2015-2020

Approved May 2015

COOS COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

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Steering Committee Members and Plan Development Participants

Current Members

- **Betty Albertson**, District Manager, *Department of Human Services*
- **Barbara Bassett**, Health Education Director, *Coos County Health and Human Services*
- **Terri Camp, RN, MHL**, Chief Quality Officer, *Bay Area Hospital*
- **Shannon Durkee**, Tobacco Prevention Program Coordinator, *Coos County Health and Human Services*
- **Cynthia Edwards**, Health Education Coordinator, *Coos County Health and Human Services*
- **Jennalyn Ford**, Communications Center Manager, *Bay Cities Ambulance*
- **Fauna Larkin, MPH,** Assistant Health and Human Services Administrator, *Coquille Indian Tribe*
- **Carla McKelvey, MD**, Pediatrician, *North Bend Medical Center*
- **Reneé Menkens, RN, MS**, Instructor, *OHSU*
- **Kay Metzger**, Innovator Agent, *Oregon Health Authority*
- **Tim Novotny,** General Manager**,** *Bay Cities Ambulance*
- **Kathleen Olson-Grey,** Epic System Site Specialist, *Waterfall Clinic*
- **Stephanie Polizzi, MPH, RD, CHES**, *Oregon State University Coos County Extension Service*
- **Florence Pourtal-Stevens,** Public Health Administrator, *Coos County Health and Human Services*
- **Bailey Richards**, CHIP Volunteer, *AmeriCorp VISTA at Coos County Health and Human Services*
- **Skaidra Scholey,** Program Development, *North Bend Medical Center*
- **Cecilee Shull,** South Coast Regional Manager, *Advantage Dental*
- **Ginger Swan,** Director, *Coos County Health and Human Services*
- **John Sweet,** County Commissioner, *Coos County*
- **Angie Webster,** Director of Clinical & Professional Development, *Bay Area Hospital*
- **Laura Williams,** Customer Service and Provider Relations Director, *WOAH*

Past Members

- **Chris Beebe,** Senior Account Executive, *KCBY Television*
- **Alison Booth,** Teen Parent Program Director, *Coos Bay School District*
- **Stephen Brown, ND, MPH**, *Coos County Public Health Department*
- **Lynda Buford, RN**, Public Health Nurse and Accreditation Assistant, *Coos County Public Health Department*
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- **Tom Holt, DDS,** *Coos Bay Dentist*
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- **Lindi Quinn,** Citizen, *Coos County Friends of Public Health and Women's Health Coalition*
- **Gregory Saunders, MD, MPH,** *Community Representative*
- **Kathy Saunders, MS, MPH, RD, LD**
- **Lonnie Scarborough, RN, BA**, *Western Oregon Advanced Health*
- **Marilyn Schmidt**, Volunteer, *Maslow Project*
- **Dane Smith, DDS,** *Cavity Free Kids*
- **Frances Smith**, Past Administrator, *Coos County Public Health Department*
- **Jennifer Stephens**, Health Programs Coordinator, *Coquille Indian Tribe*
- **Emily Thornton,** Reporter, *The World Newspaper*
- **Kathleen Walsh, RN**, Community Crossroads Café & Retired SWOCC Nursing Faculty
- **Sannie Warbis**, RNC, BS, Interim Director of Quality, *Bay Area Hospital*
- **Kathy Wright, RN**, Certified Addictions
- **Kevin Urban,** Parks and Recreation, *City of Coquille*
- **Herb Yussim,** Broker/Owner, *Oregon Bay Properties*
- **Nikki Zogg, PhD, MPH**, Past Administrator, *Coos County Public Health Department*
- **WOAH Oregon Health Plan Members – Survey Participants**

Contents

Timeline

The following timeline outlines the development of the Community Health Improvement Plan, including the Community Health Assessment process:

October 2012: At the Western Oregon Advanced Health (WOAH) Community Advisory Council Subcommittee on Assessment meeting, the requirements for a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) were reviewed. The group began drafting a plan for a collaborative community health improvement process.

January 2013: Recruiting for CHA subcommittee members began.

March-May 2013: Data collection for the CHA was conducted, including monthly meetings to collect input from committee members on resources and needs. At the conclusion of data collection, the group discussed the CHA findings and identified eight priority areas for the CHIP to address. The group performed a Strength, Weakness, Opportunity, and Threat (SWOT) analysis for the eight priority areas (see Appendix A).

June-August 2013: The CHA document was written by the Coos County Public Health Administrator. In July, the Subcommittee on Assessment began working on the CHIP based on the eight identified priority areas.

September 2013: The CHA was finalized.

October 2013: The CHIP was presented to the WOAH Community Advisory Council and accepted.

