

# 2012

## Linn County Community Health Improvement Plan



Linn County Mobilizing Action  
through Planning and Partnerships  
Committee

8/08/2012

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## **Executive Summary**

The Linn County Community Health Improvement Plan (CHIP) represents a year of work in which the County and its partners utilized the Mobilizing Action through Planning and Partnerships (MAPP) framework to assess the health status of the county and build a plan to improve priority areas.

Four key topic areas were prioritized by the MAPP committee based on collected health statistics, survey data, and key informant interviews. That collected information comprised the Linn County Community Health Assessment which was the guiding document in the creation of this plan. The Linn County Community Health Assessment can be viewed [here](#) or found on the Linn County website at [www.co.linn.or.us](http://www.co.linn.or.us).

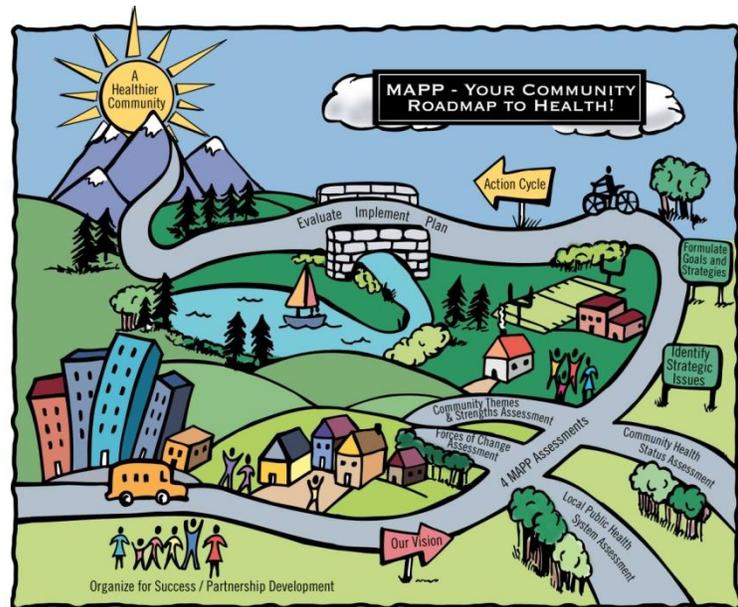
The topic areas comprising this document are: Access to Health Care, Tobacco Use, Chronic Diseases, and Substance Abuse. Under each topic is a list of goals and general strategies to help achieve those goals. It is important to note that the Community Health Improvement Plan is a living document that may be updated or revised as new resources become available, new technologies are introduced, new research happens, or events shift the community's priorities. This document has shared ownership across all partners of Linn County Public Health and has shared responsibility in achieving goals. Funding for completion of this Community Health Improvement Plan and Linn County's Community Health Assessment was provided by the Oregon Public Health Division's Performance Management Program accreditation readiness grant.

## The MAPP process

Mobilizing Action through Planning and Partnerships is a community-wide strategic planning process for improving public health. It is a method to help communities prioritize public health issues and to identify resources for addressing them.

In August of 2011, Linn County Public Health formed a coalition of community members and partners to begin the MAPP process. Over the

next 10 months, Linn County Public Health and the MAPP committee set out to assess the health of the community, identify strategic issues, and formulate goals and strategies to address key issues.



## The Assessments

Assessing the health status of the entire County was a challenging task. Linn County has a population of 116,672 as of the 2010 census, with a diverse mix of both urban and rural areas (see Table 1).

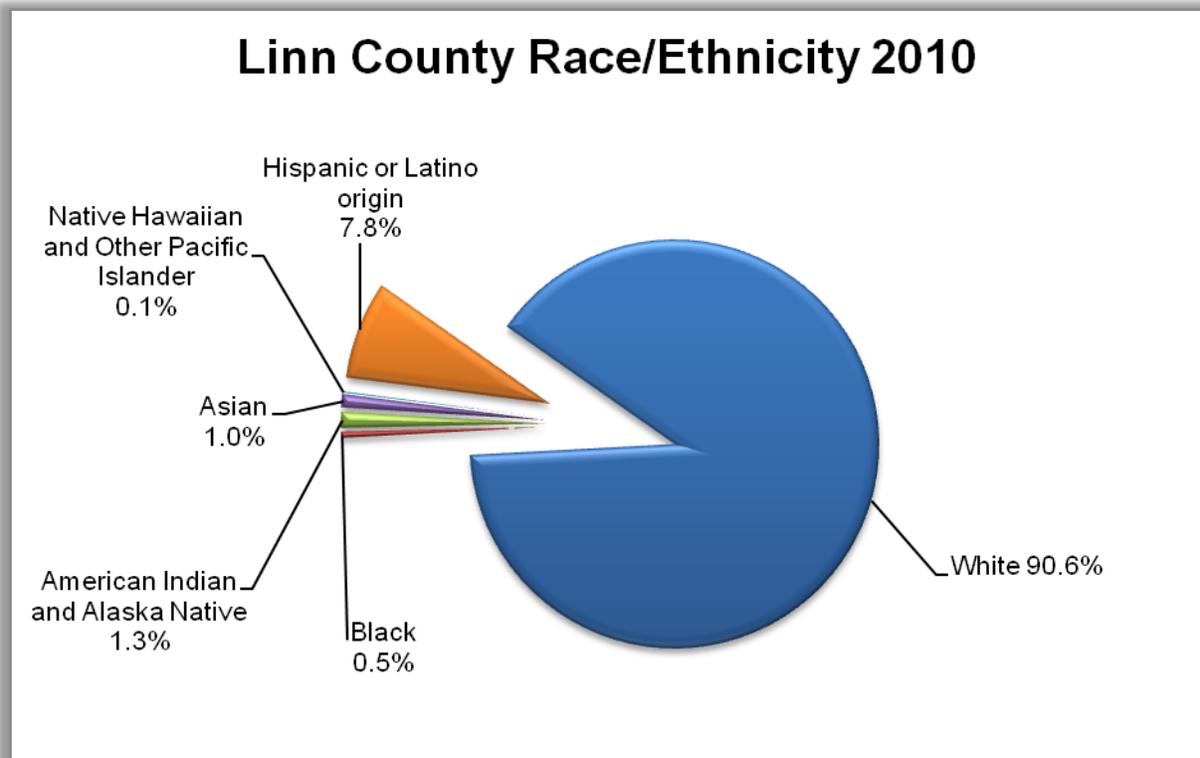
Table 1: Linn County demographics from the 2010 census

2010	Linn County	Oregon
Population	116,672	3,831,074
Population change, 2000 to 2010	+13.2%	+12.0%
Land Area	2,292 square miles	95,997 square miles
Population density	51 people per square mile	40 people per square mile
*Percent of population living in a rural location	37%	21%

Source: US Census Bureau-State and County QuickFacts: Linn County, Oregon, 2010

The MAPP committee put special attention into assessing vulnerable populations. Linn County is predominately White; however, it is home to an increasing population of Hispanics/Latinos (see Figure 1). The proportion of Hispanic/Latinos in the community has increased 3.4 percent since 2000, increasing from approximately 4,664 in 2000 to approximately 9,330 individuals today.

Figure 1: Linn county Race/Ethnicity as of the 2010 census



The Community Health Assessment was completed using the MAPP process framework. The framework calls for assessing the health of the community across several topic areas. Those assessments include the following:

**Community Themes and Strengths** was the first assessment topic area, and the area of the majority of focus and resources. Community Themes and Strengths is a way to identify what health issues are important to the members of the community, to gain insight into the quality of life in the community and to find what assets the community has to help improve health. The MAPP committee chose to create a survey to assess the quality of life of the community and to conduct Key Informant interviews to gather qualitative information on the health status, quality of life, and community strengths and weaknesses throughout the County.

*Quality of Life Survey* was developed by the MAPP committee in order to find out how the community felt about where they lived as it pertained to their health. The survey

consisted of seven single-sided pages and contained 40 questions, including detailed demographic questions. After eliminating incomplete surveys, Linn County had data from 836 respondents and representation from almost all zip codes. Demographics of the survey closely matched census demographics for Linn County, with the exception of more females and low income individuals answering. The Quality of Life Surveys were key to informing the MAPP committee about perceived health threats in the community, and directly lead to the inclusion of substance abuse as a topic area. The Quality of Life Survey also informed the MAPP committee about issues with access to care and health inequalities that exist in the County. For instance, Hispanics face much greater challenges with access to health care than non-Hispanics. Transportation, insurance, and language barriers were also identified as issues that increase barriers to care.

