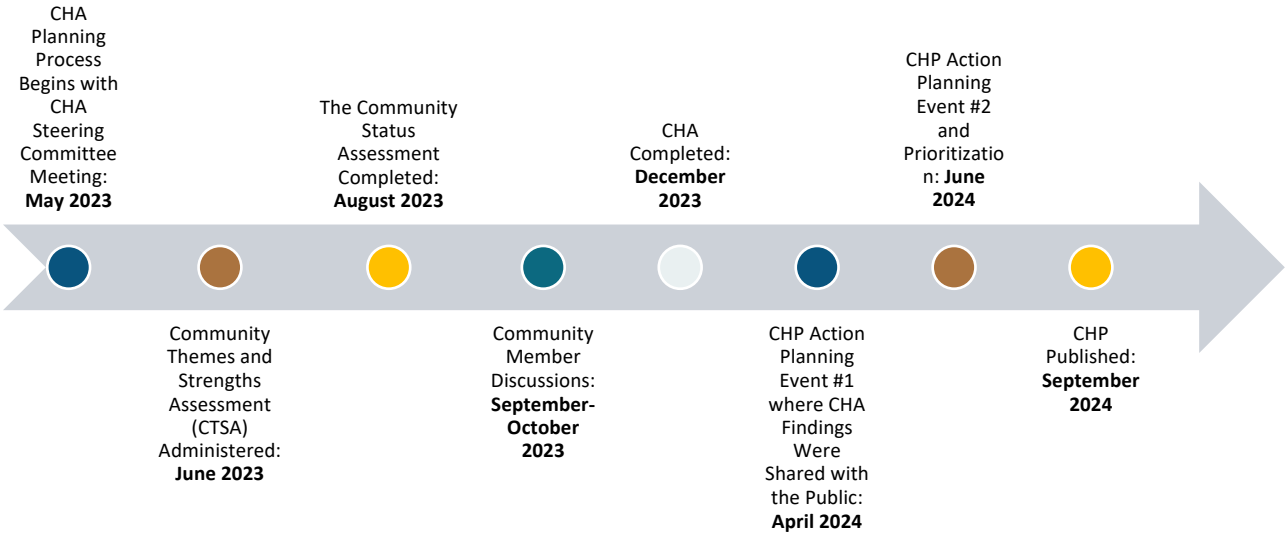
[3] https://www.cowcreek-nsn.gov/tribal-story/economic-impact/

Collaboration with community partners will be integral to the CHP's success. By involving local organizations, health care providers, government agencies, and community members, the plan will align priorities and actions across different sectors. This coordinated approach will enhance resource targeting and maximize the impact of interventions. The CHP further refines the community's vision of health by incorporating diverse perspectives and addressing specific local challenges identified in the CHA. Through data-driven strategies, the CHP sets measurable goals and allocates responsibilities, ensuring accountability and progress over the five-year period. The goal is to create a healthier, more equitable community by addressing the underlying factors contributing to health disparities.

UHA is committed to supporting the CHP collective health improvement strategies, and to help maximize collective strategies by the many community and agency partners in Douglas County.

How was the CHP Planned and Developed?

UHA began planning for the 2024-2029 CHP using the Mobilizing for Action through Planning and Partnerships 2.0 (MAPP 2.0) framework in May 2023. The figure below shows the CHP timeline for the completion of this plan.



The CHP is informed by three individual community assessments that brought together data on factors addressing health risk, quality of life, social determinants, disparities, mortality and morbidity, community assets, forces of change, threats, and strengths of the community:

- **The Community Status Assessment** used quantitative data to describe the community, including SDOH, health factors and health outcomes present in Douglas County, and where these elements intersect and influence one another.
- **The Community Context Assessment** explored the strengths, assets, lived experiences, and forces of change within a community using the Community Strengths and Themes Assessment (CSTA). By collecting the insights, expertise, and views of people and communities affected by social systems to improve the functioning and impact of those systems instead of relying on perceived community needs, this assessment centered the people and communities in Douglas County.
- **The Forces of Change Assessment** which examines the forces that are or will be influencing the health and quality of life of the community, as well as the community's efforts to improve health outcomes. These forces can be related to social, economic, environmental, technological, or political factors in the county, the state, or the nation that have an impact on the local community.

Findings from the three assessments are included in the final 2023 CHA report, available at https://www.umpquahealth.com/wp-content/uploads/2024/01/uha-cha-2023.pdf

What is in the CHP?

The UHA CHP is a detailed roadmap that documents how UHA and its partners will address the four priority areas identified through the community health assessment. It is a multi-purpose tool to guide implementation, support communication and accountability, and update and revise strategies as we learn what is working and what is not working. The CHP also helps to align UHA's work with the Governor's priorities for health improvement, the Oregon Health Authority's (OHA) 2020-2024 State Health Improvement Plan (SHP), the state's 1115 waiver and Supporting Health for All through REinvestment: the SHARE Initiative. Figure 1 provides the legend used to identify how the strategies in the CHP align with these initiatives. By aligning with these initiatives, UHA ensures they are working towards the collective's goals for improving health outcomes for Oregonians while using resources efficiently and meeting state federal requirements.

Figure 1.

Everyone involved wants to provide the best possible care for Oregonians. By working together, we can deliver the services people need and promote overall health and well-being. This includes addressing social determinants of health such as housing, education, and access to healthy and nutritious food. Additionally, we can make strides in creating equity for all by reshaping systemic or structural factors that shape the distribution of the social determinants of health in communities, physical healthcare services and behavioral health services.

As structured, the CHP includes goals, objectives, strategies, and key results. These elements are defined as follows:

- **Goals:** Goals are broad statements of what Douglas County hopes to accomplish related to the priority and may include the approach or "by or through" phrase.
- **Objectives:** Objectives are measurable, specific actions taken to achieve the goal.
- **Strategies:** Strategies may be evidence-based, practice-based, promising practices, or innovations to meet the population's needs.
- **Key Results:** Key results are a mix of quantifiable outputs and outcomes that will be used to determine whether a strategy was implemented as intended, an objective was met, and the goal was achieved.
- **Data Indicators:** Indicators are baseline estimates that are available at the start of the CHP and will be used to monitor progress and/or impact of the CHP.

