



MARION-POLK  
**COMMUNITY HEALTH**  
COLLABORATIVE



**2026-2030**

MARION-POLK

# Community Health Improvement Plan

Addressing top health priorities in Marion and Polk Counties, Oregon

# MARION-POLK COMMUNITY HEALTH COLLABORATIVE



willamette  
health council

Santiam Hospital & Clinics  
embrace HEALTH



Marion  
County  
OREGON  
Health & Human Services



POLK COUNTY  
HEALTH SERVICES



LEGACY  
HEALTH



Salem Health<sup>®</sup>  
Hospitals & Clinics



PacificSource  
Community Solutions

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We welcome community feedback and participation in improving the health of Marion and Polk Counties. To share your thoughts or get involved, contact us at [marionpolkchc@co.marion.or.us](mailto:marionpolkchc@co.marion.or.us)

**\*\*Data is provisional and may be subject to change. Differences between local, state, and national reports may exist due to the timing of when reports are run, and definitions used. The information contained in this document is a result of community input and uses various sources that may not necessarily represent the views or opinions of any particular organization, entity, or person.\*\***

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*Este informe se puede obtener en otros idiomas además del inglés, y en formatos alternativos. Correo electrónico [marion-polkchc@co.marion.or.us](mailto:marion-polkchc@co.marion.or.us) \*\**

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## Land Acknowledgment Statement

We respectfully acknowledge the Tribal sovereignty of the Kalapuya peoples, the original inhabitants, and stewards of the Willamette Valley. The Kalapuya peoples were forcibly removed from this ancestral territory following the signing of the Willamette Valley Treaty of 1855, and where they and their descendants remain Tribal citizens of the Confederated Tribes of Grand Ronde and the Confederated Tribes of Siletz Indians.

In this recognition we also acknowledge the remaining Federally Recognized Tribes and all Tribal citizens across Oregon whose contributions and sacrifices have abundantly and continually shaped the places where we live, work, play, and gather in community. We honor their enduring relationship with these lands and waters, their traditional ecological knowledge, ways of knowing, and cultural practices since time immemorial that continue to enrich our shared existence.

We commit to further honor and uphold Tribal sovereignty recognizing the unending impacts of colonization and forced assimilation upon all Tribal peoples. We affirm that our relationships and professional work beside Tribal nations and citizens will be guided by reciprocity and cultural responsiveness, which uplifts the self-determination of all Indigenous peoples and affirms the values of equitable wellness of the Marion-Polk Community Health Collaborative.

## Commitment to Tribal Engagement

By December 2030, the Marion-Polk Community Health Collaborative will implement a Tribal engagement plan to guide equitable and culturally responsive allyship with the Confederated Tribes of Siletz Indians, the Confederated Tribes of Grand Ronde, the Confederated Tribes of Warm Springs, and other Tribal partners in the Marion-Polk region. This plan will also acknowledge and include all Tribal citizens across Oregon – both federally and non-federally recognized – by advancing health equity through respectful and transparent collaboration that upholds Tribal sovereignty, supports self-determination, and recognizes the enduring impact of historical trauma on the health of all Tribal communities.

# 3 Priority Areas

MARION-POLK COUNTIES

2026-2030 Community Health Improvement Plan (CHIP)



1

## Access to Healthcare

Improving access to comprehensive, high-quality, healthcare services and providers

2

## Housing Stability

Improving the affordability, quality, safety, and local availability of housing



3

## Mental Health & Substance Use

Improving mental health and reducing substance use



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# Letter to the Community



## Dear Community,

On behalf of the Marion Polk Community Health Collaborative, we are proud to share the 2026–2030 Marion-Polk Community Health Improvement Plan (CHIP). This plan reflects our collective vision and commitment to improve the health and well-being for all who live in Marion and Polk Counties.

At its core, the CHIP is grounded in the belief that everyone deserves to feel safe, seen, heard, and valued in the community in which they live. In this spirit, it prioritizes issues that you, the community, said were of utmost concern: Access to Healthcare, Housing Stability, and Mental Health & Substance Use. These are significant, complex, and interconnected issues rooted in long-standing and widespread challenges. We recognize the urgency of these priorities and the profound impact they have on the daily lives of many in our community. We commit to taking action to make measurable improvements in these areas, and to share our progress with humility and transparency.

Further, we recognize that to meaningfully and sustainably address the CHIP priorities, we must keep community at the center of the work, by continuing to foster trust, collaboration, and a shared sense of purpose. We invite all organizations, leaders, and community members in the Marion-Polk region to join us in supporting our shared goals and uplifting the strategies that will make the greatest difference. We extend our gratitude to those who contributed their time, expertise, and lived experience to develop the CHIP. Your voices have shaped this plan and will continue to guide our efforts toward a healthier, more connected community.

With deep appreciation,

Josie Silverman-Méndez  
*Chair, Marion-Polk Community Health Collaborative*

Katrina Griffith  
*Vice-Chair, Marion-Polk Community Health Collaborative*

# Executive Summary

Community health is determined by a variety of factors that are often complicated and interconnected. No single person, organization, or agency can create a healthy community alone. Improving health requires collaboration, strategic planning, and collective action to remove barriers and build lasting solutions.

That's why the Marion-Polk Community Health Collaborative, a group of organizations united by a shared vision to improve local health, came together in early 2025 to develop the CHIP. This community-driven strategic plan guides joint efforts to improve population health and system-level challenges, ensuring everyone in our region has the opportunity to live their healthiest life.

**OUR VISION:** *A responsive and connected community where everyone can reach their highest level of health and quality of life.*

The CHIP addresses community-identified health issues based on the results of the **2025 Community Health Assessment (CHA)**.<sup>1</sup> The CHA includes data on demographics, health status and disparities, as well as insights from at least **2,286 community members and 47 organizations**.

After reviewing the data, community partners identified three priority health issues to address in the CHIP:



**Access to Healthcare**



**Housing Stability**



**Mental Health & Substance Use**

Both the CHA and CHIP are developed through a coordinated process that occurs every five years. While this process has taken place in our community for several years, the 2025 cycle marks a significant step forward, with greater community involvement and stronger commitment to this work than ever before.

The CHIP is updated annually and revised following each new CHA. More than a plan, it reflects our commitment to ongoing progress and shared responsibility. As our region continues to grow, so will this work—guided by a shared vision and a focus on the community's most pressing health needs.

# Acknowledgments

The Marion-Polk Community Health Collaborative would like to thank everyone who participated in the Community Health Improvement Plan (CHIP). This plan is grounded in community input and reflects a shared vision for healthier Marion and Polk Counties.

The CHIP is the result of collective efforts of more than 80 community partners. While the CHIP provides a shared framework, each participating organization brings its own mission, vision, values, programs, and priorities to the table. Participation in the CHIP does not mean an organization is committed to specific policy positions or new initiatives unless they choose to do so.

<b>Bridgeway Community Health</b>	<b>Polk County Behavioral Health</b>
<b>Capitol Dental Care</b>	<b>Polk County Community Corrections</b>
<b>Catholic Community Services</b>	<b>Polk County Fire District 1</b>
<b>Center for Hope &amp; Safety</b>	<b>Polk County Family &amp; Community Outreach</b>
<b>Centro de Servicios para Campesinos</b>	<b>Polk County Health Services</b>
<b>Health Equity Coalition of Marion, Polk &amp; Yamhill Counties</b>	<b>Punx with Purpose</b>
<b>Interface Network</b>	<b>Salem Free Clinics</b>
<b>Kaiser Permanente</b>	<b>Salem Health Hospitals &amp; Clinics</b>
<b>Legacy Health</b>	<b>Salem-Keizer Public Schools</b>
<b>Marion County Health &amp; Human Services</b>	<b>Salem Housing Authority</b>
<b>Marion County Housing Authority</b>	<b>Salem Leadership Foundation</b>
<b>Marion &amp; Polk Early Learning Hub</b>	<b>Salem Police Department</b>
<b>Marshallese American Network for Interacting Together</b>	<b>Salem Psychiatric Associates &amp; Valley Mental Health</b>
<b>Micronesian Islander Community</b>	<b>Santiam Hospital &amp; Clinics</b>
<b>Mid-Willamette Valley Community Action Agency</b>	<b>Sheltering Silverton</b>
<b>Mid-Willamette Valley Homeless Alliance</b>	<b>Soaring Heights Recovery Homes</b>
<b>Morrison Child &amp; Family Services</b>	<b>West Valley Housing Authority</b>
<b>Northwest Human Services</b>	<b>Willamette Education Service District</b>
<b>Northwest Senior and Disability Services</b>	<b>Willamette Health Council</b>
<b>Oregon Department of Human Services</b>	<b>Willamette Valley Vital Health</b>
<b>OYEN Emotional Wellness Center</b>	<b>WVP Health Authority</b>
<b>PacificSource Marion-Polk CCO</b>	<b>Yakima Valley Farmworkers Clinic</b>

# Mission, Vision, Values

## Mission



***Our purpose, and how we will achieve it.***

Collaborate to help our community achieve their best health and well-being by listening, asking, and responding in a culturally appropriate manner.

*-Adopted August 2023*

## Vision



***What the future state of the community will look like.***

A responsive and connected community where everyone can reach their highest level of health and quality of life.

*-Adopted August 2023*

## Values

***Our culture, and how we work together with the community.***



### **Accountability**

We have a shared commitment to do this work with integrity and transparency, honoring community self-determination.



### **Collaboration**

We acknowledge that this work takes all of us working together to identify and address the needs of our community.



### **Community Leadership**

We value the power of community-member voice in identifying and addressing their health needs. We prioritize community-led approaches and look to the community as much as possible.



### **Data Integrity**

We value collecting, sharing, and using data in ways that lead to meaningful, positive outcomes for the community.



### **Health Equity**

We know health inequities arise from social conditions in which people are born, grow, live, and work. We work to eliminate barriers and create better opportunities for those who are underserved in our community.

# Marion-Polk Community Health Collaborative

The Marion-Polk Community Health Collaborative (MP-CHC) is a group of organizations that work together to assess and improve local health. While community partners have collaborated in this capacity since 2008, the group recently adopted the name Marion-Polk Community Health Collaborative to act as an umbrella entity for regional health improvement efforts.

Throughout the years this partnership has changed, but it continues to align efforts of local health authorities, hospital systems, the region's Coordinated Care Organization (CCO), the local health council, and other community-serving organizations. The Collaborative's key products are the CHA and CHIP.

Thirty-seven organizations participated in the Collaborative to inform the CHIP, serving on the Executive Committee, Steering Committee, Data and Communications Subcommittees, or CHIP Priority Area Workgroups.

The **Data Subcommittee**, overseen by the Executive Committee is tasked with collecting, compiling, and analyzing local data to inform the CHA and CHIP. The **Communications Subcommittee**, also under the direction of the Executive Committee, develops materials and strategies to effectively communicate the CHIP and related updates to the community.

## Executive Committee

The **Executive Committee** is the decision-making body, responsible for providing strategic direction, allocating resources, and coordinating local health improvement efforts.