*Key Informant Interviews* were conducted on thirty individuals throughout the County for firsthand, personal accounts of health issues and concerns in County communities. Interviewees were selected by the MAPP committee based on their connection to the community, their education, job, and the level of influence they had in their community.

Key Informants in general were described as highly informed individuals who could provide our assessment efforts with quality information.

The Key Informant interviews allowed the MAPP committee to identify numerous areas of concern, both in specific communities and countywide. Figure 2 is a countywide look at the top reported health concerns across all 30 interviews. Key Informants were allowed to cite multiple health concerns but it is important to note that the majority of Key Informants cited social determinants (factors such as education, income, living conditions, and peer group) as important health concerns. Key Informant interviews were a terrific resource in identifying the priority areas of substance abuse and access to care in the Community Health Improvement Plan.

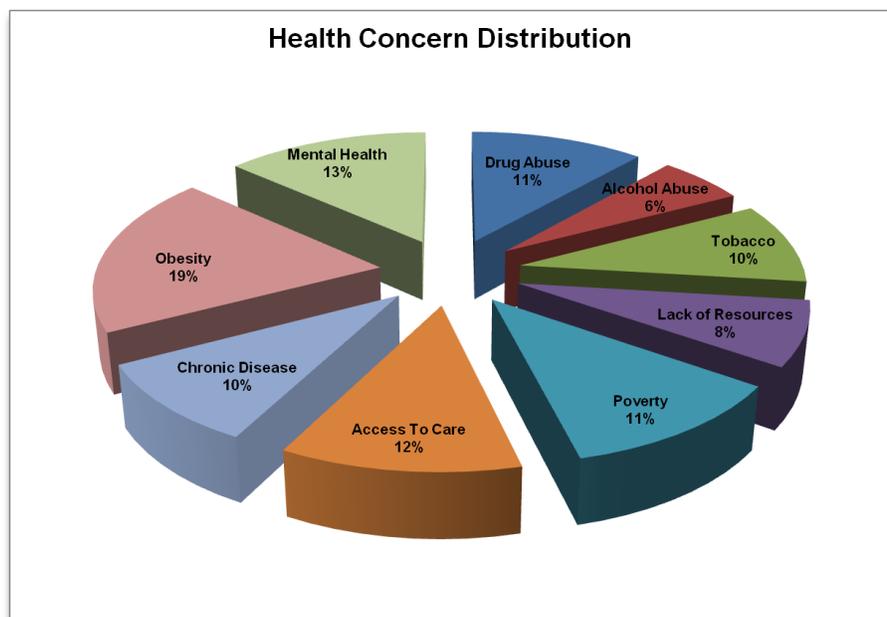


Figure 2: Health Concerns as reported by Key Informant interviews

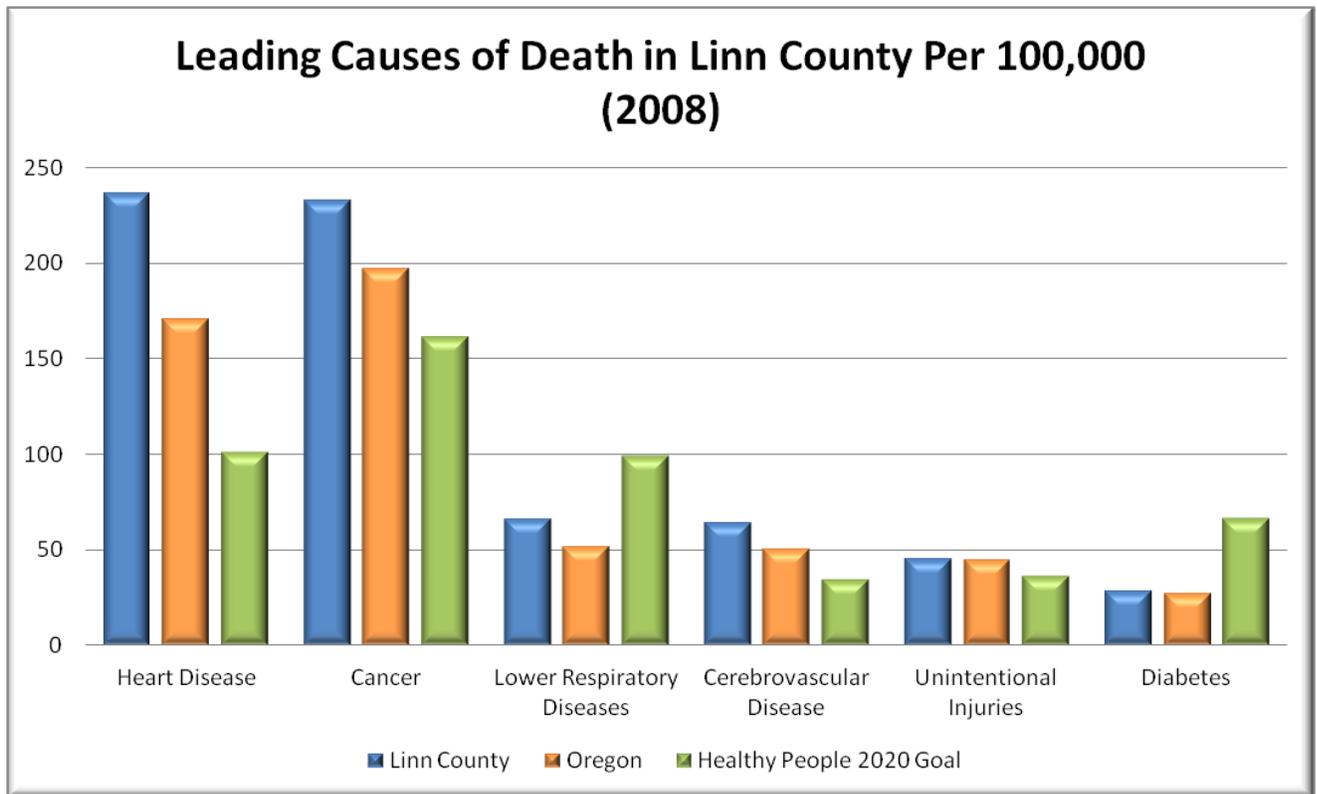


Figure 3: Mortality rates as reported in the Linn County Community Health Assessment

**The Community Health Status Report** was the second assessment area. Data was reviewed on 11 key subjects: Demographics, Socioeconomic Characteristics, Health Resource Availability, Quality of Life, Behavioral Risk Factors, Environmental Health Indicators, Mental and Social Health, Maternal Health, Mortality and Morbidity, Communicable Diseases, and Preventable Events. Data was collected using a variety of databases and surveillance systems, most notably the Centers for Disease Control and Prevention’s (CDC) *National Health and Nutrition Examination Survey (NHANES)*, the CDC’s *Behavioral Risk Factor Surveillance System (BRFSS)*, Linn County’s mandatory reportable disease information, Children First for Oregon, and Oregon Health Authority’s various epidemiological databases. Shown in Figure 3 are the leading causes of death for Linn County and is an example of the information collected for the Community Health Status Report. Please review the Community Health Assessment for complete statistics reported in the Community Health Status Report.

**The Local Public Health System Assessment** looked at how the entire public health system worked together to ensure the ten essential services of public health. The **Ten Essential Public Health Services** (see table 2) provide the fundamental framework for the Local Public Health System Assessment by describing the public health activities that should be undertaken in all communities.