Draft goals, objectives, strategies, and key results were developed and refined based on the following considerations:

- Alignment to current initiatives and programs in Douglas County
- Alignment with UHA's priorities and community investments.

- Feasibility within the five-year CHP.
- Fit within UHA's community benefit grant program, which is aligned with the Health-Related Services Guidelines as defined in OAR 410-141-3845.
- Opportunity to collect and report meaningful process and outcome metrics, including Oregon Health Authority's quality health metrics for Coordinated Care Organizations (CCOs).

Creating Goals, Objectives, and Strategies

UHA led a robust community process to develop the CHP's goals, objectives, and strategies. The process began with a day-long event where community members, key stakeholders, CHP Steering Committee members, and Community Advisory Council (CAC) members were invited to refine the goals identified through the CHA. Then, through a round of breakout sessions, participants worked to identify existing efforts and new ideas that led to the creation of strategies to support each of the priority area goals.

The efforts from the day-long event were used to draft strategies. These strategies, along with updated versions of priority issue goals, objectives, and key results, were provided to the CHP Steering Committee for their input. The refined lists were then shared back with the community at a second action planning event. The results of these efforts are reflected in this CHP.

Shared Risk & Protective Factor Approach

The complexity of improving health for a population calls for strategies that improve multiple health outcomes. One such strategy is the Shared Risk and Protective Factor (SRPF) approach. The goal of the SRPF approach is to address and impact more than one population health or quality-of-life outcome at the same time. For example, focusing on built environment strategies like the walkability of a community or increasing public transportation options can impact motor vehicle crashes, falls, community violence, obesity and improve access to health care. The SRPF approach can also address a health outcome (such as bullying) and a quality-of-life outcome (such as educational achievement) at the same time.

The SRPF approach can positively impact the social drivers of health by intervening in damaging cycles (e.g., poverty, economic inequality, structural racism, historical trauma) and reinforcing beneficial cycles (e.g., equitable access to quality education, de-stigmatized behavioral health care, community culture, resilience, and engagement). The SRPF approach can include strategies for individual, relationship, community, and societal change. **Therefore, any one strategy may be cross-cutting CHP goals and objectives.**

Protective Factors

Protective factors are characteristics at the individual (biological, psychological), relationship/family, community or societal level that are associated with a lower likelihood of negative outcomes or that reduce the negative impact of a risk factor. Shared protective factors are those that are associated with more than one type of public health issue.

Risk Factors

Risk factors are characteristics at the individual (biological, psychological), relationship/family, community or societal level of the social ecological model that are associated with a higher likelihood of negative health outcomes. Shared risk factors are those associated with more than one type of public health issue.

What are the foundational principles underlying the CHP goal, objectives, and strategies?

The foundational principles underlying the CHP goals, objectives, and strategies for Douglas County focus on a comprehensive and inclusive approach to health and wellness. These principles are designed to ensure that all residents have access to integrated systems of care that address physical, behavioral, oral, and social health needs.

- Ensure that health and wellness services are accessible and relevant for individuals at all stages of life, from early childhood to older adulthood. This includes pediatric care, adolescent health services, adult health care, and geriatric services.
- Implement health and wellness approaches that support multiple generations within families, recognizing the interconnected nature of health within family units. This includes providing family-centered care and resources that support caregivers and dependents alike.
- Ensure that health care services are available and accessible across all areas of Douglas County, including urban, suburban, and rural regions. This involves addressing transportation barriers, telehealth services, and mobile services to reach underserved areas.
- Recognize and address the health care needs of residents from various income levels. This includes providing affordable care options, sliding scale fees, and financial assistance programs to ensure that cost is not a barrier to accessing necessary services.
- Strive to eliminate health disparities and ensure that all residents have equitable access to services regardless of their race, ethnicity, gender, sexual orientation, socioeconomic status, or geographic location.
- Address the root causes of health inequities, such as systemic racism, poverty, and discrimination, and advocating for policies and practices that promote social justice and health for all.

These principles should be at the forefront of any workplan regarding each strategy.

Social Determinants of Health

Rarely does one factor determine the health of a community. Instead, it is a combination of numerous influences. Healthy People 2030 describes five SDoH, including economic stability, access to quality education, access to quality health care, neighborhood and built environment, and social and community context.[4] These determinants are defined as "the conditions in which people are born, live, learn, work, play, worship, and age and the wider set of forces and systems shaping the conditions of daily life."[5] The 2023 CHA identified the following health priorities:

Health Priorities	Primary Concerns Identified by the CHA
Access to Health and Social Services	• Roughly two in three Community Themes and Strengths Assessment (CTSA) survey respondents experience barriers to accessing health care, including the high out-of-pocket, limited appointment availability, and a lack of needed services in their area. • More than half all CSTA survey respondents strongly agreed/agreed that their communities offered sufficient social services to meet the needs of residents.
Safe and Affordable Housing	• Approximately three in 10 CSTA survey respondents indicated they were unable to afford rent/mortgage at least sometimes (three to four times per year). • Households experiencing housing cost burden ranged from a high of 46.7 percent in Canyonville to a low of 9.5 percent in Melrose. Additional towns with significantly higher housing burden compared to the county overall, included Tri-City (35.2%), Roseburg (34.0%), Glendale (33.5%), Sutherlin (32.9%), and Yoncalla (32.7%).
Community Connectedness	• Approximately seven in 10 CSTA survey respondents (69%) who identified as a person of color reported that they sometimes or often felt they had been personally discriminated against because of their race/ethnicity or skin color—higher than among survey respondents who did not identify as a person of color (15.0%). • Survey respondents were more likely to say they sometimes/often felt that some racial/ethnic groups, such as African Americans, Latinos, and Asians, are discriminated against (59%) than report that they themselves had personally experienced discrimination because of their race, ethnicity, or skin color (26%).

[4] Healthy People 2030. Social Determinants of Health. Available at: https://health.gov/healthypeople/priority-areas/social-determinants-health
5 Centers for Disease Control and Prevention. Economic Stability. Available at: https://www.cdc.gov/prepyourhealth/discussionguides/economicstability.htm#:~:text=SDOH%20are%20grouped%20by%20Healthy,socioeconomic%20status%E2%80%94and%20their%20health.