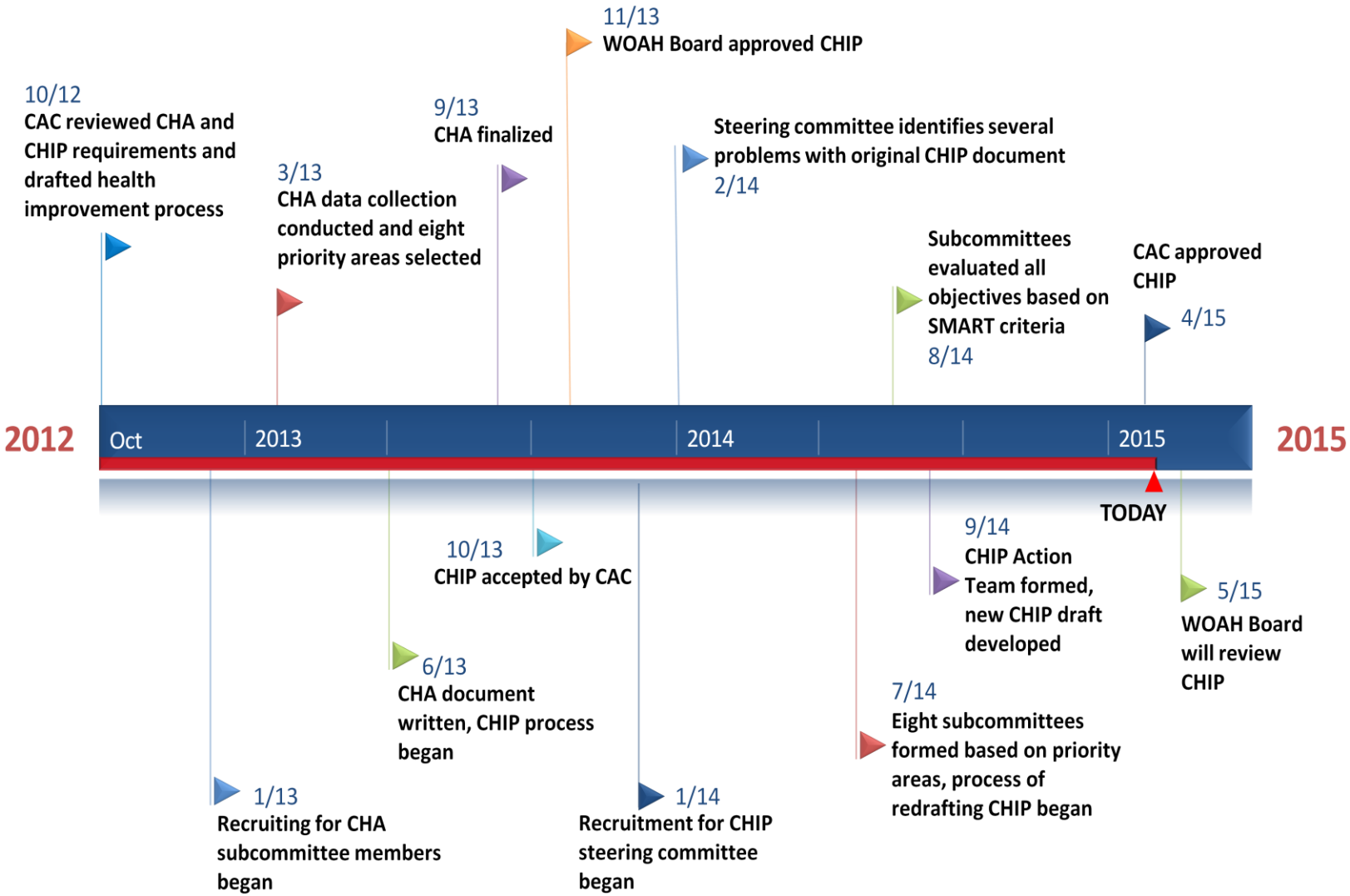
November 2013: The CHIP was referred to the WOAH Board and approved.

January 2014: Recruitment for the CHIP Steering Committee began.

February-June 2014: The first CHIP Steering Committee meeting was held in February. Over the next four months, the Steering Committee identified several issues with the original CHIP document. These included the CHIP being too expansive, the objectives being too broad, and partnering agencies lacking adequate accountability measures for their assigned objectives.

July 2014: Eight subcommittees of the CHIP Steering Committee were formed based on the eight priority areas. Subcommittee actions and the development of the updated CHIP document are outlined in more detail below.

August 2014 – March 2015: Implementation of some activities from the previous CHIP was undertaken. A CHIP revision was planned and written by the Steering Committee. The new edition reduced the number of priority areas to four using a dot prioritization exercise.


10/12
CAC reviewed CHA and CHIP requirements and drafted health improvement process
3/13
CHA data collection conducted and eight priority areas selected
9/13
CHA finalized
11/13
WOAH Board approved CHIP
Steering committee identifies several problems with original CHIP document
2/14
Subcommittees evaluated all objectives based on SMART criteria
8/14
CAC approved CHIP
4/15
2012
Oct
2013
2014
2015
2015
TODAY
10/13
CHIP accepted by CAC
6/13
CHA document written, CHIP process began
1/13
Recruiting for CHA subcommittee members began
1/14
Recruitment for CHIP steering committee began
9/14
CHIP Action Team formed, new CHIP draft developed
7/14
Eight subcommittees formed based on priority areas, process of redrafting CHIP began
5/15
WOAH Board will review CHIP

CHIP Review and Update Process

The CHIP Steering Committee began the review and update process in July of 2014. The initial goals were to prioritize remaining objectives, edit objectives to incorporate SMART (specific, measurable, attainable, relevant and time based) criteria, and identify work that was either completed or in progress by partner agencies. Eight sub-committees were formed corresponding to the original eight priority areas: access to healthcare, chronic illness management, chronic illness prevention, dental health, fall prevention, maternal and child health, mental health, and socioeconomic disparities.