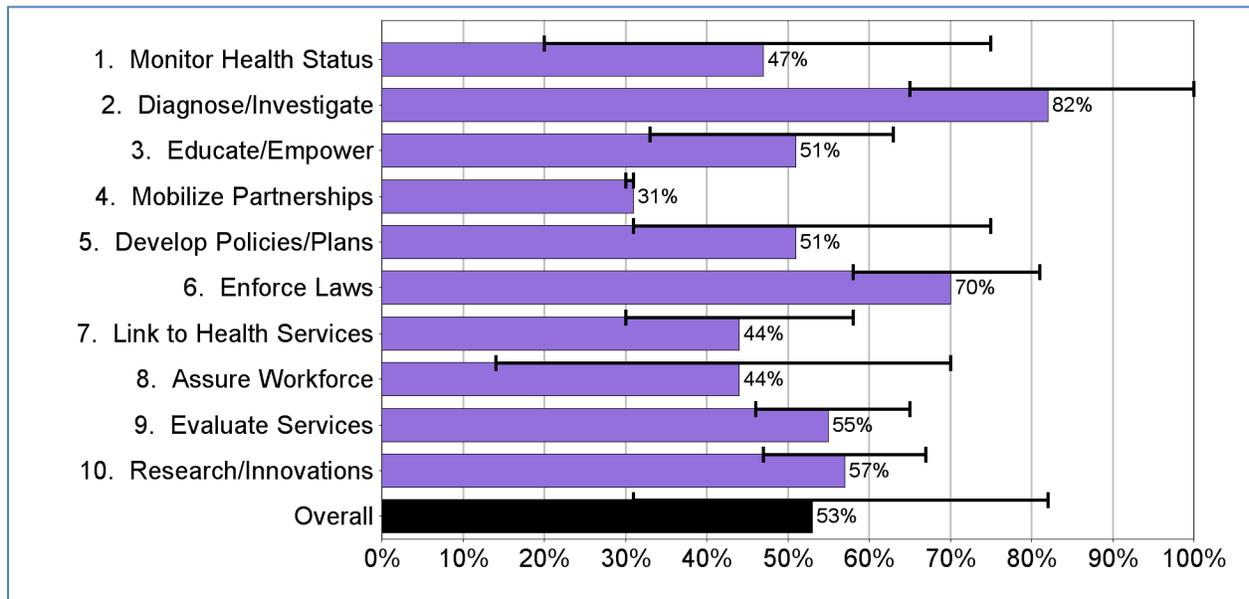
The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. This steering committee included representatives from US Public Health Service agencies and other major public health organizations. The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

Table 2: the Ten Essential Services of Public Health

<b>The Ten Essential Services of Public Health</b>
<b>Monitor</b> health status to identify and solve community health problems.
<b>Diagnose</b> and investigate health problems and health hazards in the community.
<b>Inform</b> , educate, and empower people about health issues.
<b>Mobilize</b> community partnerships and action to identify and solve health problems.
<b>Develop</b> policies and plans that support individual and community health efforts.
<b>Enforce</b> laws and regulations that protect health and ensure safety.
<b>Link</b> people to needed personal health services and assure the provision of health care.
<b>Assure</b> competent public and personal health care workforce.
<b>Evaluate</b> effectiveness, accessibility, and quality of personal and population-based health services.
<b>Research</b> for new insights and innovative solutions to health problems.

The assessment was completed using the National Public Health Performance Standards Program (NPHPSP) Local Public Health System Performance Assessment Instrument version 2.0. The MAPP committee, as well as other agencies, partners, and community members, met six times over the course of two months to complete the instrument. Questions were voted on using a remote voting system and a consensus was met upon how to rate each item. At the completion of the assessment instrument, the answers were uploaded onto the NPHPSP’s website and a report was generated. Results of the Local Public Health System Assessment (see Figure 4) were used to inform the MAPP committee about issues faced with building strong partnerships and mobilizing the community to act on health concerns. The need to mobilize the community to act on health concerns and collaborate across partners and agencies is an overarching theme reflected across the Community Health Improvement Plan. All goals and strategies will require collaboration and partnership to achieve. This report was included in the Community Health Assessment.

Figure 4: Results of Local Public Health System Assessment



## Identifying Key Issues

After reviewing data for the Community Health Assessment, the MAPP committee identified key issues. Several reoccurring themes guided the creation of the Community Health Improvement Plan: high adolescent and adult smoking rates, high adult and child obesity rates, high chronic disease rates, inability to access healthcare, high levels of substance abuse, inadequate policy and environmental factors to promote health, inadequate partnerships and communication networks, increasing minority populations, recent economic conditions, and reductions in budgets and resources.

Hundreds of individual statistics and data points were arranged into commonly themed topics. Core issues identified were: Substance Abuse, Tobacco Use, Access to Health Care, Access to Mental Health Care, Risk Behaviors, Chronic Diseases, Access to Healthy Foods, Child and Maternal Health, Resource Availability, Mobilizing Partnerships, Nutrition, Health Communication, and Safe and Affordable Housing. A community meeting was held in which the MAPP committee, community members, and members of the Linn Benton Health Equity Alliance were able to discuss the topics and data that supported those topics, and vote on their top three issues. Chart paper was hung up around the meeting room, each containing the name of the above-mentioned topic areas. Members in attendance were given three sticker dots with which they could use to vote for the top three topics they felt most deserved to be included in the Community Health Improvement Plan.

The voting and discussion resulted in the selection of four topic areas for this CHIP—Chronic Diseases, Access to Care, Tobacco Use, and Substance Abuse—as well as their accompanying goals and strategies. It was decided to combine Access to Health Care and Access to Mental Health into one topic. Additionally, Mobilizing Partnerships was tied with Substance Abuse for the fourth topic. It was decided that Mobilizing Partnerships is a topic that should be reflected in all areas, and achievement of goals in this plan will be a result of increased partnership involvement.

## **Developing Goals and Strategies**

Linn County Public Health and the MAPP committee met to conduct a brief brainstorming session called “Forces of Change.” The idea was to come up with a list of potential barriers to change we face in the community, as well as potential allies and strengths. The purpose of this exercise was to help inform the committee and community partners of what strengths Linn County had, and what barriers must be overcome in order to produce healthy changes in the community. The Linn Benton Health Equity Alliance did a similar exercise during a community conversation session they hosted at the Albany Public Library. That information was shared, and several alliance members have continued to support goal and strategy generation. The most popular barriers identified were: lack of funding, lack of resources or employee time, and political forces. Top cited strengths were strong community programs, willingness of the community, and a strong faith and charity network.

Goal formation began by looking to Healthy People 2020 and its established goals. Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. The measures and goals are based on national averages. This was done for two major reasons. First, Healthy People 2020 already has a good set of goals established that closely align with the areas chosen by the MAPP committee; there was no need to spend time establishing new metrics. Second, there has historically been grant funding attached to trying to achieve a Healthy People 2020 goal in your community. It was viewed as a wise decision to align goals to a potential funding source.

After goals were decided upon, strategies were developed to meet those goals. The Forces of Change assessment was instrumental in deciding the direction to take the creation of strategies. As stated above, resources are a significant barrier. Many strategies involve seeking funding to implement an evidence-based program or partnering with multiple agencies to share cost and employee time. Attempts were made to align strategies towards partners’ existing goals and functions. For example, tobacco use was an identified priority topic for the Community Health Improvement Plan. It was agreed upon to build from the existing objectives the Linn County Tobacco

Prevention Coordinator had developed. The idea was to create strategies that promoted partnerships and supported the lead agency’s existing work plans.

### **Implementation and Ownership**

Community Health Improvement Plans provide a direction for the entire public health system to improve health in priority areas. It is the responsibility of all partners involved in the creation of this document to see that the strategies listed are acted upon and progress toward goals is being made. It should also be noted that CHIPs are living documents that are amended as needed and may adapt to necessary changes.

Each topic has a lead agency identified that has key ownership over the strategies and goals. These groups have the responsibility to organize and work toward achieving the goals in that specific area. In terms of overall accountability and leadership, Linn County Public Health places responsibility on itself and its convened partners to update the CHIP when necessary and evaluate progress toward goals. The Linn County Public Health Program Manager has responsibility to maintain and update the CHIP. Linn County Public Health’s Program Manager will facilitate a meeting of all Linn County partners four times a year for document review and revision. The MAPP committee will meet once a quarter with the Linn County Health Advisory Council to give status updates and make necessary revisions.