Themes from the Community CHP Action Planning Events

At the CHP Action Planning event, a central theme was the vital role of social determinants of health (SDoH) in shaping community health and well-being. The discussion underscored the necessity of addressing SDoH, particularly in terms of enhancing access to affordable healthcare, housing, transportation, livable wage jobs, food security, and ensuring cultural competence in healthcare services.

The event also brought to light the pressing need for equitable distribution of community resources, which significantly impacts residents' access to essential amenities. To tackle the issue of uneven resource distribution, potential solutions such as intergenerational and intercultural programming, raising awareness about existing community resources and services, and workforce development were highlighted.

During the discussion, community members emphasized the need to braid resources more effectively to better deliver services to the community. Community members pointed out that in Sutherlin, there is a central location where many services for those in need are available, and this navigation center has been remarkably successful, serving as an inspiring model for other communities. However, in other cities, services are spread out across various locations, making it challenging for individuals to access them. In these other areas, there is a need to identify the number and types of services available and explore opportunities to consolidate them. Additionally, the community members stressed the importance of building trust among those who are receiving or in need of services. It was acknowledged that establishing trust is essential in ensuring that individuals feel comfortable and supported when accessing the necessary resources and assistance.

SDOH Goals, Objectives, and Strategies

SDOH GOAL 1

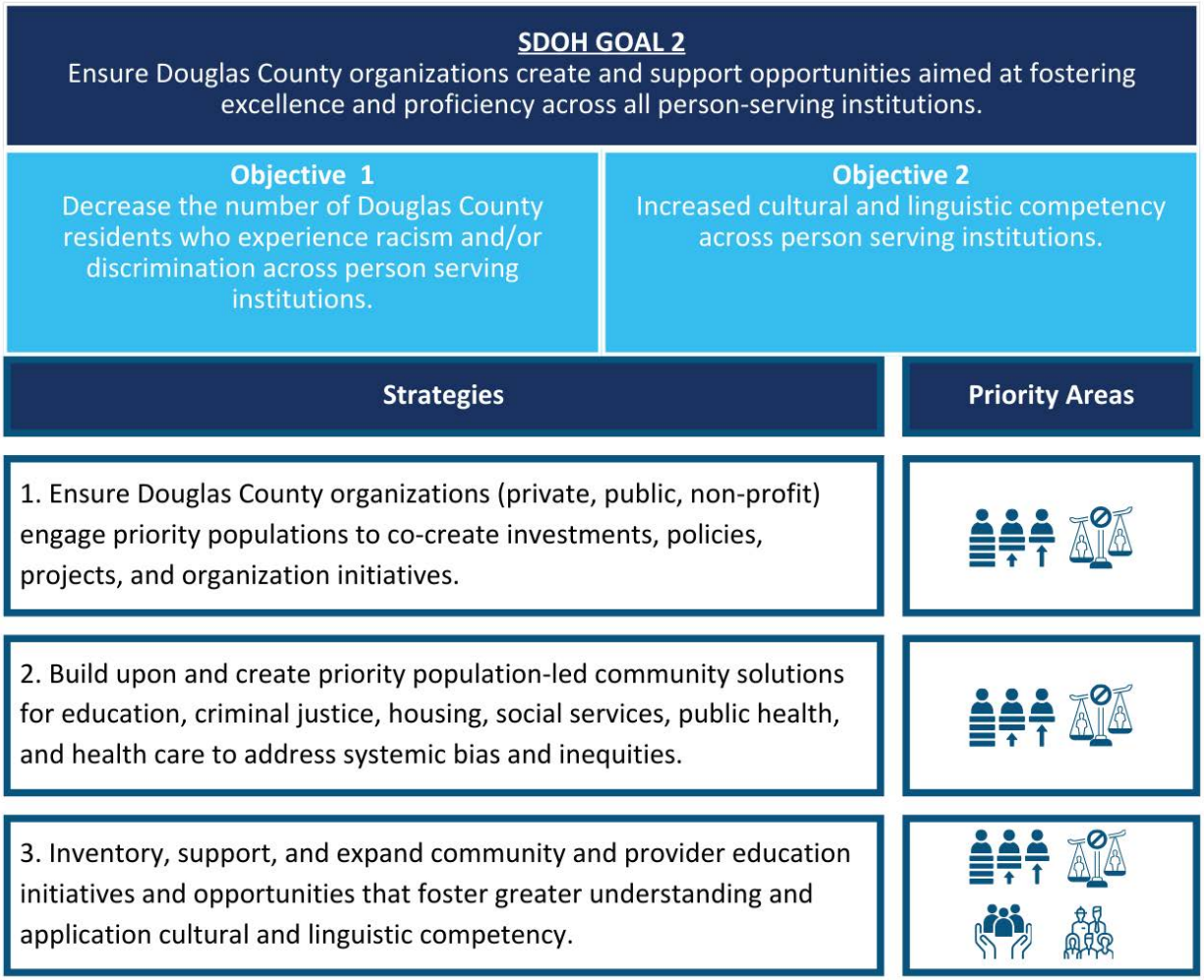
Ensure that all people in Douglas County live, work and play in a safe and healthy environment and have equitable access to stable, safe, affordable housing, transportation, childcare, social services, and other essential infrastructure so that they may live a healthy resilient life.

Objective 1	Objective 2
Strengthen and establish networks of community partners to ensure equitable resource distribution across Douglas County reflective of individual community needs.	Increase community-wide participation in the development and implementation of meaningful and sustainable solutions for stable, safe, affordable housing.

Strategies	Priority Areas
1. Inventory, assess (e.g., community awareness, proximity, eligibility, affordability), and market the housing, transportation, childcare, social services, and other essential infrastructure available to residents in Douglas County.	
2. Promote and facilitate healthcare, government, nonprofit, and other organizations participation in Connect Oregon to securely identify, deliver, and pay for services that address the needs of Douglas County residents within their communities.	
3. Engage community members in the implementation of Douglas County Transportation System Plan.	
4. Support the coordination and collaboration among stakeholders such as landlords, developers, foundations, and philanthropists to align housing efforts with community need and secure funding for housing initiatives, with an emphasis on emergency/temporary housing solutions.	