## Steering Committee

The **Steering Committee** is comprised of community-serving organizations that offer feedback and recommendations based on lived experiences, professional insight, and community knowledge from their respective organizations.

## Priority Area Workgroups

The **CHIP Priority Area Workgroups** are comprised of subject matter experts in each CHIP priority who are responsible for developing the goals and strategies of the CHIP. They also periodically review progress and provide recommendations for improvement.

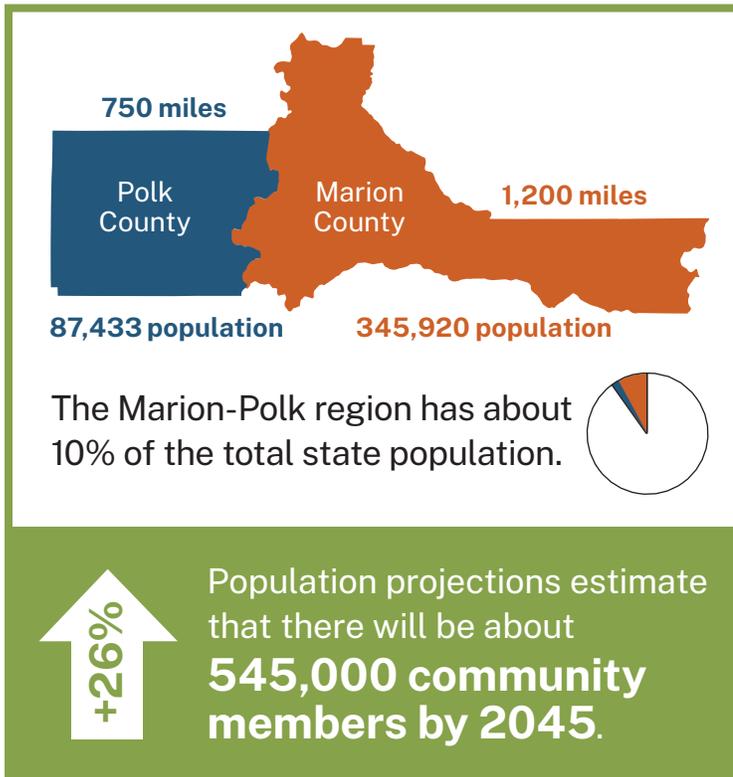
# Marion-Polk Community Health Collaborative Structure



If you or your organization is interested in joining the Collaborative, email [marion-polkchc@co.marion.or.us](mailto:marion-polkchc@co.marion.or.us) for more information.

# Description of Marion and Polk Counties

This Community Health Improvement Plan focuses on improving the health of all community members in Marion and Polk Counties, located in the Willamette Valley.<sup>2</sup>



**66%** of the Marion County population live in **Salem, Keizer, Silverton, Stayton, or Woodburn**

The remaining 34% live in one of the smaller 15 cities or on unincorporated land.



**85%** of the Polk County population live in **Dallas, Falls City, Independence, Monmouth, West Salem, or Willamina**

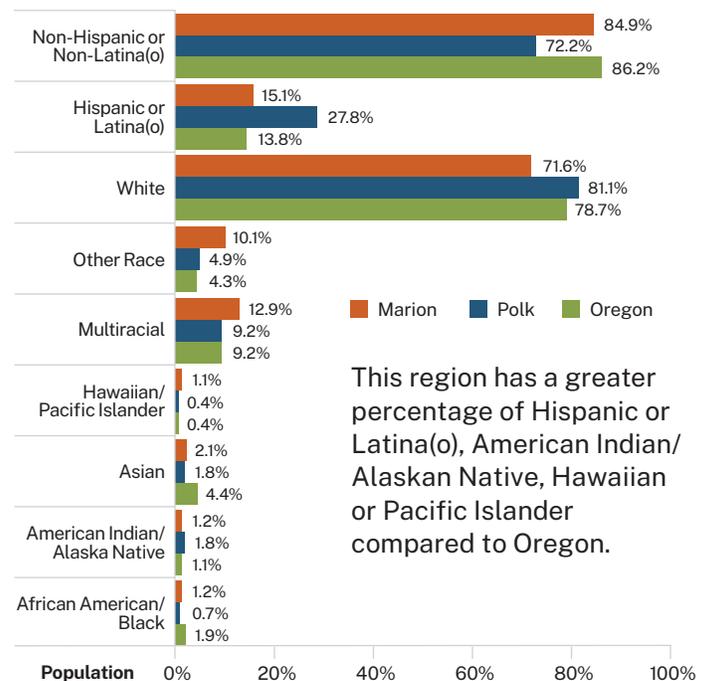
About **1 in 6** community members are living with a disability



About **1 in 3** people are under the age of 25

## Population by Race and Ethnicity\*

Race and Ethnicity



This region has a greater percentage of Hispanic or Latina(o), American Indian/Alaskan Native, Hawaiian or Pacific Islander compared to Oregon.



For a deeper look at the data, view the [2025 Marion-Polk Community Health Assessment](#)

\*ACS, American Community Survey. Survey conducted annually by the U.S. Census Bureau, which includes demographics and other

# Social Determinants of Health and Equity

Social determinants of health and equity (SDOH-E) are the circumstances in which people are born, grow up, live, work, age, as well as the systems put in place to deal with illness. Examples of these social determinants include socioeconomic status, education, housing, access and availability to healthy food, and safety among others.

SDOH-E are influenced by factors such as the economy, social policies, and politics. By changing policies related to these determinants, we can promote health equity and improve the overall health of the community. Additionally, research indicates that social determinants often have a greater impact on health outcomes than healthcare services or individual lifestyle choices.



**Poverty:** About 1 in 7 people were living in poverty in the community and households had a median annual income of \$71,022 (Marion) and \$77,368 (Polk). Poverty was higher in people who were younger, female, and from communities of color.<sup>3</sup>



**Housing:** Oregon was ranked 3rd highest overall in the nation for people experiencing homelessness and was the first in the nation for unsheltered homelessness among families with children. Over half of rents were overburdened paying 30% or more of their gross household income on rent. In a recent survey, housing was identified with the greatest needed for improvement.<sup>4</sup>



**Food Security:** About 1 out of 8 community members were food insecure.<sup>5</sup> Food insecurity is when people don't have enough to eat and don't know where their next meal will come from.



**Education:** About 86% of adults in Marion and 92% in Polk have earned a high school diploma or GED which is lower than the state average. Educational achievement is not equally shared, as males and communities of color had lower rates of high school diploma or GED completion compared to their peers.<sup>2</sup>



**Transportation:** More people in the community rely on personal vehicles to get to work compared to the state average. Fewer community members walk, bike, or use public transportation to work. Additionally, motor vehicle and pedestrian fatalities have been increasing in recent years.<sup>2</sup>



**Crime & Violence:** Violent crime has been steadily increasing in recent years in the community.<sup>6</sup> The most frequently reported violent crime is assault. Additionally, the community experienced a higher rate of child abuse compared to the state average.<sup>7</sup>

# Process of Creating the CHIP

## Strategic Framework

The Marion-Polk Community Health Collaborative utilizes the evidence-based framework Mobilizing through Planning and Partnerships (MAPP 2.0), developed by the National Association of County and City Health Officials (NACCHO). This process brings together community partners across different sectors to identify priorities for improving community health and to work together for meaningful change.

The MAPP framework consists of three phases; Phase 1: Build the Foundation, Phase 2: Tell the Community Story, and Phase 3: Continuously Improve the Community. The CHIP aligns with Phase 3, serving as a roadmap to prioritize health issues; develop shared goals, long-term measures, strategies, and objectives; and create a system to monitor and evaluate progress on CHIP activities.



### Goal

Broad, long-term aim (about 3-5 years) based on long-term measures



### Long-term measure

Population-level metric to track our goal outcomes



### Strategy

A broad statement of what will be done to address the CHIP goal



### Objective

Specific sub-step that lead to the successful completion of a goal

## Phase 1

### **Build the Community Health Improvement Foundation**

**January to December 2023**

This foundational phase was focused on building the structure and support for the process by expanding existing relationships, recruiting new members, developing overall direction (mission, vision, values), creating plans and budgets, and drafting agreements to resource activities for the CHA and CHIP.

## Phase 2

### **Tell the Community Story**

**January to December 2024**

Phase two was focused on developing the CHA to identify local health issues based on input from community members who live, work, or play in Marion or Polk Counties. Data was collected through various methods including a survey, focus groups, and community input sessions. In total, more than 2,286 community members participated in this process, with an increase of 209% compared to 2019.

After completing the assessment, the Collaborative came together to review the data and determine the priority areas for the CHIP.

## Phase 3

### **Continuously Improve the Community**

**January to December 2025**

The involvement of subject matter experts was essential, as they can speak to the needs of their clients or community and have critical knowledge of the work happening in the region.

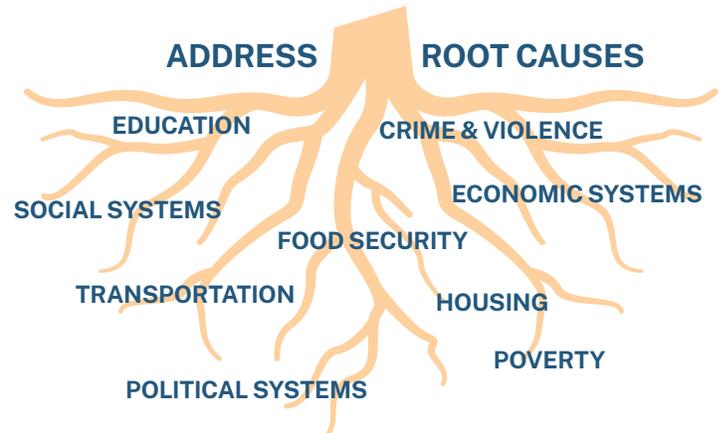
Subject matter experts for each CHIP priority were recruited to form the CHIP Priority Area Workgroups. The Workgroups met monthly from March to July to review data and help develop the goals and strategies for the CHIP. In total, there were 61 Workgroup members.

Once the goals and strategies were developed, the Executive Committee reviewed and adopted strategies their organization could support. They then worked to develop objectives and create workplans to track progress. The CHIP was finalized in December.

# CHIP Approach

## Upstream Approach

The most effective way to improve community health is through upstream approaches that address root causes. These include broad societal factors such as the underlying social, political, and economic systems as well as social determinants of health and equity.



## Evidence-based Approach

CHIP strategies were grounded in evidence-based or best practices shown to successfully improve community health. Over several months, strategies aligned with CHIP priorities were identified through a literature review performed by Marion County Health & Human Services staff and the input of the CHIP Priority Area Workgroups. This ensured strategies were evidence-based, and reflected local needs and realities.

Once the literature review was complete, CHIP Priority Area Workgroup members evaluated and prioritized each strategy using criteria such as community readiness, potential impact, policy implications, cost-effectiveness, opportunities, and available resources. The highest-ranking strategies were moved forward for further review, revision, and adoption.