Each sub-committee met twice. The first meetings occurred in July 2014, where committees used a prioritization matrix to evaluate all objectives on their feasibility, impact, morbidity, and existing resources. Committees held second meetings in August and September 2014 to evaluate objectives based on SMART criteria and clarify which organization/representative will be the main contact for data collection for each objective. Several concerns arose during these meetings:

1. Are the existing objectives an appropriate focus for the CHIP?
2. Who is responsible for working on the established objectives? There are multiple players and providers noted in the original plan but lack of ownership.
3. The original plan is not manageable. There are too many priority areas, goals and objectives. Most plans have no more than 3 to 4 priority areas.
4. Objectives are not measureable and read more like activities.

Due to the concerns expressed, Coos Health & Wellness convened a CHIP Action Team comprised of Florence Pourtal-Stevens, Public Health Administrator, Barbara Bassett, Health Education Director, Cynthia Edwards, Health Education Coordinator, and Bailey Richards, CHIP VISTA Volunteer. The goals of the CHIP Action Team were to:

1. Streamline the number of priority areas, goals and objectives
2. Create a framework to support SMART criteria within the plan
3. Publish a draft revision of the plan

First, the CHIP Action Team reviewed data collected in the 2013 Coos County Community Health Assessment and identified areas that had countywide data and baselines. These areas created a framework for measurable objectives to be drafted into, which were then grouped under the already-existing priority areas and goals. Next, all goals and objectives were reviewed against the following criteria:

1. Feasibility Yes/No
2. Measurable Yes/No
3. Baseline Yes/No

4. Impact Yes/No
5. Person willing to champion goal Yes/No

The goals and objectives that remained were reworded to ensure that they were SMART and aligned with national benchmarks such as Healthy People 2020.

The CHIP document was regularly reviewed and discussed throughout this process by the CHIP steering committee. After the CHIP Action Team identified SMART goals and objectives, the steering committee then went through a prioritization exercise and selected five overall goals for the 2015 edition of the Coos County CHIP. These goals are grouped under four of the eight original priority areas: Access to Healthcare, Chronic Disease Prevention/Healthy Lifestyles, Mental Health, and Maternal and Child Health. This structure preserves the work done on the CHA and previous CHIP, including subcommittee work, illustrates how the new CHIP is connected to those documents, and narrows the plan's scope so that future work is realistic and attainable.

Moving forward, the committee plans to divide into five subcommittees (one for each goal) to develop and implement strategies and actions. These strategies will be developed with the aid of two strategic frameworks (see page 11) and will comprise the CHIP Implementation Plan.

Strategic Frameworks

The 2013 CHA and CHIP were created using a simplified Mobilizing for Action through Planning and Partnerships (MAPP) model, with integral support from the CHIP steering committee in community partnership development. For the 2015 edition of the CHIP, we plan to develop subcommittees for each goal that will use the SWOT analysis laid out in the CHA (see Appendix A), the social-ecological prevention framework (see Appendix B), and the Community Health Improvement Matrix (see Appendix C) as the foundation for their strategy-building.

2013 CHIP Framework: MAPP

MAPP is a community-driven strategic planning tool for improving community health. The process is facilitated by public health leaders and is intended to help communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

Figure 1: MAPP Model[i]

The modified aspects of MAPP implemented in the Coos County Health Assessment project were in the area of assessment. Committee meetings were used in lieu of conducting the

Community Themes and Strengths Assessment and the Forces of Change Assessment. The CHIP describes the Strategic Issues and Goals/Strategies steps of the MAPP model as they pertain to improving health in Coos County.

2015 CHIP Framework 1: Social-Ecological Model

The social-ecological model looks at planning using a connected approach. The model suggests strategizing under the following five areas (see Appendix B for visual model):

- Individual – Enhancing skills, knowledge, attitudes and motivation
- Interpersonal – Increasing support from friends, family and peers
- Organizational – Changing policies and practices of an organization
- Community – Collaborating and creating partnership to effect change in the community and increase the efficiency and effectiveness of care
- Public Policy – Developing, influencing and enforcing local, state and national laws which promote health and create safe and healthy environments

The social-ecological model recognizes there are small and large units for planning. Small steps of forward progress contribute to large steps, and the large in turn contribute to the small. There is ecological synergy in how we address health issues that promote a more holistic, coordinated, and population-based planning structure.