SDOH Goal 1 Key Results

- Increased number of new collaborations/coalitions with a clear sustainability plan *(Source: UHA Community Benefit Reporting)*
- Increased percentage of community members responding to the CSTA who report they strongly agreed/agreed that their communities offer sufficient social services to meet the needs of its residents *(Source: CSTA Pulse Survey)*
- Increased community-wide participation in the development and implementation of meaningful and sustainable solutions for stable, safe, affordable housing *(Source: UHA Community Benefit Reporting)*
- Decreased percentage of Douglas County households who experience severe housing cost burden (spending more than 50 percent of household income housing) *(Source: American Community Survey, Five-Year Estimates, Tables B25070/B25091)*
- Implementation of the Social Needs Screening and Referral Measure *(Source: CCO Incentive Measure)*



SDOH Goal 2 Key Results:

- Decrease the percent of CTSA survey respondents who have experienced racism and/or discrimination *(Source: CSTA Pulse Survey)*
- Increase the number of population-led community solutions, education initiatives, and opportunities in Douglas County *(Source: UHA Community Benefit Reporting)*
- Increased meaningful language access to culturally responsive health care services *(Source: CCO Incentive Measure)*
- Increased access to care *(Source: CCO Incentive Measure, CAHPS Composite)*
- Promote social needs screening and referral in an equitable and trauma-informed manner (Source: CCO Incentive Measure, SDOH Measure; Rate 2)
- Increased satisfaction with care *(Source: CCO Incentive Measure, CAHPS Composite)*

SDOH Data Indicators

Indicator	Oregon	Douglas County	Trend	Disparities
Percent households who experience housing cost burden (ACS, 1-year Estimates, Tables B25070/25091)	34.8%	28.8%	Worsening 2019 to 2022	Elkton (48.2%) Gardiner (45.7%) Canyonville (45.2%) * Myrtle Creek (37.2%) Yoncalla (37.1%) Roseburg (34.4%) *
Percent CSTA respondents who report they “strongly agreed”/ ”agreed” that their communities offer sufficient social services to meet the needs of its residents	n/a	53%	n/a	
Percent CSTA respondents who have “sometimes/often” experienced racism and/or discrimination	n/a	26%	n/a	People of Color (69%)

*Rate significantly different compared to Douglas County.

Children and Families

Helping families and children live longer, healthier lives with lower rates of chronic disease and a higher quality of life requires investments in a range of programs and services that meet basic needs and strive to support families and children in developing healthy habits. The 2023 CHA identified the following health priorities:

Health Priorities	Primary Concerns Identified by the CHA
Education Access and Quality	• In school year (SY) 2021–2022, 41.7 percent (5,229) kindergarten through grade 12 students were chronically absent in Douglas County, significantly higher than the 36.1 percent of students in Oregon. • In 2021/22, the percent of ninth-grade cohort students who graduated within four years was 74.3 percent, lower than in Oregon at 81.3 percent. • Focus Group participants are facing barriers in accessing resources on college applications, scholarships, and career guidance.
Adult Connectedness Among Youth	• Percent of students in 6th, 8th, and 11th grade who feel they have at least one teacher or other adult in their school who genuinely care about them decreased from 2020 to 2022.
Economic Stability	• In 2021, the poverty rate was significantly higher in Douglas County, with 17.5 percent of people living in poverty compared with Oregon at 12.2 percent. The poverty rate in Douglas County also significantly increased to 17.5 percent in 2021 from 10.3 percent in 2019. • In 2020, the unemployment rate was 7.8 percent, which has since decreased to 5.3 percent in 2022. • Key priorities for survey respondents include good jobs, a healthy economy, and affordable housing. • Half of the CSTA survey respondents indicated they lacked enough money to pay for at least one essential item in the past month or year.
Adversity, Trauma, and Toxic Stress	• In 2018-2021, in Douglas County, the percent of adults with four or more adverse childhood experiences (ACEs) was significantly higher at 36.0 percent compared to Oregon at 24.0 percent.
Bullying	• School-related bullying increased from 2020 to 2022, with roughly a third of 11th graders experiencing bullying in 2022.
Teen Birth	• Douglas County had a significantly higher teen birth rate compared to Oregon. In 2019-2021, among teens ages 18–19, the teen birth rate was 37.1 births per 1,000 people in Douglas County compared to 20.4 births per 1,000 people.

Themes from Community CHP Action Planning Events

Several key themes emerged from the discussions. One prominent theme was the recognition of school absenteeism as an intergenerational issue influenced by various factors, including adverse childhood experiences (ACEs), a lack of family support, and systems not accommodating families with both parents working. The need to address these issues was emphasized, as well as the provision of comprehensive support to families within their homes, with a focus on wrap-around services.

Community members voiced their concerns and perspectives on these issues, highlighting specific motivations and needs that drive youth and expressing a prevailing sentiment that parents may be indifferent toward school. Factors such as difficulty fitting in, parental trauma, and other circumstances were identified as potential contributors to these perceptions. Questions were raised regarding the responsibility for school attendance, with discussions centered on whether it primarily falls on the child or the family. Additionally, the community emphasized the need to break the cycle of generational poverty, highlighting the lack of support for families in Douglas County. Another important point raised by community voices was the need to attract higher-paying jobs and develop a workforce capable of filling those positions. These discussions shed light on the multifaceted challenges faced by the community and the various interconnected issues that impact the well-being of families and youth.

Children and Family Goals, Objectives, and Strategies

Children & Families GOAL 1
Collaborate with education partners to build a community-wide understanding of the barriers to K-12 school attendance and the factors contributing to absenteeism rates.

Objective 1	Objective 2
Strengthen community awareness of chronic absenteeism.	Increase community accountability and support in getting children and youth engaged in school.