# CHIP Approach

## SMART Objectives

Objectives are activities to support the CHIP strategy and contribute to achieving the overall goal. To promote consistency and accountability across partner organizations and enable easier tracking, the Collaborative adopted the SMART framework for developing objectives.

Equity is central to this work, guiding intentional engagement with communities most affected, and driving efforts to address systemic barriers to promote fair health outcomes throughout the process.

SMART stands for:

**Specific**

Clearly defining what will be done

**Measurable**

Establishing metrics to track progress

**Achievable**

Ensure objective is realistic given available resources

**Relevant**

Aligning with CHIP strategy and goal

**Time-bound**

Setting a clear timeline for completion

# Aligning with State and National Frameworks

## National Framework

**Healthy People 2030** identifies national public health priorities developed by the U.S. Department of Health and Human Services. It outlines measurable public health objectives to be achieved over a 10-year period. Where applicable, the CHIP’s long-term measures have been aligned with similar indicators from Healthy People 2030 (marked HP2030). Progress towards these Healthy People 2030 goals will be widely shared with the community.<sup>8</sup>

## State Framework

**Healthier Together Oregon** also known as the State Health Improvement Plan (SHIP), developed by Oregon Health Authority (OHA), it outlines the State’s top health priorities for their 2025-2029 cycle.<sup>9</sup>

This table compares the focus areas across both the SHIP and CHIP, showing alignment in healthcare access, behavioral health, and economic drivers of health. It also identifies additional SHIP priorities that are not explicitly included in the CHIP. Because the Collaborative aimed to narrow its focus to three priorities, issues such as adversity, trauma, toxic stress, and institutional bias, were not selected as standalone priorities. However, these factors still contribute to health disparities within the selected CHIP priorities and will be addressed throughout implementation.

2025-2029 SHIP Priorities	2026-2030 CHIP Priorities
Access to equitable preventative healthcare	Access to Healthcare 
Behavioral health	Mental Health & Substance Use 
Economic drivers of health, such as housing, transportation, and living wage jobs	Housing Stability 
Adversity, trauma, and toxic stress	<i>Not identified</i>
Institutional bias	<i>Not identified</i>

# Implementation and Monitoring of the CHIP

The CHIP is an adaptable document designed to be flexible and responsive to meet the needs of the community. It will be reviewed annually by the Marion-Polk Community Health Collaborative and revised as needed to reflect progress, challenges, and new developments.

During the annual review, the Collaborative will assess progress on each objective. The Collaborative will document the status and determine next steps. Based on the findings, the following options will be considered:

1. Continue monitoring without changes
2. Monitor and implement recommended changes
3. Refer to quality improvement initiatives for targeted interventions
4. Remove the objective indefinitely

Any changes adopted—whether related to priorities, goals, long-term measures, strategies, objectives, targets, or timeframes will be incorporated into an updated version of the CHIP. Revisions may be based on accomplished objectives, progress on strategies/objectives, shifting long-term measures, newly developing or identified health issues, and varying levels of resources or funding.

Targets for long-term measures were developed by the Data Subcommittee and are generally based on a 10% improvement, which is public health best practice. These targets will be reviewed alongside CHIP progress and updated to reflect new data and trends. The Collaborative will assess and adjust targets to ensure they continue to represent meaningful improvement. The most recent version of the CHIP, along progress updates, will be available on our website: [marionpolkcommunityhealth.org](http://marionpolkcommunityhealth.org)



This figure illustrates how the components of the CHIP fit together. The long-term measures, goals, strategies, and objectives should reflect the capacities of the organizations implementing this work and should not be a set number.

# How to Use This Document

Improving community health is a continuous process that depends on our whole community. If you, or your organization, want to get involved in developing recommendations, implementing initiatives or evaluating progress, we invite you to join us. Contact [marion-polkchc@co.marion.or.us](mailto:marion-polkchc@co.marion.or.us) to learn how you can support our CHIP.

## Individuals and families can:

- Focus on one or more of the priorities that align with your personal health goals.
- Volunteer with one of our community partner organizations to help implement a part of the CHIP that inspires you.
- Talk to elected officials, representatives, organizations in the community, and community leaders about why these health priorities are important and ask them what they are doing to improve community health.

## Organizations can:

- Discuss the CHIP with your employees, members, or clients. Talk about how the priorities impact their community and provide resources when appropriate.
- Partner with the Marion-Polk Community Health Collaborative to help support implementation efforts.
- Use the CHIP to apply for grants and sponsorships.
- Leverage the CHIP to fine-tune project ideas to be better suited to community needs.
- Rely on the CHIP to identify advocacy efforts or develop policy recommendations.

## Workplaces can:

- Support the health and well-being of employees and their families through programs and policies that improve access to care, housing stability, and mental health and substance use.<sup>10</sup>



# Implementation Overview



## Access to Healthcare

### Goal 1: Improve access to healthcare services

**Strategy 1:** Strengthen care coordination and integration of services

**Strategy 2:** Improve access to culturally and linguistically responsive services to better meet the needs of diverse populations

**Strategy 3:** Increase healthcare access points

### Goal 2: Increase the number of providers serving the community

**Strategy 1:** Create programs to train providers

**Strategy 2:** Provide professional development support to promote workforce retention

**Strategy 3:** Develop new collaborative recruitment efforts

### Goal 3: Increase the utilization of preventive care

**Strategy 1:** Expand the availability and accessibility of preventive care services

**Strategy 2:** Identify and address gaps in school-based health services and networks

**Strategy 3:** Explore and adopt new care delivery models



## Housing Stability

### Goal 1: Prevent homelessness

**Strategy 1:** Advocate to improve supportive housing models

**Strategy 2:** Expand and strengthen existing housing programs and services

**Strategy 3:** Improve coordination between health, housing, and homeless service providers as people move through the housing continuum

### Goal 2: Increase access to sustainable and affordable housing options

**Strategy 1:** Support local advocacy efforts that promote accessible housing options

**Strategy 2:** Improve educational opportunities to maintain stable housing and achieve long-term financial wellbeing

## Mental Health & Substance Use



### Goal 1: Improve mental health

**Strategy 1:** Identify and address gaps in the mental health continuum of care

**Strategy 2:** Develop a regional mental health education and outreach initiative

**Strategy 3:** Enhance alignment and coordination between Marion County, Polk County and the local CCOs behavioral health and public health plans

### Goal 2: Increase sense of belonging

**Strategy 1:** Develop a regional mental health education and outreach initiative

**Strategy 2:** Support community-based, culturally responsive, and trauma-informed practices, and programs to address physical and psychological safety

### Goal 3: Reduce substance use

**Strategy 1:** Improve system infrastructure to increase access to substance use prevention, harm reduction, and treatment services

**Strategy 2:** Enhance quality of substance use prevention, treatment, and recovery services

# Priority Area #1: Access to Healthcare



# Priority Area #1: Access to Healthcare



## Overview

This priority is focused on improving access to comprehensive, high-quality healthcare services and providers. These services include physical, oral, and behavioral health. Some people experience barriers when accessing healthcare, including not having health insurance, high cost of care, inability to get a timely appointment (lack of providers), live too far away from care, or a lack of culturally and linguistically responsive services. Addressing these barriers and others will help to ensure that everyone is able to get the care they need when they need it.

## Why this is important

Access to healthcare came up as the **#1 needed improvement area** in community input sessions



About **2 out of 3** survey respondents indicated they have experienced barriers to care

There is an increase in providers, however it's **still not enough to meet the needs of the community**<sup>10</sup>

**37%** of survey respondents were satisfied with the quality of available doctors and/or services

**48%** of survey respondents were satisfied with getting the medical care they needed

**52%** of respondents were satisfied with getting the dental care they needed



*It helped me a lot to have pediatricians who supported my needs, and their service was not limited to just administering vaccines; it went beyond that. Because this is where health starts, and they are the first contacts for our children and for us, the family.*

– Focus Group Participant

# What We're Going To Do About It

## Goal 1: Improve access to healthcare services

**Strategy 1:** Strengthen care coordination and integration of services

**Strategy 2:** Improve access to culturally and linguistically responsive services to better meet the needs of diverse populations

**Strategy 3:** Increase healthcare access points

## Goal 2: Increase the number of providers serving the community

**Strategy 1:** Create programs to train providers

**Strategy 2:** Provide professional development support to promote workforce retention

**Strategy 3:** Develop new collaborative recruitment efforts

## Goal 3: Increase utilization of preventive care

**Strategy 1:** Expand the availability and accessibility of preventive care services

**Strategy 2:** Identify and address gaps in school-based health services and networks

**Strategy 3:** Explore and adopt new care delivery models

# Access to Healthcare



## Goal 1: Improve access to healthcare services

### Long-term Measures of Population Impact

**Long-term Measure:** Percentage of people with health insurance

- **Baseline:** Marion 92.4%; Polk 96.7% (2024)
- **Target:** Marion 96.2%; Polk 98.4% (2030)
- **Data Source:** American Community Survey (ACS)



*...The elderly. What happens with these people who cannot work any longer and have no insurance? As a result, we unfortunately see older people working at an age they shouldn't be.*

*-Focus Group Participant*

# Goal 1: Improve access to healthcare services

**Strategy 1:** Strengthen care coordination and integration of services

## Objective 1.1

By December 2026, **Marion County Health & Human Services** will ensure at least 15% of new client appointments for ongoing services will be scheduled through Centralized Intake, with 90% receiving next-day follow-up to ensure timely enrollment after intake.

## Objective 1.2

By December 2027, **Marion County Health & Human Services** will increase the number of programs actively using Centralized Scheduling by at least two compared to 2025 levels.

## Objective 1.3

By December 2028, **Marion County Health & Human Services** will develop and implement clear referral pathways between internal programs and external health and community partners to improve care coordination, reduce service gaps, and ensure individuals and families can seamlessly access the full spectrum of health and human services.

## Objective 1.4

By December 2026, **PacificSource Marion-Polk CCO** will convene two biannual community cohorts to identify service gaps, delivery challenges, and navigation barriers related to Oregon Health Plan (OHP) benefits, coverage, and access through the Marion-Polk CCO, including the regional Federally Recognized Tribes, Confederated Tribes of Warm Springs, Confederated Tribes of Siletz Indians, and Confederated Tribes of Grand Ronde.

## Objective 1.5

By September 2027, **PacificSource Marion-Polk CCO** will provide funding and technical assistance to support Marion and Polk Counties in convening at least 10 bimonthly meetings of Health-Related Social Needs (HRSN) service providers serving the Marion-Polk CCO membership.



### Objective 1.6

By December 2027, **PacificSource Marion-Polk CCO** will publish a Non-Emergency Medical Transportation (NEMT) frequently asked questions (FAQs) for providers and community partners so they are equipped to support members with access barriers.

### Objective 1.7

By December 2026, 100% of **Polk County Health Services** managers and supervisors will attend and contribute to the integration of services through monthly cross-division discussions, strategic workgroups and operational projects.

### Objective 1.8

By December 2027, **Santiam Hospital & Clinics** will complete and present an updated feasibility report with recommendations for establishing a co-located Community Care Hub in Stayton. The Hub will be designed to provide bilingual (English/Spanish) wraparound services, including mental health care, housing support, and food assistance for under-resourced rural residents, and will also serve as an emergency cache site.