The schedule of updates and revisions is as follows:

Quarter 1	July – September	Progress Checks
Quarter 2	October – December	CHIP Update Meeting
Quarter 3	January – March	Progress Checks
Quarter 4	April – June	CHIP Revisions Meeting

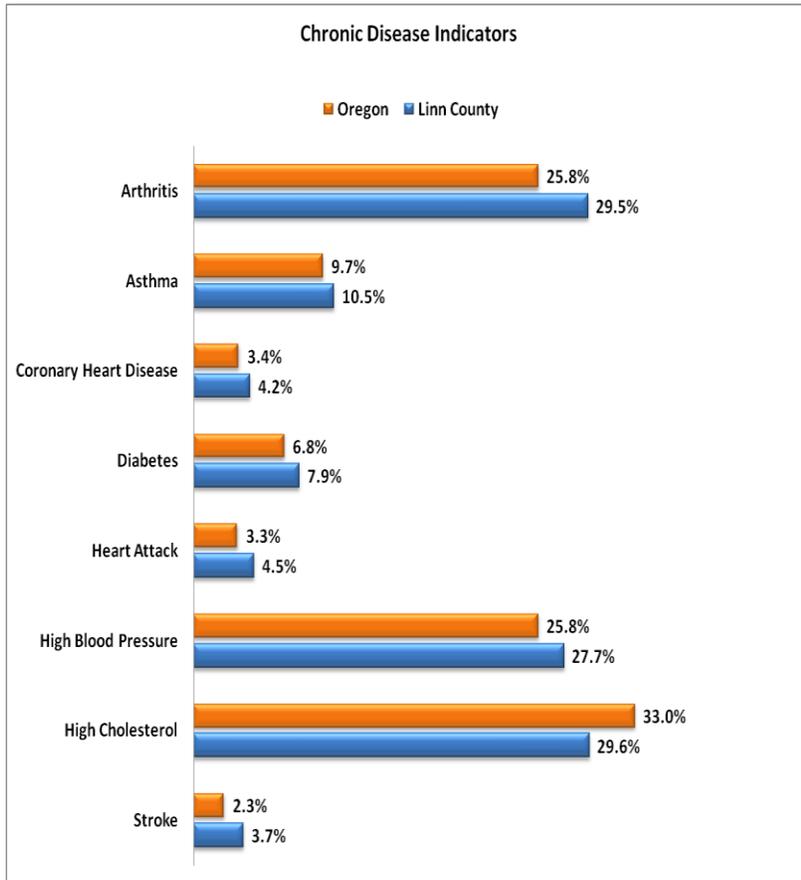


Figure 5: Chronic disease prevalence in Linn County and Oregon

## Chronic Diseases

Chronic Disease (Figure 5) was considered a priority area because addressing the burden of chronic diseases means addressing the lifestyle choices and risk behaviors that lead to them. Smoking, diet, and exercise are the primary risk factors that lead to chronic diseases. As the Community Health Assessment showed (Figure 6), Linn County has high rates of obesity and overweight populations among children and adults, as well as low levels of exercise and low levels of fruit and vegetable consumption. In earlier

work, Linn County had used the CDC’s Community Health Assessment and Group Evaluation (CHANGE) tool to assess the environmental and policy factors that influence nutrition, exercise, and tobacco use in worksites, schools, and community organizations. Generally speaking, Linn County scored low in having strong policy and environmental factors to manage chronic diseases.

Obesity is a primary risk factor for many chronic diseases. Diabetes, cardiovascular disease, many cancers, and arthritis all have increased odds associated with obesity. Obesity is not a problem in just Linn County or Oregon, but is quickly escalating to a nationwide epidemic. Population level reductions in obesity would be reflected in chronic disease rates. Eliminating obesity and smoking as well as improving exercise and diet would have a remarkable impact on the rate of chronic disease in Linn County. By focusing on childhood obesity through education in lifestyle choices, the MAPP committee hopes to create fundamental changes in behavior that will last a lifetime and lead to future reductions in obesity rates.

Eliminating risk factors and promoting a healthy lifestyle is the primary way to prevent chronic disease. That, however, does not help those that are currently living with chronic conditions. Linn County is fortunate to have Samaritan Health Services as an organization that

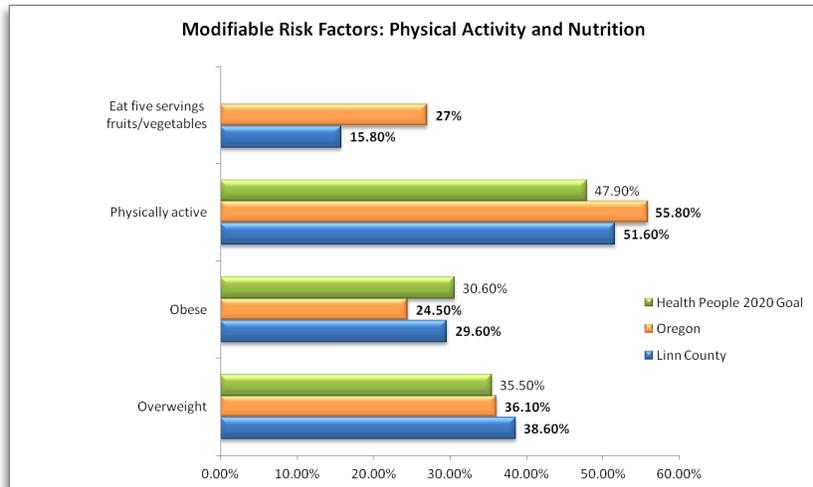


Figure 6: Selected risk factors for chronic disease

offers many options for those living with chronic conditions. Samaritan helps support Living Well with Chronic Conditions workshops in the area, along with other educational programs and events. Working to expand and promote these events is an important element in the strategy to reduce chronic disease.

## Chronic Disease

Strategic Issue Statement:

*How do we address the underlying causes of chronic disease, improve prevention efforts, and thereby reduce the burden of chronic disease for everybody in Linn County?*

### Goal 1: Reduce the rate of childhood obesity.

Objective:

- A. Reduce the rate of childhood obesity by 5 percent by August 2016.

Strategies:

- A. Implement an action plan to promote wellness councils in local schools. Through wellness councils, promote food and nutrition policy changes, physical activity, and education. Schools will be engaged to become more active with their wellness councils and take an active role in adopting policy and promoting healthy activities. Promote school based health initiatives to address chronic disease, including increased physical activity and nutrition. The wellness councils will address the eight dimensions of wellness.
  - Examples: Samaritan Health Services Coordinated Approach to Child Health (CATCH) and Peaceful Playgrounds

- **Lead: All Linn County Partners**
- B. Work to establish lines of communication between parents and chronic disease representatives. Create educational health materials for distribution via packets, websites, and newsletters etc. that inform parent about mental, physical and environmental health issues.
  - C. Incorporate healthy behavior education in breastfeeding, daycare, providers, and WIC programs to increase routine use of healthy behaviors at a young age, as well as the education of guardians.

**Goal 2: Increase usage and awareness of tobacco cessation options.**

Strategies:

- A. Work with Samaritan Health Services to establish policy for clinicians to display tobacco cessation information, as well as information on health navigation and coaching, in offices. Encourage the hiring of staff behaviorists for immediate one-on-one counseling if a patient indicates a desire to quit tobacco. Look towards the East Linn Health Center as a model for behaviorist usage.
  - **Lead: Samaritan Health Services**
- B. Work with area clinicians to offer training in evidence-based tobacco cessation.
  - **Lead: Linn County Tobacco Prevention Coordinator**
- C. Engage with the Coast to Cascade Community Wellness Network to discuss health communication strategies and policies.
  - **Lead: All Linn County Partners**
- D. Equip clinicians with behavioral change strategies to give patients preliminary education about cessation pathways.

**Goal 3: Improve appropriate preventative screening rates for everyone.**

Screening	Current Rate	Goal
<b>Cholesterol test</b>	<b>68.1%</b>	<b>74.9%</b>
<b>Mammogram</b>	<b>77.4%</b>	<b>85.1%</b>
<b>PAP smear</b>	<b>83.3%</b>	<b>91.6%</b>
<b>Colonoscopy</b>	<b>57.9%</b>	<b>63.7%</b>

Objectives:

- A. Increase rate of cholesterol checks, mammograms, colonoscopies, and PAP smears at recommended intervals by 10 percent from current baseline by August 2016.

Strategies:

- A. Promote education and opportunities for free screens when dealing with clients or potential clients (ex: health fairs). Engage with Western University of Health Sciences as well as area pharmacy organizations to build up the number of events and the attendance at such events. Increase interagency promotion and awareness of sponsored events. Look towards engagement with the Global Health Club from Western University of Health Sciences as well as the pharmacy school at Oregon State University.
  - Lead: **All Linn County Partners**
- B. Work with area urgent care, emergency rooms, In-Reach clinic, and the East Linn Health Center to strengthen policy on communicating about screenings and promoting their use. Work with Mental Health workers to inform clients about preventative screenings and to promote their use when appropriate.
  - Lead: **Samaritan Health Services**
- C. Develop materials and strategies that are linguistically and culturally sensitive.
- D. Develop a referral pathway for providers to better address the preventative screening needs of patients.