Figure 2: Social-Ecological Model[ii]

2015 CHIP Framework 2: Community Health Improvement Matrix

The Community Health Improvement Matrix is "a bivariate map that includes the level of prevention on the vertical axis and the level of intervention on the horizontal axis, to conceptualize all community health improvement/ implementation activities. The matrix's prevention levels include the three traditional public health categories: primary (reduce susceptibility or exposure to health threats), secondary (detect and treat disease in early stages), and tertiary (alleviate the effects of disease and injury)." NACCHO also added a fourth category: "contextual (preventing the emergence of predisposing social and environmental conditions that can lead to causation of disease)."[iii]

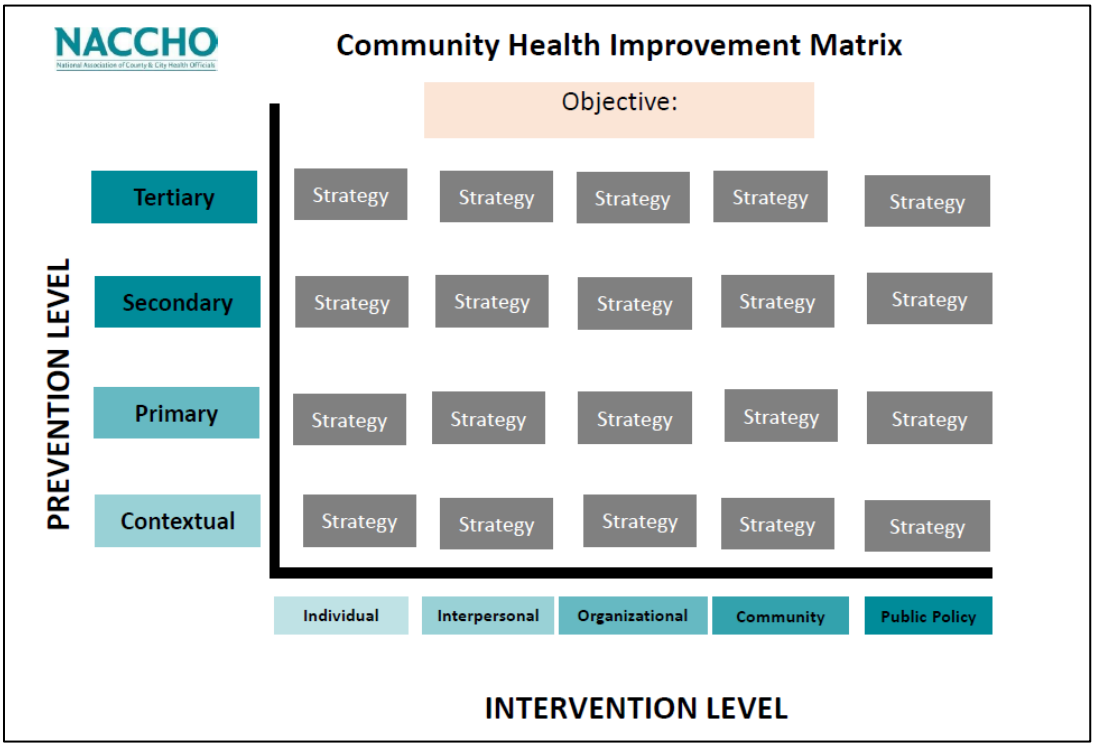


Figure 3: Community Health Improvement Matrix[iv]

CHIP Priority Areas

Access to Healthcare

According to Healthy People 2020, access to health services means "the timely use of personal health services to achieve the best health outcomes." Access to healthcare impacts:

- Overall physical, social, and mental health status
- Prevention of disease and disability
- Detection and treatment of health conditions
- Quality of life
- Preventable death
- Life expectancy[v]

Having access to Primary Care Providers (PCPs) is especially important, as PCPs are a consistent source of health services for patients. PCPs can develop personal and long-term relationships with patients, provide integrated services, and practice with family and community context in mind.[vi]

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. (Healthy People 2020)

The national benchmark ratio of primary care providers to population, as listed in the 2015 County Health Rankings, is 1:1,045. The state ratio in Oregon is 1:1,105, while Coos County has a ratio of 1:1,117. According to the Health Resources and Services Administration, Coos County is classified as a Medically Underserved Area/Population for low-income people and a Primary Care Health Care Professional Shortage Area for low-income and homeless people.[vii] Additionally, based on research completed by the Oregon Office of Rural Health, Powers has a 0% capacity to provide medical care, while Coquille and Myrtle Point have a 57.1% capacity for primary care appointments.[viii]

The CHIP steering committee selected access to healthcare as a priority area because our provider-to-patient ratio falls short of state and national standards. Additionally, the communities of Coquille, Myrtle Point, and Powers are consistently ranked among the top ten worst rural Oregon communities in healthcare access.[ix] Having inadequate access to health services leads to unmet health needs, delays in receiving appropriate care, inability to get preventive services, and hospitalizations that could have been prevented,[x] and we plan to reduce loss of life and cost to the county by addressing this issue.

Chronic Disease Prevention/Healthy Lifestyles

According to the 2015 Robert Wood Johnson County Health Rankings, Coos County ranks 32nd (with 34th being the worst) for overall health factors in Oregon.[xi] Much of this ranking is based on preventable or behavioral health risk factors in Coos County, such as smoking and obesity.

More than 75% of U.S. health care spending is on people with chronic conditions. These conditions are the nation's leading cause of death and disability, many of which could have been prevented. (Centers for Disease Control and Prevention)

Prevalence of tobacco use poses a significant challenge to the health of Coos County residents. 26% of Coos County adults smoke, including 23.4% of pregnant mothers.[xii] In the 2012 Student Wellness Survey, 11.4% of eleventh graders reported smoking within the last thirty days, and 14.1% reported using other tobacco products within the same period.[xiii] [xiv] Overall rates for the state of Oregon show lower numbers in all but one of these areas: 16.1% of adults, 12.2% of pregnant mothers, and 11.9% of 11th graders smoke, and 9.7% of 11th graders use other tobacco products.

