HEALTHY KLAMATH
A CERTIFIED BLUE ZONES COMMUNITY™

2022-25 Klamath County Community Health Improvement Plan

On the cover: Mount McLoughlin seen from Four Mile Lake.

March 29, 2022
DRAFT December 7, 2022
DRAFT November 19, 2022
DRAFT October 22, 2022
DRAFT September 27, 2022

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Introduction

The Healthy Klamath network knows that people are the community's greatest asset. An important part of community health improvement work is protecting and promoting the health of community members and improving the quality of life for everyone.

This is done through a collaborative process, that involves the creation of documents to measure where the community is and where we would like to work together to be in the future.

We do this through the shared work of the Healthy Klamath network and by implementing a Community Health Improvement Plan (CHIP). A CHIP is a long-term, systematic effort to address health issues and concerns, and the factors that influence them. The Plan builds from the Community Health Assessment and the community health improvement planning process. It is a living document and the workplans included will change over the three-year lifespan of this CHIP.

The CHIP is used by healthcare agencies, in coordination with community partners, to establish priorities and to coordinate activities and resources to improve the health and well-being of community members, and the overall health status of the community.

This document is Klamath County's fourth CHIP, with other three-year plans dated 2013, 2016 and 2019. It is based upon the work done in 2021 in the Klamath County Health Assessment, but can be used as a stand alone document.

The steering committee for the document included Cascade Health Alliance, the Healthy Klamath agency, Klamath Basin Behavioral Health, Klamath County Public Health, Klamath Health Partnership, Klamath Tribal Health & Family Services and Sky Lakes Medical Center.

Support and valuable input was provided by Healthy Klamath network partners and members of the community.

A community is only as great as its residents are willing to make it. The Healthy Klamath network invites community members and community partners to join an assessment subcommittee. Or, to provide feedback on this and other documents.

To read the 2021 Klamath County Community Health Assessment and learn more about the health improvement work happening in Klamath County visit the Healthy Klamath website at www.healthyklamath.org.

Please send your comments or suggestions to info@healthyklamath.org.

Healthy Klamath network

The network is a multi-sector partnership established in 2012 to guide community health improvement efforts in Klamath County, Oregon.

Healthy Klamath agency

Following the successful certification of Klamath Falls as a Blue Zones Project community in 2020, the Project staff migrated into a new organization. Healthy Klamath, as an agency, is a department of Sky Lakes Medical Center with professional staff addressing population health needs within the local community.

Executive team

- Cascade Comprehensive Care/Cascade Health Alliance (CHA)
- City of Klamath Falls
- Klamath Basin Behavioral Health (KBBH)
- Klamath County
- Klamath Health Partnership
- Sky Lakes Medical Center
- Wendt Family Foundation

CHIP steering committee

- Cascade Health Alliance (CHA)
- Klamath Basin Behavioral Health (KBBH)
- Klamath County Public Health (KCPH)
- Klamath Health Partnership (KHP)
- Klamath Tribal Health & Family Services (KTHFS)
- Sky Lakes Medical Center (SLMC)

Member agencies

- 173rd Fighter Wing/Kingsley Field
- Area Agency on Aging
- Cascades East Family Medicine
- Child Abuse Prevention Coalition
- Citizens for Safe Schools
- City of Klamath Falls
- Community Action Partners of Oregon
- Department of Human Services — Klamath and Lake counties
- Friends of the Children
- Herald and News
- Integral Youth Services
- KFLS Radio News — Klamath Talks
- Klamath Advocacy Center
- Klamath and Lake Community Action Services
- Klamath Basin Oral Health Coalition
- Klamath Basin Research & Extension Center (OSU)
- Klamath Basin Senior Citizens' Center
- Klamath Community College
- Klamath County Chamber of Commerce
- Klamath County Developmental Disabilities Services
- Klamath County Public Health
- Klamath County School District
- Klamath Falls City Schools
- Klamath Falls Downtown Association
- Klamath Falls Farmers' Market
- Klamath Grown
- Klamath Housing Authority
- Klamath-Lake CARES
- Klamath-Lake Counties Food Bank
- Klamath Promise
- Klamath Trails Alliance
- Klamath Tribal Health & Family Services
- The Klamath Tribes
- Klamath Works
- KVLR News — Klamath Voice
- Lutheran Community Services Northwest
- Max's Mission
- Mills Neighborhood Association
- Oregon Health & Science University
- Oregon Tech
- Red is the Road to Wellness
- Sky Lakes Outpatient Care Management
- Sky Lakes Wellness Center
- South-Central Early Learning Hub
- South Central Oregon Economic Development District
- Steens Sports Park
- Transformations Wellness Center
- Trends on Thriving (TOTs)
- You Matter to Klamath
- YMCA of Klamath Falls

Process

The Healthy Klamath network uses the Mobilizing for Action through Planning and Partnerships (MAPP) model to develop, on a three-year cycle, a Community Health Assessment, followed by a Community Health Improvement Plan.

MAPP Phases

Community Health Assessment

Phase 1: Organize for Success/Partnership Development

Phase 2: Visioning

Phase 3: Four MAPP Assessments

- Forces of Change Assessment
- Community Themes and Strengths Assessment
- Community Health Status Assessment
- Local Public Health System Assessment

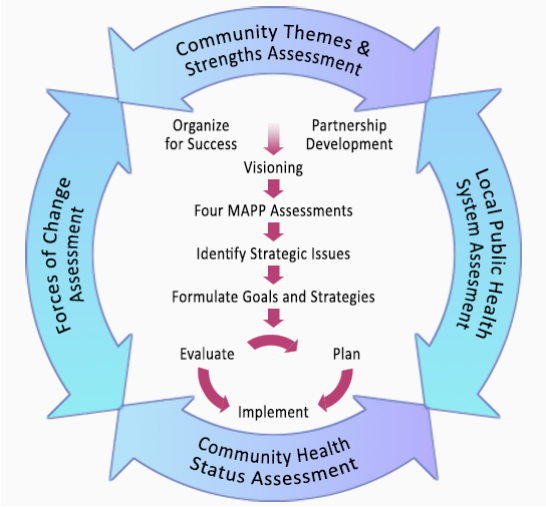
Community Health Improvement Plan

Phase 4: Identify Strategic Issues

Phase 5: Formulate Goals and Strategies

Phase 6: Action Cycle

MAPP action cycle



Timeline

April 2022

Finalized Community Health Assessment

May-July 2022

CHIP Survey shared in English and Spanish with over 300 responses

June-July 2022

Hosted listening sessions in communities across Klamath County

August 2022

Finalized CHIP priorities

September 2022

Created CHIP and detailed workplans

December 2022

Finalized 2022 CHIP

Vision

One of the first steps in beginning work on the Community Health Assessment was creating a shared vision for the future. The vision is the desired outcome of the work done in the Community Health Improvement Plan. Community members agreed that it is:

To be a balanced, beautiful and accessible community.

Balanced = having mental, spiritual, physical, social and emotional aspects working in unison for health and vitality.

Beautiful = seeing each other as human beings with infinite potential and worth; appreciating the natural surroundings of the community; providing space for people to reach their goals and dreams.

Accessible = resources in place to help people along their journey; room for everyone at the table; understanding historic trauma and other influences that are the root cause of lack, disease and unease.

Action cycle for health improvement

MAPP assessments

Through the four MAPP assessments, 16 issues were seen to be areas of potential concern within the community. They fit into three specific areas of public health interest — environmental health, factors of health and behavioral health. Two of these issues appeared in both the factors of health and behavioral health lists: physical activity and trauma/chronic stress.

Environmental Health

Clean air

Oregon Department of Environmental Quality data shows wildfire smoke and wood stove smoke both contribute to poor air quality throughout the year in Klamath County.

Drought

Klamath County is in its third year of emergency declaration due to drought. The National Integrated Drought Information System listed January through March 2022 as the driest year to date over the past 128 years.

Wildfire

In 2021, the Bootleg Fire burned 413,717 acres in and near Klamath County. There have been other, smaller fires in recent years, too. Wildfire smoke has caused poor air quality throughout the county in the last several years.

Factors of Health

Access to care

US News & World Report scores Klamath County 57 of a perfect 100 for hospital bed availability, people with no health insurance, and primary care doctor availability.

Healthcare cost/affordability

15% of Klamath County residents surveyed said cost prevented them from using healthcare services in the past year.

Food insecurity/hunger

More than 18% of survey respondents said they worried about having enough food to eat.

Housing availability & cost

About 12% of survey respondents did not have housing, or were worried about housing.

Maternal & child health

Conversations with mothers indicate they may skip care for themselves to focus on their families. In vital statistics tracked by Oregon Health Authority and annual County Rankings & Roadmaps data, Klamath County has consistently had higher infant death rates than the state of Oregon.

Oral health

The Rural Health Information Hub indicates all of Klamath County has a shortage of dental care.

Physical activity

In the most recent County Rankings & Roadmaps, 23% of Klamath County residents were not physically active.

Quality of life

The County Rankings & Roadmaps rate quality of life on reports of poor or fair health (21%), poor physical health days (5.0), poor mental health days (5.4), frequent physical distress (16%), frequent mental distress (17%) among other measures.

Social isolation

More than one-third of Klamath County's population lives outside of Klamath Falls urban area. Many people in outlying areas lack regular interaction with others. This is also true for elders throughout the county.

Trauma/chronic stress

In the most recent County Rankings & Roadmaps, 17% of Klamath County residents said they were in frequent mental distress.

Behavioral Health

Chronic illness

In the most recent County Rankings & Roadmaps, 16% of Klamath County residents said they were in frequent physical distress. In a different survey, 22% said they were being treated for a chronic illness.

Drug, alcohol use

Drug overdoses have increased in the last year; 22% of Klamath County residents reported excessive drinking in the most recent County Rankings & Roadmaps.

Physical activity

In the most recent County Rankings & Roadmaps, 29% of Klamath County residents were not physically active.

Suicide prevention

In 2020 there were 23 suicide deaths in Klamath County, according to Oregon Health Authority vital statistics.

Trauma/chronic stress

In the most recent County Rankings & Roadmaps, 17% of Klamath County residents said they were in frequent mental distress.