Strategies	Priority Areas
1. Establish a collaborative group consisting of school districts and other key stakeholders to develop and implement strategies aimed at improving school attendance.	
2. Increase youth engagement and mentorship opportunities. (SOC Strategic Plan)	
3. Facilitate conversations "listening sessions" with families to understand the driving factors for absenteeism and design strategies to improve attendance rates that address identified barriers.	
4. Support parental outreach and education initiatives, such as educational workshops and school-based resource fairs. (CBHP Strategy)	
5. Enhance school-based screening in alignment with age-appropriate recommended preventative health-schedule(s) screenings. (SHP Strategy)	
6. Promote school and community-based partnerships designed to meet the needs of children, youth, and families. (SOC Strategic Plan)	

Children and Family Goal 1 Key Results

- Increase the number of mentions in public-facing communications (e.g., news articles, community events, school materials, etc.) on the issue of chronic absenteeism from school *(Source: UHA Community Benefit Reporting)*
- Increase the number of new programs/efforts to address chronic absenteeism from schools funded through UHA community benefit dollars *(Source: UHA Community Benefit Reporting)*
- Increase the number of school-based health services, including health-related screenings asking students about their social needs, disabilities, mental health status, and chronic diseases *(Source: UHA Community Benefit Reporting)*
- Decrease percent of students chronically absent from school *(Source: Oregon Department of Education)*

Children & Families GOAL 2
Enhance resilience by fostering safe, connected, and strengths-based environments for individuals, families, caregivers, and communities.

Objective 1	Objective 2
Increase the financial resilience of families living in Douglas County.	Expand intergenerational and cultural opportunities in Douglas County.

Strategies	Priority Areas
1. Conduct an inventory of existing programs in Douglas County, that assist with financial empowerment, training, skill development, and childcare services.	
2. Promote screening and assessment of individuals with economic hardship.	
3. Support the implementation of seamless referrals for Douglas County residents encountering economic disparities, barriers to training and skill development and access to high quality childcare services.	
4. Enhance capacity and infrastructure for community-serving organizations that address economic disparities and provide training and skill development programs.	
5. Launch a unified campaign to educate and raise awareness within the community about available resources and opportunities focused on financial empowerment, training and skill development, and childcare services.	
6. Expand culturally and linguistically responsive community-based mentoring programs and other services, with a focus on intergenerational initiatives and peer-delivered supports. (SHP Strategy)	
7. Promote art and cultural events that celebrate and showcase the rich diversity of BIPOC, LGBTQIA2S+, and Tribal communities. (SHP Strategy)	
8. Establish a working group comprised of representatives from different organizations to review and align data from the various community assessments to better understand resident's needs.	

Children and Families Goal 2 Key Results

- Decrease the percentage of CSTA survey respondents were asked to share to what extent they lacked enough money to pay for essential items, such as food, hygiene, housing, or clothing *(Source: CSTA Pulse Survey)*
- Increase in the number of new intergenerational and cross-cultural programs/efforts funded through UHA. *(Source: UHA Community Benefit Reporting)*
- Increase in the number of new programs/efforts funded through UHA to intentionally bring together different perspectives and life experiences to offer input and inform decisions for the CHP implementation or other initiatives requiring community input and decision making. *(Source: UHA Community Benefit Reporting)*
- Increase the percent of students in 6th, 8th, and 11th grade who feel they have at least one teacher or other adult in their school who genuinely care about them *(Source: Oregon Department of Education, Student Health Survey)*

Children and Families Data Indicators

Indicator	Oregon	Douglas County	Trend	Disparities
Percent of students chronically absent from school (Oregon Department of Education)	36.1%	41.7*	Worsening 2017-18 to 2021-2022	Students experiencing insecure housing (65.5%) Native American/Alaska Native (54.4%) Native Hawaiian/Pacific Islander Students (54.5%) Students with Disabilities (50.8%) Migrant Students (50%)
Percent CSTA respondents who lacked enough money to pay for essential items, such as food, hygiene, housing, or clothing (CSTA Pulse Survey)	n/a	50%	n/a	People of Color (79%)
Percent of students in 6th, 8th, and 11th grade who feel they have at least one teacher or other adult in their school who genuinely care about them (Oregon Student Health Survey)	6th (43.0%) 8th (33.4%) 11th (33.5%)	6th (41.0%) 8th (37.5%) 11th (32.6%)	Worsening	n/a

Healthy Lifestyles

A healthy lifestyle encompasses a range of practices and behaviors that contribute to overall well-being and longevity. It involves making conscious choices that positively impact both physical and mental

Health Priorities	Primary Concerns Identified by the CHA
Health Status	• In 2018–2021, in Douglas County, nearly one in five (17.8%) adults (18+ years) self-rated health status as fair or poor. This rate was higher than the statewide rate of 15.9 percent. • In both Douglas County and Oregon, the average number of poor physical health days (i.e., days in the previous 30 days that a respondent's physical health was subpar because of illness or injury) improved between 2019 and 2020; yet was still significantly worse in Douglas County—3.5 days versus 2.9 days in Oregon.
Tobacco Use	• In 2018-2021, approximately one in five (20.4%) adults used cigarettes in Douglas County, higher than in Oregon at 14.5 percent of adults. • Cigarette use among adults did not significantly improve since 2010-2013 in Douglas County whereas the rate during this time did improve in Oregon. • Past 30-day electronic cigarette use among youth was 19.9 percent or one in five 11th graders, a percentage higher than across Oregon at 10.8 percent. • Tobacco-related death rates per 100,000 people were higher in Douglas County than in Oregon. In 2018–2021, this rate was 215 deaths per 100,000 people compared with 147 deaths per 100,000 people in Oregon. This rate has been consistently higher in Douglas County than in Oregon since 2006–2009.
Food Access and Security	• The food insecurity rate in Douglas County was 12.0 percent in 2021 (13,300 people). Among these individuals, 17.0 percent were ineligible for the federal nutrition programs (SNAP). The child (younger than 18 years old) food insecurity was higher (16.8%). • In 2022, an average of 55.1 percent of students in Oregon were eligible for free and reduced priced meals. In Douglas County, this rate was higher, at 65.5 percent of students. • 42.5 percent of residents have limited access to food and 6.7 percent live in a food desert, a concern also identified in CSTA survey responses and in community member discussions
Obesity	• When including the percent of adults considered overweight (BMI 25 or higher), approximately seven in 10 adults (18+ years, 71.7%) in Douglas County were overweight or obese in 2018–2021. This rate was significantly higher compared to statewide rate of 64.4 percent.