Of preventable causes of death in Coos County, 27% were caused by tobacco use.[xv] Cancer related to smoking and tobacco use is the leading cause of death in Coos County, particularly lung and bronchus cancer.[xvi] Of all the counties in Oregon, Coos has the third highest rate of esophagus cancer, second highest rate of lung cancer, and the highest rate of oral and pharyngeal cancer. In 2011, 1,250 years of life were lost due to cancer in Coos County.[xvii]

Due to these factors, the economic cost of tobacco in the county is immense. In 2013, the county spent an estimated $39.1 million on tobacco-related medical care. The county also lost $34.2 million from indirect costs due to tobacco-related deaths.

Obesity is also a serious risk factor for chronic disease in Coos County. The CDC defines obesity in adults having a Body Mass Index (BMI) of 30 or higher, and in children as having a BMI at or above the 95th percentile. 30% of adults in the county are obese, compared to 27% statewide and 25% for national top performers.[xviii] Child obesity rates are relatively on par with state rates, although there is still much room for improvement: 10.8% of 8th graders and 10.9% of 11th graders in Coos County are obese.[xix] The county is less physically active than the state average, as 22% of residents are categorized as "physically inactive," compared with Oregon's 20%.[xx]

Poor nutrition and weight status have been linked with multiple poor health outcomes. These include being overweight or obese, malnutrition, iron-deficiency anemia, heart disease, high blood pressure, dyslipidemia (poor lipid profiles), type 2 diabetes, osteoporosis, oral disease, constipation, diverticular disease, and some cancers.[xxi]

The Centers for Disease Control and Prevention (CDC) cites prevention as one of the most important determinants of health and wellness outcomes.[xxii] Poor nutrition and weight have been shown to be highly preventable by using strategies such as

building public knowledge, social support, food and agriculture programs, and food assistance policies.[xxiii] The CHIP steering committee has decided to focus on decreasing tobacco use and obesity to address chronic disease, not only because of the devastating health impacts they are having on Coos County, but also because they are considered "winnable battles" of public health.[xxiv] By taking a preventive approach to tobacco and obesity, we plan to help Coos County residents begin healthy cycles of behavior.

Mental Health

Healthy People 2020 states that mental disorders are the most common causes of disability in the United States, and that the disease burden of mental illness is among the highest of all diseases. Mental illness accounts for 25% of all years of life lost to disability and premature mortality.[xxv]

According to the Centers for Disease Control and Prevention, in 2011 over 39,500 people killed themselves, and suicide and self-inflicted injuries resulted in an estimated $41.2 billion in combined medical and work loss costs. Suicide was the second leading cause of death among persons aged 15-35, fourth among persons aged 36-54 years, eighth among persons aged 55-64, and tenth overall.[xxvi]

Suicide is a concerning problem in Coos County. From 2008 to 2010, 7% of adults in Coos County self-reported having at least one major depressive episode in the last year,[xxvii] and from 2009 to 2011, there were 142 suicide-related hospitalizations in the county. From 2003 to 2010, 149 individuals committed suicide, the majority of which were committed by individuals 45 to 64 years of age.[xxviii] Coos County's suicide rates per 100,000 people are also considerably higher than the state's in every age group, and are over double the state rate for people ages 18-24.[xxix]

Of additional concern is Coos County's high use of residential-based psychiatric treatment for children. Coos County averages approximately 6.5 children in residential care on a daily basis, a figure that is three times the state average.[xxx] However, there are no psychiatric residential facilities within the county or region, which means that children and their families must travel to Eugene or Portland to access care. This often results in inadequate use of family therapy, parent training, and other evidence-based modalities. Coos County exceeds the state in rates of youth who exhibit psychological distress: 12% of eighth graders and 11.4% of eleventh graders, versus 8.4% of eighth graders and 8.3% of eleventh graders at the state level.[xxxi]

Suicide is a leading cause of death in the United States. Over 483,586 people with self-inflicted injuries were treated in U.S. emergency departments since 2012. (Centers for Disease Control and Prevention)

The CHIP steering committee selected this priority area because of the high suicide rate in Coos County, as well as mental health's close intersection with various other health areas. According to Healthy People 2020, "mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery."[xxxii] We plan to address health and wellness holistically, and improving mental health and suicide rates in Coos County is a critical piece of this.