Strategic issues

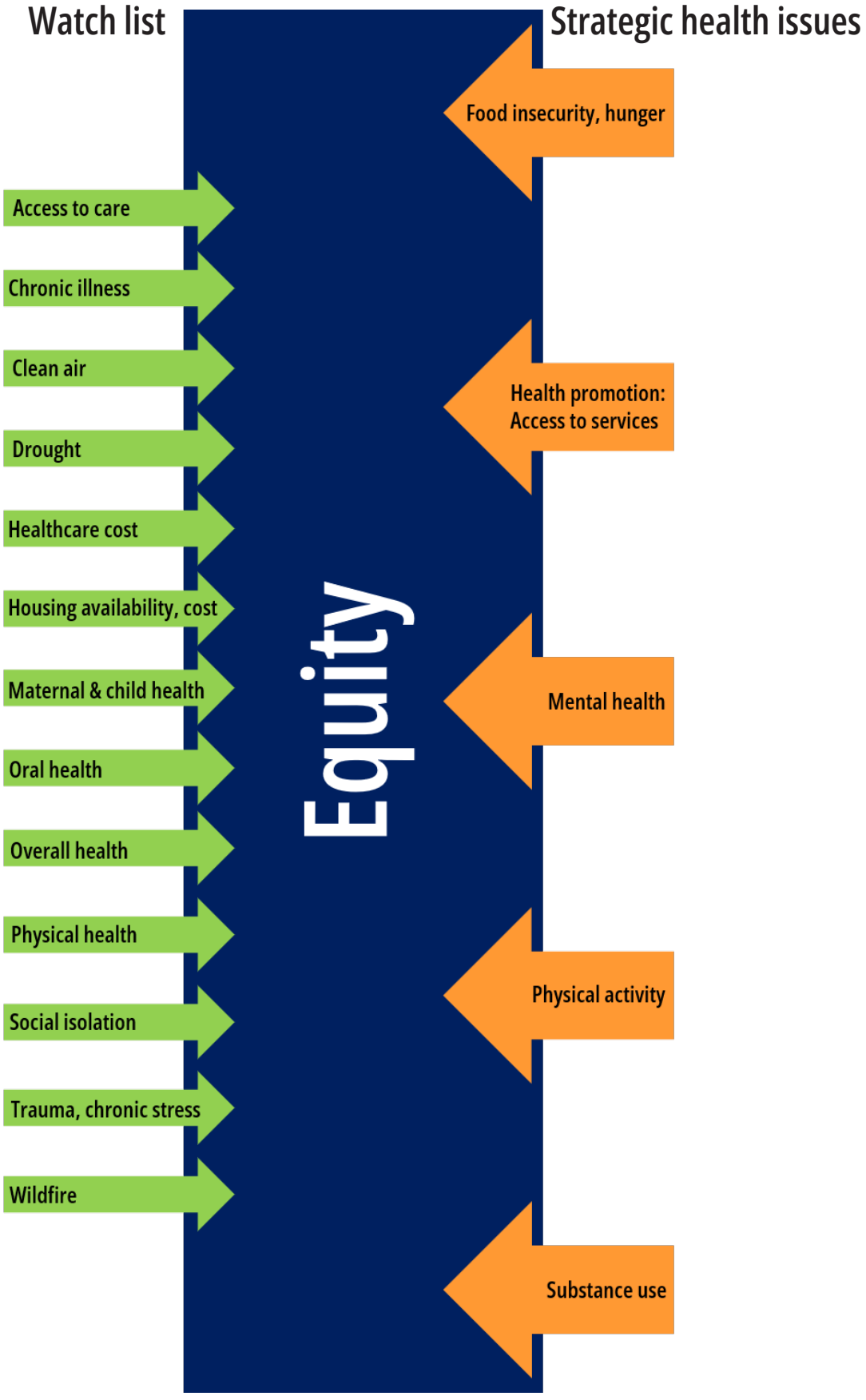
A community survey, with more than 300 participants and listening sessions held in the smaller county communities, outside of the county seat of Klamath Falls, helped inform the Healthy Klamath network about what local residents were thinking in regard to ranking the health issues.

The community survey was found to be difficult for many people, as ranking in order the 12 issues in factors of health was very time consuming and confusing. This will be taken into account in future surveys.

The network was presented with the community findings and a second survey was conducted with the network membership to decide on the priority issues. Results of both surveys are available in the Appendix.

Healthcare cost and access were part of the priority topics, but steering committee members discussed making a new focus area of health promotion: access to services. The network cannot hire new professionals or reduce the cost of services, which would be access to care. It can, however, help people understand what services are available and how to qualify for specific programs.

Strategic health issues & watch list areas



The selected strategic health issues are:

- Food insecurity, hunger
- Health promotion: Access to services
- Mental health
- Physical activity
- Substance use

While it was not a specifically addressed issue in the issue selection process, equity was adopted by the steering committee as a sixth area of focus. In the graphic on the previous page, equity is at the heart of the strategic health issues and of the issues that were not selected, which were placed on a watch list.

No issue is well addressed without equity considerations. Equity will be a tangible element in all of the strategic health issues work.

As an example, on the equity front, Klamath Falls City Schools is now hosting a professional in-service training about Klamath Tribes history to enhance local understanding and awareness of the Indigenous experience and the Oregon Trail, including the historical trauma still being experienced.

The remaining issues are of community importance and an annual report will be produced by Klamath County Public Health addressing these topics, which include:

- Access to care
- Chronic illness
- Clean air
- Drought
- Healthcare cost
- Housing availability, cost
- Maternal & child health
- Oral health
- Overall health
- Physical health
- Social isolation
- Trauma, chronic stress
- Wildfire

Lead agencies for each strategic issue gathered small, multi-sector groups to draft workplans, with measurable objectives, strategies and tasks. The Community Health Improvement Plan is a living document that will evolve over its three-year lifespan, with changes to objectives, strategies and tasks.

One task that will specifically be addressed are policy changes. For accreditation purposes, Klamath County Public Health is required to demonstrate the pursuit of two policies through the Community Health Improvement Plan and all of the strategic areas are fertile ground for policy work.

As an example for an opportunity to affect policy change: At the time this plan was written, Oregon Measure 110 had been in effect for two years. The legalizing of small quantities of otherwise illegal drugs and a delay in disbursing funds to treatment facilities has affected communities statewide. In many instances there are no incentives for those with substance use disorder to seek help.

Social determinants of health affecting strategic issues						
	Equity	Food security, hunger	Health promotion: Access to services	Mental health	Physical activity	Substance use
Economic stability: employment, income, expenses, debt, medical bills, support	X	X	X	X	X	X
Neighborhood and physical environment: housing, transportation, safety, parks, playgrounds, walkability, zip code, geography	X	X	X	X	X	X
Education: literacy, language, early childhood education, vocational training, higher education	X	X	X	X	X	X
Food: hunger, access to healthy options	X	X	X	X	X	
Community and social context: social integration, support systems, community engagement, discrimination, stress	X	X	X	X	X	X
Healthcare system: health coverage, provider availability, provider linguistic and cultural competency, quality of care	X		X	X	X	X

Assets & resources

Each strategic issue has its own assets and resources within the community, in addition to supporting information and efforts being made statewide and nationally. Local resources include staff time, subject matter knowledge, promotion through communication channels and financial support, wherever possible and necessary. In addition to these resources, best practices are available through Healthy People 2030, the Centers for Disease Control & Prevention (CDC), Oregon Health Authority (OHA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), among other national and regional agencies.

Equity

All Healthy Klamath network agencies are working toward equity in a variety of ways. Two have professionals assigned to equity efforts — Cascade Health Alliance and Klamath County Public Health. These two individuals will be supported in their work by other agencies, which include, but are not limited to:

- Healthy Klamath agency
- Klamath County Libraries
- Klamath Health Partnership
- Klamath Tribal Health & Family Services
- The Klamath Tribes
- Oregon Health & Science University (OHSU) Residency Program & OHSU School of Nursing
- Sky Lakes Medical Center

Regional, statewide & national agencies

SO-Health-E (Jackson County based health equity coalition)

American Public Health Association: Health equity fact sheets

CDC: Inclusive communication

Oregon Health Authority: Office of Equity and Inclusion

Oregon: Services for seniors and people with disabilities

Portland: Q Center

Pronoun use: mypronouns.org

LGBTQ+: Safe zones project

Healthier Together Oregon: 2020–2024 State Health Improvement Plan

Note: In the text below from the plan, BIPOC-AI/AN stands for Black, Indigenous, People of Color - American Indian/Alaska Native.

Equity and justice

The plan states: "Oregon has a unique history of white supremacy. This history and current institutional racism has created disadvantages for communities that are real, unjust and unacceptable. COVID-19 has shined a spotlight on the impacts of systemic racism; COVID-19 has disproportionately affected BIPOC-AI/AN communities in infections and death. All people in Oregon feel the stress of COVID-19, but non-white communities have the most burden. To increase health and reduce inequities for affected communities, institutions need to change how they do business. We will only reach our equity goals through co-creation and power-sharing with communities.

"Racial equity needs to be built into everything state agencies do. Policies and initiatives need to rectify past injustices while honoring the resilience of communities of color. Until historically marginalized populations share decision-making authority in our state, decisions will favor the dominant culture, reinforcing institutional bias and contributing to disparities. Funding needs to reflect greater investment in communities that have been affected. BIPOC-AI/AN-led committees should be funded to inform state agency plans, policies and budgets. Agencies need to collect and analyze data to understand the unique needs of communities. The following strategies have been identified to advance equity and justice:

- "Declare institutional racism as a public health crisis.
- "Ensure state health indicators are reported by race and ethnicity, disability, gender, age, sexual orientation, socioeconomic status, nationality and geographic location.
- "Require state agencies to commit to racial equity for BIPOC-AI/AN in planning, policy, agency performance metrics and investment.
- "Ensure state agencies engage priority populations to co-create investments, policies, projects and agency initiatives.
- "Build upon and create BIPOC-AI/AN-led community solutions for education, criminal justice, housing, social services, public health and healthcare to address systemic bias and inequities.
- "Require all public-facing state agencies and state contractors to implement trauma-informed policy and procedure.
- "Reduce legal and system barriers for immigrant and refugee communities, including people without documentation.
- "Ensure accountability for implementation of anti-racist and anti-oppression policies and cross-system initiatives."

Healthy People 2030

The initiative's website states: "As Healthy People has evolved over the decades to reflect the most current science and address the latest public health priorities, it has strengthened its focus on health equity. This focus is reflected in one of the overarching goals of Healthy People 2030: 'Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.'

"Healthy People 2030's emphasis on health equity is closely tied to its focus on health literacy and social determinants of health. Social determinants — like structural racism or systemic bias — can affect health literacy and contribute to health disparities. Taking steps to address these factors is key to achieving health equity.

"In line with this focus, Healthy People 2030 provides tools for action to help individuals, organizations, and communities committed to improving health and well-being advance health equity."

Food insecurity, hunger

Local agencies, which include, but are not limited to Klamath Lake Counties Food Bank, WIC, SNAP, Klamath Grown and The Klamath Tribes.

Healthier Together Oregon: 2020–2024 State Health Improvement Plan

The plan states: "Many households also struggle to afford healthy food. Oregon has one of the highest rates of food insecurity in the country, especially in families with children. Some people, especially in rural areas of the state, must travel long distances to get to a grocery store. Other people live in neighborhoods with a lot of fast-food and convenience stores, but few places to buy fresh fruits and vegetables. A resilient food system provides enough food to meet current needs while maintaining healthy systems that ensure food for future generations."

It specifically calls out the following goals on food security:

- Increase access to affordable, healthy and culturally appropriate foods for BIPOC-AI/AN and low-income communities.
- Maximize investments and collaboration for food-related interventions.
- Build a resilient food system that provides access to healthy, affordable and culturally appropriate food for all communities.

Healthy People 2030

The initiative has two related leading health indicators:

- Household food insecurity and hunger
- Children and adolescents with obesity

It also provides the following goal and supporting text:

Goal: Improve health by promoting healthy eating and making nutritious foods available.

Many people in the United States don't eat a healthy diet. Healthy People 2030 focuses on helping people get the recommended amounts of healthy foods — like fruits, vegetables, and whole grains — to reduce their risk for chronic diseases and improve their health.[1] The Nutrition and Healthy Eating objectives also aim to help people get recommended amounts of key nutrients, like calcium and potassium.

[1] U.S. Department of Health and Human Services and U.S. Department of Agriculture. (2015). 2015-2020 Dietary Guidelines for Americans. Retrieved from https://health.gov/our-work/food-nutrition/2015-2020-dietary-guidelines/guidelines/

People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

Health promotion: Access to services

Local agencies, which include, but are not limited to Cascade Health Alliance, Healthy Klamath staff, Integral Youth Services, Kingsley 173rd Fighter Wing, Klamath Basin Behavioral Health, Klamath Basin Senior Citizens' Center, Klamath County Public Health, Klamath County School District, Klamath Falls City Schools, Klamath Health Partnership, Klamath Tribal Health & Family Services, and Sky Lakes Medical Center.

Healthier Together Oregon: 2020–2024 State Health Improvement Plan

The plan states: "Modernizing the healthcare system includes adoption of emerging technology. This includes use of electronic medical record technology, centralized referral systems that address social needs and expansion of telehealth. Telehealth can be used to address barriers to healthcare, including transportation, provider capacity and access to specialty care. It has proven to be a critical tool in the response to COVID-19. Most healthcare providers use electronic health record systems; however, it is difficult for healthcare providers to share data with each other. Electronic health record reminders can also prompt providers to ask questions or order tests to prevent illness or diseases. Referral and information systems such as 211 exist to address social needs such as housing, food and childcare. However, a comprehensive referral system doesn't exist. Once a referral is made, it's also challenging to follow up to ensure the person received the service they needed.