health. Many factors influence an individual's health status and their ability to live a healthy lifestyle. The 2023 CHA identified the following health priorities:

Themes from Community CHP Action Planning Events

At the CHP Action Planning events, community members delved into the necessity of implementing initiatives that expand culturally relevant health lifestyle services into various communities. They emphasized the importance of concentrating on two to three target geographic areas:

1. Conducting surveys to comprehend the cultural needs of each community and determining the optimal times for service delivery.
2. Ensuring safety in parks to encourage community engagement and physical activity.
3. Leveraging existing infrastructure, such as schools and churches, forging partnerships with community groups, involving city authorities and using existing community centers.
4. Prioritizing specific populations based on criteria, such as those at risk of homelessness or various clinical risk factors and facilitating screening and referral processes.
5. Engaging communities through partnerships with summer meal programs and other initiatives to promote awareness and participation in healthy lifestyle activities.
6. Funding and providing alternative services for communities lacking resources, such as gym sharing, mobile food services, and health promotion.
7. Expanding mental health support.

During the discussions, community members stressed the need to identify the entity responsible for implementing the ideas for healthy lifestyles. They suggested the necessity to establish a clear leadership structure and emphasized the importance of collaboration among various organizations involved in this endeavor. Additionally, they highlighted the significance of involving city authorities and utilizing existing community centers, such as those present in many areas of Douglas County, to facilitate and support these initiatives.

Furthermore, community members pointed out the need to make public spaces, especially parks, safer and more inviting for community members to engage in healthy activities. They emphasized the importance of creating opportunities for individuals to feel secure and motivated to participate in such spaces. Moreover, they emphasized the necessity of understanding each community's specific desires regarding physical activity and nutrition, emphasizing the importance of tailoring services to meet the unique needs of different communities.

Healthy Lifestyles Goals, Objectives, and Strategies

Healthy Lifestyles GOAL 1
Create a culture of health in Douglas County.

Objective 1
Create conditions for Douglas County residents to achieve good health and wellness.

Strategies	Priority Areas
1. Support culturally and linguistically responsive lifestyle interventions such as supervised exercise, diet and education counseling, physical activity education and counseling, or diet activity (e.g., meal plan, food diary, individualized support).	
2. Build or improve on areas encouraging physical activity, such as fitness centers, walking trails, while also increasing access to already existing amenities (e.g., improving safety and accessibility in existing parks and other outdoor recreational areas, create safe and inclusive programs through which residents of all ages can engage in physical activity).	
3. Educate and provide resources to youth and families about the dangers, consequences, and the underlying conditions of using tobacco, including e-cigarette utilizing evidence- based, evidence-informed, and innovative practices through engagement activities, presentations, school campus events, and leadership-building projects.*	
4. Support worksite programs, including informational, educational, behavioral, and social strategies, along with policy and environmental approaches, to improve health-related behaviors and health outcomes.	

*Shared strategy with behavioral health and addictions

Healthy Lifestyles Goal 1 Key Results

- Decrease the percentage of Douglas County adults who report their health status is poor/fair. *(Source: Behavioral Risk Factor Surveillance System (BRFSS) or CSTA Pulse Survey)*
- Decrease the percentage of Douglas County 6th, 8th, and 11th grade students who report their health status is poor/fair. *(Source: Oregon Department of Education, Student Health Survey)*
- Decrease the percentage of Douglas County adults who use cigarettes *(Source: BRFSS)*
- Decrease the percentage of students past 30-day electronic cigarette use *(Source: Oregon Department of Education, Student Health Survey)*
- Decrease cigarette smoking prevalence *(Source: CCO Incentive Measure)*

Improve diabetes management for Hispanic Individuals (*Source: CCO Incentive Measure: Diabetes HbA1c Poor Control by race/ethnicity)*

Healthy Lifestyles GOAL 2
Ensure all Douglas County residents have access to healthy, nutritious, and affordable food that meets their dietary and cultural needs.

Objective 1
Decrease the percent of residents experiencing food insecurity.

Strategies	Priority Areas
1. Develop a white paper describing the factors limiting the number of grocery stores in Douglas County and explain state and local zoning regulations that impact the types of grocery store options.	
2. Co-locate mobile pantry and other services in areas identified as a food desert or with low access to food.	
3. Support and expand multicomponent interventions in early care, education, school, afterschool, and/or community settings, with parent nutrition education supports, focused on increasing fruit and vegetable consumption in children and families.	
4. Implement healthy and culturally sensitive home-delivered and congregate meal services for older adults tailored to independence levels and group setting.	

Healthy Lifestyles Goal 2 Key Results

- Decrease in the percent of Douglas County residents who experience food insecurity *(Data Source: Feeding America, Map the meal gap)*

Healthy Lifestyles Data Indicators

Indicator	Oregon	Douglas County	Trend	Disparities
Percent Douglas County adults who report their health status is poor/fair (BRFSS)	15.9%	17.8%	Improving 2010-2013 to 2018-2021	
Percent Douglas County 6th, 8th, and 11th grade students who report their health status is poor/fair (Oregon Student Health Survey)	6th (15.3%) 8th (21.4%) 11th (28.2%)	6th (14.6%) 8th (20.3%) 11th (25.0%)	Worsening 2020 to 2022	
Percent experiencing food insecurity (Map the Meal Gap)		12.0%	Improving 2017 to 2021	Youth (0-18 years) (16.8%)
Percent of Douglas County adults who use cigarettes (BRFSS)	14.5%	20.4%	No change	Males (23.9%)
Percent of students past 30-day electronic cigarette use (Oregon Student Health Survey)	6th (1.4%) 8th (4.7%) 11th (10.8%)	6th (3.0%) 8th (8.6%) 11th (19.9%)	Improving 2020 to 2022	Grade 11 (19.9%)

Behavioral Health and Addictions

Behavioral health is a broad term that encompasses mental health, substance use disorders, and overall well-being. It focuses on the interaction between our thoughts, emotions, behaviors, and physical health. In Douglas County, access to behavioral health services across the lifespan is critical for a healthy community. The mental health of community members collectively influences overall community health.