### Objective 1.9

By July 2026, **Santiam Hospital & Clinics** will expand recruitment efforts to ensure that 25% of presenters at its biannual Service Integration Conferences are new, representing a broader range of sectors and including multi-lingual services. This aims to enhance cross-sector collaboration and the sharing of best practices among healthcare providers, social service agencies, and community organizations serving marginalized populations.

### Objective 1.10

By December 2027, **Santiam Hospital & Clinics** will assess the sustainability and potential for expansion of integrated clinical services, including behavioral health clinicians, community health workers, and outpatient clinic-based pharmacists. The assessment will result in a set of recommendations determining whether expansion is feasible across Santiam's rural health clinics, in support of integrated care models that unify physical, behavioral, and social health services.

**Objective 1.11**

By December 2027, **Santiam Hospital & Clinics** will evaluate and improve social determinants of health (SDOH) screening processes to ensure that at least 70% of the patient panel is screened, as measured through EPIC electronic medical records, across all outpatient clinics.

**Objective 1.12**

By December 2030, **Santiam Hospital & Clinics** will host at least one annual bilingual (English/Spanish) outreach event, in collaboration with local partners, in high-need rural neighborhoods within Santiam service area, to build trust and connect residents to services.



***You have to wait eight months for your first visit to the dentist.***

***-Focus Group Participant***

# Goal 1: Improve access to healthcare services



**Strategy 2:** Improve access to culturally and linguistically responsive services to better meet the needs of diverse populations

## Objective 2.1

By December 2028, **Marion County Health & Human Services** will ensure that at least 75% of its most frequently used public-facing materials are written at or below a 6th grade reading level and translated into English, Spanish, and Russian.

## Objective 2.2

By December 2027, **PacificSource Marion-Polk CCO** will increase the number of bilingual and bicultural providers who complete the PacificSource Healthcare Interpreter Training program by 10%.

## Objective 2.3

By December 2028, **PacificSource Marion-Polk CCO** will publish an Oregon Health Authority (OHA)-approved continuing education program for qualified health care interpreters to renew their certification with OHA.

## Objective 2.4

By December 2027, **Polk County Health Services** will establish an internal workforce development program to recruit, train, and retain staff members proficient in languages spoken by our linguistically diverse populations, ensuring sustainable growth and the delivery of culturally and linguistically appropriate programming.

## Objective 2.5

By December 2026, **the Willamette Health Council** and **PacificSource Marion-Polk CCO** will identify opportunities to align efforts, reduce duplication, streamline member and provider communications and outreach, and explore continued partnership to sustain existing Traditional Health Workers functions.

## Objective 2.6

By December 2030, **the Willamette Health Council** and **PacificSource Marion-Polk CCO** will jointly identify and implement at least five community-driven strategies to improve access to culturally and linguistically responsive services for local Oregon Health Plan (OHP) members.

# Goal 1: Improve access to healthcare services

**Strategy 3:** Increase healthcare access points

## Objective 3.1

By December 2027, **Marion County Health & Human Services** will implement at least two new accessible service models; at least two mobile response and co-locating services with at least one community partner in a shared physical space to enhance accessibility and integrated care.

## Objective 3.2

By June 2026, **Santiam Hospital & Clinics** will open a pharmacy in Mill City to expand healthcare access in high-need rural and low-income areas of Marion County.

## Objective 3.3

By December 2030, **Santiam Hospital & Clinics** will host five (one annually) bilingual (English/Spanish) health fair events in high-need rural neighborhoods within the Santiam service area to engage community members, build trust, and provide free services including sports physicals and/or vaccination clinics.

## Objective 3.4

By December 2026, **Santiam Hospital & Clinics** will create one full-time (1.0 FTE) position to assist uninsured and underinsured patients with insurance navigation, including Oregon Health Plan (OHP) application support and Marketplace referrals, with the goal of increasing the number of newly insured individuals.

## Objective 3.5

By December 2030, **the Willamette Health Council** and **PacificSource Marion-Polk CCO** will support at least five new community-level interventions that address local Oregon Health Plan (OHP) healthcare delivery system cost drivers.

## Objective 3.6

By December 2030, **the Willamette Health Council** and **PacificSource Marion-Polk CCO** will support at least five integrated approaches that help Oregon Health Plan (OHP) members maintain healthcare coverage and access to healthcare services to the greatest extent possible.



### **Objective 3.7**

By June 2027, **PacificSource Marion-Polk CCO, the Willamette Health Council, Salem Health Hospitals & Clinics, Santiam Hospital & Clinics, and Legacy Health** will explore ways to pool funds and deliver a set of recommendations (including partnership guiding principles, financial models, and oversight/administration options), to sustain and/or expand free or low-cost healthcare services and supports.

### **Objective 3.8**

By December 2027, **the Willamette Health Council, Salem Health Hospitals & Clinics, Santiam Hospital & Clinics, Legacy Health, and Marion County Health & Human Services** will collaborate to launch a pilot of a multidisciplinary mobile health services model that delivers care in at least two under-resourced and/or rural communities.



***We should partner with healthcare and the community so that way they don't just look at us like, 'Oh they missed their appointments,' but to communicate what the barriers are.***

***– Focus Group Participant***

## Goal 2: Increase the number of providers serving the community

### Long-term Measures of Population Impact

#### Long-term Measure: Ratio of people to physicians

- **Baseline:** Marion 409 people per provider; Polk 2,016 people per provider (2024)
- **Target:** Marion 368 people per provider; Polk 1,814 people per provider (2030)
- **Data Source:** Healthcare Workforce Reporting Program

#### Long-term Measure: Ratio of people to dentists

- **Baseline:** Marion 1,788 people per provider; Polk 3,067 people per provider (2024)
- **Target:** Marion 1,609 people per provider; Polk 2,760 people per provider (2030)
- **Data Source:** Healthcare Workforce Reporting Program

#### Long-term Measure: Ratio of people to mental health providers

- **Baseline:** Marion 210 people per provider; Polk 320 people per provider (2024)
- **Target:** Marion 189 people per provider; Polk 288 people per provider (2030)
- **Data Source:** County Health Rankings

*Mental healthcare providers include psychiatrists, psychologists, licensed social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental healthcare.*

## Goal 2: Increase the number of providers serving the community

### Long-term Measures of Population Impact



**Long-term Measure:** Ratio of people to traditional health workers

- **Baseline:** Marion 555 people per provider; Polk 224 people per provider (2023)
- **Target:** Marion 500 people per provider; Polk 202 people per provider (2030)
- **Data Source:** Traditional Health Worker Registry

*Traditional health workers includes community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators.*

**Long-term Measure:** Ratio of people to non-physician primary care providers

- **Baseline:** Marion 1,090 people per provider; Polk 1,760 people per provider (2024)
- **Target:** Marion 981 people per provider; Polk 1,584 people per provider (2030)
- **Data Source:** County Health Rankings

*Non-physician primary care providers includes nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists.*



***Something I think that's really unique to our community is the stigma around mental healthcare in particular. ... it's devastating and also scary sometimes to see.***

**- Focus Group Participant**

## Goal 2: Increase the number of providers serving the community

**Strategy 1:** Create programs to train providers

### Objective 1.1

By December 2026, **PacificSource Marion-Polk CCO** will train at least six organizations in the Marion and Polk region through a new Health-Related Social Needs (HRSN) provider onboarding program.

### Objective 1.2

By December 2030, **the Willamette Health Council, PacificSource Marion-Polk CCO, and Willamette Workforce Partnership** will support local Oregon Health Plan (OHP) providers in accessing training and other professional development opportunities in alignment with community need, resulting in more providers accessing these opportunities year over year.



***It was difficult to find a therapist and good mental healthcare in this area since everyone is at capacity. Having a lot of anxiety in the morning makes it difficult to get up and look forward to the day.***

***– Age 16, Salem, PhotoVoice Submission***



## Goal 2: Increase the number of providers serving the community

**Strategy 2:** Provide professional development to promote workforce retention

### Objective 2.1

2.1 By December 2030, **the Willamette Health Council** and **Willamette Workforce Partnership** to establish and sustain affinity groups of local healthcare providers to provide targeted wellness programming, opportunities for community connection, and safe spaces for peer-to-peer interaction to reduce burnout and improve wellness by 10%.

### Objective 2.2

By December 2026, **the Willamette Health Council** and **Willamette Workforce Partnership** will to explore developing a regional Provider Wellness Standard with criteria for clinic certification or attestation, resulting in improved workforce wellness, recruitment efforts, and retention.



***Healthcare...is structured to not consider human life, but capital.***

***- Focus Group Participant***

## Goal 2: Increase the number of providers serving the community

**Strategy 3:** Develop new collaborative recruitment efforts

### Objective 3.1

By December 2030, the **Willamette Health Council, PacificSource Marion-Polk CCO, Salem-Keizer Public Schools, Mano a Mano Family Center, Marion & Polk Early Learning Hub**, and the **Willamette Workforce Partnership** will conduct workforce mapping of regional children, youth, and family services, resulting in the identification of target areas for training and recruitment.

### Objective 3.2

By June 2027, the **Willamette Health Council** and **Willamette Workforce Partnership** will develop a regional recruitment campaign aimed at attracting more diverse providers to the Marion-Polk region, resulting in a provider workforce that matches community health needs and demographics.



*The quality of service for low-income people...is very different. You go to an appointment, and the contact with the doctor is 5 or 10 minutes at the most.*

*- Focus Group Participant*

# Access to Healthcare



## Goal 3: Increase utilization of preventive care

### Long-term Measures of Population Impact

**Long-term Measure:** Percentage of 11th graders who received an annual checkup/physical

- **Baseline:** Marion 57 .8%; Polk 55 .3% (2024)
- **Target:** Marion 82 .6%; Polk 82 .6% (2030) (Healthy People 2030)
- **Data Source:** Student Health Survey

**Long-term Measure:** Percentage of 11th graders who received an annual dental checkup

- **Baseline:** Marion 68 .2%; Polk 66 .9% (2024)
- **Target:** Marion 75 .0%; Polk 73 .6% (2030)
- **Data Source:** Student Health Survey

**Long-term Measure:** Percentage of mothers who received prenatal care in their first trimester of pregnancy

- **Baseline:** Marion 78 .4%; Polk 80 .6% (2023)
- **Target:** Marion 86 .2%; Polk 88 .7% (2030)
- **Data Source:** Oregon Vital Statistics

## Goal 3: Increase utilization of preventive care

### Long-term Measures of Population Impact

**Long-term Measure:** Percentage of thirteen-year-olds who have received recommended vaccinations

- **Baseline:** Marion 35 .0%; Polk 32 .0% (2024)
- **Target:** Marion 38 .5%; Polk 35 .2% (2030)
- **Data Source:** Oregon Immunizations Program

*Includes Tdap (tetanus, diphtheria, acellular pertussis), Meningococcal, and 3 doses of HPV (human papillomavirus) vaccine before 13 years of age.*

**Long-term Measure:** Percentage of females aged 50 – 74 who have received recommended breast cancer screenings

- **Baseline:** Marion 78 .4%; Polk 80 .1% (2018-2021)
- **Target:** Marion 80 .3%; Polk 80 .3% (2030) (Healthy People 2030)
- **Data Source:** Behavioral Risk Factor Surveillance System

**Long-term Measure:** Percentage of people aged 50 – 75 who have received recommended colon cancer screenings

- **Baseline:** Marion 75 .1%; Polk 70 .4% (2018-2021)
- **Target:** Marion 82 .6%; Polk 77 .4% (2030)
- **Data Source:** Behavioral Risk Factor Surveillance System

**Long-term Measure:** Percentage of females aged 21 – 65 who have received recommended cervical cancer screenings

- **Baseline:** Marion 78 .3%; Polk 74 .0% (2018-2021)
- **Target:** Marion 79 .2%; Polk 79 .2% (2030) (Healthy People 2030)
- **Data Source:** Behavioral Risk Factor Surveillance System

## Goal 3: Increase utilization of preventive care



**Strategy 1:** Expand the availability and accessibility of preventive care services

### Objective 1.1

By June 2026, **PacificSource Marion-Polk CCO** will increase access to mobile dental services by scheduling two events in partnership with a dental provider or dental care organization.