- "Expand use of telehealth, especially in rural areas and for behavioral health.
- "Use electronic health records to promote delivery of preventive services.
- "Improve exchange of electronic health record information and data sharing among providers.
- "Support statewide community information exchange to facilitate referrals between healthcare and social services."

Healthy People 2030

The initiative provides the following goal and supporting text:

Goal: Improve health communication.

Effective health communication is critical to health and well-being. Healthy People 2030 focuses on improving health communication so that people can easily understand and act on health information.

Health information and messages are often overly complex, making them hard to understand and use. Healthcare providers who communicate clearly and use methods like teach-back and shared decision-making can help people make informed health-related decisions. These strategies can help improve outcomes, especially for certain groups — like people who have limited health literacy skills or speak English as a second language.

Making electronic health information easy to understand and use is also key to improving health and well-being. And news organizations and health departments can promote health and safety through effective communication strategies — for example, by providing complete, actionable information and using social marketing.

Mental health

Local agencies, which include, but are not limited to Klamath Basin Behavioral Health, Klamath Health Partnership, LCS, Klamath Tribal Health & Family Services' Youth & Family Guidance Center, and You Matter to Klamath coalition.

Healthier Together Oregon: 2020–2024 State Health Improvement Plan

The plan provides the following key indicators and context for statewide behavioral health:

- Unmet emotional or mental healthcare need among youth (Student Health Survey) [Key Indicator]
- Suicide rate (Oregon Vital Statistics) [Key Indicator]
- Adults with poor mental health in past month (Behavioral Risk Factor Surveillance Survey) [Key Indicator]

Behavioral health

Behavioral health describes the relationship between behaviors, physical health and overall well-being. Behavioral health includes, but is not limited to, mental health, substance use and gambling. Oregon has the highest prevalence of mental health conditions among youth and adults in the nation. Access to behavioral healthcare is a challenge. Communities describe many barriers related to provider shortages, long wait times, transportation challenges, and difficulty finding a culturally and linguistically responsive provider. The following strategies are specific to mental health. For strategies specific to alcohol and substance use, please see the Alcohol and Drug Policy Commission 2020-2025 Statewide Strategic Plan.

- Conduct behavioral health system assessments at state, tribal and local levels.
- Enable community-based organizations to destigmatize behavioral health by providing culturally responsive information to people they serve.
- Implement public awareness campaigns to reduce the stigma of seeking behavioral health services.
- Create state agency partnerships in education, criminal justice, housing, social services, public health and healthcare to improve behavioral health outcomes among BIPOC-AI/AN.
- Improve integration between behavioral health and other types of care.
- Incentivize culturally responsive behavioral health treatments rooted in evidence-based and promising practices.
- Reduce systemic barriers to receiving behavioral health services, such as transportation, language and assessment.
- Use healthcare payment reform to ensure comprehensive behavioral health services are reimbursed.
- Continue to strengthen enforcement of the Mental Health Parity and Addictions Law.
- Increase resources for culturally responsive suicide prevention programs for communities most at risk.

Healthy People 2030

The initiative provides the following leading health indicators, goal and nationwide context:

- Suicides (Leading Health Indicator)
- Adolescents with major depressive episodes who receive treatment (Leading Health Indicator)

Goal: Improve mental health.

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime.[2] Healthy People 2030 focuses on the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. The Mental Health and Mental Disorders objectives also aim to improve health and quality of life for people affected by these conditions.

Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.[3]

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

Physical activity

Local agencies, which include, but are not limited to Healthy Klamath agency, Klamath Basin Senior Citizens' Center, Klamath County School District, and Klamath Falls City Schools.

Healthy People 2030

The initiative provides the following leading health indicator, goal and nationwide context:

- Adults who meet current minimum guidelines for aerobic physical activity and muscle-strengthening activity (Leading Health Indicator)

Goal: Improve health, fitness, and quality of life through regular physical activity.

Only 1 in 4 adults and 1 in 5 adolescents in the United States meet physical activity guidelines for aerobic and muscle-strengthening activities.[4] [5] Healthy People 2030 focuses on improving health and well-being by helping people of all ages get enough aerobic and muscle-strengthening activity.

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at child care centers can also increase activity in children and adolescents.

Substance use

Local agencies, which include, but are not limited to Klamath Tribal Health & Family Services' Youth & Family Guidance Center, KBBH, Red is the Road to Wellness, The Stronghold, LCS, Best Care, Klamath Health Partnership, and Sky Lakes Medical Center.

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2 Centers for Disease Control and Prevention. (2018). Mental Health: Data and Publications. Retrieved from https://www.cdc.gov/mentalhealth/data_publications/index.htm

3 National Institutes of Mental Health. (2018). Statistics. Retrieved from https://www.nimh.nih.gov/health/statistics/index.shtml

4 U.S. Department of Health and Human Services. (2018) Physical Activity Guidelines for Americans, 2nd Edition. Retrieved from https://health.gov/paguidelines/second-edition/pdf/Physical_Activity_Guidelines_2nd_edition.pdf

5 Centers for Disease Control and Prevention. (n.d.) Trends in Meeting the 2008 Physical Activity Guidelines, 2008–2018.

Healthy People 2030

The initiative provides the following leading health indicators, goal and nationwide context:

- Drug overdose deaths (Leading Health Indicator)
- Adults engaging in binge drinking of alcoholic beverages during past 30 days (Leading Health Indicator)

Goal: Reduce misuse of drugs and alcohol.

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year.[6] Healthy People 2030 focuses on preventing drug and alcohol misuse and helping people with substance use disorders get the treatment they need.

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

6 Lipari, R.N., & Van Horn, S.L. (2017). Trends in Substance Use Disorders Among Adults Aged 18 or Older. The CBHSQ Report. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/28792721

Overarching goal

Provide cultural competency, equity, health literacy and social justice resources to Healthy Klamath network agencies, which will also be available to the community at large

U.S. Census data			
From July 1, 2021	Klamath County	Oregon	US
Population estimate	70,164	4,246,155	331,893,745
Persons 65 years and older	21.9%	18.6%	16.8%
Female persons	49.9%	50.1%	50.5%
White alone	88.0%	86.2%	75.8%
Black or African American alone	0.9%	2.3%	13.6%
American Indian and Alaska Native alone	5.0%	1.9%	1.3%
Asian alone	1.2%	5.0%	6.1%
Native Hawaiian & Other Pacific Islander alone	0.2%	0.5%	0.3%
Two or more races	4.6%	4.2%	2.9%
Hispanic or Latino	14.5%	14.0%	18.9%
White alone, not Hispanic or Latino	76.3%	74.1%	59.3%
Foreign born persons	5.5%	9.8%	13.5%
Language other than English spoken at home, persons age 5+	9.3%	15.3%	21.5%
With disability, under 65 years	13.4%	9.9%	8.7%
Persons in poverty	19.7%	11.0%	11.4%

Two Spirit, LGBT+ population

According to the 2020 Oregon Student Healthy Survey, in Klamath County roughly one in 10 youth (14.3% of 8th graders and 9.9% of 11th graders) are gay, lesbian or bisexual. Gender identity information was not available on a county basis.

Lead agency

Klamath County Public Health

Baseline

There have been no equity coalition-based cultural competency/equity activities in several years

Benchmarks

Increase Healthy Klamath network agencies' reporting of equity principles used and education accessed by 10% over baseline survey by October 2025.

Sponsor at least one cultural competency/equity activity, beyond what exists within the community, and resource each quarter throughout the three-year CHIP period

However, statewide 11.2% of 8th grade females and 3% of 8th grade males identified as non-binary. At the 11th grade level 10.6% of females and 3.5% of males also identified as non-binary.

Statewide, 14.8% of 8th graders and 18.0% of 11th graders reported being gay, lesbian or bisexual.

Nationwide, a 2021Gallup survey reflected 7.1% of the population self-identify as lesbian, gay, bisexual, transgender or something other than heterosexual.

Objective 1

Support the equity elements of the other five CHIP focus areas by providing at least one resource quarterly

Strategy 1

Create a cultural competency, health literacy and equity library that can be accessed at healthyklamath.org

Tasks

- Provide a glossary with equity-related definitions for reference. This would include various ways health equity is defined from organizations such as the Health Resources & Services Administration, Oregon Health Authority, World Health Organization and others. Other information in the glossary would include, but not be limited to, different ways inequities happen, such as racism, classism, ageism and the like. Process measure: Develop health equity glossary; number of partner websites sharing glossary. Process target: 1 glossary developed and published on 2 partner websites.)
- Create short videos with glossary terms defined for sharing via social media and other outlets (Process measure: Create short videos for social media with possible audio for radio use. Process target: 2 videos per quarter shared by at least 2 partner agencies.)
- Provide the University of Washington Leadership Institute's table of questions that move groups toward more equitable participation in group settings. Continue to build similar resource library at healthyklamath.org (Process measure: Number of partner websites housing table and similar resources; number of partner institutions receiving information. Process target: Table posted on 2 partner websites; table distributed to 50 partners institutions (such as OHSU and Oregon Tech students).)
- Provide resources for cultural insight, such as the National Standards for Culturally and Linguistically Appropriate Services, materials from the Lacrosse Consortium and other organizations promoting cultural competency, equity, diversity and inclusion. (Process measure: Number of partner websites publishing these resources. Process target: 2 partner institutions sharing these resources on their websites.)
- Support use of qualified or certified translation and interpretation resources and plain language in written and oral communication. (Process measure: One-page translation resource directory/guide developed and shared; plain language one-page guide developed and shared. Process target: 1 translation resource directory/guide developed and shared with 2 partners; 1 plain language guide developed and shared with 2 partners.)

Strategy 2

Provide an annual update of demographics and population health statistics about Klamath County

Tasks

- Establish baseline information about disparities and update annually. (Continue to pursue information about disparities that may not be available at the beginning of the CHIP workplan.) (Process measure: Develop baseline disparity report; update annually. Process target: 1 baseline disparity report developed and shared on 2 partner websites; 1 updated disparity report annually.)

- Establish baseline information about community demographics, available through census.gov, and update annually. (Process measure: Develop baseline demographic report; update annually. Process target: 1 baseline demographic report developed and shared on 2 partner websites;1 updated demographic report annually.)

Objective 2

Sponsor at least one quarterly community event to promote awareness, conversation and action about cultural competency, equity, health literacy and social justice

Strategy 1

Host speakers who can reflect upon the experience of under-represented populations

Tasks

- Research and create a list of possible speakers, including those who might be available from a distance. (Process measure: Possible speakers researched and list developed. Process target: 1 list developed and updated annually.)
- Schedule location, speaker and invite community. Whenever possible record session for future viewing. (Process measure: Number of speakers hosted. Process target: 4 speakers hosted annually.)

Strategy 2

Host multimedia events (video showings, book discussions, etc.) to inform and stimulate discussion about local cultural, health equity, health literacy and social justice

Tasks

- Create a list of potential multimedia resources, including those produced by Klamath Tribal Health and the library at Klamath County Public Health (Process measure: Resource list developed and shared. Process target: 1 resource list developed and shared with 2 partners.)
- Research multimedia recommendations from Klamath County Library, SPOKES Unlimited, Klamath County Developmental Disability Services, among other agencies and partners (Process measure: Book and video recommendation list developed. Process target: 1 recommendation list developed and shared with 2 partners.)
- Select multimedia, schedule location and invite the community (Process measure: Number of video showings or book discussions hosted. Process target: 2 video showings or book discussions hosted per year.)

Strategy 3

Host open-format meetings that allow communities to provide feedback on personal experience related to equity and cultural concerns

Tasks

- Create a list of desired locations and demographics, such as Mills School and Hispanic community members or Red is the Road to Wellness and people on parole and/or with substance use issues. (This would be driven by the topics and subjects where more information is desired.) (Process measure: List developed and updated annually. Process target: 1 list developed; 1 update per year.)
- Select location, invite community to attend (Process measure: Number of open-format meetings hosted per year. Process target: 2 meetings per year.)