Communities with a higher prevalence of mental health issues, such as depression or anxiety, may experience higher healthcare costs, lower workforce productivity, and higher crime rates. On the other hand, communities with mentally healthy individuals tend to be more resilient, productive, and supportive of one another[6]. The use of alcohol, tobacco, and other drugs (ATOD) is associated with a wide range of health issues, including addiction, chronic diseases, mental health problems, and injuries. The following table lists the 2023 identified health priorities for mental health and substance use.

[6] Reducing the Economic Burden of Unmet Mental Health Needs, White House Issue Brief, May 31, 2022

Health Priorities	Primary Concerns Identified by the CHA
Mental Health	• In 2020, residents of Douglas County reported 4.9 mentally unhealthy days (i.e., days in the previous 30 days that a respondent's mental health was not good), compared with 3.9 mentally unhealthy days for people elsewhere in Oregon. • In Douglas County, the prevalence of students saying they felt sad or hopeless almost every day for two weeks or more in a row in 2022 and that they stopped doing some usual activities increased to nearly half of the 11th grade students (42.7%), compared with 20.8 percent of the grade six students. • In 2022, approximately one in five 11th graders (20.7%) self-reported that they had seriously considered attempting suicide in the past 12 months. Slightly more than one in 10 grade six (12.5%) and grade eight students (12.2%) self-reported that they have seriously considered attempting suicide in the past 12 months. • The suicide rate in Douglas County was also significantly higher compared to Oregon in both 2019 and 2021. In 2021, the suicide rate in Douglas County was 31.5 deaths per 100,00 people (38 deaths) compared to a rate of 19.6 deaths per 100,000 people in Oregon.
Substance Use	• An estimated one in five (18.2%) of Douglas County residents ages 12 and older (17,691) have a substance use disorder. Statewide, this rate was similar at 18.2 percent. • Drug-induced death rates increased in Douglas County between 2016 and 2021, from 16.7 deaths to 38.4 deaths per 100,000 people. Douglas County and Oregon have similar substance use-related death rates in 2021; however, in Oregon, alcohol and drug-induced deaths increased significantly in 2016 to 2021. • Survey respondents identified addiction to stimulants, opioids, and alcohol as the top three contributors to health deterioration in the community,

Themes from Community CHP Action Planning Events

During the CHP Action Planning events, several central themes for behavioral health emerged from the discussions, shedding light on the diverse needs and challenges faced by the community and the essential steps required to address them.

One significant topic of discussion was the issue of stigma and biases experienced by individuals seeking care. Community members stressed the need for community and provider education to address these issues openly and candidly. It was recognized that a proactive approach is required to tackle stigma and biases, involving both the community and healthcare providers.

Another key point raised by community members was the perceived need for leadership from city authorities in actively participating and engaging in community efforts. There was a strong emphasis on the necessity for city leaders to take a more active role and engage with community initiatives. Community members raised important questions about how to involve city leaders in community efforts, including those related to the CHP.

The discussions also highlighted the need to focus on the often-overlooked population of adults aged 55 and older, described as an "invisible population."

Community members expressed the desire for enhanced collaboration, improved access to services for communities outside specific areas, and the adoption of universal approaches to address behavioral health issues. There was a recognized need for increased efforts to foster interpersonal connections, which play a significant role in behavioral health outcomes.

Community members highlighted the importance of addressing underlying prevention needs. They advocated for improved collaboration between sectors, all of which had a role in addressing behavioral health issues. They also stressed the need for expanding low-barrier behavioral health programs to improve access to care and the necessity of funding and support for specific groups of school-aged children with SDOH needs and behavioral issues who may not have formal diagnoses and/or access to adequate resources.

Community members further emphasized the need for higher levels of care within the community, effective coordination of service delivery among various funding streams, and the importance of distinguishing between clinical intervention and addressing underlying conditions in individuals' lives. The community members stressed the need to tailor conversations effectively and ensure that the right services are provided at the right time.

Overall, the discussions at the CHP Action Planning events displayed the collective commitment of community members to address critical healthcare and social challenges while emphasizing the importance of collaboration, proactive leadership, and tailored, community-driven approaches to meet the diverse needs of the community effectively.

Behavioral Health and Addictions Goals, Objectives, and Strategies

Behavioral Health & Addictions GOAL 1

Provide more accessible and culturally aware behavioral health services in diverse locations.

Objective 1	Objective 2
Improve access to low-barrier community mental health and substance use services.	Promote visibility and awareness of local mental health and substance use treatment services.

Strategies	Priority Areas
1. Summarize recent behavioral health system assessments conducted in Douglas County and evaluate the need for an updated evaluation.	
2. Increase availability of low-barrier treatment programs designed to improve access to mental health and substance use services (e.g., co-location of providers in community-based organizations). (CBHP Strategy)	
3. Promote behavioral health workforce development to increase the number of community-based mental health and substance use disorder treatment providers, with a particular focus on increasing representation from underrepresented communities (e.g., Foster nontraditional workforce development through certification and training programs, such as CHWs and peer support specialists). (CBHP Strategy)	
4. Establish shared data sets to track behavioral health professionals/paraprofessionals and to identify most underserved populations and locations in Douglas County.	
5. Establish an online behavioral health directory of providers, programs, and services. (CBHP Strategy)	

Behavioral Health and Addictions Goal 1 Key Results

- Increase the number of community-based substance use treatment providers offering harm reduction services (*Source: Behavioral Health Provider, Program, and Services Directory*)
- Increase access to peer-delivered services by increasing the number of individuals certified as behavioral health paraprofessionals (including but not limited to community health workers, peer support specialists, or wellness coaches). (*Source: MHACBO Registry*)
- Improve provider engagement in locally based workforce development training focused on motivational interviewing, person-centered and trauma-informed care, and cultural competency (*Source: Quarterly CHP Reporting)*
- Increase the number of pre-licensed behavioral health providers who become licensed in the 3-year period (including but not limited to, social workers, marriage and family therapists, professional counselors, psychology interns and fellows, and psychiatry residents and fellows). (*Source: Health Care Workforce Reporting Program*)
- Establish a baseline estimate of the BH workforce by service area and key demographic characteristics (race/ethnicity, age, LGBTQIA, language spoken) (*Source: Health Care Workforce Reporting Program*)

Behavioral Health & Addictions GOAL 2
Reduce stigma and increase community awareness that mental health and substance use issues are common and widely experienced.