Maternal and Child Health

Healthy People 2020 states that maternal and child well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system.[xxxiii]

Improving the well-being of mothers and children is an important public health goal for Coos County and the nation. Helping pregnant mothers access early and timely prenatal care will increase their chances of identifying existing health risks and preventing future problems for mother and child. These issues can include hypertension and heart disease, diabetes, depression, genetic conditions, sexually transmitted diseases, tobacco and alcohol use, inadequate nutrition, and unhealthy weight.[xxxiv]

In Coos County, 74% of expectant mothers receive prenatal care in their first trimester. While this is a better rate than some surrounding counties, Coos County falls short of meeting the state average of 78% or the national average of 84%.[xxxv]

Additionally, only 34.4% of Oregon mothers report that after their baby was born, a healthcare worker talked with them about how to prevent their baby from getting tooth decay. In Coos County, 81% of eighth graders saw a dentist in the past 24 months, while 87.7% of 11th graders did.[xxxvi]

Likewise, poor oral health has been shown to increase risk factors for dental caries (tooth decay), periodontal (gum) diseases, cleft lip and palate, oral and facial pain, and oral and pharyngeal cancers. This impacts a person's ability to speak, smile, smell, touch, taste, chew, swallow, and make facial expressions to show feelings and emotions.[xxxvii]

The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality care. (Healthy People 2020)

Certain conditions contribute to people's likelihood of receiving early prenatal and dental care. Age, cultural differences, health literacy, work status, comorbid diagnoses, and socioeconomic status can all have an impact on a woman's ability to access first trimester care. Additionally, health system factors like cost, scheduling systems, or location may also be preventive.[xxxviii]

The CHIP steering committee selected Maternal and Child Health as a priority because health risk factors can begin forming for a human being as early as preconception. We aim to improve health outcomes for mothers, children, and future generations through early prevention and intervention.

Community Health Improvement Plan

The Community Health Improvement Plan (CHIP) identifies the top health priority areas from Community Health Assessment data, outlines strategies for action, and provides baselines and targets to measure progress. This document is not intended to describe every possible area for health improvement in the community – rather, it identifies the areas of highest concern and potential for change, and combines the efforts of many organizations in the community so that they are cooperatively working towards common health improvement goals.

This section outlines the broad plan for addressing community health priority areas by breaking them down into goals and objectives. The goals and objectives describe more specifically what the group wishes to achieve within each priority area, and parallel national priorities when possible by using Healthy People 2020 targets.

Priority Area: Access to Healthcare

Goal 1: Increase access to care providers

Objective 1: To be determined by subcommittee

Priority Area: Chronic Disease Prevention/Healthy Lifestyles

Goal 1: Decrease tobacco initiation and use

Objective 1: By 2020, develop a strategic plan that takes a comprehensive approach to addressing tobacco initiation in Coos County.

Objective 2: By 2020, increase the percentage of adult non-smokers from 71.9% to 88% (Healthy People 2020).

Objective 3: By 2020, increase the percentage of youth non-smokers from 85.8% (11th grade) to 100%.

Objective 4: By 2020, increase the percentage of women who do not smoke during pregnancy from 76.7% to 98.6% (Healthy People 2020).

Goal 2: Obesity reduction and prevention

Objective 1: By 2020, decrease the percentage of people (adults and youth) in Coos County who are obese from 30% to 25% (Robert Wood Johnson County Health Rankings).

Objective 2: To be determined by subcommittee – will incorporate nutrition programs

Priority Area: Mental Health

Goal 1: Prevent suicides

Objective 1: By 2020, decrease the number of suicides from 29.7 suicide deaths per 100,000 people to 10.2 deaths per 100,000 people (Healthy People 2020).

Priority Area: Maternal and Child Health

Goal 1: Increase the timeliness of prenatal care

Objective 1: By 2020, increase the percent of women who receive prenatal care in the first trimester from 75.3% to 77.9% (Healthy People 2020).

Objective 2: By 2020, expand the First Tooth Training to all service agencies and family practice pediatric offices in Coos County (Strategic Plan for Oral Health in Oregon: 2014-2020).

Objective 3: By 2020, promote oral exams and treatment for pregnant women in all OBGYN practices in Coos County (Strategic Plan for Oral Health in Oregon: 2014-2020).