Strategy 4

Promote equity/multilingual opportunities within the community

Tasks

- Determine next steps in rebroadcast of Spanish-language radio programming (Process measure: Develop feasibility report as a result of conversations with local media partners; share results with Healthy Klamath partners. Process target: 1 feasibility report developed and results shared with Healthy Klamath partners.)
- Determine feasibility of KTEC health-topic talk show to promote social determinants of health among other subjects (These could also be podcasts that are YouTube based.) (Process measure: Develop feasibility report as result of conversations with KTEC. Process target: 1 feasibility report developed and results shared with Healthy Klamath partners.)
- Determine feasibility of having a health-based Spanish-language publication (Process measure: Develop feasibility report of having a health-based Spanish-language publication. Process target: 1 feasibility report developed and results shared with Healthy Klamath partners.)
- Explore language exchange opportunities (Process measure: Develop overview of what language exchange might include and research feasibility of implementation. Process target: 1-page overview document; list of potential implementation sites.)

Objective 3

Provide at least one annual cultural competency, health equity, health literacy and social justice training for Healthy Klamath member agencies and the community

Strategy 1

Develop list of trainings available locally, electronically and by other means

Tasks

- Ask local partners if any staff members have the ability to facilitate trainings, such as Safe Zones, classism, budgeting with equity in mind, and the like (Process measure: Compile list of partners with ability to facilitate trainings; update annually. Process target: 1 list developed and updated annually.)
- Develop list of available trainings (Process measure: Develop training list and update annually. Process target: 1 list developed and updated annually.)
- Select training, schedule and invite partners (Process measure: Number of cultural competency trainings hosted. Process target: 1 training hosted per year.)

Objective 4

By January 2025, provide information to Healthy Klamath partners, and other interested agencies, about measuring internal and external perceptions about cultural competency and equity

Strategy 1

Create a list of frameworks and tools available for measurement

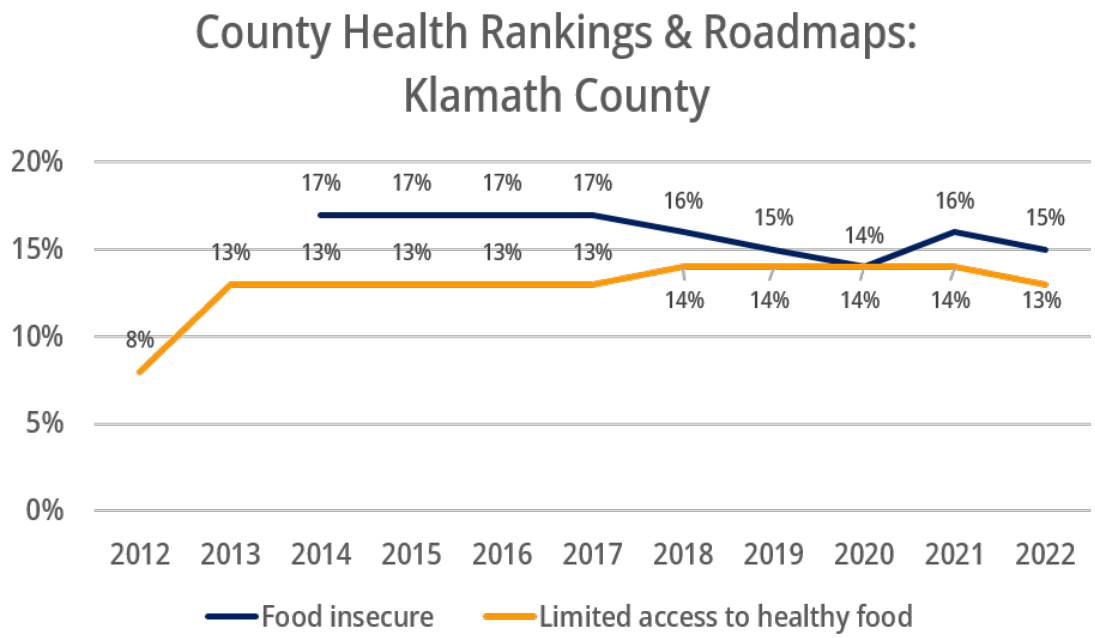
Tasks

- Research and compile a list of resources (Process measure: Resource list compiled and shared with Healthy Klamath partners. Process target: 1 resource list compiled and shared with all Healthy Klamath network partners.)
- Publish resources on healthyklamath.org (Process measure: Resource list published on healthyklamath.org. Process target: 1 resource list posted on healthyklamath.org.)

Food insecurity, hunger

Overarching goal

Decrease food insecurity and increase access and education about local foods



Objective 1

Identify strategies in remote communities to improve food security

Strategy 1

Partner with community stakeholders that have programs in remote areas to increase reach and connectivity to food

Tasks

- Collect data utilizing the Nutrition Hub and other programs in order to assess impact of current programs (Process measure: Number of surveys and qualitative interviews performed. Process target: 10 surveys or interviews conducted.)
- Create ambassador or champion program (a remote resident) with incentives for them, and have them help us collect better data to assess needs and impact. (Process measure: Ambassador materials developed. Process target: One ambassador trained or materials developed.)
- Host a FEAST or alternative event to identify key projects that meet the needs within communities. (Process measure: Number of events hosted. Process target: One event per year.)

Lead agency

Healthy Klamath

Baseline

The projected food insecurity rate for Klamath County, as measured by Feeding America in July 2021, is 15.9%

Benchmark

Decreased food insecurity by 2% as measured by Feeding America, which is published at healthyklamath.org

Oregon

The projected food insecurity rate for Oregon, as measured by Feeding America in July 2021, is 12.3%

United States

The projected food insecurity rate for the US, as measured by Feeding America in July 2021, is 10.2%

Strategy 2
Increase access to local foods and producers

Tasks

- Provide resources for new and existing producers (financial, education, training, etc.) (Process measure: Number of resources developed and hosted. Process target: One new resource per year.)
- Assist Klamath Works with development of community garden (Process measure: Amount raised towards community garden. Process target: $30,000.)
- Create resources about local food system, availability and guide, such as when is the peak season or in season products for Farmer's Market and types of foods, etc. Also, tips and tricks for trying new foods. (Process measure: Number of resources developed and hosted. Process target: One new resource each year.)
- Create Facebook or group for the farmers to discuss what's being grown and problem solving. (Could be Facebook or in person.) (Process measure: Number of groups facilitated or created on Facebook. Process target: One new Facebook page or group facilitated.)
- Increase free/affordable transportation to markets, such as Basin Transit Service and Quail Trail. (Process measure: Number of transportation opportunities to markets. Process target: One new transportation route to market(s).)

Objective 2

Increase education and utilization of existing resources and programs in Klamath County with campaigns at least twice annually

Strategy 1
Leverage partnerships to build awareness of local programs

Tasks

- Develop an interactive map, in partnership with IYS, of where SNAP and WIC can be used. (Process measure: Number of interactive maps developed. Process target: One map created.)
- Facilitate an EBT machine for mobile hub and Merrill market, in partnership with IYS and Merrill market. (Process measure: Number of EBT card readers in place. Process target: One EBT card reader.)
- Create "ambassadors for resources" in partnering organizations by having them commit to "spreading the word." (Process measures: Number of organizations that sign the "pledge to share". Process target: Five organizations sign the pledge.)

Strategy 2
Promotional campaign on food system

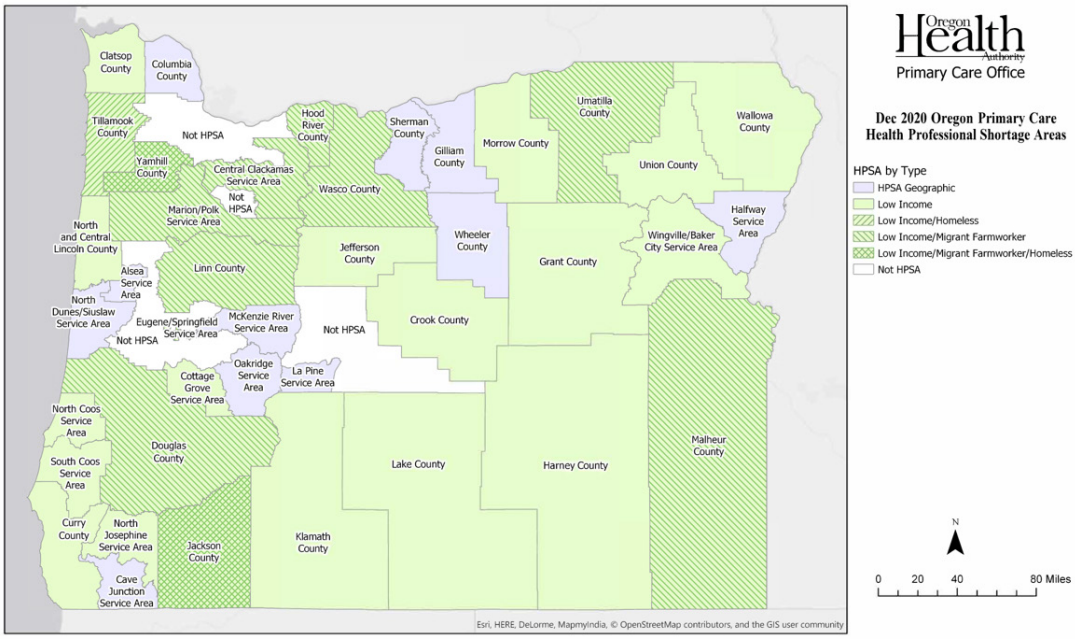
Tasks

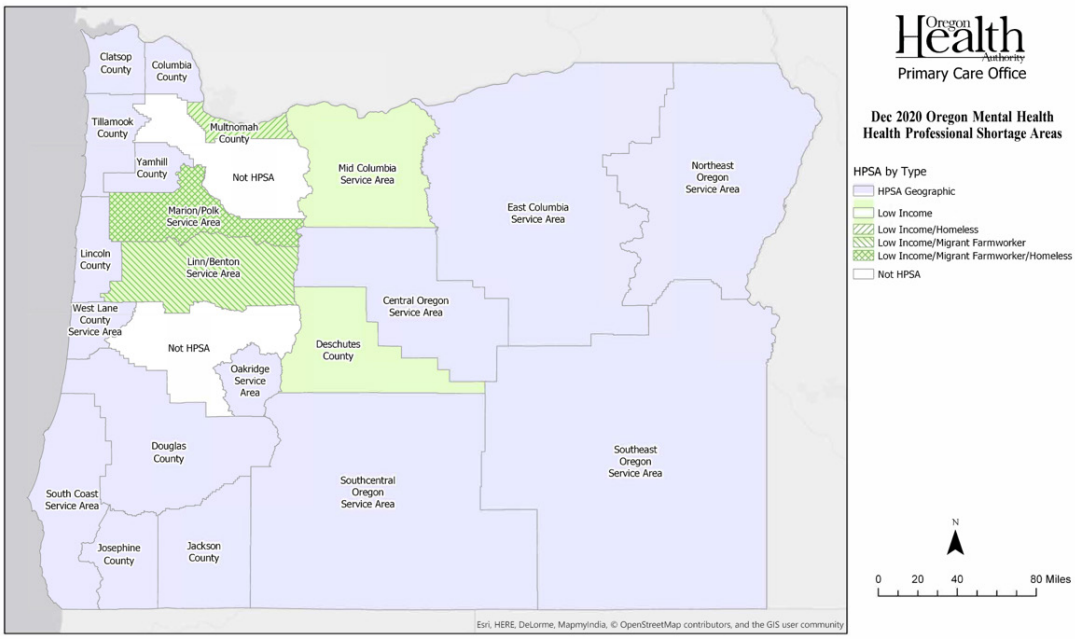
- Create videos about food. (Process measure: Videos created, posted and shared. Process target: One new video.)
- Launch marketing campaign about where money goes when you buy local "more expensive" food. Pursue 10% commitment for purchasing locally grown food. Include double-up bucks program and that SNAP is accepted at the Farmer's Market. Break down how many meals you can get out of the fruit or vegetable you are buying at market. (Process measure: Number of materials developed and number of people engaged. Process target: 50 people engaged in campaign.)