Objective 1	Objective 2
Strengthen individual, community, and systemic resilience through a coordinated behavioral health system of prevention, treatment, and recovery- oriented services.	Leverage Douglas County cross-sector partnerships to educate residents about the dangers of drug misuse and the availability of treatment and recovery resources.

Strategies	Priority Areas
1. Support the creation of a culturally and linguistically responsive education campaign in Douglas County to reduce stigma around seeking treatment for mental illness and substance use disorders by educating residents to view these conditions as chronic diseases. (SHP Strategy)	
2. Improve access and availability of low barrier treatment services and promote harm reduction initiatives. (CBHP Strategy)	
3. Increase the availability of culturally and developmentally specific treatment services. (CBHP Strategy)	
4. Educate youth and families about the dangers and consequences of using alcohol, cannabis, and e-cigarette utilizing evidence- based, evidence-informed, and innovative practices through engagement activities, presentations, school campus events, and leadership-building projects.*	
5. Promote community education on harm reduction strategies for substance use disorders and improve awareness for the benefits associated with their implementation.	

*Shared strategy with healthy lifestyles

Behavioral Health and Addictions Goal 2 Key Results

- Increase the number of young children birth to five receiving social-emotional services (*Source: CCO Incentive Metric Set*)
- Increase depression screening rate among individuals twelve (12) and older (ages 12 and older) *(Source: CCO Incentive Measure)*
- Improve follow-up planning for individuals identified through depression screenings *(Source: CCO Incentive Measure)*
- Increase the percentage of adults initiating follow-up treatment for substance use within 14 days of a new substance use disorder diagnosis *(Source: CCO Incentive Measure)*

- Increase the percentage of adults continuing to engage in substance use disorder treatment in the 34 days after their initial appointment *(Source: CCO Incentive Measure)*
- Increase screening and brief intervention for drugs and alcohol (SBIRT) *(Source: CCO Incentive Measure)*
- Decrease average fatal overdose rate in Douglas County *(Source: Oregon Center for Health Statistics – Oregon Overdose Prevention Dashboard)*
- Increase the number of individuals receiving Naloxone in Douglas County *(Source: Oregon Prescription Drug Monitoring Program – Data Dashboard)*

Behavioral Health and Addictions Data Indicators

Indicator	Oregon	Douglas County	Trend	Disparities
Average number of mental unhealthy days among adults (BRFSS via County Health Rankings, 2020)	4.6	4.8	n/a	n/a
Number of mental health providers per 100,000 residents, such as psychiatrists, psychologists, and specialists in addiction medicine, counseling, therapy, and behavioral health. Includes advanced practice nurses and nurse practitioners (National Provider Identifier Files, 2021)	722.8 per 100,000	375.7 per 100,000	n/a	n/a
Percent Douglas County 6th, 8th, and 11th grade students reported ever feeling so sad or hopeless for almost every day for two or more consecutive weeks in the past year that they stopped doing some usual activities (Oregon Student Health Survey, 2022)	6th (23.7%) 8th (29.8%) 11th (38.4%)	6th (20.8%) 8th (30.5%) 11th (42.7%)	Improving 2020 to 2022	n/a

How Will We Monitor Our Progress?

The health priority area goals and objectives are long-range, and data collected to determine the impact on these areas may not readily be available. Often, CHPs must actively develop ongoing data sources for measures that support the evaluation of strategies, activities, and timelines that are linked to the goals and objectives. While there may be times when the original health priorities, goals, and objectives need to be revised, the primary focus of monitoring and revision will be on activities that make a substantial contribution to implementing a particular strategy and achieving a particular goal.

A key component of monitoring and updating the CHP is keeping track of the advancements made possible by the efforts of agencies, community organizations, and other partners in addressing the objectives listed in the CHP. While UHA will be the coordinator and convener of the work, in part through funding distributed CHP program payments to the UHA Community Advisory Council (CAC), the CHP is, most fundamentally, a community health improvement plan and not a UHA plan. The community partners involved in implementing the strategies in the CHP will be active in monitoring the work's progress and recommending revisions. It is essential to have a clear plan in place for monitoring and revising the CHP before the plan is implemented and it is important to communicate the roles and responsibilities of community partners at the onset to make engagement in the process more meaningful and successful.

Collecting data for key results will require new processes to both collect new data and monitor existing population health data. These processes include the following:

- **UHA Community Benefit Reporting:** In partnership with the CAC, UHA will implement a community benefit reporting system designed to track, manage, and evaluate relevant key results data used to monitor CHP implementation and outcomes.
- **CSTA Pulse Survey:** UHA will regularly administer an abbreviate version of the CHA's CSTA survey to its members and the public to monitor progress on key results
- **CCO Incentive and Quality Measures Reporting**: UHA will implement CCO incentive and quality measures relevant to the CHP as both a CHP accountability strategy and as tangible opportunity to link the CHP to its own strategy plan goals and initiatives.
- **Population Health Data Reporting:** UHA will design and implement a system through which to monitor population health data (e.g., BRFSS, Oregon Student Health Survey, American Community Survey etc.) as is relevant to the CHP.

An analysis of the impact of the health system's initiatives to address the primary health concerns identified in the 2023 CHA will be reported in the next scheduled CHA.

Conclusion: Advancing Health in Douglas County

This CHP was developed with involvement from the community and represents a community-wide plan for enhancing and improving the health of communities in the county. Community involvement is important in the implementation of this plan. There are many ways to engage community-based organizations, governmental agencies, foundations, and residents in helping to realize the goals and objectives outlined in this plan as the UHA undertakes implementation.

We support the involvement of all organizations and public officials that wish to contribute to the CHP. If you want to find out how you can support the CHP, please follow this LINK to contact us.