Appendix A: SWOT Analysis

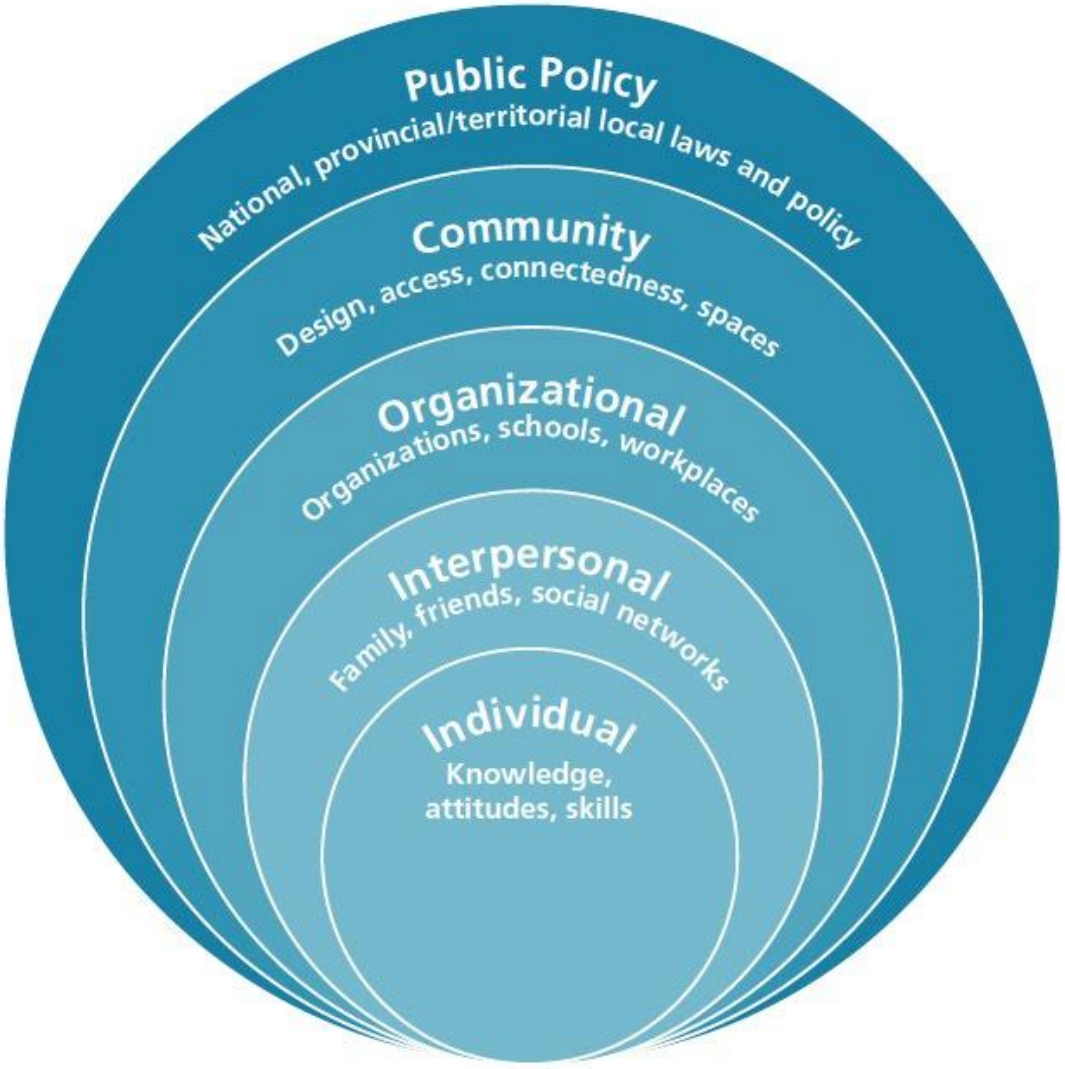
Table 63: Coos County Priority Areas and Gap Analysis Results

Priority Area ~ Gap Analysis				
Priority Area	**Strength**	**Weakness**	**Opportunity**	**Threat**
Access to healthcare	• Radiation Center, Oncology Clinic, and Cardiac Unit • Fewer uninsured people • Area FQHC, CHCs and SBHCs • Critical Access Hospitals • Nursing homes • Care management • Memory care • SWOCC – educating future healthcare industry workers	• Lack urgent care • Low pay for providers • Rural location • National Health Services Corp shortage • Timely access • Individual compartmentalization	• Telehealth • Recruiting new providers • J1 waiver: foreign-trained providers • Care management • Student/residency programs for RNs, NPs, PAs, MDs • Different models for healthcare delivery	• Provider shortage • Costly recruitment • Larger communities competing for and more attractive to providers, and have historically held the market • Lower income for providers • Lack of specialty care • Socioeconomic status • Public transportation • High liability costs to provide transportation for clients

Priority Area	Strength	Weakness	Opportunity	Threat
Chronic illness management	• Home health agencies • Dialysis/wound management • Care management • Diabetic education through Bay Area Hospital • Collaborative effort to decrease hospital readmissions	• Individual weakness to manage health issues (self-care) • Rates of chronic conditions in Coos/Curry County • Burden on physicians • Lack continuous flow of communication, which allows people to fall through the cracks resulting in ED visits/readmits • Dementia patients with no affordable place to go for long-term care	• Living Well with Chronic Conditions program and similar programs • Streamline chronic illness management programs • Identify common goals for organizations that want to collaborate • Diabetic education through Southern Coos Hospital • Cancer treatment navigator	• Non-compliant patients • Schools nursing capacity on decline • Multi-generational families with chronic conditions • Changing federal & state rules that create problems for end-of-life care
Chronic illness prevention	• Funding for tobacco initiation and use prevention	• Clear vision/ plan • Funding for policy development; physical activity/nutrition and built environment; sustainable quality programs • Sustainability • Link education to schools • Grocery store displays/ marketing strategies • Lack of nutrition expertise	• New funding streams • Untapped expertise • Eliminate food deserts • Peer support • Health in all policies • Worksite wellness programs • SNAP & EBT @ Farmers Markets • SWOCC – community would benefit from a new workforce trained/educated in community healthcare	• Local culture • Built environment • Funding doesn't support prevention • Lack of support for healthy foods in schools • State stops promoting healthy choices
Dental health	• Private funding (*Ready to Smile*) • Cavity Free Kids • Advantage Dental	• Need exceeds service availability • Diet and nutrition	• OHP expansion • Expand models • WIC-Dental linkage • Personal dental hygiene	• Medicare does not cover dental