### Objective 1.2

By August 2026, **PacificSource Marion-Polk CCO** will increase access to preventive care by providing a wider variety of age-appropriate incentives for children offered to clinics with extended office hours.

### Objective 1.3

By September 2026, **PacificSource Marion-Polk CCO** will increase primary care usage by offering a texting service to two provider partners to reach more patients.

### Objective 1.4

By December 2027, **PacificSource Marion-Polk CCO** will partner with Non-Emergency Medical Transportation (NEMT) brokerages to establish written policies, procedures, and educational materials and make improvements to the automated scheduling system to increase the accessibility of NEMT services for Oregon Health Plan (OHP) members with limited English proficiency.

### Objective 1.5

By December 2027, **PacificSource Marion-Polk CCO** will increase access to oral health services by successfully engaging all Patient-Centered Primary Care Homes (PCPCH) clinics in incorporating oral health screenings for Oregon Health Plan (OHP) patients and creating new technical assistance resources for clinics.

### Objective 1.6

By December 2026, **Polk County Health Services** will create and fill a dedicated Community Prevention and Response position, responsible for coordinating and implementing strategies to address challenging community events--- such as suicide, overdose, natural disasters, and other crises---ensuring timely and effective support for affected populations.

### Objective 1.7

By June 2026, **Salem Health Hospitals & Clinics** will conduct three free sports physicals events for 350 youth.

**Objective 1.8**

By June 2026, **Salem Health Hospitals & Clinics** will complete a full review of health education classes to assess alignment with Salem Health's CHIP priorities and current community availability including a need versus a gap analysis.

**Objective 1.9**

By June 2027, **Salem Health Hospitals & Clinics** will facilitate at least six free health screenings, with 50% or more in rural areas. 100% of people with abnormal results will be referred for follow-up care and receive a follow-up call from our health educators within 45 days of screening. 75% of those referred will have the opportunity to see a provider within 45 days of screening.

**Objective 1.10**

By December 2026, **Santiam Hospital & Clinics** will provide 10 community health education presentations to the public on preventive care, including chronic disease states and emergency preparedness.

**Objective 1.11**

By December 2026, **Santiam Hospital & Clinics** will improve access to care for patients in its service area who present to the Emergency Department (ED) without an assigned Primary Care Provider (PCP) by assisting at least 75% of them in scheduling a new patient appointment to establish care within six months of their ED visit.

**Objective 1.12**

By December 2030, **Polk County Health Services, PacificSource Marion-Polk CCO, Marion & Polk Early Learning Hub, and Marion County Health & Human Services** will improve integration and collaboration of home-visiting programs across both counties, resulting in increased utilization and improved early childhood and postpartum health outcomes.

**Objective 1.13**

By December 2030, **the Marion-Polk Community Health Collaborative** will develop and implement a regional immunization strategy in partnership with healthcare providers, schools, and community organizations across Marion and Polk Counties to improve children, adolescents, and adult immunization rates.



***Free medical check-ups. It is something that personally benefits me a lot.***

***– Focus Group Participant***



## Goal 3: Increase utilization of preventive care

**Strategy 2:** Identify and address gaps in school-based health services and networks

### Objective 2.1

By December 2026, **the Willamette Health Council's System of Care** will assess the adequacy and effectiveness of school-based health services, and improve connections between healthcare providers and schools through December 2030.

### Objective 2.2

By December 2026, **the Willamette Health Council** will collaborate with local organizations to conduct a feasibility study, including identification of medical sponsor(s), to develop new school-based health centers in the region.



*It's very difficult for me to get an appointment for my child, because we have to wait one to two months...For example, my child will go to kindergarten in a month, but I can't schedule an appointment to get vaccinations.*

*– Focus Group Participant*

## Goal 3: Increase utilization of preventive care

**Strategy 3:** Explore and adopt new care delivery models

### Objective 3.1

By December 2026, **PacificSource Marion-Polk CCO** will partner with 80% of clinics providing pediatric care in its service regions to encourage the adoption of the ALERT Immunization Information System (IIS) website to verify immunizations due for each member.

### Objective 3.2

By December 2030, **Polk County Health Services** will introduce and establish Infra-Low Frequency Neurofeedback as a component of mental health and co-occurring treatment programs, with at least 50 clients participating in neurofeedback sessions and measurable improvements in client outcomes tracked through pre- and post-intervention assessments.



*A problem with the healthcare system in general is nobody is really comfortable and knowledgeable dealing with the Deaf and Hard of Hearing Community so I think it's really important to have...a dedicated worker who could work with our population...That person would be already trained. There wouldn't need to be any additional training.*

*– Focus Group Participant*

# Priority Area #2: Housing Stability



# Priority Area #2: Housing Stability



## Overview

This priority area is focused on improving the affordability, quality, safety, and local availability of housing. When housing is affordable, people can spend more of their income on things that support their health and well-being. Affordable housing also reduces the risk of homelessness, which has been a persistent challenge in the community.

## Why this is important

**#1 most needed improvement area** on CHA survey

Only  
about  
14%

of survey respondents  
agreed that there is enough  
affordable housing available



**1,428** community members  
in Marion and

**256** in Polk were homeless,  
a 41% increase in Marion and a  
7% increase in Polk since 2018

About half of renters pay high  
rent relative to their income



30+%

(30% or more of their  
household income)<sup>10</sup>



*“I am supporting my disabled Mom, my two kids, and my sister in an old manufactured home that I can’t afford the upkeep on. I am trying to find housing, but I can’t afford any of the current rates, not even close.”*

– Survey Respondent

# What We're Going To Do About It

## Goal 1: Prevent homelessness

**Strategy 1:** Advocate to improve supportive housing models

**Strategy 2:** Expand and strengthen existing housing programs and services

**Strategy 3:** Improve coordination between health, housing, and homeless service providers as people move through the housing continuum

## Goal 2: Increase access to sustainable and affordable housing options

**Strategy 1:** Support local advocacy efforts that promote accessible housing options

**Strategy 2:** Improve educational opportunities to maintain stable housing and achieve long-term financial wellbeing

# Housing Stability



## Goal 1: Prevent homelessness

### Long-term Measures of Population Impact

**Long-term Measure:** Rate of people who are homeless per 100,000 population

- **Baseline:** Marion 411 .9 per 100,000; Polk 285 .7 per 100,000 (2023)
- **Target:** Marion 370 .7 per 100,000; Polk 257 .1 per 100,000 (2030)
- **Data Source:** Oregon Housing and Community Services

*Homeless people are those who are unsheltered, sheltered, and/or chronically homeless.*

**Long-term Measure:** Percentage of enrolled students who are homeless/unstably housed

- **Baseline:** Marion 3.5%; Polk 3.0% (2023 - 2024)
- **Target:** Marion 3.2%; Polk 2.7% (2030)
- **Data Source:** Oregon Department of Education

*Homeless students are those who are doubled up, sheltered, unsheltered, and/or living in a hotel/motel.*



***There is a lack of available, affordable housing for sale and for rent, which is leading people out of the county and into neighboring places.***

***– Survey Respondent***

## Goal 1: Prevent homelessness

**Strategy 1:** Advocate to improve supportive housing models

### Objective 1.1

By January 2027, **Mid-Willamette Valley Community Action Agency** will partner with providers and community-based organizations to create and publish a detailed report with actionable recommendations to guide targeted advocacy efforts for our region during the 2027 legislative session.

### Objective 1.2

By December 2026, and on an annual basis, **Mid-Willamette Valley Homeless Alliance** will convene five annual listening sessions with providers, people with lived experience, and key partners resulting in a briefing for policymakers and participation by at least 20 attendees.

### Objective 1.3

By December 2027, **PacificSource Marion-Polk CCO** will partner with local community organizations to host a community conversation (potentially including a movie screening) focused on older adults experiencing houselessness and housing insecurity, to raise awareness of the growing issue, identify needs, and highlight advocacy opportunities.



*I have a growing concern over the homeless population. I want to find a solution that helps them be a positive part of our community.*

*– Survey Respondent*

# Goal 1: Prevent homelessness



**Strategy 2:** Expand and strengthen existing housing programs and services

## Objective 2.1

By December 2026, **Marion County Health & Human Services** will take the lead in convening Health-Related Social Needs (HRSN) providers to increase engagement and knowledge of housing benefits, resources, and referral pathways.

## Objective 2.2

By December 2030, **Marion County Health & Human Services** will increase permanent housing placements for individuals engaged in MCHHS services by 25% demonstrating integration between systems.

## Objective 2.3

By May 2027, **Mid-Willamette Valley Community Action Agency** will develop and implement a shared information platform that provides community-based organizations with easy access to resources, including guides, frequently asked questions (FAQs), funding updates, policy briefs, toolkits, and program updates.

## Objective 2.4

By December 2026, **Mid-Willamette Valley Homeless Alliance** will use Environmental Scan & Integration Mapping recommendations to identify two high-impact opportunities to expand or strengthen housing programs resulting in two recommendations being selected and initial steps implemented.

## Objective 2.5

By July 2026, **Santiam Hospital & Clinics'** Service Integration Coordinator will actively collaborate with the **Mid-Willamette Valley Community Action Agency's** Housing and Homeless Services Advisory Council to provide rural input on service gaps in the Santiam region and help develop at least two strategies for improvement.

## Goal 1: Prevent homelessness

**Strategy 3:** Improve coordination between health, housing, and homeless service providers as people move through the housing continuum

### Objective 3.1

By June 2026, **Santiam Hospital & Clinics** will evaluate housing-related needs through Service Integration and Community Health Worker Health-Related Social Needs (HRSN) referrals by documenting the number of assistance requests, referrals, and outcomes.