Health promotion: Access to services

Overarching goal

Increase awareness and understanding of health services





Lead agency

Healthy Klamath

Benchmarks

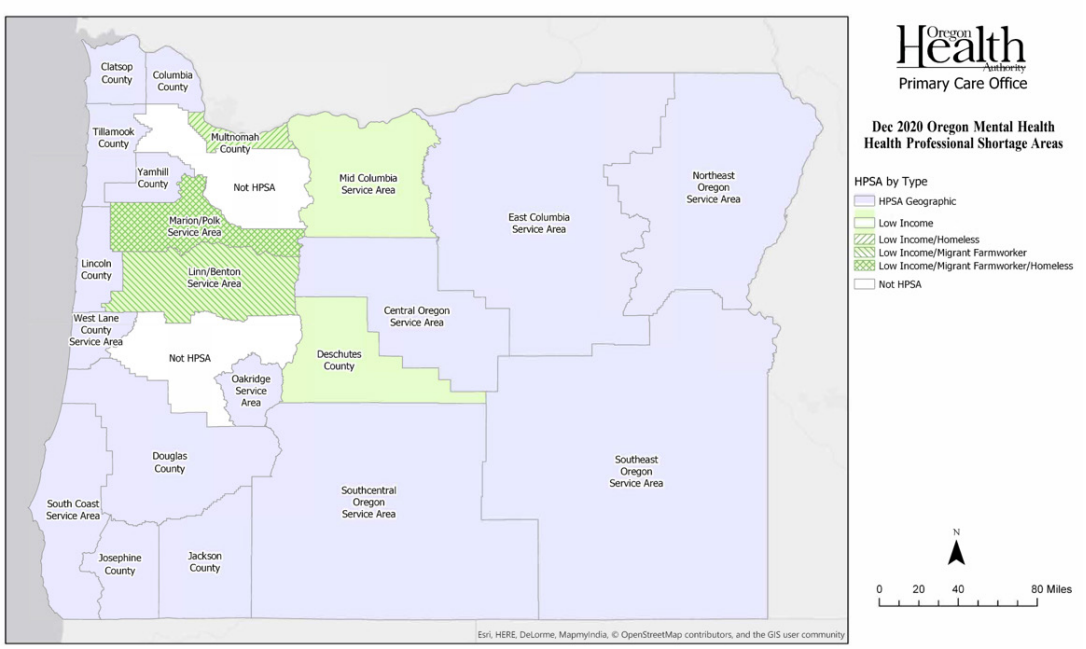
Reach 22,000 of Klamath County's population with resource guides as measured by print distribution and digital traffic and aim to grow that number by 5% each year.

Increase awareness of existing services, benefits and eligibility by 5% as measured by community survey.

Cross promote 3 events or programs per year.

Increase awareness of health equity and literacy issues amongst the Healthy Klamath Network, providers and public by 10% as measured by community surveys.

Run a coordinated campaign to improve recruitment, retention, reputation and healthcare workforce development, the success of ➤



Objective 1

Reach 22,000 of Klamath County's population with resource guides as measured by print distribution and digital traffic and aim to grow that number by 5% each year.

Strategy 1

Increase the amount of providers and people using healthyklamathconnect.com.

Tasks

- All partner websites resource sections link to Healthyklamathconnect.com (Process measure: How many partners are linking and how much traffic.)
- Promote and host training webinars to increase provider use (Process measure: How many hosted, many attended and how many programs claimed.)
- Promote and help the public become familiar with it (Process measure: How many people are visiting and engaging with the site.)
- Get statewide and national resource guides and sources to link to healthyklamathconnect.com for local resources where applicable (Process measure: How many external sources are linking back to healhtyklamathconnect.com.)
- Reporting and tracking referrals within healthyklamathconnect.com (Process measure: How many referrals are made within the system.)

Strategy 2

Provide a current print resource guide to people without Internet or technology access.

Tasks

- Research what other communities are doing for print resource guides (Process measure: Put together research summary.)

which is as measured by the tasks' process measures.

Baseline

US News & World Report scored Klamath County 57 of a perfect 100 for hospital bed availability, people with no health insurance, and primary care doctor availability in a 2022 report. In the 2022 County Rankings & Roadmaps, 13% of Klamath County adults were uninsured, with 4% of children uninsured. In 2020, Klamath County was a health professional shortage area for primary care providers for low income clients, dental providers for low income/migrant farm worker/homeless clients, and mental health providers for the geographic region including Lake County.

Guiding principles

Equity and health literacy

- Coordinate with KLCAS to develop or revise print resource guide (Process target: Finished print resource guide.)
- Figure out distribution plan for guide and schedule (Process measure: Determine print resources, costs, and timeline to production.)
- Look into the option of healthyklamathconnect.com having a print out version (Process measure: Determine feasibility.)
- Research and find out all existing resource guides for the community (Process measure: Put together resource guide directory.)

Objective 2

Increase awareness of existing services, benefits and eligibility by 5% as measured by community survey.

Strategy 1

Connect people with existing resources, create new content as needed and share with the public.

Tasks

- Determine all existing resources (Process measure: Put together research summary.)
- Develop promotional campaigns and materials (Process measure: Determine what campaign messages to promote and what content is needed.)
- Create one pagers, website pages, flowcharts, infographics for how to qualify for certain services, checklist, where to go, FAQ, navigation guide, videos, public forum and host events (SNAP, sliding scale, etc.) (Process measure: Develop editorial calendar and produce content.)
- Create a services glossary that identifies programs by category and aligns it with possible need. (Process measure: Glossary created.)

Strategy 2

Focus on accessibility.

Tasks

- Determine what materials need translation or alternative formats (Process measure: List of materials needing translation and/or alternative formats.)
- Determine what channels to distribute materials to specific populations (Process measure: List of channels for distribution.)
- Match what materials would be best suited for specific populations and developing culturally and linguistically correct content (Process measure: List of materials by target population.)

Objective 3

Cross promote 3 events or programs per year.

Strategy 1

Better promote existing events and programs.

Tasks

- Utilize the Engagement Committee (Process measure: How many partners are linking and how much traffic.)
- Create a promotional campaign guide, toolkit and media contacts that members can use (Process measures: How many hosted, how many attended and how many programs claimed.)

- Consolidate or figure out LISTSERV (Process measure: Effective mailing list created.)
- Partners help to share out relevant programs or events (Process measures: How many hosted, how many attended and how many programs claimed.)

Strategy 2

Coordinate between organizations and run shared campaigns.

Tasks

- Look at the annual and national calendar and determine what campaigns partners want to promote (Men's Health Month, Fall Awareness, Child Abuse) (Process measure: Campaigns selected and collaboratively promoted.)
- Run coordinated campaigns between partners (Process measure: Campaigns selected and collaboratively promoted.)
- Pool resources (event space, marketing help, budget) (Process measure: Campaigns selected and collaboratively promoted.)
- Publish quarterly Living Well magazines (Process measure: Four editions each year.)
- Publish monthly Healthy Klamath newsletter (Process measure: 12 editions each year.)

Objective 4

Increase awareness of health equity and literacy issues amongst the Healthy Klamath Network, providers and public by 10% as measured by community surveys.

Strategy 1

Promote health equity through our work.

Tasks

- Develop health equity checklist that can be used by partners, start by reviewing existing state and national material (Process measures: State and national material reviewed, checklist created.)
- Coordinate with equity committee for health equity opportunities, events and training (Process measure: Quarterly facilitation with equity committee.)

Strategy 2

Ensure our work supports health literacy.

Tasks

- Develop health literacy checklist (accessibility, reading level, etc.) to apply to our content and share with partners (Process measure: Checklist created.)
- Host health literacy trainings for public (Process measures: Trainings held, number of attendees.)
- Host health literacy trainings for providers (Process measures: Trainings held, number of attendees.)

Objective 5

Run a coordinated campaign to improve recruitment, retention, reputation and healthcare workforce development the success of which is as measured by the tasks' process measures.

Strategy 1

Focus on education and careers.

Tasks

- Develop health internship relationships between schools and community organizations (Process

measure: Number of internship facilitating organizations.)

- Run an internship/externship fair (Process measure: Fair organized and held.)
- Run a health career fair (Process measure: Fair organized and held.)
- Run a health career path event with high schoolers (AHEC) (Process measure: Event organized and held.)
- Create Klamath Promise Scholarship for Health Career Path. (Process measure: Scholarship created and awarded.)

Strategy 2

Focus on retention.

Tasks

- Identify jobs for spouses of healthcare professionals (Process measure: Annual job market analysis.)
- Identify housing for healthcare professionals (Process measure: Annual housing outlook analysis.)

Strategy 3

Focus on reputation.

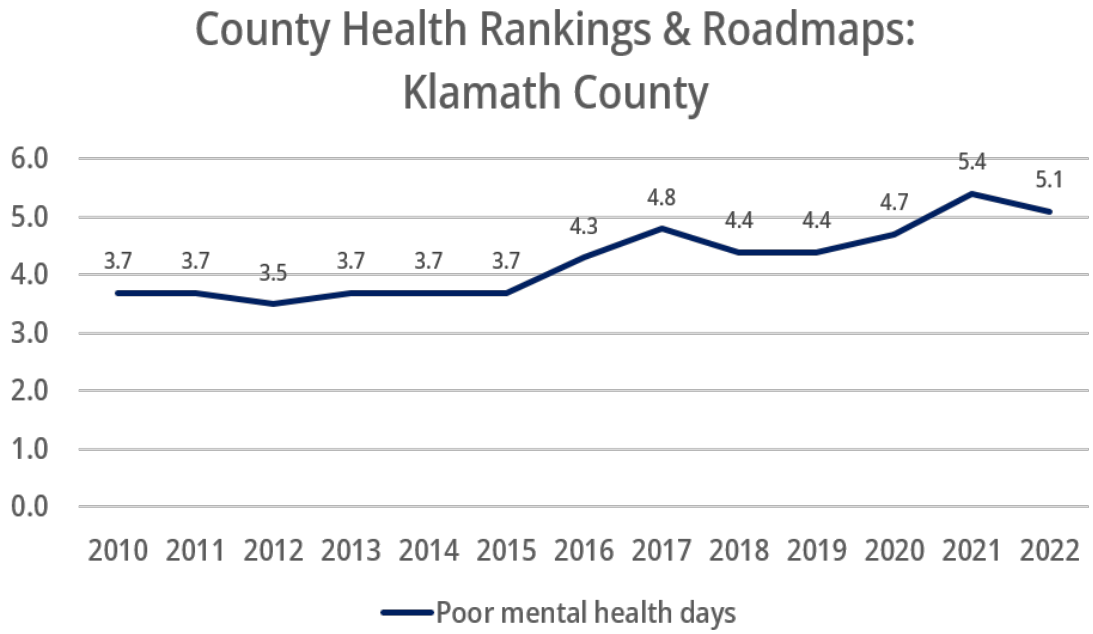
Tasks

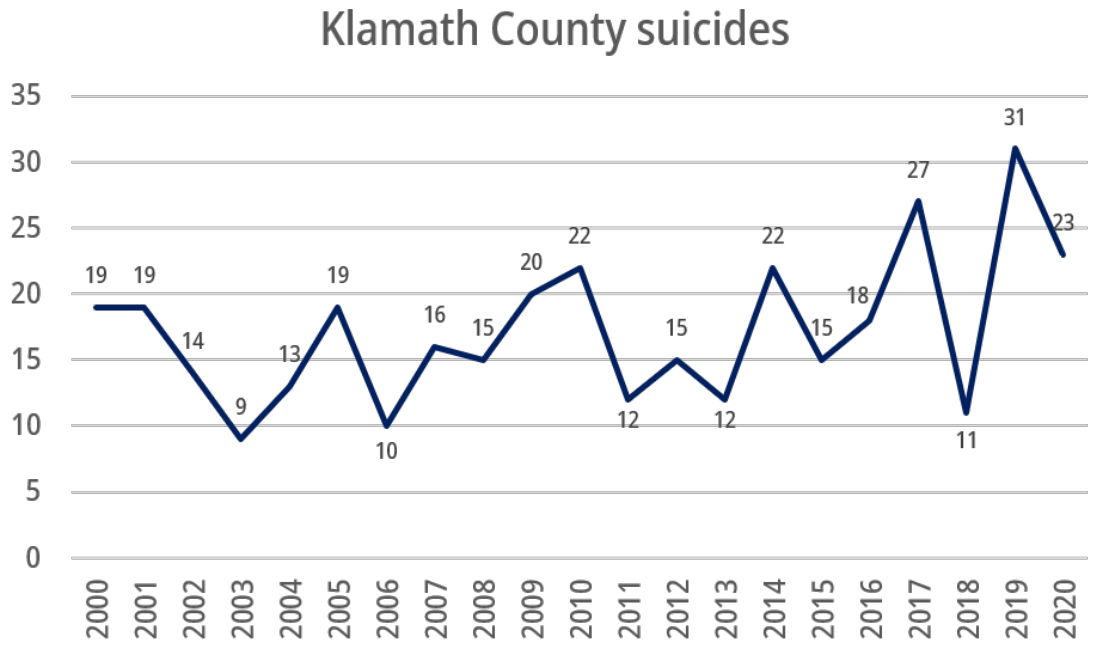
- Create a reputation campaign (Process measure: Campaign created and launched.)
- Create testimonial videos (born and raised, transplants, people from out of town served here) (Process measure: Campaign created and launched.)
- Create shared history (Museum, Chamber, etc.) (Process measure: Campaign created and launched.)
- Scale and expand reputation management program (Process measure: Program scaled and expanded.)
- Create a video content library (Process measure: Library created.)

Mental health

Overarching goal

Decrease mental health stigma and promote awareness of mental health resources to increase community connection





Lead agency

Klamath Basin Behavioral Health

Benchmark

Decrease stigma and increase health-seeking behaviors by 5%.

Baseline

Frequent mental distress was experienced by 17% of the residents in the 2022 County Rankings & Roadmaps report.

The same report found Klamath County residents experiencing 5.1 poor mental health days each month.

There were 23 suicides in 2020, which was the most recent official data released by Oregon Health Authority.

Objective 1

Addressing isolation in Klamath Falls

Strategy 1

Events to decrease loneliness and increase connection of community members

Tasks

- Support community-sponsored block parties hosted by different neighborhoods in the Klamath Basin to promote community connections through engagement with individual neighbors (Process measure: Number of block parties per year. Process target: Two block parties in year one with 70 participants)
- Implement community moais (affinity groups) to promote connecting with different community members, such as a dog walking moai, new parent moai, older adult moai, and men's moai. The purpose of a moai is a chance to create a group to support individuals and help them find and live with a purpose. (Process measure: Implement a moai. Process target one moai in year one with five participants.)
- Develop and implement six-week grief and loss support group hosted by community mental health agencies by a Qualified Mental Health Professional. (Process measure: Group development and implementation. Process target: Two six-week groups in year one with five members of the community participating.)

Strategy 2

Develop community groups

Tasks

- Develop and implement a men's mental health community group that meets once a month for one year. This will be in partnership with an existing high-risk employer, such as Rocky Mountain Construction, firefighters, ODOT, law enforcement, military servicemen, school systems and the like. (Process measure: Curriculum developed. Process target: One curriculum developed.)
- Collaborate with interested employers to promote and host community groups for employees. (Process measure: Number of interested employers. Process target: One agreement for an employer.)
- Men's community group to be held once a month and facilitated by a different clinicians or subject matter experts from a different mental health organizations to promote and discuss a mental health topic to decrease stigma and increase connection. (Process measure: Number of men attending the monthly meeting. Process target: One monthly group facilitated for a year with eight participants.)

Objective 2

Community mental health education campaigns

Strategy 1

Men's mental health media campaign

Oregon

The 2022 Rankings averaged 4.6 poor mental health days monthly; 15% were in frequent mental distress.

The 2022 County Rankings & Roadmaps reflected an age-adjusted suicide rate of 19 per 100,000 population, with a crude rate of 20 per 100,000.

United States

The 2021 American's Health Rankings report indicated 13.2% of adults reported frequent mental distress.

The 2021 America's Health Rankings reflected a suicide rate of 14.5 per 100,000 population.

Tasks

- Research existing campaigns centered on the importance of men's mental health and decreasing the stigma around men seeking mental health help. Implement the campaign in the community. (Process measure: Campaign developed. Process target: One campaign developed.)
- Host a men's focus group to gauge mental health awareness and gain perspective of how men in the community view seeking behavioral health services (Process measure: Number of focus groups and number of people who participated. Process target: Two focus groups with 10 participants per group.)
- Roll out media component of the campaign using messaging and data to promote men's mental health through print materials such as newspaper, radio, billboards, bus billboards and social media and public service announcements. (Process measure: Number of ads created, print materials distributed and the number of views on social media. Process target: Two newspaper ads, one radio ad, three billboards, one boosted social media post per month, one public service announcement, 50,000 views for social media.)
- Develop resources for men's mental health, suicide prevention and reduction of lethal means (firearms) reduction to distribute to the community. (Process measure: Completed resources. Process target: Three resources created.)

Strategy 2

Campaign to empower the community to place importance on personal mental health

Tasks

- Research existing campaigns centered around decreasing the stigma around seeking mental health services and the taboo surrounding talking about mental health. Use focus groups to gain perspective of potential campaigns. (Process measure: Campaign developed, number of focus groups and participants. Process target: One campaign developed and two focus groups with 10 participants per group.)
- Develop resources around building a personal mental and behavioral health tool kit. The toolkit will be designed for community members to focus on their mental health and that of their fellow community members, without the need to seek mental and behavioral health services. (Process measure: Completed resources. Process target: Three resources created.)
- Implement the campaign in the community and roll out the media component of the campaign to place positive mental health messages and self-care advice through print materials such as the newspaper, radio, billboards, bus billboards, and social media and public service announcements. (Process measure: Number of ads created, print materials distributed and views on social media ads. Process target: Two newspaper ads, one radio ad, three billboards, one bus billboard, one boosted social media post per month, one public service announcement, 50,000 views for social media.)
- Promote local and national resources such as 988 and other mental health crisis call and text lines. (Process measure: Number of resources distributed. Process target: 2,000 resources distributed.)

Objective 3

Promotion of mental health focused community events, resources and trainings

Strategy 1

Promote community mental health resources

Tasks

- Promote local and national community mental health resources through print materials at local events (Process measure: Number of resources distributed. Process target: 2,000 resources distributed.)
- Update the local and national community mental health resource list and release it on the Healthy Klamath website. (Process measure: Compile a list of community resources. Process target: One completed community mental health resource list.)

Strategy 2

Promote trainings and events that focus on mental health

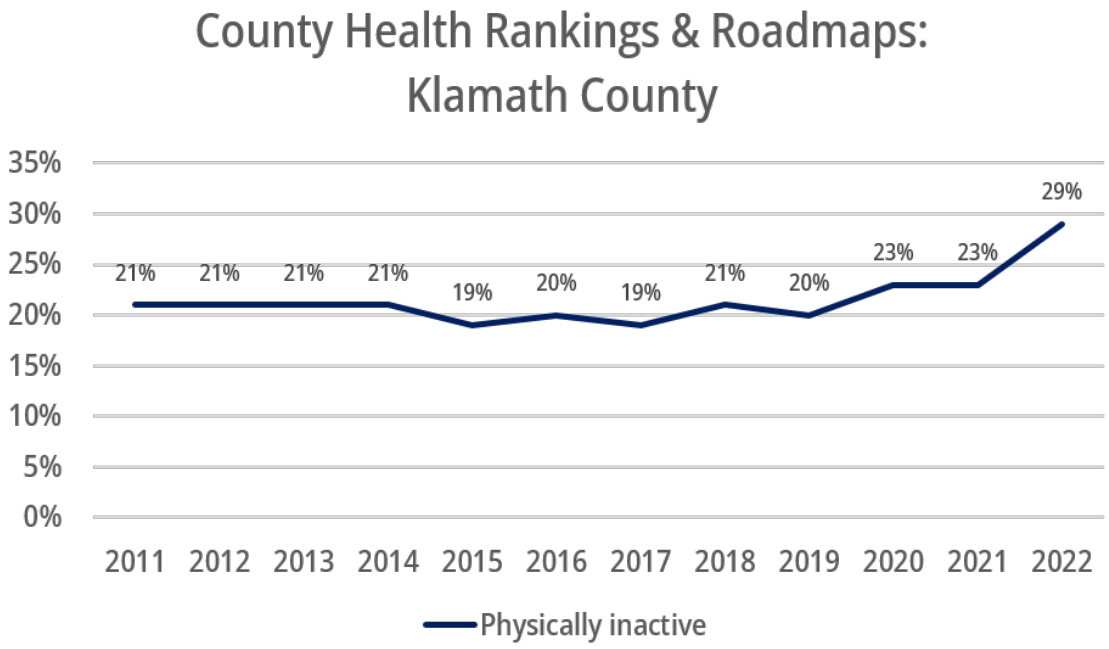
Tasks

- Promote local community events on Healthy Klamath website as well as promotion through community agencies' social media pages. (Process measure: Number of times Healthy Klamath Community Calendar is updated for events. Process target: Update the community calendar once a month for events.)
- Promote local community trainings on the Healthy Klamath website as well as promotion through community agencies' social media pages. (Process measure: Number of times Healthy Klamath Community Calendar is updated for trainings. Process target: Update the community calendar once a month for trainings.)
- Promote Mental Health First AID (MHFA) and Question Persuade Refer (QPR) trainings in Klamath County on the Healthy Klamath website as well as promotion through community agencies' social media pages. (Process measure: The number of trainings offered in year one and the number of participants. Process target: One MHFA with 15 participants and 10 QPR trainings with 100 total participants.)

Physical activity

Overarching goal

Increase physical activity among all ages in all of Klamath County



Objective 1

Increase awareness and access to physical activity opportunities in Klamath County

Strategy 1

Increase physical activity opportunities in parks, schools, and worksites

Tasks

- Continue fundraising for pump track (Process measure: Number of grants submitted and amount of money raised. Process target: Two grants submitted per year or fundraising efforts facilitated.)
- Build Moore Park playground (Process measure: Ground breaking. Process target: playground installed and open for public use.)
- Implement Safe Routes to Schools programming (Process measure: Number of events hosted. Process target: Four events per year.)
- Host physical activity competitions and challenges (Process measure:

Lead agency

Healthy Klamath

Benchmark

By October 2025, decrease number of residents that are physically inactive by 3% as measured by County Rankings.

Baseline

In the 2022 County Rankings & Roadmaps, 29% of Klamath County residents were not physically active; 53% had access to exercise opportunities. In 2021, 23% were physically inactive.

Oregon

In the 2022 County Rankings & Roadmaps, 24% of Oregonians were not physically active; 84% had access to exercise opportunities.

United States

The 2021 America's Health Rankings report indicated 22.4% of the population are inactive.

Number of competitions/challenges hosted. Process target: Two competitions/challenges per year.)

- Partner with government and community organizations, such as BTS and Quail Trail, to increase accessibility to parks and trails (Process measure: Number of transportation opportunities created. Process target: One transportation route.)

Strategy 2

Increase physical activity with built environment prompts

Tasks

- Transform sidewalks/asphalt trails with opportunities to increase movement (Process measure: Number of prompts installed, including painting and etching of concrete and the like. Process target: Three prompts installed..)
- Determine feasibility of creating a downtown walking loop complete with signage (Process measure: Number of meetings facilitated gauging support. Process target: Four facilitated meetings to gauge interest and feasibility.)
- Increase way finding, interpretive and educational signage in community (Process measure: Number of signs installed on trails. Process target: Two new signs installed.)

Strategy 3

Increase community awareness and education around physical activity

Tasks

- Partner with engagement committee to create awareness about physical activity and promote existing opportunities in the community. (Process measure: Number of marketing materials created for physical activity opportunities. Process target: Five materials created a year.)
- Develop and implement a natural movement campaign (Process measure: Number of people engaged. Process target: 35 people participating.)
- Collaborate with community partners to increase awareness about winter activity opportunities (Process measure: Number of winter activity opportunities marketed. Process target: Three winter activities marketed.)
- Increase resources for rural communities on physical activity (Process measure: Number of resources created. Process target: Two resources created.)
- Expand community calendar to communicate events and opportunities for activity (Process measure: Number of events added to calendar. Process target: Twelve events per year.)

Strategy 4

Increase physical activity programming and events

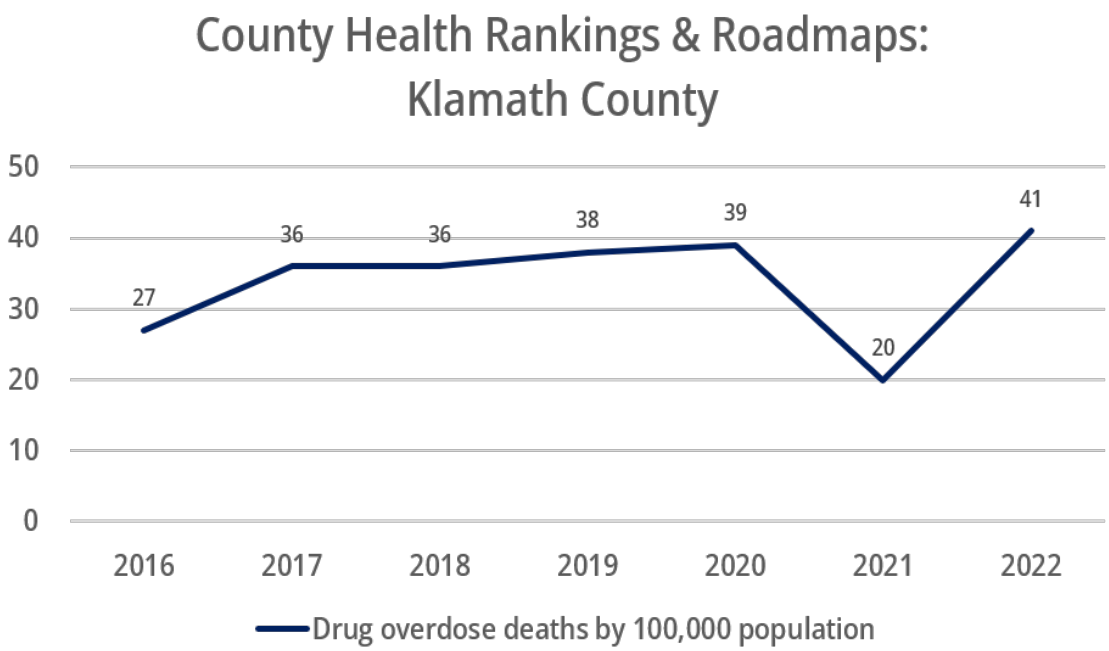
Tasks

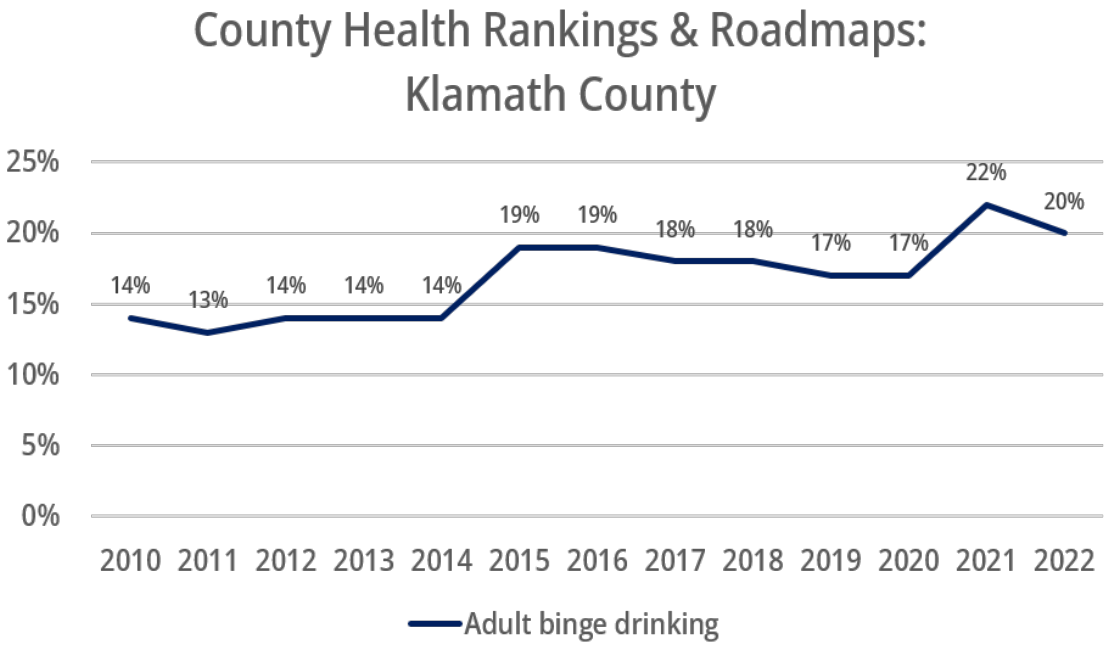
- Host get outdoors events that encourage children and parents to get outside and play (Process measure: Number of events hosted. Process target: Three events hosted.)
- Host community fitness classes weekly (Process measure: Number of classes hosted. Process target: One class per week.)
- Host community give back and clean-up events (Process measure: Number of events hosted. Process target: Four events per year.)
- Seek funding to expand programs and projects (Process measure: Number of grants submitted. Process target: Two grants submitted per year.)

Substance use

Overarching goal

Increase community engagement to prevent harmful substance use, including nicotine





Lead agency

Klamath County Public Health

Benchmarks

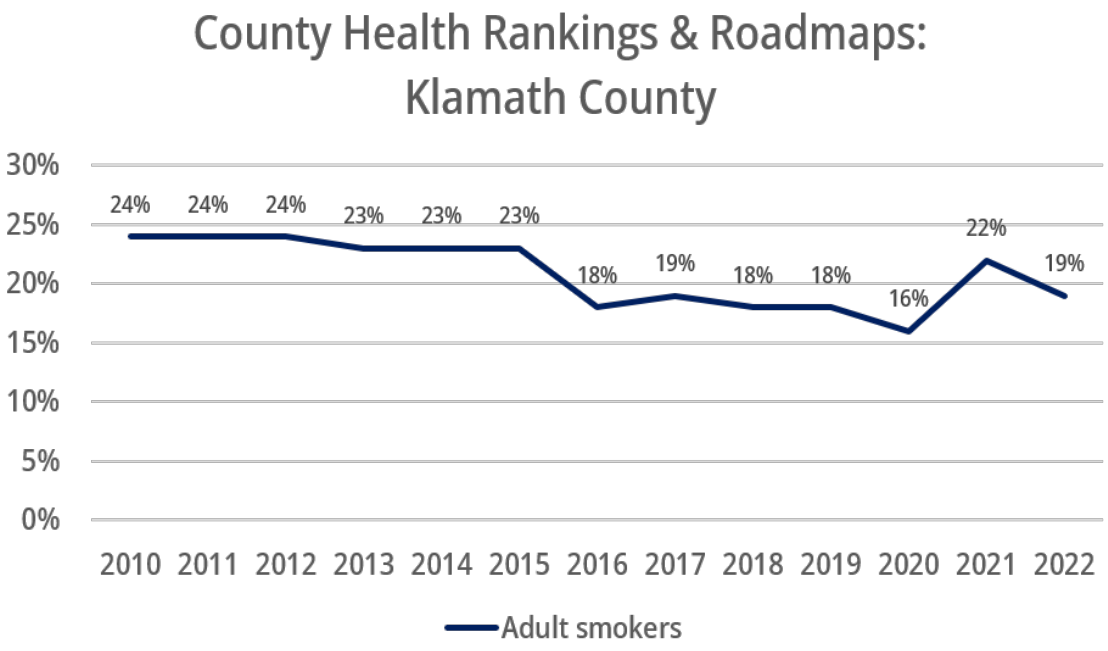
By October 2025 reduce drug overdose deaths by three per 100,000 population, reduce binge drinking by 5% and reduce adult smokers by 5%.

Baseline

In the 2022 County Rankings & Roadmaps, the drug overdose death rate was 41 per 100,000 people. 20% of Klamath County adults reported excessive drinking. Also, 19% of adults were smokers.

Oregon

In the 2022 County Rankings & Roadmaps, the rate for drug overdoses was 16 per 100,000 people; 21% of Oregonians reported excessive drinking.



Objective 1

Support and collaborate in community prevention activities

Measurements

1. One community event each quarter promoted as an alcohol, nicotine and drug-free event
2. Two best practices promoted annually through social media or other medium
3. One youth-based program initiated each year for three total at the end of the plan
4. One annual environmental campaign

Strategy 1

Promote a positive community norm that alcohol consumption is not necessary at community events (This is an alcohol, nicotine and drug-free event)

Tasks

- Explore tobacco, nicotine, alcohol and drug prevention messaging/signage opportunities in public places
- Participate in national Alcohol Awareness Month, National Prevention Week and National Recovery Month activities

Strategy 2

Promote best practices as a positive community norm

Tasks

- Research best practices
- Implement selected practices
- Create community norm that cultural practices are best practices

United States

The 2021 America's Health Rankings report indicated the drug overdose rate was 21.5 per 100,000 population; 17.6% reported excessive drinking.

Equity elements

Ensure messaging is available in English and Spanish, explore opportunities for use of Klamath Tribal languages, sign language and potential functional needs adaptations; promote cultural practice as a best practice; be mindful that a large number of local youth identify as Two-Spirit/LGBTQ+

- Create an environment where those in recovery are welcome and their experience builds community strength

Strategy 3

Implement school and community-based prevention education targeting youth 12-20

Tasks

- Present substance use education in health classes, starting in middle school (or earlier)
- Collaborate with other local agencies providing in-school education
- Collaborate and promote youth-based prevention campaigns
- Reduce advertising and access to substances through retail environments
- Increase positive advertising, why staying clean and sober is healthy, in schools and local businesses
- Use youth activities and culture to help youth peers create a clean and sober community. Engage youth in creating the environment. (Straight Edge, Addicts to Athletes, Phoenix Multi-sport)

Strategy 4

Decrease the continued use of substances by youth in middle and high school

Tasks

- Introduce suspension diversion classes, such as INDEPTH (Intervention for Nicotine Dependence, Education, Prevention, Tobacco and Alcohol and Health) at local schools. Inform all youth during the education class that these sessions are available.
- Inform youth about programs such as N.O.T. (Not on Tobacco) to learn skills to quit nicotine and reduce the risk of future use of other substances.

Strategy 5

Collaborate with multiple local and regional agencies to provide environmental campaigns targeting underage drinking and substance use

Tasks

- Implement Chiloquin First campaigns, with possible expansion into other communities.
- Continue Sticker-shock campaign encouraging adults not to purchase alcohol for youth, seeking local advocates in each community.
- Educate the community on the Keep Tobacco Sacred campaign.
- Investigate ways to incorporate the trauma cycle and generational healing into the prevention, use and recovery landscape.
- Pursue policy work around increase in penalties for purchasing alcohol for youth; marijuana and alcohol products.

Objective 2

Support and collaborate in community drug overdose prevention plan

Measurements

1. Two annual meetings of the multi-sector stakeholder group
2. Emergency response protocol tested, refined and in place by September 2025
3. One coordination meeting held quarterly for harm reduction efforts
4. One annual overdose prevention project

5. Increase school-based prevention programs by one each year (This could be separate programs at the same school, or a single program offered at different schools.)
6. Three partner agencies will share prevention messaging to amplify efforts at least twice annually

Strategy 1

Engage a multi-sector stakeholder group to assist with drug overdose prevention initiative

Tasks

- Gather input, consensus, and approval from key stakeholders including, but not limited to: emergency department, law enforcement, emergency medical service (EMS), addictions treatment specialist, medical provider, Local Public Safety Coordinating Council (LPSCC) board members, emergency manager, health promotion and prevention staff, the justice system, Klamath Tribes
- Convene 6 meetings with the overdose coalition (host emergency meeting as necessary)
- Identify new coalition members (rural EMS departments, recovery organizations, Behavioral Health Resource Network (BHRN) members) recruit to join the overdose coalition group
- Enhance data sharing across public health and public safety partners, such as law enforcement, first responders, emergency rooms, fire department, etc.
- Develop or strengthen programmatic partnerships to leverage the resources and expertise of law enforcement officers (LEO), first responder organizations, and rural fire departments. (for example, clearinghouse, hand out Narcan)
- Collaborate with community partners, supporting and promoting the related work of each. These include, but are not limited to, Klamath Basin Behavioral Health, Sky Lakes Medical Center, Klamath County Office of Emergency Management, Red is the Road to Wellness, Community Corrections, Klamath County Sheriff's office, Klamath Tribes, Klamath Falls Police Department, Chiloquin Fire, Circuit Court, Lutheran Community Service, Transformation Wellness, Bestcare, Tayas Yawks, City and County Schools, Citizens for Safe Schools, Healthy Klamath, Oregon Health Authority, Lake County, Local Alcohol and Drug Planning Committee, LPSCC, Klamath County

Strategy 2

Implement overdose emergency response protocols. Use data to alert and inform community partners of overdose spikes and clusters.

Tasks

- Gather input, consensus, and approval from key stakeholders including, but not limited to: emergency department, law enforcement, EMS, addictions treatment specialist, medical provider, Local Public Safety Coordinating Council (LPSCC) board members, emergency manager, health promotion and prevention staff, the justice system, Klamath Tribes
- Conduct tabletop exercise to test plan
- Modify plan as needed based on table top exercise
- Create after action reports based on table top findings
- Create memorandum of understanding between partners to adopt plan
- Expand and train 1 new partner each quarter on Overdose Detection Mapping Application Program (ODMAP) within the county with support from law enforcement, EMS and other local rural partners (4 partners total).
- Expand systems-wide overdose emergency response plans among physical, mental, and behavioral health providers, hospitals, emergency departments, first responders, treatment and recovery systems, corrections and other providers as appropriate.

Strategy 3

Coordinate naloxone and other harm reduction strategies to prevent overdoses in the county by assessing or coordinating naloxone availability and partnering with harm reduction organizations, first responders, clearing house recipients and people who use drugs.

Tasks

- Host naloxone trainings for 2 new partners each quarter agencies/businesses/ community action teams.
- Identify 2 new agencies/ businesses willing to have a naloxone "first aid" kit in their building for a total of 8 new locations.
- Identify additional funding sources for ordering naloxone. (for example: clearinghouse, grants)
- Address stigma around drug use through activities such as media campaigns, etc.
- Recruit local organizations to receive clearinghouse supplies, such as Narcan.
- Build and strengthen relationships with organizations that received clearing house supplies to further overdose prevention work
- Outreach/activities to get the word out about local resources, harm reduction efforts, Living Well, and addressing stigma

Strategy 4

Develop and implement sustainable overdose prevention projects such as strengthening linkages to care.

Tasks

- Connect harm reduction resources for inmates released from jail.
- Develop a post-overdose protocol to improve opportunities to link people to care following a non-fatal drug overdose.
- Analyze strength, feasibility of Healthy Klamath Connects referral platform for Klamath County.
- Operationalize referral system (Healthy Klamath Connects referral platform)
- Test referral system
- Announce referral system go-live via partner staff meetings, newsletters, press release, social media, health alert network
- Work with County and City schools to create a naloxone policy

Strategy 5

Expand local school-based prevention programs.

Tasks

- Engage with schools (such as Sources of Strength) to determine programming for youth. Identify opportunities to partner and assist with prevention messaging.
- Engage with youth-serving organizations to determine partnership opportunities.
- Develop campaign messages — ensure linguistically and culturally responsive — social media, audio/visual, and print
- Roll out campaign.

Strategy 6

Expand local prevention messaging, empowering individuals to make safer choices.

Tasks

- Engage with youth-serving organizations to determine partnership opportunities.

- Develop campaign messages- ensure linguistically and culturally responsive — social media, audio/visual and print
- Roll out campaign.
- Promote the Good Samaritan Law so people know they will not be held responsible for being in the vicinity of illegal drugs
- Share lived experience stories, including parents who have used with their children; youth who have their own inspirational story; those who have overcome generational use or addiction
- Homeless outreach
- Explore opportunities to work with pharmacies

Evaluation

The steering committee and Healthy Klamath network will use several methods to monitor progress in achieving the goals and objectives in the CHIP. Monitoring progress is an important part of ensuring that the CHIP goals and strategies, along with the workplan activities, are effective in addressing and improving the priority health issues. Workplans, community meetings, success stories, fact sheets, and annual progress reports will be the methods used to monitor and share progress made in addressing the priority health issues.

Methods

Workplans

Workplans will be used to track the actions taken to implement the strategies in the CHIP. The steering committee will work with the assessment sub-committees focused on each priority health issue to develop the workplans. The workplans will be an expansion of the fact sheets in the previous pages, which include the goals, SMART objectives, baseline, target, and benchmark data, with the relevant data year and source. The workplan will include the activities, measures, person and agency responsible, the target completion date, and the status to monitor progress in achieving the goals and objectives. As a part of an ongoing process evaluation, the assessment sub-committees will work with their steering committee liaison to update the status of the workplan activities on a regular basis. The workplan update will take place, at a minimum of every quarter, to monitor whether or not the activities are being implemented as intended.

When possible, the workplans will be published on the Healthy Klamath website to share progress with the community.

Community meetings

The Healthy Klamath network meeting takes place every other month. Community partners and community members are welcomed to attend this meeting to learn more about and to become involved in the community health improvement work. The CHIP priority health issues will be a regular agenda item at the Healthy Klamath meetings. The designated representative, or steering committee liaison, from each assessment sub-committee, will provide updates on the CHIP priority health issues at every meeting. Minutes from the Healthy Klamath meetings are posted on the Healthy Klamath website in order to share updates with the community.

In addition, the steering committee will make more of an effort to share information with the community outside of the Healthy Klamath network meet-

Who, what, where, when and how?

1. Progress on objectives
2. Progress on strategies
3. Progress on tasks
4. Successes
5. Necessary revision to original workplan

ings and the Healthy Klamath website. This can be done with the assistance of Cascade Health Alliance's Community Advisory Council (CAC) members. To keep community members informed about community health improvement efforts, the steering committee will work with CAC members to host a quarterly information session in the community. These information sessions will be held during the evenings in a central and accessible location to encourage attendance and participation.

Success stories

Sharing successes and achievements in improving the priority health issues is also a part of the community's health improvement journey. As the assessment sub-committees start to achieve their activities and strategies, the designated representative from each sub-committee will complete a standard form detailing how the achievement was accomplished. The completed form will be submitted to the steering committee and will address the pertinent goal, objective, strategy, or activity that was fulfilled. Success stories are a positive way to maintain momentum and to highlight the collective impact of the community working together to address these health issues. As the different activities are completed and the goals and objectives for each priority health issue are met, these accomplishments will be reported out to community partners and community members via success stories. Stories that highlight the achievements will be shared in press releases and fact sheets, via website updates, the Healthy Klamath network meetings and community information sessions.

Fact sheets

Fact sheets are a way to highlight the health information in a simple, easy to share format. Fact sheets will be used as another way to keep the community informed about the CHIP priority health issues. Klamath County Public Health will create fact sheets summarizing the six priority health issues. The fact sheets will be updated annually in conjunction with the CHIP Progress Report. Updates to the fact sheets will include overall progress with a description of current activities, strategy changes, data indicator changes, and achievements. The fact sheets will be shared throughout the community and published on the Healthy Klamath website to keep community partners and community members informed of progress being made in addressing the priority health issues.

CHIP progress report

The steering committee will use the workplan updates and success stories submitted throughout the year to compile an annual CHIP Progress Report. The steering committee will evaluate the overall progress in achieving the goals and objectives for each priority health issue. Consideration of available resources and the continued feasibility of the strategies and workplan activities will also be assessed. As a part of this annual outcome evaluation, updated data indicators with a brief trend analysis will be included in the CHIP Progress Report. The report will also include any changes in the priority health issues and strategies, changes in community assets and resources, and how achievements were accomplished. Based on this information, the steering committee and assessment sub-committees will work together to reassess strategies and revise the workplans as needed. The first CHIP Progress Report will be due in June 2023 and will be completed annually thereafter. The annual CHIP Progress Reports will also be made available on the Healthy Klamath website.

CHIP revisions

The CHIP document will be reviewed and revised, as necessary, every year. As goals, objectives, and activities are completed, new strategies will need to be identified. The strategy tables and workplans will be updated to align with the direction of the community health improvement work based on changed priority health issues, completed strategies, changes in assets and resources, such as new or decreased funding streams, and changes in the data indicators. The revisions will be reflected in the revised CHIP document posted on the Healthy Klamath website. In addition, there is a CHIP Priorities section on the Healthy Klamath website, which highlights the data indicators used in the CHIP and includes trend analysis. This section will be another way to share the CHIP revisions.

Appendix

2022 Klamath County Community Health Improvement Plan possible priority areas

Focus area	Healthy Klamath prioritization	Community prioritization	Notes on community prioritization
Drug & alcohol use	60%	27% rated it first in behavioral health	48% thought it ranked second or third
Food insecurity, hunger	50%	10% rated first in factors of health	25% thought it ranked second or third
Housing availability & cost	50%	16% rated first in factors of health	23% thought it ranked second or third
Access to care	45%	22% rated first in factors of health	29% thought it ranked second or third
Quality of life: Mental Health	45%	7% rated first in factors of health	22% thought it ranked second or third
Physical activity	40%	4% rated first in factors of health; 20% rated it first in behavioral health	10% thought it ranked second or third; 34% thought it ranked second or third
Drought	30%	48% rated first in environmental health	There were only three options in EH
Chronic illness	30%	23% rated first in behavioral health	38% thought it ranked second or third
Suicide prevention	30%	16% rated first in behavioral health	41% thought it ranked second or third
Wildfire	25%	28% rated first in environmental health	There were only three options in EH
Trauma, chronic stress	25%	6% rated first in factors of health; 17% rated first in behavioral health	9% thought it ranked second or third; 41% thought it ranked second or third
Maternal & child health	20%	5% rated first in factors of health	15% thought it ranked second or third
Social isolation	15%	7% rated first in factors of health	6% thought it ranked second or third
Clean air	10%	25% rated first in environmental health	There were only three options in EH
Healthcare cost, affordability	10%	16% rated first in factors of health	35% thought it ranked second or third
Quality of life: Physical Health	5%	7% rated first in factors of health	15% thought it ranked second or third
Quality of life: Overall Health	5%	10% rated first in factors of health	15% thought it ranked second or third
Oral health	0%	1% rated first in factors of health	7% thought it ranked second or third