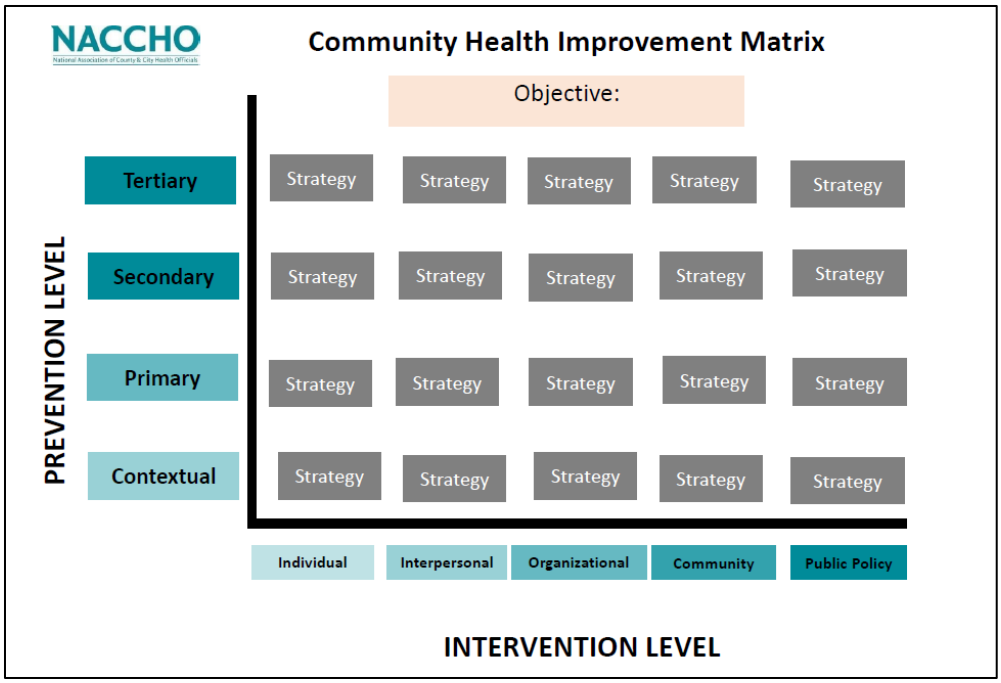
Priority Area	Strength	Weakness	Opportunity	Threat
Fall prevention	• Fall prevention programs at acute & long-term care settings • Personal alert systems (for when falls occur)	• Lack collaborative effort by community	• Community-based fall prevention programs • Personal knowledge of how to use assisting devices	• Increased proportion of older adults in Coos County • Limited resources • Home bound • Lack of family support
Maternal and child health	• Head Start • Title X • Midwives • Home visiting programs • MOMS • Breastfeeding programs • No-cost pregnancy testing • BCHC & FQHC • WIC • Children's Relief Nursery	• High percent of tobacco use among pregnant women • Low birth weight • Births to women < 19 years of age • Births to unwed mothers • High rates of fetal mortality	• Preventing unintended pregnancies • Access to prenatal care (1st trimester) • Preventing preterm labor • Food insecurity/nutrition • Promotion of services for programs • Healthy Start	• Family support
Mental health	• Well-coordinated services between Coos County Mental Health and other service providers • CaCoon home visiting program • Nancy Deveraux Center • Children's Advocacy Center	• Provider shortage • Recruiting • Need exceeds capacity • Serving outlying rural areas (e.g., Myrtle Point, Powers) • Housing • Local care for children who require higher levels of care	• Peer support • Integrate child psychologist into clinics • Better treatment options (medications and evidence-based program) • Integrate care for children	• Lack social/parental support • Access to providers for people not on OHP • Stigma • Higher levels of care becoming less available statewide for children and adults • Intergenerational poverty • Rates of domestic violence, child abuse, and substance abuse
Socioeconomic disparities	• OHP • Local food cupboards • Safety net clinics • Churches with fresh food • THE & Bay Area Mission (homeless housing) • ORCCA • SWOCC and their partnerships with other education institutions	• Programs focus on symptoms not root cause • Getting new businesses here • Helping students be successful (e.g., graduate)	• Linking services (e.g., WIC and SNAP) • Tying education to local industry needs • Chamber of Commerce working on jobs • City Managers and Parks & Recreation working on developing safe places to live and recreate (e.g., parks, bike-ways, walking paths)	• Economic environment • Lack of affordable housing • Multigenerational poverty • Low education attainment

Appendix B: Social-Ecological Model of Prevention



A Social-Ecological Model for Physical Activity - Adapted from Heise, L., Ellsberg, M., & Gottemoeller, M. (1999)

Appendix C: Community Health Improvement Matrix



Using the Community Health Improvement Matrix

Prevention Levels: *Prevention aims to minimize the occurrence of disease or its consequences. Levels include:*

Contextual:	Prevent the emergence of predisposing social and environmental conditions that can lead to causation of disease
Primary:	Reduce susceptibility or exposure to health threats
Secondary:	Detect and treat disease in early stages
Tertiary:	Alleviate the effects of disease and injury

Intervention Levels: *Intervention levels are built on a socioecological model that recognizes different factors affecting health.*

Individual:	Characteristics of the individual such as knowledge, attitudes, behavior, self-concept, skills, etc. Includes the individual's developmental history
Interpersonal:	Formal and informal social network and social support systems, including family, work group, and friendship networks
Organizational:	Social institutions with organizational characteristics, and formal (and informal) rules and regulations for operation
Community:	Relationships among organizations, institutions, and informal networks within defined boundaries
Public Policy:	Local, state, and national laws and policies

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