### Objective 3.2

By December 2026, **Mid-Willamette Valley Homeless Alliance** will use findings from the Environmental Scan to identify priority gaps in coordination between health, housing, and homeless services providers by convening an annual cross-sector session to select at least two achievable improvements, assign partner leads for implementation, and incorporate consultant recommendations into the Alliance's funding decisions by directing available resources towards projects of initiatives that address identified gaps and improve coordination.



***The homeless issue is a travesty. To see people panhandling is common and was almost a “never event” when I was young. It is a mind-numbing problem that should not be handed to the next generation.***

***– Survey Respondent***

# Housing Stability



## Goal 2: Increase access to sustain and affordable housing options

### Long-term Measures of Population Impact

**Long-term Measure:** Percentage of households that rent who spend 30% or more of their gross household income on rent

- **Baseline:** Marion 53 .0%; Polk 54 .3% (2024)
- **Target:** Marion 47 .7%; Polk 48 .9% (2030)
- **Data Source:** American Community Survey



*We need more resources such as drop in centers, transitional homes, etc. to open the door and help the community.*

*– Age 18, Monmouth PhotoVoice Submission*

## Goal 2: Increase access to sustain and affordable housing options

**Strategy 1:** Support local advocacy efforts that promote accessible housing options

### Objective 1.1

By February 2027, **Mid-Willamette Valley Community Action Agency** will develop a structured system for advocacy education and information-sharing, including an annual cycle of forums, policy briefings, partner updates, and publication of an advocacy impact brief documenting how education and mobilization efforts have influenced housing policy and expanded equitable access to housing options.

### Objective 1.2

By June 2027, **Mid-Willamette Valley Homeless Alliance** will work with partners and community advocates to coordinate an advocacy campaign that elevates affordable housing priority identified in the Environmental Scan & Integration Mapping resulting in documented partner participation, and at least one policy, funding, or resources action advanced.



*Language is the biggest hurdle for newcomers. It's not just about speaking English; it's about understanding how things work here, and that's really hard when you don't know the language well.*

*- Focus Group Participant*

## Goal 2: Increase access to sustain and affordable housing options



**Strategy 2:** Improve educational opportunities to maintain stable housing and achieve long-term financial wellbeing

### Objective 2.1

By June 2027, **Mid-Willamette Valley Homeless Alliance** will coordinate with partners to provide at least two educational opportunities with attendance tracked and participant feedback collected to help households maintain stable housing and strengthen long-term financial well-being.



*If you got a family, and you got little kids, you have to explain to them, why you can't...get the \$8 ice cream, and people will avoid even free events, because there's nothing they eat. Especially when you're low income, you feel bad it's like depressing, you know. You can't even afford your kid an ice cream cone.*

*– Focus Group Participant*

# Priority Area #3: Mental Health & Substance Use



# Priority Area #3: Mental Health & Substance Use

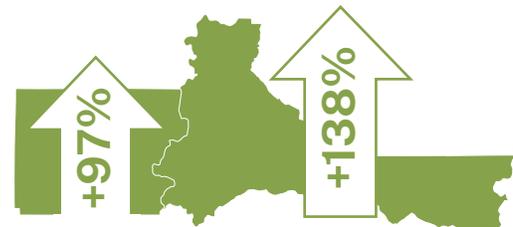


## Overview

This priority area is focused on improving mental health and reducing substance use in the community. As these issues are often, but not always related, there is value in developing approaches that can address both. Good mental health is essential to well-being and is closely connected to physical health in addition to protecting from behaviors like substance use. Community based interventions aimed at addressing the root causes of these issues could do much to improve overall local health.

## Why this is important

**High area of importance**  
on survey and community sessions



Emergency visits for opioid overdoses increased by **138% (Marion) and 97% (Polk)**



of adults had poor mental health  
in the last month



About **1 in 7 adults**  
**smoke cigarettes**

Tobacco use is associated with  
about 20% of all local deaths



About **1 in 7**  
**local adults**  
**binge drank**  
in the last month



About **1 in 5**  
**adults used**  
**marijuana**  
in the last month<sup>10</sup>



***“Mental health and drug and alcohol treatment are badly needed in this community.”***

– Survey Respondent

# What We're Going To Do About It

## Goal 1: Improve mental health

**Strategy 1:** Identify and address gaps in the mental health continuum of care

**Strategy 2:** Develop a regional mental health education and outreach initiative

**Strategy 3:** Enhance alignment and coordination between Marion County, Polk County and the local CCOs behavioral health and public health plans

## Goal 2: Increase sense of belonging

**Strategy 1:** Develop a shared definition of belonging & community-level measures

**Strategy 2:** Support community-based, culturally responsive, and trauma-informed practices, services, and programs to address physical and psychological safety

## Goal 3: Reduce substance use

**Strategy 1:** Improve system infrastructure to increase access to substance use prevention, harm reduction, and treatment services

**Strategy 2:** Enhance quality of substance use prevention, treatment, and recovery services



## Goal 1: Improve mental health

### Long-term Measures of Population Impact

**Long-term Measure:** Percentage of 11th graders who experienced poor mental or emotional health in the last month

- **Baseline:** Marion 10 .2%; Polk 12 .0% (2024)
- **Target:** Marion 9 .2%; Polk 10 .8% (2030)
- **Data Source:** Student Health Survey

**Long-term Measure:** Percentage of adults (18 and over) who experienced poor mental or emotional health in the last month

- **Baseline:** Marion 41 .8%; Polk 43 .1% (2018-2021)
- **Target:** Marion 37 .6%; Polk 38 .8% (2030)
- **Data Source:** Behavioral Risk Factor Surveillance System

**Long-term Measure:** Rate of people who died by suicide per 100,000 population

- **Baseline:** Marion 16 .7 per 100,000; Polk 13 .5 per 100,000 (2023)
- **Target:** Marion 12 .8 per 100,000; Polk 12 .8 per 100,000 (2030) (Healthy People 2030)
- **Data Source:** Oregon Vital Statistics

**Long-term Measure:** Rate of people who attempted suicide who were seen at an emergency department or urgent care

- **Baseline:** Marion 146 .2 per 100,000; Polk 130 .3 per 100,000 (2024)
- **Target:** Marion 131 .6 per 100,000; Polk 117 .3 per 100,000 (2030)
- **Data Source:** Oregon ESSENCE

## Goal 1: Improve mental health

**Strategy 1:** Identify and address gaps in the mental health continuum of care

### Objective 1.1

By December 2026, **Santiam Hospital & Clinics** will evaluate capacity, utilization, and one-year sustainability data for the Santiam Health and Wellness Center and implement at least two service adjustments to address identified mental health service gaps.

### Objective 1.2

By December 2027, **the Willamette Health Council** and **PacificSource Marion-Polk CCO** will conduct a feasibility study, including identifying key partners, to develop at least one new/expanded program or service for Oregon Health Plan (OHP) members experiencing mental health crises to divert from higher levels of care.



*Stress is the number one issue for me. Even though I was eating well, when I faced stress from the war, I had heart surgery here...I know people in Ukraine who developed very serious illnesses due to stress. If a person has everything set in life, good sleep, and proper nutrition, and if stress...is managed well, it makes a big difference.*

*- Focus Group Participant*

# Goal 1: Improve mental health



**Strategy 2:** Develop a regional mental health education and outreach initiative

## Objective 2.1

By December 2026, **Marion County Health & Human Services** will partner with Mid-Valley Suicide Prevention Coalition to develop the Power of Social Connection workshops for specific age groups (19-24, 25-55, and 55+) and make the presentation for community use.

## Objective 2.2

By December 2030, 95% of **Marion County Health & Human Services'** clients will be screened for loneliness and connected to relevant resources.

## Objective 2.3

By December 2030, 95% of **Marion County Health & Human Services'** clients will be screened for suicide risk and referred to appropriate mental health support resources.

## Objective 2.4

By January 2027, **Marion County Health & Human Services** will expand suicide prevention efforts by providing three additional trainings to local first responders

## Objective 2.5

By December 2028, **Marion County Health & Human Services** and **Willamette Education Service District** will complete an assessment and resource mapping to evaluate suicide postvention supports and capacities throughout Marion County.

## Objective 2.6

By September 2026, **PacificSource Marion-Polk CCO** will plan and facilitate a one-hour virtual collaboration with primary care and behavioral health providers focused on mental health prevention and promotion.

## Objective 2.7

By December 2027, **Santiam Hospital & Clinics** will increase the number of staff trained in suicide prevention and culturally responsive care by at least 50%, using a train-the-trainer model to build internal capacity and sustainability.

## Goal 1: Improve mental health

**Strategy 3:** Enhance alignment and coordination between Marion County, Polk County and the local CCO's behavioral health and public health plans

### Objective 3.1

By December 2027, based on guidance from the Oregon Health Authority, **the Willamette Health Council, PacificSource Marion-Polk CCO, Marion County Health & Human Services, and Polk County Health Services** will align community health planning efforts to strengthen connections between regional and state behavioral and public health plans and priorities.



*My biggest obstacle is myself. It's hard not to overthink when it seems like other kids my age are doing so much better. It feels like people are more focused on what I can improve rather than who I am as a person with feelings. But I'll never truly know if it's just me overthinking, so I keep it to myself out of fear of rejection.*

*– PhotoVoice Participant*



## Goal 2: Increase sense of belonging

**Strategy 1:** Develop a shared definition of belonging & community-level measures

### Objective 1.1

By December 2026, **the Marion-Polk Community Health Collaborative** will convene a diverse group of at least 10 cross-sector stakeholders to develop a shared definition of "belonging."

### Objective 1.2

By December 2027, **the Marion-Polk Community Health Collaborative** will create and adopt measures of "belonging" for the Marion-Polk region.

### Objective 1.3

By December 2028, **the Marion-Polk Community Health Collaborative** will explore opportunities for data sharing and analysis of county-wide culture and climate survey data from Marion and Polk County school districts.



*My wellness is most supported by my security. My ability to thrive anyways, my ability to build off of nothing, and my ability to ask for help when I need it.....My health – mental and physical, is at its best when I'm doing what I do best: helping the wellness of others.*

*– Age 17, Photo Voice Submission*

## Goal 2: Increase sense of belonging

**Strategy 2:** Support community-based, culturally responsive, and trauma-informed practices, services, and programs to address physical and psychological safety

### Objective 2.1

By June 2026, **Salem Health Hospitals & Clinics** will increase the number of children fitted for and receiving life jackets by 100% and increase that number by an additional 50% by June 2027.

### Objective 2.2

By June 2027, **Salem Health Hospitals & Clinics** will ensure a minimum of six events, partnered with community organizations, law enforcement, and other emergency medical service providers, to offer community resources to improve physical safety, build trust and reduce crime with the goal of lowering toxic stress felt by residents of impacted neighborhoods by 25%.

### Objective 2.3

By June 2027, **Salem Health Hospitals & Clinics** will increase enrollment in *Be Smart Gun Safety* classes by 50%.

### Objective 2.4

By December 2030, **the Willamette Health Council** will invest in at least 10 local programs and initiatives that increase the sense of belonging for Marion-Polk community members.