#### **Goal 4: Improve Chronic Disease program use.**

##### Objectives:

- A. Increase average attendance and use of CD programs by 25 percent by August 2016 from current baseline numbers.

##### Strategies:

- A. Work with the CCO development to house programs for sustainable existence and to provide consistent programming.
  - Lead: **Samaritan Health Services**
- B. Increase and improve communication to increase utilization. Actively recruit a larger volunteer and community health worker base to help run programs.
  - Lead: **All Linn County Partners**
- C. Promote the use of online training programs with individuals in rural locations. Living Well with Chronic Conditions has an online program as well as many others. Compile a comprehensive list of available online resources for those who cannot attend a class.
  - Lead: **Samaritan Health Services**

## Access to Health Care

Access to Health Care was chosen as a priority area from firsthand testimony and data. Almost every one of the thirty individuals the MAPP committee interviewed during the key informant interviews discussed difficulties some individuals have accessing care. In July 2012, Linn County's unemployment rate was 10.7 percent and it has been consistently in double digits for the past four years. According to CDC surveillance data, 19 percent of adults do not have insurance, and Linn County's Quality of Life Survey reported the same figure. Data from Linn County's Quality of Life survey also indicate that 25 percent of respondents had a time in the past year where they needed healthcare and could not get it (Figure 7). In addition, 21 percent of all respondents did not have a primary care physician (Figure 8).

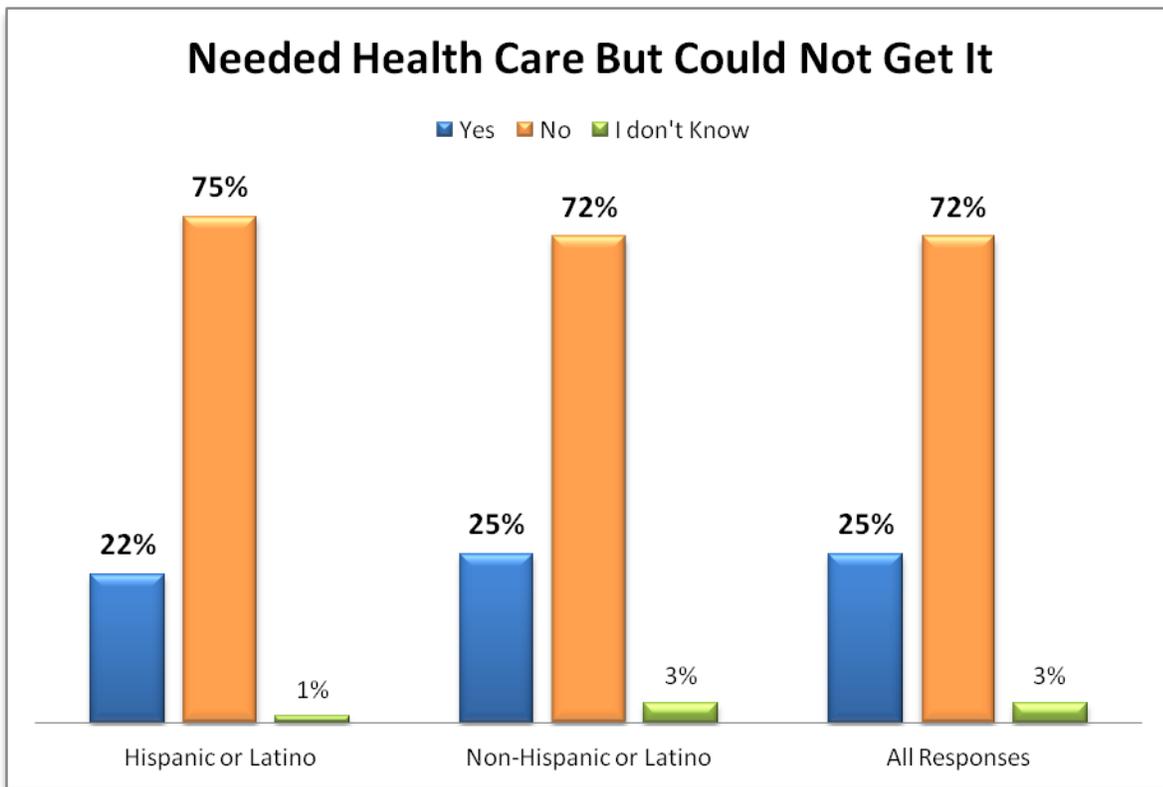


Figure 7: Was there a time in the past year you needed health care but could not get it?

Transportation creates barriers to access to health care. Individuals that utilize the Oregon Health Plan often are required to receive services from their local network health provider. That means a resident of Harrisburg, Mill City, or another rural location has to travel to Albany for many services despite having closer population centers in another county. Knowledge and awareness of available programs and services is a constant battle in the county. The launching of the 2-1-1 information line helps match people with needed services, but in many cases transportation will still be a barrier.

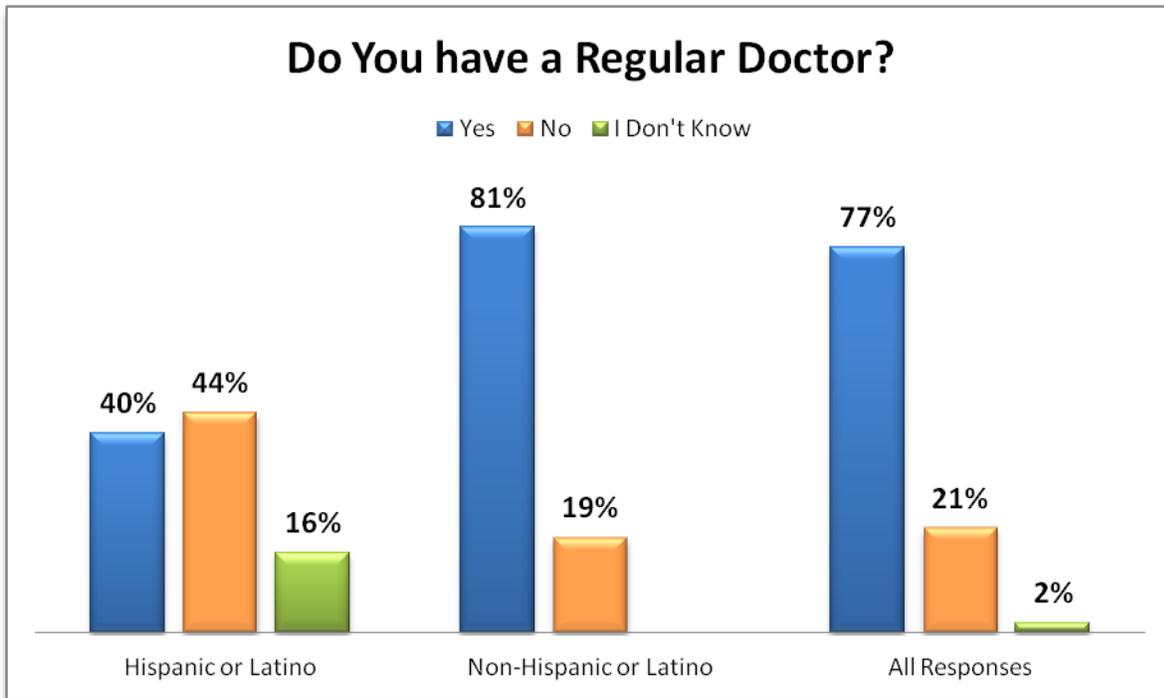


Figure 8: Do you have a regular doctor?

Access to health care also means working with vulnerable populations. Our Quality of Life Survey, as well as key informant interviews, revealed health disparities within the Hispanic population in Linn County. Only 55 percent of Hispanic/Latino respondents on the survey reported having health insurance (Figure 9). Among those Hispanic/Latinos

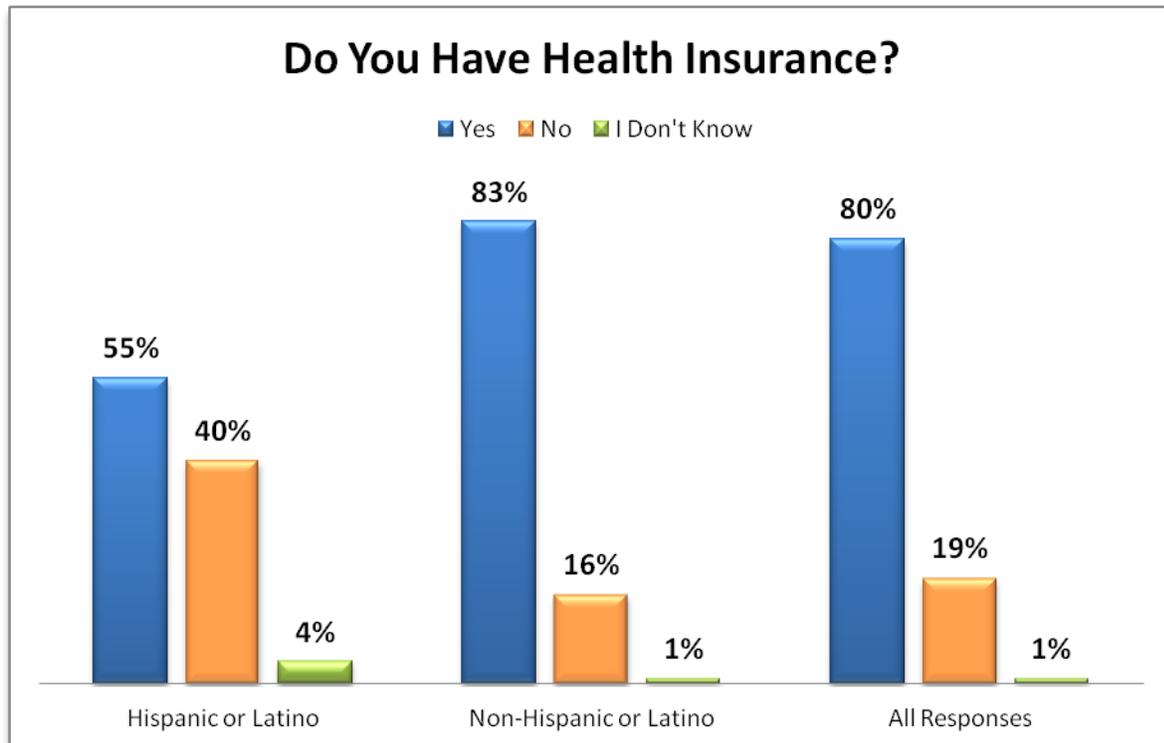


Figure 9: Do you have health insurance?

that have insurance, 23 percent are insured through Medicaid or Medicare, 26 percent are insured through work plans, and the remaining are self-insured or insured through a family member. The significant difference between Hispanics/Latinos and non-Hispanics/Latinos is the proportion of coverage provided by work; 45 percent of non-Hispanics/Latino with insurance have coverage provided by work, nearly twice the rate as Hispanics/ Latinos.

## **Access to Health Care**

Strategic Issue Statement:

*How can the residents of Linn County have increased access to physical, behavioral, and dental health?*

### **Goal 1: Improve the number of people who have timely access to health care.**

Objectives:

- A. Increase the number of people who have access to timely health care from 79 percent of Linn County residents to 82 percent.

Strategies:

- A. Work to maintain and expand the offerings of safety net clinics in the County.
  - Lead: **All Linn County Partners**
- B. Continue to build a strong partnership with Oregon State University, Western University of Health Services College of Osteopathic Medicine Pacific-Northwest, and Samaritan Health Services to identify and promote potential reduced cost services or population-level health programs and interventions. These services would be basic preventative care, immunizations, and check-ups that would give medical school students quality learning opportunities or provide researchers at OSU a location to test pilot programs.
  - Lead: **All Linn County Partners**
- C. Actively pursue grants that promote improving the health status for vulnerable populations.
  - Lead: **All Linn County Partners**
- D. Increase capacity of grassroots organizations and priority populations to identify needs, build leadership, address cultural and language barriers as well as barriers of hours of service and childcare, and promote policy change.
  - Lead: **Linn Benton Health Equity Alliance**
- E. Better understand transportation needs, services, patterns, and gaps in Linn County. Work to install or expand programs that address transportation needs.
  - Lead: **Linn Benton Health Equity Alliance**

- F. Increase education and awareness around health equity and social justice among stakeholders and decision makers.
  - Lead: **Linn Benton Health Equity Alliance**
- G. Build and strengthen advocacy and leadership for health equity and social justice among Linn County partners.
  - Lead: **Linn Benton Health Equity Alliance**

**Goal 2: Improve communication of available services.**

Strategies:

- A. Continue to promote information lines such as 2-1-1 and ADRC.
  - Lead: **All Linn County Partners**
- B. Work with 2-1-1 information line to update the community resource directory.
  - Lead: **Linn County Health Services**
- C. Increase utilization of local newspapers and media to celebrate program successes and advertise available programs.
  - Lead: **All Linn County Partners**
- D. Promote health services to target populations throughout the County through the utilization of websites, 2-1-1, community partners, flyers, referral networks, navigators, etc., to increase knowledge of the services offered in the County.
  - Lead: **All Linn County Partners**

**Goal 3: Coordinate with CCOs and regional partners for aligning vision, goals and work plans, as well as for data access and planning.**

Strategies:

- A. Ensure that the policies, systems, and practices associated with the development and implementation of a regional CCO reflect the input and involvement of key health disparity communities in Linn County.
  - Lead: **IHN-CCO, CAC, LBHEA**
- B. Establish clear communication pathways for data sharing. What data is available, what needs to be collected, who owns the data, who is responsible for confidentiality, who analyzes it, when is it appropriate to share with partners?
  - Lead: **All Linn County Partners**
- C. Continue to vigilantly assess the health state of the County and engage academic partners. By having a clear set of issues, the County can advocate for becoming a location for future research or intervention development that can benefit both the County and academic institutions.
  - Lead: **Linn County Public Health**

D. Continue to work toward building internal and partnership capacity. Investigate organizational changes to fund sustainable positions that build capacity, such as a full-time grant writer.

- Lead: **Linn County Public Health**

## Tobacco Use

Tobacco is the leading cause of preventable death. In addition to lung cancer and other respiratory diseases, tobacco usage increases the risks for stroke, heart disease, other cancers, and diabetes. Linn County has high rates of tobacco use compared to both the state and the nation. In Linn County 23 percent of 11<sup>th</sup> graders, 21 percent of adults, and 20 percent of pregnant women smoke (Figure 10). The 11<sup>th</sup> grade smoking rate has increased by 64 percent in the past 7 years; increasing from 14 percent in 2005 to 23

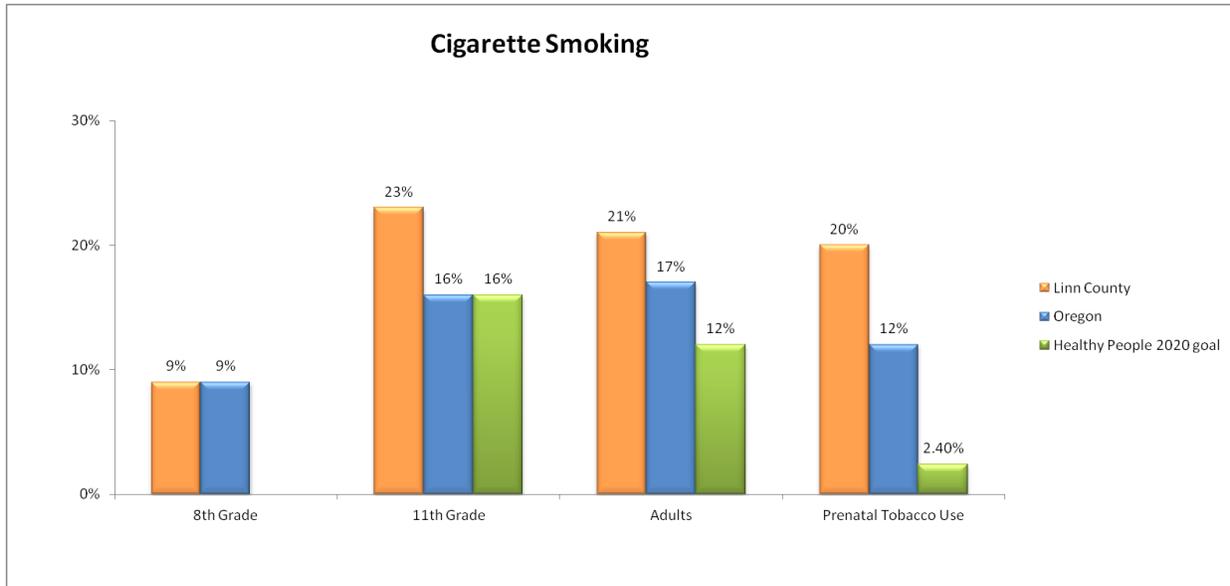


Figure 10: Cigarette smoking rates in Linn County compared to Oregon and to Healthy People 2020 goals

percent today.

Unlike alcohol and drug abuse, the community does not view tobacco use as a significant health issue, despite statistics to the contrary. On the Linn County Quality of Life Survey, tobacco use ranks 10<sup>th</sup> out of 22 possible health issues. Drug abuse was considered the biggest health issue in the county, and alcohol abuse was tied for third place. This speaks to the level of normalcy that tobacco use has in our community and society in

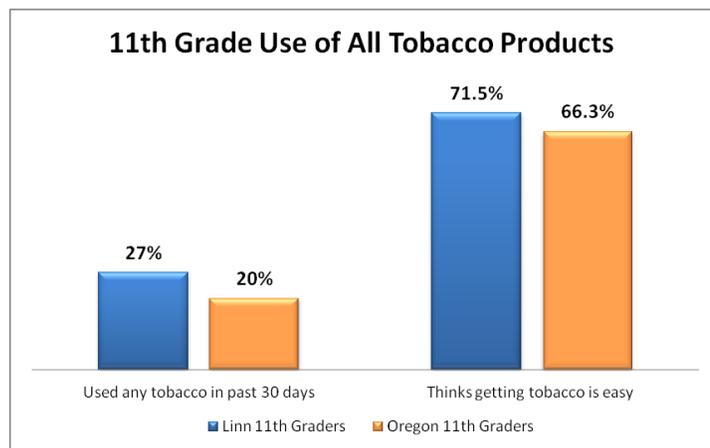


Figure 11: 11th grade tobacco usage and access

general. Despite its high level of use in the County, and its proven negative health consequences, county residents do not consider it a pressing health issue. This creates challenges with moving forward on tobacco policies.

Linn County Alcohol and Drug Prevention Program, in partnership with the state of Oregon, administers the Student Wellness survey to all Linn students in 6<sup>th</sup>, 8<sup>th</sup> and 11<sup>th</sup> grade. The 2010 Student Wellness Survey shows that about 38 percent of Linn County parents do not have conversations with their children about use of tobacco or other substances. The Wellness Survey also reveals that, compared to the state, Linn County has a significantly higher rate of all tobacco use, and more 11<sup>th</sup> graders feel that accessing tobacco is easy or very easy. Linn County does not require tobacco retailers to be licensed to sell tobacco. Tobacco retailer licensing acts as a mechanism to ensure responsible retailing and compliance with important tobacco laws.

Tobacco goals and strategies are focused on policy measures that aid in prevention of initiation among youth and increase the usage of tobacco cessation services. Additionally, the promotion of tobacco-free outdoor areas is a focus not only within Linn County, but statewide.

## **Tobacco Use**

### Strategic Issue Statement

*How can we reduce the use of tobacco in Linn County?*

### **Goal 1: Reduce use and initiation of tobacco among children, adolescents, and young adults.**

#### Objectives:

- A. Reduce tobacco use in 11<sup>th</sup> graders from 23 percent to 21 percent by August 2016.

#### Strategies:

- A. Work with municipalities to strengthen tobacco regulations for youth including the use of hookah and e-cigarettes.
  - Lead: **Linn County Public Health Tobacco Prevention Coordinator**
- B. Increase the life skills school based curriculum into more Linn County Schools.
- C. Work to move Linn County School Districts towards having the gold standard tobacco free policy including e-cigarettes.

### **Goal 2: Increase health care provider involvement in tobacco cessation.**

Objectives:

- A. Increase the number of providers using the quit-line referral process by 25 percent by August 2016.

Strategies:

- A. Develop referral pathways for patient-centered medical homes and other treatment agencies to the Quit Line.
  - Lead: **Samaritan Health Services**
- B. Train medical professionals in 5 A's and motivational interviewing.
  - Lead: **Linn County Public Health Tobacco Prevention Coordinator**

**Goal 3: Increase the number of tobacco-free areas.**

Strategies:

- A. Conduct an assessment of existing policies and the number of smoke-free outdoor areas in the county.
  - Lead: **Linn County Public Health Tobacco Prevention Coordinator**
- B. Work with city councils to adopt policies on smoke-free outdoor areas.
  - Lead: **Linn County Public Health Tobacco Prevention Coordinator**
- C. Work with municipalities to adopt countywide policy on smoke-free playgrounds and outdoor areas frequented by children.
  - Lead: **Linn County Public Health Tobacco Prevention Coordinator**

**Goal 4: Work towards a controlled use or a restricted use Tobacco policy on all Linn County Health Services properties.**

- A. Linn County Public Health Tobacco Prevention Coordinator and Health Advisory Council work to educate County decision makers and commissioners on importance of tobacco policy.

**Goal 5: Create policies regarding new and emerging nicotine markets.**

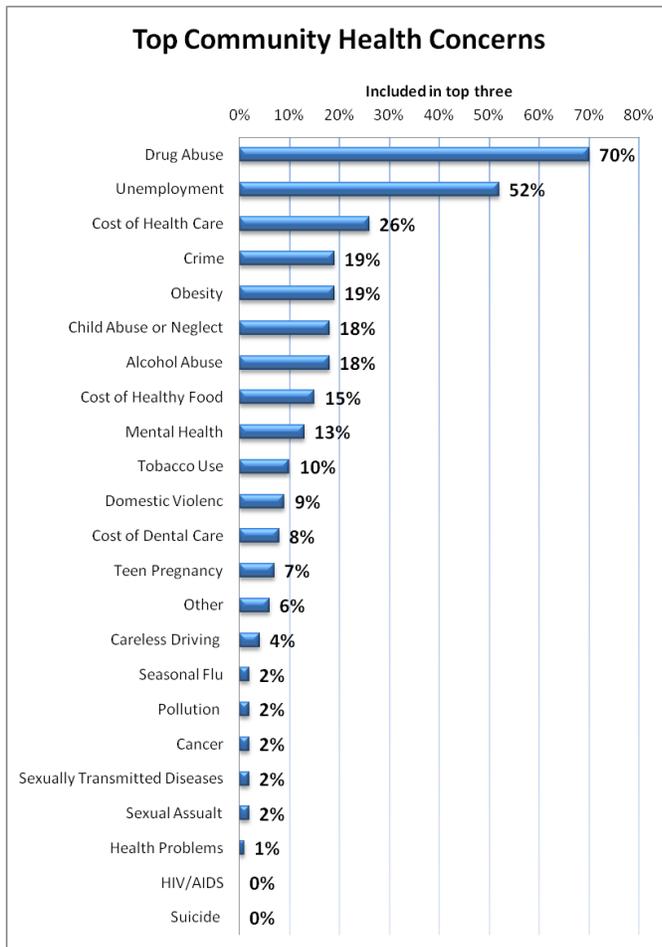


Figure 12: Ordered results from Linn County's Quality of Life Survey

## Behavioral Health

Behavioral Health refers to a state of mental/emotional well-being and the choices and actions that affect wellness. Behavioral health problems include mental disorders, suicide, substance abuse and addiction, and problem gambling, which often appear together as “co-occurring disorders”. Behavioral Health services cover a continuum that includes health promotion, illness prevention, early intervention, treatment, and recovery maintenance.

Behavioral Health is a focus area based on results from our Quality of Life Survey, our Key Informant interviews, and our health statistics. On the survey, 70 percent of respondents included drug abuse as a top health concern in their community (Figure 12). Additionally, Key

Informant health concern analysis in the Linn County CHA placed mental health and substance abuse second from the top (combining alcohol and drug abuse) among highest of the nine concerns. 85.8 percent of residents reported that they do not know where to go to get help with sadness or depression. Individuals with behavioral health issues tend to have increased physical health issues that include diabetes and heart disease, and life expectancy in these individuals is decreased by approximately 20 years. One of the biggest issues faced by the homeless in Linn County, according to the Linn County CHA, is the availability of psychotropic medication they need. Our Key Informant estimates that over half the homeless in Linn County have or need a prescription for a mental health problem and most of them do not have access to maintain that prescription. Behavioral and property crimes are often a consequence of substance abuse. Linn County ranks second in the State for behavioral crimes and fourth in the state for methamphetamine-related incidents according to the Oregon Uniform Crime Reporting, State of Oregon report of criminal offenses and arrests (2011).

The IHN-CCO is an active partner in supporting and funding behavioral health services to Oregon Health Plan members. The Linn County Alcohol and Drug (LCAD) Prevention Program works with a variety of local partners to coordinate behavioral health promotion and prevention strategies in Linn County, and actively participates in regional (Linn-Benton-Lincoln) prevention planning. LCAD provides a number of prevention services, including Life Skills Training (an evidence-based prevention and skill-building curriculum) in area schools, reaching 1500 students each school year; and facilitating the Linn County Youth Council STAND (Students Taking Action Not Drinking), a peer-led group that is active in developing teen-orientated social marketing messages to prevent substance abuse and promote mental wellness. A focus of Linn County social media messaging is prevention of early alcohol access and involving parents in having a stronger role in monitoring teenage activities, as well as messages to teens to assist peers in emotional distress in getting help from an adult. Linn Together, a community prevention coalition assisted by LCAD, is an area partnership of local schools, law enforcement, parents, faith leaders, youth services, local government, students, health care professionals, and business owners that work to launch evidence-based prevention strategies. A focus of Linn Together’s messaging is to educate parents on laws regarding providing alcohol in the home and policies to prevent teens from gaining alcohol access from parents. Data from the Student Wellness Survey continually show that teens access alcohol through parents, with or without parental knowledge, as well as through older siblings and friends of legal age.

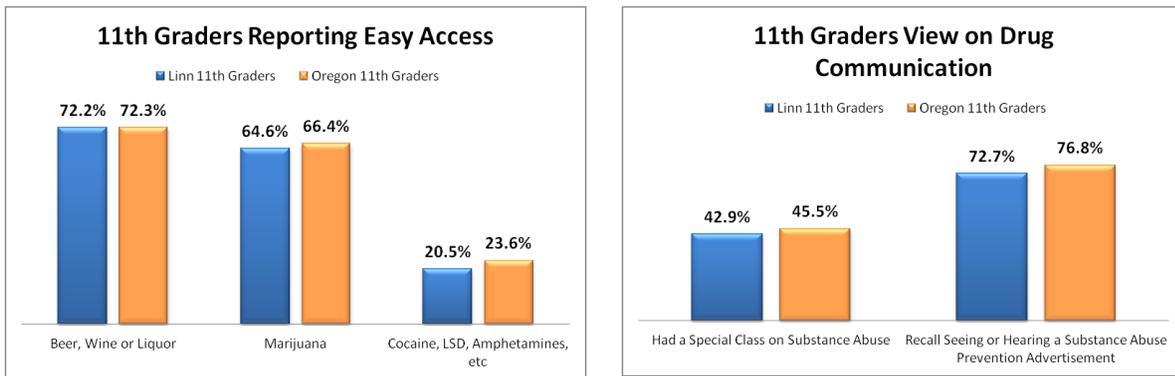


Figure 13: Findings from the 2010 Student Wellness Survey on ease of access and substance abuse prevention

The largest behavioral health treatment providers in the County are the Linn County Mental Health Program (LCMH) and the Linn County Alcohol & Drug Program (LCAD). Both programs strive to provide services to adults and children as well as partnering with agencies including, but not limited to, schools, Child Welfare, Parole & Probation, police, primary care physicians, emergency rooms, and hospitals. Both programs work closely with IHN-CCO in developing improvements in the local health system. LCMH currently serves 4% of the population of Linn County and currently has 2,740 actively

enrolled clients. Linn County Mental Health has a robust treatment team approach for the most at risk children as well as individuals who have a serious persistent mental illness. These services include medication management, skills training, residential services, therapy, and case management. There is a 24/7 crisis team and an open access intake process that will see people the same day in the Albany office. Lastly, there is work with local medical homes to provide coordinated care (mental health and physical health) to promote prevention, provide integrated treatment and improve health and life expectancy. LCAD provides substance and gambling addiction treatment to over 800 youth and adults each year. With a focus on low-income or higher risk individuals, LCAD also provides supportive services such as drug-free housing assistance, transportation, parenting education, child care, and medication management. Local private providers provide substance abuse treatment to another 800 adults annually, and take the lead in providing treatment services to DUI offenders.

Keys to improving behavioral health concerns lie with effective interventions that prevent initiation of substance use, improve awareness of behavioral health resources, and increase access to behavioral health care.

## **Behavioral Health**

### Strategic Issue Statement

*How can Linn County reduce the burden and prevalence of behavioral health concerns?*

### **Goal 1: Delay initial onset of youth substance use.**

#### Objectives:

- A. Reduce the number of 8<sup>th</sup> graders who report drinking at least one drink of alcohol in the past 30 days by 5 percent from 17.6 percent to 16.7 percent by August 2016.

#### Strategies:

- A. Maintain and expand the use of Life Skills, a school-based prevention curriculum, in Linn County Schools.
  - Lead: **Linn County Alcohol and Drug Prevention Program, The Youth Council, Linn County School Districts**
- B. Support the youth council, Students Taking Action Not Drinking (STAND) by helping grow local business partners and resources.
  - Lead: **Linn County Alcohol and Drug Prevention Program**
- C. Create social marketing messages and health communication through Linn Together grant.

- Lead: **Linn Together**
- D. Expand social marketing campaigns about parental responsibility and social hosting policies and law.
  - Lead: **Linn Together**
- E. Support the Linn Together community coalition's effort to increase prevention education among parents.
  - Lead: **Linn Together**
- F. Review local and state data to identify emerging trends in youth substance abuse including the Student Wellness Survey (SWS), local law enforcement data, alcohol and tobacco sales compliance data and other available local data.
  - Lead: **Linn Together, Linn Council**

**Goal 2: Improve the coordination of transportation options in order to improve access to treatment services.**

Objectives:

- A. Achieve a 30% rate of Non-Emergent Medical Transportation that are either shared/group rides or reimbursements for clients providing their own resources.

Strategies:

- A. Oregon Department of Transportation funds, which support van purchases and maintenance, are ending. Investigate alternative payment methodology.
  - Lead: **Linn County Alcohol and Drug Prevention Program, Cascades West COG Rideline**
- B. Investigate better interagency sharing of vans (Public Health, Mental Health, Alcohol and Drug) to better serve clients among the agencies and potentially share certain costs across various departments. Partner with the IHN CCO to determine feasibility of sharing the costs of OHP client transportation. This has linkages to strategies in the access to care topic.
  - Lead: **Linn County Health Services**

**Goal 3: Improve access and appropriate utilization of mental health services.**

Objectives:

- A. Reduce stigma associated with diagnosis and treatment of mental health issues through increased awareness and access to information.

- B. Provide/increase timely access and capacity of mental health treatment for children, youth, adults and families.

Strategies:

- A. Offer Mental Health First Aid Training courses
- B. Recognize the mental health concerns of caregivers and the elderly population throughout the County.
- C. Involve all municipalities in the County Advisory Board sponsoring of Mental Health Month (May) and Mental Illness Awareness Week (October).
- D. Increase mental health services in school-based settings throughout Linn County.
- E. Increase partnerships with Patient Centered Primary Care Homes throughout the County to ensure integrated care.

**Goal 4: Expand options for drug free housing for recovering addicts in treatment.**

Strategies:

- A. Maintain funding streams that provide supportive housing models. Linn County has the most supportive houses per capita in the state.
  - Lead: **Linn County Alcohol and Drug Treatment Program**
- B. Expand services for clients transitioning out of treatment to ensure they have the ability to gain employment, afford rent, and have the necessary support to prevent relapse.
  - Lead: **All Linn County Partners**
- C. Explore the potential for employment for housing models in Linn County. Work for rent arrangements which provide vocational training and employment experience for recovering addicts and help to offset the cost of providing drug-free housing to recovering addicts.
  - Lead: **Linn County Alcohol and Drug Prevention Program**
- D. Work with Community Services Consortium to help identify replacement funds to restore vocational training services that were lost in budget cuts.
  - Lead: **All Linn County Partners**