*If we want to see a brighter future, we have to invest in our youth. Things like after-school programs, mentorship, and opportunities to learn outside the classroom can really help kids succeed.*

*- Focus Group Participant*

## Goal 3: Reduce substance use

### Long-term Measures of Population Impact

**Long-term Measure:** Rate of people whose cause of death was related to alcohol use per 100,000 population

- **Baseline:** Marion 21 .3 per 100,000; Polk 24 .6 per 100,000 (2023)
- **Target:** Marion 19 .2 per 100,000; Polk 22 .1 per 100,000 (2030)
- **Data Source:** Oregon Vital Statistics

**Long-term Measure:** Percentage of 11th graders who used alcohol in the last month

- **Baseline:** Marion 6 .2%; Polk 11 .0% (2024)
- **Target:** Marion 5 .6%; Polk 6 .3% (2030) (Healthy People 2030)
- **Data Source:** Student Health Survey

**Long-term Measure:** Percentage of adults (18 and over) who used cigarettes (non-electronic) in the last month

- **Baseline:** Marion 14 .9%; Polk 13 .6% (2018-2021)
- **Target:** Marion 6 .1%; Polk 6 .1% (2030) (Healthy People 2030)
- **Data Source:** Behavioral Risk Factor Surveillance System

**Long-term Measure:** Percentage of 11th graders who used electronic cigarettes in the last month

- **Baseline:** Marion 3 .5%; Polk 6 .0% (2024)
- **Target:** Marion 3 .2%; Polk 5 .4% (2030)
- **Data Source:** Student Health Survey

## Goal 3: Reduce substance use

### Long-term Measures of Population Impact



**Long-term Measure:** Rate of people who died from an opioid overdose per 100,000 population

- **Baseline:** Marion 29 .4 per 100,000; Polk 17 .8 per 100,000 (2023)
- **Target:** Marion 26 .5 per 100,000; Polk 16 .0 per 100,000 (2030)
- **Data Source:** Oregon Injury and Violence Prevention Program

*Opioid overdose deaths include fentanyl.*

**Long-term Measure:** Rate of people who overdosed on opioids and were seen at an emergency department or urgent care

- **Baseline:** Marion 106 .4 per 100,000; Polk 55 .7 per 100,000 (2024)
- **Target:** Marion 95 .8 per 100,000; Polk 50 .1 per 100,000 (2030)
- **Data Source:** Oregon ESSENCE

*Opioid overdose deaths include fentanyl.*



*I applied for like 15 different jobs...I did probably seven background checks and seven drug tests, and then all of them were denied, and I really got discouraged.*

*- Focus Group Participant*

## Goal 3: Reduce substance use

**Strategy 1:** Improve system infrastructure to increase access to substance use prevention, harm reduction, and treatment services

### Objective 1.1

By December 2026, **Santiam Hospital & Clinics** will evaluate referral and treatment pathways to the Santiam Health & Wellness Clinic and implement at least two system improvements to increase successful treatment connections for patients.

### Objective 1.2

By January 2027, **PacificSource Marion-Polk CCO** will hold six meetings of the Marion Polk Substance Use Disorder (SUD) Forum to strengthen collaboration in the community while addressing substance use disorder prevention, harm reduction, and treatment services.



*I experienced people running into doctors who, as soon as they're honest about their substance use, they feel judged and that can make them not want to go back to any doctor or professional. You know, they want to feel safe.*

*– Focus Group Participant*

## Goal 3: Reduce substance use



**Strategy 2:** Enhance quality of substance use prevention, treatment, and recovery services

### Objective 2.1

By December 2026, **Marion County Health & Human Services** will implement the pilot project for Peers Expanding Engagement in Methamphetamine Harm Reduction with Contingency Management (PEER-CM) Peripartum, enrolling at least 8 participants.

### Objective 2.2

By December 2027, **Marion County Health & Human Services** will provide 10 targeted education and outreach activities to law enforcement partners, thereby increasing referrals into treatment for individuals who encounter enforcement while using or under the influence of substances.

### Objective 2.3

By June 2027, **Marion County Health & Human Services** will implement the evidence-based parent education program Guiding Good Choices with six cohorts--- four in English and two in Spanish — to increase parenting skills and family communication.

### Objective 2.4

By June 2027, **Marion County Health & Human Services** will implement 10 training sessions for healthcare providers and health-related organizations on opioid misuse prevention for pregnant women, women of childbearing age, and adolescents.

### Objective 2.5

By June 2027, **Marion County Health & Human Services** will organize three screenings of The New Drug Talk Oregon for parents, with at least 75% of attendees reporting increased understanding of the dangers of fentanyl use.

### Objective 2.6

By December 2028, **Marion County Health & Human Services** will implement a standardized screening, brief intervention, referral to treatment (SBIRT) tool across 100% of programs in MCHHS to increase internal referrals for those at risk of substance use.

**Objective 2.7**

By December 2026, **PacificSource Marion-Polk CCO** will host four office hours specific to substance use disorder (SUD) providers to enable sharing of best practices around the Initiation and Engagement of Substance Use Disorder Treatment (IET) quality incentive measure.

**Objective 2.8**

By December 2030, **Polk County Health Services** will implement a co-occurring team-based model in the outpatient setting to more effectively deliver care. This model seeks to increase people with co-occurring mental health substance use, receiving support for their substance use disorder.



*I think we need to normalize not drinking...it's not a stigma that we need to be afraid of.*

*– Focus Group Participant*

# Appendix A: Organizations Serving on MP-CHC

## Executive Committee

- Legacy Health
- Marion County Health & Human Services
- PacificSource Marion-Polk CCO
- Polk County Health Services
- Salem Health Hospitals & Clinics
- Santiam Hospital & Clinics
- Willamette Health Council
- VACANT, The Confederated Tribes of Siletz Indians
- VACANT, The Confederated Tribes of Grand Ronde
- VACANT, The Confederated Tribes of Warm Springs
- VACANT, Chemawa Indian Health Center

## Steering Committee

- Capitol Dental Care
- Centro de Servicios para Campesinos
- Health Equity Coalition of Marion, Polk, and Yamhill Counties
- Interface Network
- Legacy Health
- Marion County Health & Human Services
- Marion & Polk Early Childhood Learning Hub
- Marshallese American Network for Interacting Together
- Mid-Willamette Valley Community Action Agency
- Northwest Senior and Disability Services
- Mid-Willamette Valley Homeless Alliance
- Northwest Human Services
- PacificSource Marion-Polk CCO
- Polk County Health Services
- Salem Health Hospitals & Clinics
- Salem-Keizer Public Schools
- Salem Psychiatric Associates & Valley Mental Health
- Santiam Hospital & Clinics
- Willamette Health Council
- WVP Health Authority
- Yakima Valley Farmworkers Clinic

## Access to Healthcare Workgroup

- Bridgeway Community Health
- Capitol Dental Care
- Kaiser Permanente
- Legacy Health
- Micronesian Islander Community
- Mid-Willamette Valley Community Action Agency
- Northwest Human Services
- PacificSource Marion-Polk CCo
- Polk County Health Services
- Polk County Family and Community Outreach
- Salem Free Clinics
- Salem Health Hospitals & Clinics
- Salem-Keizer Public Schools
- Santiam Hospital & Clinics
- Willamette Health Council
- Willamette Valley Vital Health
- WVP Health Authority
- Yakima Valley Farmworkers Clinic

## Housing Stability Workgroup

- Catholic Community Services
- Center for Hope & Safety
- Centro de Servicios para Campesinos
- Marion County Health & Human Services
- Marion County Housing Authority
- Mid-Willamette Valley Community Action Agency
- Mid-Willamette Valley Homeless Alliance
- Morrison Child & Family Services
- Northwest Human Services
- Oregon Department of Human Services
- PacificSource Marion-Polk CCO
- Polk County Health Services
- Salem Housing Authority
- Sheltering Silverton
- West Valley Housing Authority

## Mental Health & Substance Use Workgroup

- Bridgeway Community Health
- Marion County Health & Human Services
- Marion-Polk Early Learning Hub
- Northwest Human Services
- OYEN Emotional Wellness Center
- PacificSource Marion-Polk CCO
- Polk County Behavioral Health
- Polk County Community Corrections
- Polk County Fire District 1
- Punx with Purpose
- Salem Health Hospitals & Clinics
- Salem-Keizer Public Schools
- Salem Leadership Foundation
- Salem Police Department
- Santiam Emergency Medical Services
- Soaring Heights Recovery Homes
- Willamette Education Service District
- Willamette Health Council

# Appendix B: Executive Committee Signatures



**Josie Silverman-Méndez** (Chair)  
*Willamette Health Council*



**Kari Wilhite**  
*Polk County Health Services*



**Katrina Griffith** (Vice-Chair)  
*Marion County Health  
and Human Services*



**Kim Klotz**  
*Santiam Hospital & Clinics*



**Christina Korkow**  
*Community Advisory Council,  
Willamette Health Council*



**Tricia Frizzell**  
*Salem Health Hospitals & Clinics*



**Diana Netter**  
*Legacy Health*



**Zaira Flores Marin**  
*PacificSource Community Solutions,  
Marion-Polk Coordinated Care  
Organization (CCO)*

# Glossary of Terms

## Organizations, Agencies, Groups

**Confederated Tribes of Grand Ronde:** A federally recognized confederation made up of more than 30 Tribes and bands with traditional homelands expanding from western Oregon, parts of Washington, and northern California. Key Tribes and bands include: Kalapuya (various bands of Tualatin, Yamhill, Santiam, Rogue River (including Takelma and Shasta), Molalla, Umpqua (including Upper Umpqua and Cow Creek Umpqua), Chasta (often combined with Rogue River), Clackamas, Tillamook, Clatskanie.

**Confederated Tribes of Siletz Indians:** A federally recognized confederation of more than 27 distinct Tribes and bands expanding from northern California to southwest Washington, and from the summit of the Cascade Mountains to the Pacific Ocean. Key Tribes and bands include: Clatsop, Chinook, Klickitat, Molala, Kalapuya, Tillamook, Asea, Siuslaw/Lower Umpqua, Coos, Coquille, Upper Umpqua, Tututni (including all the lower Rogue River Bands and those extending up the coast to Floras Creek and down to Whales Head), Chetco (including all of the villages from Whales Head to the Winchuck River), Tolowa, Takelma (including the Illinois Valley/mid-Rogue River and Cow Creek peoples), Galice/Applegate, and Shasta.

**Confederated Tribes of Warm Springs:** A federally recognized confederation that encompasses a vast region of central, north central, and southeastern Oregon, historically inhabited by three distinct tribal groups: the Wasco, Warm Springs (Tenino), and Northern Paiute.

**Coordinated Care Organization (CCO):** A network of all types of health care providers (physical, mental, and dental care, as well as pharmacy services, and health-related social needs providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

**Legacy Health:** A community-based, non-profit health system that includes a hospital and clinics serving the Silverton and Woodburn area in Marion County, Oregon.

**Mano a Mano Family Center:** A Latino-led community-based organization in Salem-Keizer.

**Marion County Health & Human Services:** A local governmental agency in Marion County, Oregon responsible for delivering public health, behavioral health, environmental health, and social services.

**Marion-Polk Substance Use Disorder (SUD) Forum:** A collaborative network of community partners and treatment providers committed to strengthening substance use service delivery and continuum of care. Through shared learning, strategic planning, and barrier busting, the forum strives to enhance access, quality, and outcomes for individuals impacted by substance use.

**Marion-Polk Community Health Collaborative:** A group of local organizations in the Marion-Polk region that work together to assess and improve local health.

**Marion & Polk Early Learning Hub:** A community-serving organization that brings together schools, health providers, social services, and families to support the health and safety of young children (ages 0-6).

**Mid-Willamette Valley Community Action Agency:** A non-profit social service provider serving the Marion-Polk region.

**Mid-Willamette Valley Homeless Alliance:** Recognized by the U.S Department of Housing and Urban Development, the Alliance serves as the region's Continuum of Care---a collaborative organization engaging in community-wide commitment to prevent and end homelessness.

**Mid-Valley Suicide Prevention Coalition:** A group of local organizations in the Marion-Polk region focusing on mental health promotion and suicide prevention.

**National Association of County and City Health Officials (NACCHO):** A Non-profit organization that represents local health departments across the United States.

**Oregon Health Authority (OHA):** State government agency responsible for improving health and healthcare for all Oregonians.

**PacificSource, Marion-Polk CCO:** A not-for-profit health insurance company serving as the Coordinated Care Organization (CCO) for the Marion-Polk region.

**Polk County Health Services:** A local governmental agency in Polk County, Oregon is responsible for delivering behavioral health, developmental disabilities and public health services.

**Polk County Family & Community Outreach:** A department within Polk County that provides a variety of community-focused programs, from prevention services addressing drug, alcohol, gambling and suicide, to programs supporting early learning & family engagement.

**Salem Health Hospitals & Clinics:** A community-based, non-profit health system that includes hospitals and clinics serving the Marion-Polk region.

**Salem-Keizer Public Schools:** Second largest public school district in Oregon, serving the cities of Salem and Keizer.

**Santiam Hospital & Clinics:** A community-based, non-profit health system that includes a hospital and clinics serving the Santiam Canyon area including parts of Marion County.

**Service Integration Program:** Collaboration among community partners to provide coordinated resources, information, and support for individuals and families in the Marion-Polk region.

**System of Care (Willamette Health Council):** A network of community partners working to address barriers to access to healthcare for children, youth, and families in the Marion-Polk region.

**Traditional Health Workers (THW) Alliance (Willamette Health Council):** A local initiative that provides support for the THW workforce in the Marion-Polk region.

**Willamette Education Service District:** A student-centered organization serving 21 Oregon school districts through early learning, special education, technology, school improvement, and administrative services.

**Willamette Workforce Partnership:** A workforce development board committed to building a thriving workforce in the Mid-Willamette Valley.

**Willamette Health Council:** The community governance body for PacificSource Marion-Polk CCO providing strategic direction and oversight, and responsible for much of its community-facing work.

## Additional Terms

**Accessibility/Accessible:** Approach that ensures that all people—regardless of ability—can interact with the information and/or services provided.

**Action plan:** A detailed document that outlines the steps to achieve the CHIP goal.

**ALERT Immunization Information System (IIS):** Oregon’s statewide immunization registry to guide patient care and improve vaccination rates.

**Applied Suicide Intervention Skills Training (ASIST):** Training focused on helping individuals prevent youth suicide.

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

**Belonging:** Active and ongoing practice of building shared humanity by bridging across differences leading to co-creation around cultural and structural challenges that leave people outside the circle of human concern (Ben McBride).

**Co-located services:** Different healthcare or social care providers that share the same physical space, building, or campus to offer combined services to patients or clients.

**Community Health Assessment (CHA):** Assessment portion of the MAPP process that identifies key priority areas for the CHIP by its supporting assessments.

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

**Community health worker (CHW):** A frontline public health worker who is a trusted member of and/or has a close understanding of the community served.

**Continuum of Care:** An integrated system of care that offers a spectrum of services from prevention to treatment and ongoing support.

**Culturally and linguistically appropriate services (CLAS):** Set of 15 action steps intended to improve quality of care to help eliminate health disparities by providing a blueprint for healthcare organizations to implement culturally and linguistically appropriate services.

**Evidence-based approach:** The process of integrating the best available research to guide the implementation of community health initiatives.

**Federal Poverty Level (FPL):** National income threshold that takes into account household income relative to household member size that's often used as the basis for government program eligibility.

**Food insecurity:** State of being without reliable access to a sufficient amount of affordable nutritious food.

**Goal:** Broad, long-term aims (about 3-5 years) based on long-term measures.

**Harm reduction:** Reducing the harm associated with using substances through a variety of public health interventions.

**Healthcare access points:** The places, people, or digital tools that allow individuals to receive healthcare services.

**Healthcare services:** A broad range of professional activities and interventions aimed at maintaining, restoring, or improving an individual's health and well-being. This includes diagnosis, treatment, and prevention services, hospitalization, outpatient care,

mental health care, rehabilitation services, home health care, long-term care, and preventive care.

**Healthier Oregon Program:** Expands free healthcare coverage through the Oregon Health Plan (OHP) to nearly all low-income adults regardless of age or immigration status.

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

**Health equity:** Absence of unfair, avoidable, or remediable differences in health among social groups; is achieved when all people are able to reach their full health potential.

**Healthy People 2030 (HP 2030):** Science-based, ten-year national objectives for improving the health of people living in the United States. These objectives are often used as benchmarks for setting goals at the local, state, and national level.

**Health-Related Social Needs (HRSN):** Social and economic needs that affect a person's ability to maintain health and well-being. HRSN benefits are offered to Oregon Health Plan (OHP) members facing certain life challenges by helping them maintain their health and well-being through housing, nutrition and climate-related supports.

**House Bill 2208:** Requires local public health authorities, community mental health programs and coordinated care organizations to include in a community health improvement plan any behavioral health plans required by law or by the Oregon Health Authority.

**Housing programs and services:** Initiatives, usually by government or non-profit organizations, that assist low-to-moderate-income individuals and families in obtaining safe, affordable, and stable housing.

**Infra-Low Frequency Neurofeedback:** A type of biofeedback therapy that uses infra-low frequency brainwave feedback to help the brain improve self-regulation.

**Long-term measure:** Population-level metrics to track our goal outcomes.

**Mental health:** State of well-being that allows people to cope with stresses, realize abilities, learn and work well, and contribute to their community. It is an integral component of health and wellbeing.

**Medicaid:** A joint federal and state health insurance program providing comprehensive health coverage and long-term care services to low-income individuals and families. In Oregon, the Medicaid program is called the Oregon Health Plan (OHP).

**Mobile health services:** A healthcare delivery unit that travels to communities to provide medical, preventive, and social services directly to patients, typically out of a vehicle such as a van, bus, or RV.

**Mobilization for Action through Planning and Partnerships (MAPP):** Community-level strategic planning framework used to create the CHA and CHIP.

**Objective:** Specific activity that leads to the successful completion of a goal.

**Older adults:** Individuals in late adulthood, generally defined as people age 55 and above.

**Oregon Health Plan (OHP):** Oregon's Medicaid program provides healthcare coverage for low-and middle-income Oregonians from all walks of life. This includes working families, children, pregnant persons, single adults, older adults and more.

**Patient-Centered-Primary-Care Home Program (PCPCH):** Oregon's statewide program that sets standards of care and certifies primary care clinics that meet those standards.

**Peers Expanding Engagement in Methamphetamine Harm Reduction with Contingency Management (PEER-CM):** An evidence-based intervention rooted in harm reduction approaches aimed at reducing methamphetamine use.

**Prevention:** A set of activities aimed at reducing the likelihood of a disease, injury, or disability.

**Preventive care:** Healthcare measures taken to prevent diseases. It includes screening and tests to detect diseases in their early stages, identifying and managing risk factors, encouraging healthy behaviors such as nutrition, exercise, and smoking cessation, and vaccinations to protect against preventable infections.

**Primary Care Provider (PCP):** A healthcare professional who serves as the first point of contact for a patient's ongoing health needs. PCPs can be both physician and non-physicians. Non physicians include nurse practitioners, physician assistants, and clinic nurse specialists.

**Priority area:** Emerging health issues identified in the CHA process.

**Providers:** Includes physicians, non-physician providers (such as physician assistants, nurse practitioners, and clinical nurse specialists), dentists, mental health professionals (such as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and drug abuse, and advance practice nurses specializing in mental health care), and traditional health workers (such as community health workers, peer support specialists, doulas, and personal health navigators).

**Power of Social Connection:** Training that helps individuals build and maintain meaningful relationships to improve physical, mental, and emotional well-being while raising awareness of the importance of social connection.

**Qualified healthcare interpreter:** A trained and tested individual who serves as a communication bridge between healthcare providers and people who prefer to communicate in a language other than English (including sign language), ensuring accurate understanding and quality care.

**Recovery services:** Non-clinical services that assist individuals and families to recover and stabilize from alcohol and other drugs. They include social support, linkage to and coordination among service providers, and a full range of services that facilitate recovery and wellness, contributing to an improved quality of life.

**Rural:** Geographic area that is more than 10 miles from a population center greater than 40,000 people.

**School-based Health Center:** A clinic located in or near a school that provides students with comprehensive health services including medical, mental, and often dental services.

**Short-term measure:** Organization-level metrics that measure immediate impact

**Social Determinants of Health and Equity (SDOH-E):** Root causes responsible for the health of a community.

**State Health Improvement Plan (SHIP):** Comprehensive, multi-year plan developed by the state's public health agency to address identified health priorities and improve the overall health of all its residents.

**Strategy:** A broad statement of what will be done to address the CHIP goal.

**Student Health Survey (SHS):** Statewide survey administered at the local level every year in schools to assess the health of teens, including substance use and other factors.

**Substance use:** The consumption of substances, including alcohol, tobacco, and opioids.

**Substance use disorder (SUD) treatment services:** A range of programs and therapies designed to help individuals with SUD achieve abstinence or reduce harm, manage withdrawal symptoms, prevent relapse, and improve their overall functioning and well-being.

**Substance use prevention:** Activities to educate and support individuals and communities to prevent the use of and misuse of drugs and alcohol and the development of substance use disorders.

**System infrastructure:** The combination of physical facilities, technological systems, essential equipment, skilled personnel, and organized processes required to effectively deliver healthcare services and promote public health.

**Traditional Health Worker (THW):** Trusted individuals from their local communities provide person and community-centered care by bridging communities and the health systems that serve them. THWs include Community Health Workers, Peer Support Specialists, Peer Wellness Specialists, Personal Health Navigators, and Doulas.

**Transitional housing:** Temporary, supportive housing designed to bridge the gap between homelessness and permanent housing.

**Trauma-informed approach:** A strength-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, and emphasize physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to build a sense of control and empowerment.

**Urban:** Geographic area that is less than 10 miles from a population center greater than 40,000 people.

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**Page 43:** Ron Cooper

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# Notes:



