# 2026-2030

# LIVE HEALTHY LANE COMMUNITY HEALTH IMPROVEMENT PLAN

Heceta Head Lighthouse by Holly Moser

"Together we can do more than each of us can do alone."

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# Letter from Live Healthy Lane

Dear Community Partners and Residents of Reedsport, Harrisburg, and Lane County,

As a ***collective impact*** effort to improve the health and wellbeing of our communities, Live Healthy Lane is proud to share the 2026-2030 Community Health Improvement Plan – our community's roadmap for advancing health and wellbeing across Reedsport, Harrisburg, and Lane County.

Over the past two years, hundreds of residents and organizations representing public, private, and nonprofit sectors have helped identify the community's most pressing health concerns through a Community Health Assessment and worked together to develop a community-based plan for addressing these concerns: a five-year living Community Health Improvement Plan. This plan reflects the voices, experiences, and priorities of the community. It is grounded in shared vision, built on collaboration, and committed to health equity for all.

As we move into implementing this plan, Live Healthy Lane invites all sectors, including businesses, foundations, and civic organizations to see themselves in this work, because health is shaped by more than healthcare. Where people live, learn, work, and play deeply impacts their ability to be well. Whether through workforce policies, local investment, or community engagement, every business and organization have a role to play in building a healthier community.

Live Healthy Lane invites you to support this plan by:

- Aligning charitable giving, sponsorships, and grant programs with the priority areas to amplify community impact.
- Integrating community health priorities into your organization's strategic plan, sustainability initiatives, or employee wellness programs.
- Utilizing the Community Health Assessment to support work you are passionate about.
- Developing a workplace committee focused on impacting one of the priority areas.

The work ahead belongs to all of us and every contribution, big and small, moves us closer to a healthier, more connected community. To learn more and explore ways to support, visit www.LiveHealthyLane.org or email Health@LiveHealthyLane.org. Thank you for your partnership and dedication to making our communities places where everyone can live a healthy life.

*Together we can do more than each of us can do alone!*

With appreciation,
Live Healthy Lane Resource Partners

# A Note on Acronyms & Links

During our review process, we received thoughtful feedback that the use of too many acronyms can make documents difficult to follow and less welcoming, especially for community members, partners, and readers who may be new to this work. In response, we carefully examined all acronyms used throughout this document and made decision to limit them. To support clarity and accessibility, this document uses only three acronyms:

- CHA – Community Health Assessment
- CHP – Community Health Improvement Plan
- CCO – Coordinated Care Organization

These were selected because they are the most frequently used terms. All other terms are written out in full. Updating the acronyms increased the length by about a page. Additionally, we have eliminated the need for an acronym's glossary, using the document footer to provide a reference for each acronym on every page. We believe this small and worthwhile adjustment will improve readability and ensure the CHP is welcoming and accessible to all.

Additionally, any term that is ***underlined, bolded, and italicized*** links to its definition in Appendix B: Definitions and Clarifications. Terms that are underlined indicate a document link or external webpage link. If you are unable to click on external webpage links, you can access a digital version of the 2026-2030 CHP using your smartphone camera to scan the QR code below.

Live Healthy Lane's 2026-2030 CHP webpage

# Live Healthy Lane's Purpose & Structure

Live Healthy Lane is a multi-county partnership and collaborative effort designed to carry out a shared CHA and CHP for Lane County, Reedsport, and Harrisburg (see Appendix A: Live Healthy Lane Service Areas). Coordinated Care Organizations (CCOs) administer Medicaid benefits to Oregon Health Plan members and by state contract are required to publish a CHP, based on a CHA, at least every five years. Non-profit hospitals and public health accreditation similarly require a CHA and CHP.

In 2015, Live Healthy Lane was formed to support coordination and collaboration across these large systems. Live Healthy Lane strengthens capacity building, fosters meaningful community engagement, and supports community's creation of a shared framework that partners, businesses, and the community can use for community health planning through the CHP.

Live Healthy Lane's mission is to promote working together to create a caring community where all people can live a healthy life. Everyone needs certain things to do well spanning from housing and food to purpose and social connection. The CHP works to ensure that the conditions to meet these needs exist for everyone. Improving overall health is the central purpose of Live Healthy Lane's work. The CHP outlines strategies for our community to work together to ensure everyone can get the things they need in fair and respectful ways to improve health and well-being.

**Compassion**
We are creating a community where all people are treated with dignity and respect.

**Equity**
We believe everyone should have the opportunity to live a healthy life.

**Inclusion**
We strive to embrace our differences and treat the whole person.

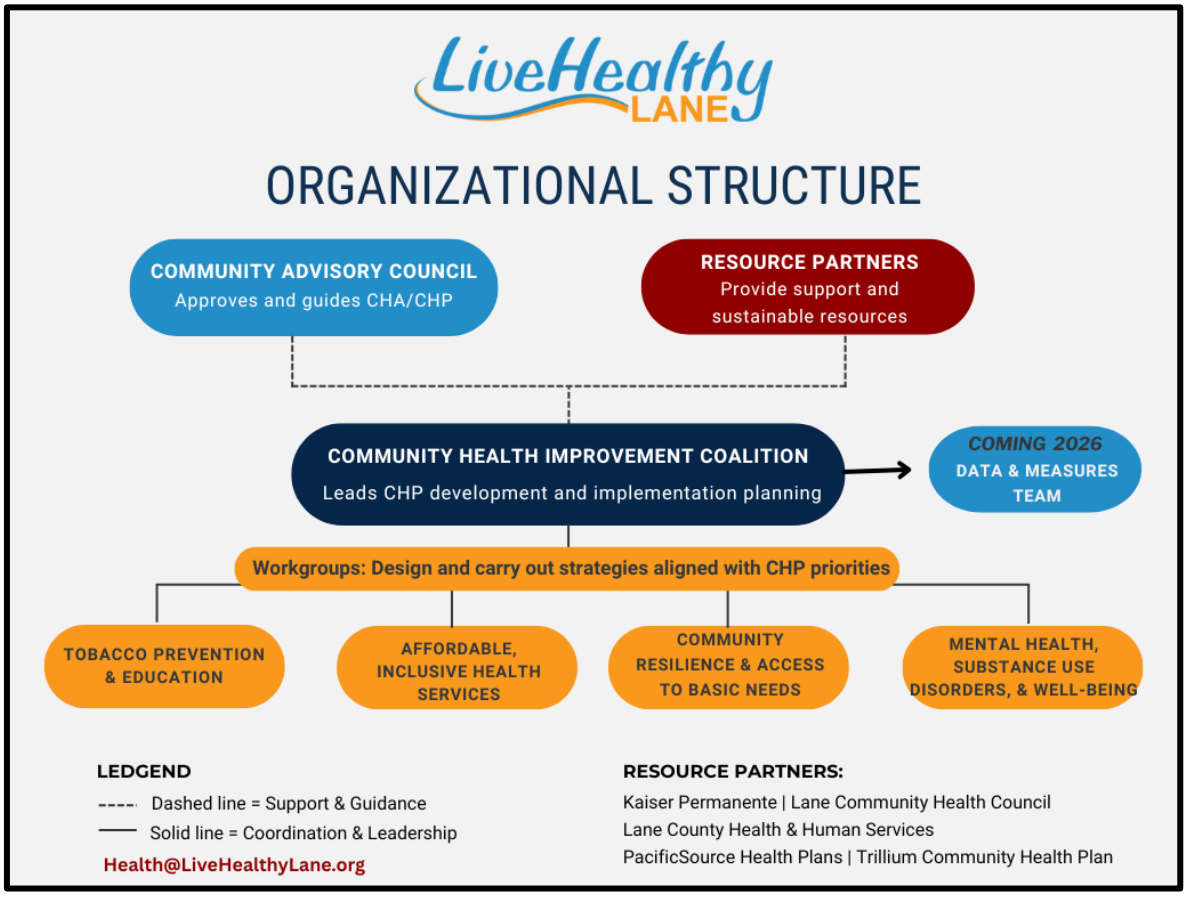
**Collaboration**
We have committed our collective resources to innovation, coordination, and integration of services.

Live Healthy Lane's structure is supported by a formal group of resource partners who help steward and advance the goals of this shared CHP. Lane County Health & Human Services serves as the backbone agency, providing in-kind resources and supervision for Live Healthy Lane's full-time staff member. Lane County Public Health, a division of Lane County Health & Human Services, is an essential partner, offering epidemiological, community engagement, and administrative support for both the CHA and CHP. Together, resource partners, which also include Kaiser Permanente, Lane Community Health Council (the governing body for PacificSource Community Solutions), PacificSource Health Plans, and Trillium Community Health Plan, contribute staff time, expertise, funding, and community connections. Each partner signs a memorandum of

understanding that adopts a common agenda, aligns measurement and activities, and coordinates implementation throughout collective structures. This shared accountability and multi-partner commitment is foundational to moving the CHP from a written plan to meaningful action.

Live Healthy Lane works closely with the Lane County Community Advisory Council, a Medicaid consumer voice council, throughout this process. Community Advisory Council members participate in assessments, contribute community expertise during priority-setting, and serve as an important community voice. Once the CHP is developed, the Community Advisory Council formally adopts the CHP on behalf of Lane County CCOs, ensuring alignment with regional health system priorities (see Letter from the Community Advisory Council). Lane County Public Health also adopts the CHP extending its role as a shared roadmap for public health action. Other partners across the community are encouraged to use the CHP priorities to guide their own strategic planning and collective action, strengthening alignment and accelerating impact across the community.

The Community Health Improvement Coalition is a dedicated body created specifically to lead in the development of the CHP and support its implementation and ongoing progress monitoring. The Community Health Improvement Coalition is made up of 16 community leaders, 1 Tribal community leader, and 16 sector leaders and partners with diverse regional representation from Florence, Veneta, Reedsport, Cottage Grove, Confederate Tribes of Siletz Indians, Junction City, Springfield, and Eugene. Its purpose is to guide CHP priority selection, refine strategies and measures, and help transition the community from assessment findings to an actionable plan.



## *Telling the Community Story*

Before we can create a plan to improve community health and eliminate health inequities, we have to understand the current conditions in Lane County. That is the work of the CHA. The first step in conducting that assessment was to ask the community what a healthy and equitable Lane County would look like. In June 2024, the CHA Design Team hosted six visioning events across Lane County to create a shared vision of health and equity.

This vision was used by the Design Team to guide the selection of indicators (pieces of information tracked over time to understand if things are getting worse, better, or staying the same), develop survey and focus group questions, analyze data, and identify themes across multiple assessments. A total of five assessments, using both qualitative and quantitative data were conducted:


- The Community Partner Assessment used a survey and collaborative data analysis to assess the capacity of the public health system to deliver the 10 essential public health services and address health inequities
- The Community Status Assessment used data from many secondary sources and a collaborative data analysis to assess health status and access to the social determinants of health
- The Community Context Assessment:
    - Community Assets and Barriers assessed people's experiences of living in Lane County through a community survey
    - Built Environment looked at the influence of housing, transportation, and schools on health
    - Forces of Change examined the cultural and historical context and how those impact health and equity in Lane County

Data from these assessments were reviewed by the community to identify themes and develop the issue profiles that inform this CHP.

# Letter from the Community Advisory Council

Dear Community,

In Oregon, Coordinated Care Organizations (CCOs) are required to bring together Community Advisory Councils called CACs to inform their work. These groups include people who get care through the Oregon Health Plan and organizations that serve them.

Lane County's CCOs, PacificSource and Trillium work together like a beehive. The Oregon Health Plan community is like the flowers and trees that need pollination to stay healthy. In this analogy, Community Advisory Councils serve as the bees. They gather information about member's problems, questions, and needs. Then they bring this information to the CCOs, which helps make decisions that support a healthy, strong community.

This input helps in the creation of both the CHA and CHP for Lane County ensuring that member voice is heard throughout the process. The CHA is an organized way to create a shared vision for a thriving community, and the CHP is how we take collective action. Adopting the 2026-2030 CHP means the Community Advisory Council recommends the CCOs, Lane Community Health Council, and all interested partners spend their time and resources supporting the priorities in the plan.

Part of the Community Advisory Council's role includes promoting upstream primary prevention, health equity, member engagement, and rural connection. We are committed to being active in CHP implementation, reflecting on annual progress, and serving as stewards for aligning CCO investments with these priorities.

We hope you will join us as we work to improve the health and well-being of our community over the next five years and beyond. Together, we can support each other in this important work.

To learn more about the Community Advisory Council, visit https://preventionlane.org/coalitions-councils/

With appreciation,

Lane County CCO Community Advisory Council

*CHP formally adopted on November 24, 2025*

# Thank You

Live Healthy Lane is deeply grateful for the support of our resource partners, which helped sustain Live Healthy Lane throughout the development of the 2024-25 CHA and 2026-2030 CHP. These partners have provided guidance, funding, and staff support and include Kaiser Permanente, Lane County Health & Human Services, Lane County Public Health, PacificSource Health Plans, Trillium Community Health Plan, and Lane Community Health Council. Together, we share a commitment to aligning efforts and resources to create meaningful, measurable improvements in health outcomes.

Live Healthy Lane extends sincere appreciation to the Community Health Improvement Coalition, whose members along with subcommittee chairs and Community Health Organizing Meeting members (highlighted with an asterik), brought community expertise, experience and sector leadership to shaping the CHP. Their dedication, collaboration, and shared vision were essential to transforming data and community input into clear strategies and actions.

| | | |
|---|---|---|
| **Abby Harrison**<br>*Community Leader* | **Hayley Van Horn**<br>*Lane County System of Care* | **Megan Walker**<br>*Community Health Centers of Lane County, Dovetail* |
| **Britni D'Eliso**<br>*Lane County Behavioral Health* | **Jessi Preston***<br>*Community Advisory Council* | **Michelle Thurston**<br>*Community Advisory Council* |
| **Brodie Hylton**<br>*Cascadia Mobility* | **Jessica Lloyd-Rogers**<br>*Veterans Mental Health Advocacy Council* | **Miranda Mitchell**<br>*Tribal Community Leader* |
| **Caitlynn Hatteras***<br>*Community Advisory Council* | **Jessica Sargent***<br>*Corvallis Housing First* | **Pamela Berrian***<br>*Broadband Sector Leader* |
| **Callee Ackland**<br>*Lane County Tenant Coalition* | **Kate Budd**<br>*Lane County Human Services* | **Rachel Falconer**<br>*Community Leader* |
| **Darci Standefer***<br>*Community Advisory Council* | **Laura Dahill**<br>*The Arc Lane County* | **Sally Cummings**<br>*Eugene Family YMCA* |

| | | |
|---|---|---|
| **Denise Bunnell**<br>*Community Advisory Council* | **Leah Edelman**<br>*Community Leader* | **Samantha Duncan**<br>*Be Your Best Cottage Grove* |
| **Diane Peterson**<br>*Alliance for a Safe Oregon* | **Lee Bliven II**<br>*Community Advisory Council* | **Steve Schneider**<br>*Alliance for a Safe Oregon* |
| **Emily Moore**<br>*United Way of Lane County* | **Lindsay Montgomery**<br>*American Cancer Society* | **Suzy Kropf**<br>*United Way of Lane County* |
| **Eric Richardson**<br>*Beyond Toxics* | **Lisa Willis**<br>*Lane County Health & Human Services* | **Tara DaVee***<br>*Community Advisory Council* |
| **Genevieve Schaack**<br>*Burrito Brigade, Community Advisory Council* | **Maggie Bagon**<br>*Siuslaw Vision Team, Florence Farmers Market* | **Theya Joslin**<br>*Parenting Now* |

Live Healthy Lane is grateful to the consulting partners who promptly joined the process to fill knowledge gaps identified by subcommittees. Their timely expertise and insights helped ensure each strategy was supportive of work already happening and responsive to community need.

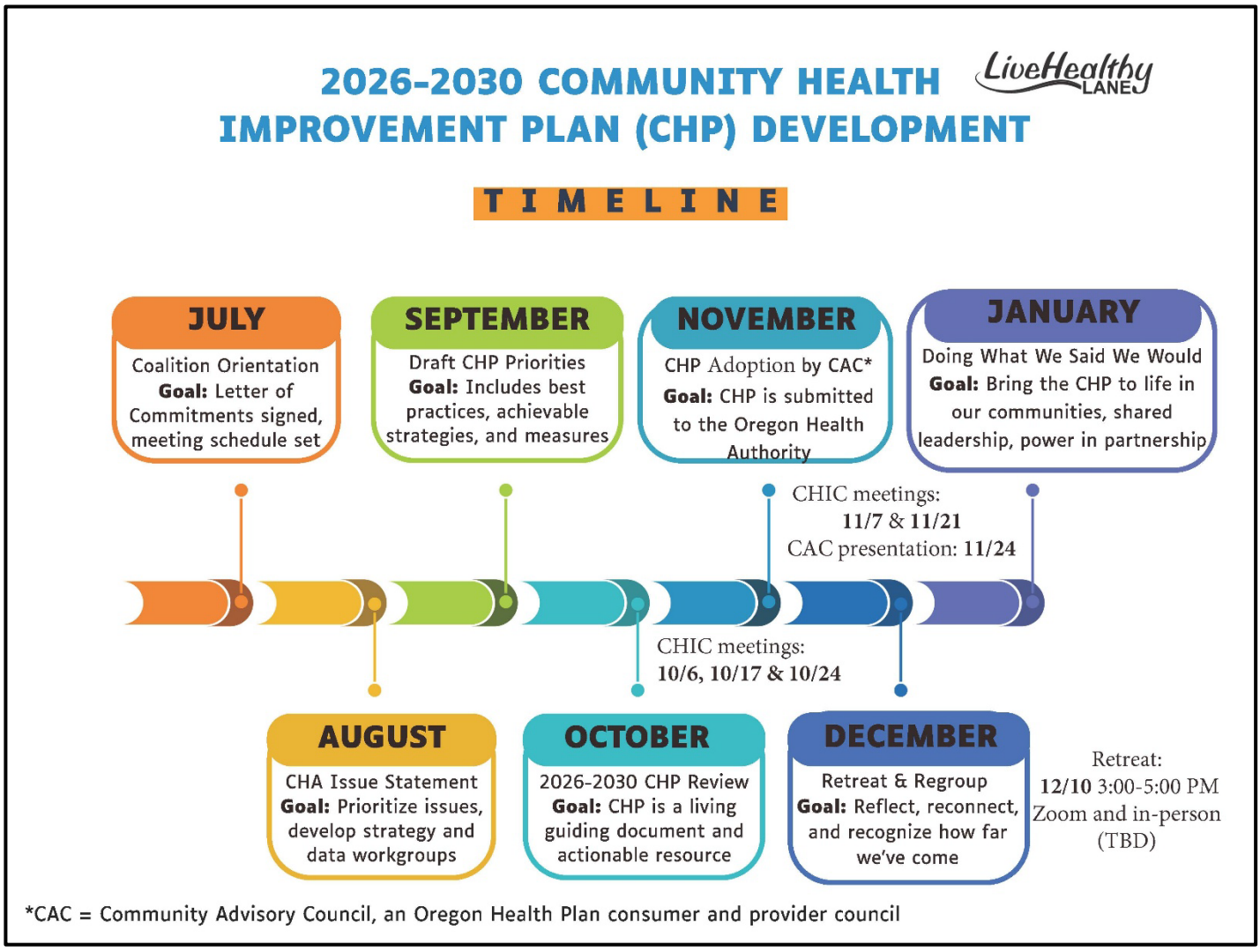
| | | |
|---|---|---|
| **Alex Curtis**<br>*Quality Care Connections* | **David Hill**<br>*Ko-Kwel Wellness Center* | **Jennifer DeVault**<br>*ShelterCare* |
| **Ally Wimberly**<br>*Charlie Health* | **Elaine Walters**<br>*Trauma Healing Project* | **Jo McClain**<br>*Our Community Birth Center* |
| **Casey Reid**<br>*Lane Education Service District* | **Iris Bicksler**<br>*15th Night* | **Kris Coomes**<br>*Early Childhood Hub of Lane County* |
| **Cheryl Henderson**<br>*Lane Community College* | **Jennifer Ablow**<br>*Center for Family Development, University of Oregon* | **Kristinia Rogers**<br>*Trillium Community Health Plan* |

Live Healthy Lane recognizes the staff who supported facilitation, coordination, and project management throughout this process; their behind-the-scenes work ensured meaningful community engagement. Together, these collective contributions made the development of the CHP possible.

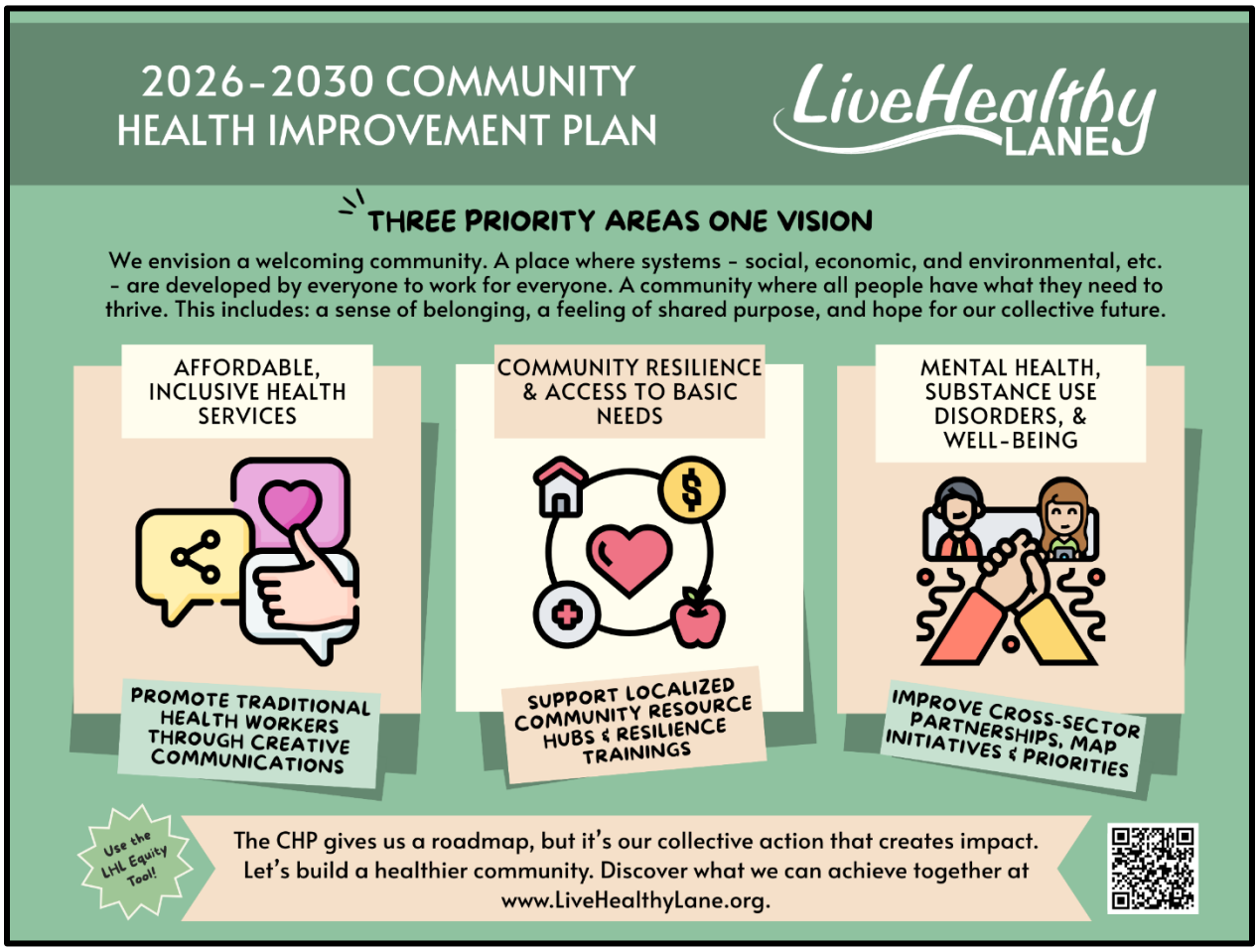
| | | |
|---|---|---|
| **Debi Farr**<br>*Trillium Community Health Plan, Community Engagement Manager* | **Leilani Brewer**<br>*Live Healthy Lane, CHP Project Manager* | **Teresa Roark**<br>*Lane County Public Health, Prevention Plan Coordinator* |
| **Jennifer Webster**<br>*Lane County Public Health, Epidemiologist* | **Olatorera Adeniji**<br>*Lane County Public Health, Community Health Analyst* | **Yazelis Benitez -Villegas**<br>*Lane Community Health Council, Community Health Program Manager* |
| **Kayla Gray**<br>*Lane County Public Health, Community Advisory Council Coordinator* | **Sadie Baratta**<br>*Lane County Public Health, Epidemiologist* | |

# Community Health Improvement Coalition Timeline

Recruitment materials and updates were shared publicly though the Live Healthy Lane website at www.LiveHealthyLane.org/the-coalition and via Facebook (materials were posted and available at outreach events in Spanish). All coalition members signed a letter of commitment.



# 2026-2030 CHP PRIORITIES, GOALS, AND STRATEGIES




Priorities are listed in alphabetical order and do not reflect any order of importance.

**Interested in a presentation on the 2026-2030 Community Health Improvement Plan?** Let us know by submitting a request on the Live Healthy Lane website or use the QR code below.

# Priority 1: Affordable, Inclusive Health Services

## *Building on the CHA*

The 2024-25 CHA shows that access to health services is worsening, even after years of progress. Many residents continue to experience barriers to physical health, mental health, and dental care, preventative services, and culturally responsive treatment. Routine check-ups and cancer screenings remain below desired levels. In 2022, 18% of adults living in poverty and 21% of adults with disabilities reported not accessing care due to cost, and community members, especially in rural areas, described long travel times and provider shortages as major obstacles. This orienting document, which links to useful CHA documents, was developed to support the Community Health Improvement Coalition in developing this priority.

The Affordable, Inclusive Health Services priority focuses on ensuring that physical, behavioral, mental, and dental health services are affordable, culturally relevant, and ***trauma-informed/healing-centered***. A key strategy is to promote the use of ***Traditional Health Workers***, strengthen the workforce, and increase awareness among community members and providers to:

- Build trust and understanding.
- Improve health literacy.
- Connect to the right care at the right time.
- Reduce pressure on an overburdened and inequitable healthcare system.

## *The Affordable, Inclusive Health Services Subcommittee*

The Affordable, Inclusive Health Services subcommittee included community members and partners whose diverse expertise informed the development of strategies for this priority. Organizations participating in this work included:

- Alliance for a Safe Oregon
- American Cancer Society
- Arc of Lane County
- Community Advisory Council
- Eugene Family YMCA
- Federally Qualified Health Centers of Lane County
- Lane County Human Services Division, Dovetail Program
- Our Community Birth Center
- ShelterCare

## *Community Expertise in Action to Guide Strategy*

Community Health Improvement Coalition members emphasized that access challenges go beyond service availability. People often struggle to navigate a fragmented, profit-driven, complex healthcare system with barriers such as insurance restrictions, provider shortages, transportation limitations, and digital inequities affecting telehealth access. Members highlighted valuing trust, relationships, and community connection. These principles are central to the Traditional Health Worker model.

> *There is a need to change healthcare from for-profit to for-people.*
>
> *– Community member*

***Community Health Workers***, a type of Traditional Health Worker, play a key role in bridging gaps by providing culturally relevant, trauma-informed/healing centered, community-based support, helping people understand options, connect to care, and manage their health. However, both community members and some providers noted limited awareness of Community Health Worker roles.

During this CHP cycle, the coalition will prioritize elevating Community Health Workers, increasing understanding of their role, and improving community access through clear communication, intentional outreach, and data-driven evaluation.

## *Goal, Strategies, and Objectives*

Strategies, timelines and measures may become more specific as the coalition and subcommittee focused on this priority reconvene in 2026. SMARTIE objectives are Specific, Measurable, Achievable, Relevant, Time-Bound, Inclusive, and Equitable.

Because this is a living CHP, implementation of this strategy will intentionally include ongoing engagement with all types of Traditional Health Workers, utilizing the Lane County Traditional Health Worker Collaborative and other engagement avenues. Through this engagement, Community Health Workers will share insights on barriers they are able to help community members overcome, challenges that remain in accessing care, and gaps in systems or services. Qualitative feedback collected from Community Health Workers will be reviewed periodically to identify emerging barriers and inform updates to the CHP. This feedback will be used to refine existing strategies and support the development of future strategies and objectives over the life of the CHP.

**Goal:**
Ensure physical, behavioral, mental, and dental health services meets everyone's needs by being affordable, culturally relevant, and trauma-informed/healing centered.

**Strategy:**
Promote the use of Traditional Health Workers, starting with Community Health Workers, among both community members and providers to improve health literacy and help people connect to the care.

**SMARTIE Objectives:**

1. By December 2030, increase community and provider understanding of Community Health Workers, who they are, and what they do, by developing and sharing culturally relevant, plain-language educational materials in at least three communication formats. Materials will be co-designed with Community Health Workers and community members to ensure accessibility, cultural relevance, and representation.
2. By December 2030, create a short comic or animation that explains Community Health Workers' roles using trauma-informed/healing centered and culturally appropriate storytelling, created in partnership with Community Health Workers and community members from ***systemically marginalized*** groups. Beginning the quarter following its release, share the content at least once per quarter on social media and maintain permanent placement on the Live Healthy Lane website, while also distributing through at least five community outreach partners that serve different populations.
3. By December 2030, work with CCOs and relevant data partners to collect and analyze pre and post Community Health Worker utilization data, disaggregated, if available, by race, ethnicity, language, disability, age, zip code, and insurance status. Evaluate quarterly social media and website analytics for the Community Health Worker campaign to measure reach and engagement and use these findings to make at least two equity-focused adjustments to communication or outreach strategies to ***improve access*** and effectiveness for different groups.

## *Building on What Works: Proven Practices to Explore*

Improving community health takes many people working together, each using their own strengths. While the coalition has selected a central strategy to guide our shared efforts, meaningful progress also comes from organizations, businesses, and community members taking action in the ways they are most passionate about and well positioned to lead. This section highlights a few proven strategies from the Robert Wood Johnson Foundation "What Works for Health".

- Cultural competence training for health care professionals
  Increase health care providers' skills and knowledge to understand and respond to cultural differences, value diversity, etc. via factual information, skills training, and other efforts
- Patient navigators
  Provide culturally sensitive assistance and care coordination, and guide patients through available medical, insurance, and social support; also called systems navigators
- Culturally adapted health care
  Tailor health care to patients' norms, beliefs, and values, as well as their language and literacy skills

Policies and programs to **expand access**:

- Telemedicine
- Rural transportation services
- School-based health centers
- Mobile health for mental health
- Telemental health services

# Priority 2: Community Resilience and Basic Needs

## *Building on the CHA*

Access to basic needs, including safe and stable housing, sufficient income, nutritious food, childcare, transportation and supportive service, is fundamental to individual and community health. Community resilience is the capacity of individuals and neighborhoods to ***thrive*** in the face of stress, uncertainty, and systemic inequities. Bringing access to basic needs and community resilience together is what Live Healthy Lane defines as ***localized community resilience hubs*** and identifying where these exist, where there are gaps, and how we can strengthen what's already there is a key strategy under this priority. The 2024 CHA revealed that many Lane County residents face significant barriers to meeting basic needs, making localized community resilience hubs a priority for the CHP (see related orienting document).

Nearly half of all households in Lane County are experiencing financial hardship or living below the ALICE (Asset-Limited, Income-Constrained, Employed) threshold, limiting their ability to afford essentials. Affordable housing shortages further worsen economic strain, with high rental costs and limited housing options contributing to instability and, in some cases, homelessness.

> *Lane County is considered a childcare desert – a community where there are three or more children for a single childcare slot. In 2022, 26% of children 5 and under lacked access to childcare. The median annual cost of having a toddler in childcare in Lane County is more than $17,000 dollars.*
>
> *Community Status Assessment*

Data shows that these challenges disproportionately affect historically excluded communities, including Black, Indigenous, Latine, and other populations, highlighting persistent inequities. Residents frequently reported that unmet basic needs interfere with their ability to maintain good health. By prioritizing community resilience and access to basic needs, the CHP aims to:

- Tackle the root causes of health inequities.
- Make sure everyone can access the resources they need to thrive.
- Promote policies that create fair and supportive economic and social conditions for all.

## *The Community Resilience and Basic Needs Subcommittee*

The development of the Community Resilience and Basic Needs priority was informed by community members and partners representing a wide range of expertise. Collectively, these partners ensured the priority reflects the full spectrum of community needs, from social and environmental determinants of health to disaster resilience, mobility, and equitable access to resources. Organizations participating in this work included:

- Be Your Best Cottage Grove
- Beyond Toxics
- Burrito Brigade
- Cascadia Mobility
- Community Organizations Active in Disaster
- Community Advisory Council
- Corvallis Housing First
- Lane County Human Services
- Siuslaw Vision


## *Community Expertise in Action to Guide Strategy*

Across subcommittee and coalition discussions, participants consistently emphasized that access to basic needs is shaped by broader structural conditions. Themes centered on three primary areas: basic needs, housing, and climate justice. Community members underscored the need to better map and strengthen existing efforts so that supports are easier to find, navigate, and use.

Early conversations highlighted the critical role of community expertise and grassroots solutions in meeting basic needs. People noted that community-based organizations often fill gaps in transportation, food access, and system navigation in ways that the larger system cannot.

In housing discussions, members emphasized persistent shortages of accessible and affordable housing, rising costs, and limited pathways for renters and first-time homebuyers. They also noted that many existing housing supports remain under-resourced, difficult to navigate, or inconsistently available across the county. Housing emerged as one of the most urgent and interconnected basic needs affecting health and stability. These insights reinforced the importance of understanding and uplifting current housing efforts while identifying opportunities to strengthen coordination, expand capacity, and ensure equitable access to safe, stable housing for all.

**Are you working on housing initiatives?** In the spirit of "together we can do more", consider joining A.C.T. Now Lane to stay informed of work happening to keep homelessness rare, brief, and non-reoccurring.

Another theme centered on economic pressures. Discussions including wages not keeping pace with the cost of living, barriers to higher education and job training, and the decline of local job opportunities. Participants emphasized the value of examining existing programs that support workforce development, financial literacy, and small business stability.

**Opportunity for Community Feedback!** The Oregon Department of Transportation is updating its Public Involvement Policy for three major transportation plans: the Oregon Transportation Plan, the Statewide Transportation Improvement Plan, and the new 10-year Capital Investment Plan.
Read the draft policy and share your feedback here
*Public comments are open until January 23, 2026*

Finally, climate justice discussions underscored that extreme weather, declining air quality, and infrastructure challenges disproportionately affect people already struggling to meet basic needs. While many local efforts such as resilience hubs, food system initiatives, transportation planning, and climate action plans are addressing components of this issue, they remain under-resourced or disconnected. Participants stressed the importance of building community resilience, improving air quality enforcement, investing in nonprofit and community preparedness, expanding sustainable transportation options, and strengthening policies that protect health.

Climate impacts are inequitable and increasingly affect both mental and physical health, making climate justice essential to health equity. Together, these themes reveal a community rich in dedicated efforts, but also highlight a clear need for greater visibility, coordination, and assessment of the work already underway.

**Working on climate justice initiatives or related policy?**
Consider reviewing local plans such as:
City of Eugene Comprehensive Plan (specifically Ch. 5 on Community Health)
Community Wildfire Protection Plan
Lane County Climate Action Plan

## *Goals, Strategies, and Objectives*

Strategies, timelines and measures may become more specific as the coalition and subcommittee focused on this priority reconvene in 2026. SMARTIE objectives are Specific, Measurable, Achievable, Relevant, Time-Bound, Inclusive, and Equitable.

**Goals:**

1. Everyone has access to the material things (housing, food, utilities, clean air, and water) and services (transportation, childcare, and education) they need to thrive.
2. Everyone has opportunities to build social connections, create support networks, and contribute to making their community a safe and healthy place.
3. Access to resources for disaster preparedness, response, and recovery are equitable.

**Strategy:**

Identify localized community resilience hubs that can help people in accessing basic needs, support equitable access to emergency preparedness and disaster response, and offer places of connection for everyone.

**Objectives:**

1. By December 2030, identify and assess existing local efforts that help community members access basic needs (e.g., food, housing, utilities, transportation, and childcare). Prioritize efforts serving the systemically marginalized groups identified in the CHA, as well as other disproportionately impacted groups, supported by most recent available data. Complete a strengths, gaps, and equity-barriers analysis, developed with input from partners and community members to inform the development of localized community resilience hubs.
2. By December 2030, identify and convene at least three localized community resilience hubs, or strengthen existing ones, that coordinate basic needs support efforts. Mid Lane Cares/Fern Ridge Service Center, and Community Action Service Centers (for more information see "Anti-Poverty Programs" drop down) like Catholic Charities in Springfield, Community Sharing in South Lane County, and Siuslaw Outreach Services in Florence are examples of organizations that currently provide basic needs services. Each hub will include representation from community-based organizations, culturally specific organizations, local governments, and residents, ensuring accessibility for rural communities, people with disabilities, and low-income households. Produce a shared coordination plan that outlines roles, communication pathways, and opportunities for collaboration among hubs.
3. By December 2030, develop and implement an equity-centered training and communication plan for emerging or existing hubs. The plan will identify training needs (e.g., trauma-informed/healing centered response, emergency communication, cultural responsiveness, ADA accessibility) and establish inclusive communication practices. These will be co-designed with community partners to ensure that preparedness and response information is accessible across languages, abilities, and zip code. Pilot the plan with at least two resilience hub sites and adjust based on participant feedback.

## *Building on What Works: Proven Practices to Explore*

This section highlights a few proven strategies from the Robert Wood Johnson Foundation.

- Community centers
  Provide space to promote socializing among community members and offer programs and services
- Shared use agreements
  Contracts that support community access to existing public, private, or nonprofit facilities before or after business hours; also called joint use, open use, or community use agreements
- Food hubs
  Support businesses or organizations that aggregate, distribute, and market local and regional food products (e.g., fresh fruits and vegetables, meat, dairy, grains, and prepared items)
- Community organizing
  Developing leadership, campaigning, and building power to influence decisions, agendas, and worldviews, by collaborating with community organizing groups to use these methods, or both

Policies and programs for **affordable housing**:

- Rapid re-housing programs
- Low Income Housing Tax Credits
- Legal support for tenants in eviction proceedings
- Tax increment financing (TIF) for affordable housing
- Housing First
- Inclusionary zoning & housing policies
- Permanent Supportive Housing

Policies and programs for **economic stability:**

- Living wage laws
- Child tax credit expansion
- Childcare subsidies
- Universal basic income
- Microfinance & microenterprise

# Priority 3: Mental Health, Substance Use Disorders, and Well-Being

## *Building on the CHA*

The 2024-25 CHA reveals that, while 84% of adults rated their overall health as good to excellent, only 57% reported good to excellent ***mental health***. Among 8th and 11th graders, 26% reported unmet mental health needs, with rates reaching 44.2% among transgender/non-binary youth and 41.8% among LGBQA+ students.

Additionally, substance use among youth in 2022 show that about 18% of 11th graders and about 8% of 8th graders reported having at least one drink of alcohol in the past 30 days, and about 16% of 11th graders reported using tobacco in the same period. Adults and youth, people with disabilities, those living in poverty, and individuals from ***systemically marginalized*** identities report disproportionate burden of poor mental health, substance use, and unmet care needs.

*In 2022, 35% of 6th, 8th, and 11th graders reported fair to poor mental health, and in that same year, 34% of youth reported experiencing symptoms of depression in the past 12 months.*

Mental Health, Substance Use Disorders, and Well-Being Orienting Document

The high percentages of youth reporting poor mental health, depression, and suicidal ideation signal a crisis among young people. If left unaddressed, this can lead to long-term negative outcomes across education, employment, physical health, and community engagement. Significant youth and adult substance use rates highlight substance use as a common coping strategy and underscore to the need for integrated, trauma-informed/healing centered, and culturally responsive services.

These findings directly informed the Mental Health, Substance Use Disorders, and Well-Being strategies. Improving system coordination and collaboration addresses fragmented services and helps ensure that people can access care efficiently. Promoting positive community norms through inclusive storytelling confronts stigma, encourages help-seeking, and fosters resilience. Expanding early screening and referral for perinatal and early childhood mental health targets critical developmental periods, supporting families and preventing escalation of mental health challenges. Together, these strategies reflect community-identified needs and aim to:

- Reduce health inequities in mental health and substance use outcomes.
- Strengthen community and system supports for mental well-being.
- Promote overall mental health and well-being across the community.

## *The Mental Health, Substance Use Disorders, and Well-Being Subcommittee*

The development of this priority was informed by community partners bringing together expertise across early childhood development, family and veteran support, mental health advocacy, and trauma-informed/healing centered care. Their collaboration ensured strategies were grounded in the experience of individuals and families across the community, reflecting the interconnected nature of health, wellness, and social supports. Participating organizations included:

- Alliance for a Safe Oregon
- Center for Family Development
- Charlie Health
- Community Advisory Council
- Early Childhood and Mental Health Workgroup
- Early Childhood Hub of Lane County
- GamAware Coalition of Lane County
- Ko-Kwel Wellness Center
- Lane County Behavioral Health, Lane Care
- Lane County System of Care
- Lane County Veteran Services
- Lane Education Service District
- NAMI Lane
- Parenting Now
- Quality Care Connections
- Relief Nursery
- Suicide Prevention Coalition of Lane County
- Trauma Healing Project
- United Way of Lane County
- University of Oregon
- Veterans Mental Health Advocacy Council
- Western Lane Mobile Crisis

## *Community Expertise in Action to Guide Strategy*

Coalition members emphasized that mental health is deeply interconnected with basic needs, social determinants of health, and community resilience. Discussions highlighted persistent gaps in access to qualified mental health providers, long waitlists, and challenges in serving rural and systematically marginalized populations. Members noted that shortages are compounded by workforce limitations, certification barriers for in-and-out-of-state providers, and insufficient funding, which collectively prevent individuals from receiving timely, culturally relevant, and disability-informed care.

*Participants stressed the importance of upstream strategies to build a local mental health workforce, including training programs, licensure support, and incentives for providers to remain in the community.*

Parenting Education & Resource Assessment in Lane County 2024-2025

Early childhood interventions, parenting education, anti-bullying curricula, peer-to-peer support programs, and integrated social and basic needs strategies were highlighted as critical prevention measures. Members emphasized that addressing housing instability and food insecurity is essential for promoting mental well-being and preventing crisis such as suicide.

Additional priorities included expanding public awareness of the social drivers of mental health, improving transportation access to care in rural areas, supporting medication adherence through pharmacy engagement, and preparing communities to respond to climate-related stressors. Collectively, these discussions highlighted the need for strategies that strengthen coordination, expand capacity, and integrate mental health supports across systems to ensure that all community members can access the care and resources they need. These strategies aim to:

- Expand access to mental health care where and when people need it.
- Grow and retain a local, skilled mental health workforce.
- Strengthen early intervention and prevention supports for children, families, and schools.

## *Goals, Strategies, and Objectives*

Strategies, timelines and measures may become more specific as the coalition and subcommittee focused on this priority reconvene in 2026. SMARTIE objectives are Specific, Measurable, Achievable, Relevant, Time-Bound, Inclusive, and Equitable.

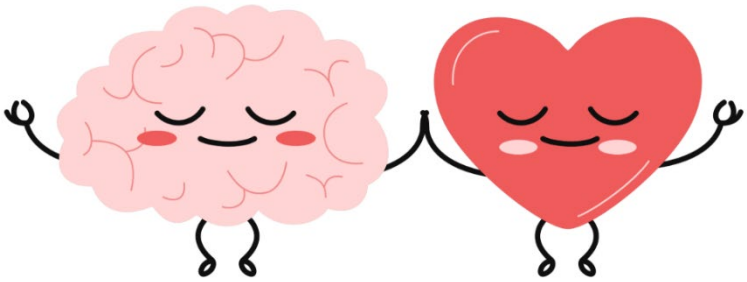
| **Goal 1:**<br>Strengthen communication and coordination across early childhood and mental health systems. |
|---|
| **Strategy:**<br>Support mental health system coordination and collaboration by improving information-sharing opportunities between providers, CCOs, and organizations, developing a centralized bank of knowledge of current initiatives to refer to before launching something new. |
| **Objectives:**<br>1. By December 2030, identify and formalize a cross-sector collaboration network that includes public, private, schools, providers, and nonprofit partners that coordinate or provide early learning and mental health services. The network will include partners serving systemically marginalized groups and meet at least quarterly to review system gaps, overlaps, and partnership opportunities, including funding partnerships. Meeting formats and materials will be designed to be accessible and culturally responsive.<br>2. By December 2030, create a centralized, accessible "knowledge bank" or visual map that documents current early childhood and mental health initiatives, organizational priorities, and areas of alignment. Develop this tool in collaboration with cross-sector partners to ensure accuracy and equitable representation and share it across the network to support informed decision-making and reduce duplication before new initiatives are launched. *This is not a resource/service map that lists current offerings and service availability, but a bank focused on organizational expertise, initiatives, and goals.* |

**Goal 2:**
Build resilient, informed communities that can support mental health for all, humanizing the experience of help-seeking and nurturing one's mental health.

**Strategy:**
Promote positive community norms around mental health, well-being, and help-seeking through inclusive, strengths-based communications and storytelling.

**Objectives:**

1. By December 2026, launch a strengths-based public awareness campaign that uplifts culturally diverse stories of help-seeking, healing, and recovery. Modeled after Why We Build and informed by local socio-economic experiences. Co-create campaign content with community members, ensuring trauma-informed/healing centered, accessible, and stigma-reducing messaging. Track campaign reach and engagement quarterly across multiple platforms.
2. By December 2030, partner with at least 10 community organizations, local businesses, schools, and healthcare providers to host reoccurring conversational events that normalize mental health, help-seeking, and healing journeys. Incorporate elements of the Sources of Strength model by equipping participating hosts with simple tools and conversation guides so they can sustain these gatherings over time, fostering community connection, trust, and belonging.
3. By December 2030, assess existing mental health communication resources and, if needed, develop a culturally responsive, health-literacy-aligned community toolkit that promotes consistent, strengths-based messaging around mental health and help-seeking. Co-design the toolkit with community partners, ensure translation into Spanish and distribute it to at least 50 organizations, including schools, community-based organizations, clinics, businesses, and neighborhood groups, while also gathering feedback to support future improvements.



**Goal 3:**
Strengthen community and family resources for mental health and well-being.

**Strategy 1:**
Expand early screening and referral for perinatal and early childhood mental health, beginning in pregnancy and continuing through early childhood, working closely with the Early Childhood Hub of Lane County and Lane County System of Care.

**Objectives:**

1. By December 2030, co-develop a provider engagement toolkit with input from perinatal providers, early childhood specialists, CCO partners, culturally specific organizations, and families, to support improved mental health screening and referral pathways during pregnancy through early childhood. Pilot the toolkit with at least three clinics or provider groups, prioritize those serving communities disproportionately impacted by perinatal stress and barriers to care. Collect feedback for improvement.
2. By December 2027, increase development and health screenings for children ages 0-6 by improving coordination among healthcare providers, early learning programs, and community partners. Implement targeted outreach to families facing barriers to care, supported by data, such as rural families, migrants, and low-income households, with a goal of increasing completed screenings by at least 20% across participating systems. Track progress through disaggregated screening data to monitor impacts.

**Strategy 2:**
Support the expansion of prevention programs, peer-to-peer, parenting support, and school-based mental health initiatives to build resilience in communities and schools.

**Objectives:**

1. By December 2030, explore and formalize partnerships, across school districts, community organizations, youth-serving nonprofits, and prevention coalitions, to support expansion of the Sources of Strength model. Aim to implement in at least 75% of middle and high schools. Document implementation readiness, support needs, and pathways to sustainability.
2. By December 2030, increase participation in evidence-based family prevention programs like Family Check-Up, Family Connects, and Triple P – Positive Parenting Program by at least 25% through collaborative outreach, referral coordination, and targeted engagement strategies. Ensure programs are accessible in Spanish. Monitor participation using disaggregated data to evaluate access.
3. By December 2030, enhance community-wide awareness of mental health and suicide prevention trainings, including Mental Health First Aid; Be Sensitive Be Brave; Question, Persuade, and Respond, and stress -warning-sign education, by developing an inclusive, multi-communication promotion plan in partnership with community members, schools, community-based organizations, and peer leaders. Achieve a 30% increase in training participation with intentional outreach to high-risk populations.

## *Building on What Works: Proven Practices to Explore*

This section highlights a few proven strategies from the Robert Wood Johnson Foundation.

- Early childhood home visiting programs
  Provide at-risk expectant parents and families with young children with information, support, and training regarding child health, development, and care from prenatal stages through early childhood via trained home visitors

- Social service integration
  Coordinate access to services across delivery systems and disciplinary boundaries (e.g., housing, disability, physical health, mental health, child welfare, workforce services, etc.)

- Mental Health First Aid
  Provide an 8- or 12-hour training to educate laypeople about how to assist individuals with mental health problems or at risk for problems such as depression, anxiety, and substance use disorders

**School-based** policies and programs:

- School-based suicide risk awareness programs
- Trauma-informed schools
- School-based violence & bullying prevention programs
- Preschool education programs
- School-based social and emotional instruction

Policies and programs **to prevent/treat addiction**:

- Medication-assisted treatment access enhancement initiatives
- Naloxone education & distribution programs
- E-cigarette regulations
- Alcohol brief interventions
- Tobacco taxes

# Partners Leading Change: Together We Can Do More

The CHP priority areas are already being advanced. The following section highlights programs and initiatives shared by community partners, along with investments made by Live Healthy Lane resource partners. Together, these examples reflect the collective work already underway. They also demonstrate how aligned community action and aligned investments can build momentum for continued progress throughout the 2026–2030 CHP cycle.

To ensure a meaningful and representative snapshot, we cast a wider net in outreach than what is reflected here. Partners were invited to share about their programs and initiatives based on recommendations from the Community Health Improvement Coalition or direct involvement in the CHP's development process. These examples serve as illustrations of the many efforts already moving our community toward shared health priorities.

As we move forward, Live Healthy Lane will continue uplifting community efforts through organizational spotlights in the Live Healthy Lane Newsletter, to launch in 2026. If your organization would like to share how your work aligns with the CHP and contributes to community health, we welcome you to reach out to Health@LiveHealthyLane.org because we would love to feature your work in a future spotlight.

## *Eugene Family YMCA*

The Eugene Family YMCA is a powerful example of how organizations across Lane County can use the CHA and CHP to sharpen their focus and deepen their impact. With a long-standing commitment to youth development, healthy living, and social responsibility, the Y intentionally aligned its internal structure to support community health. Three core committees, each representing a pillar of the Y's mission, bring together staff from across departments to elevate shared leadership and ensure decisions are grounded in community needs.

After forming the Healthy Living Core Committee in 2023, the Y dedicated several months to studying the CHA and CHP. Committee members looked closely at the data and community voices reflected in these documents, identifying where the organization's strengths aligned with the most pressing health issues facing the community. Through this process, the Y found a clear role in supporting mental health and child well-being; areas where the organization could make meaningful contributions.

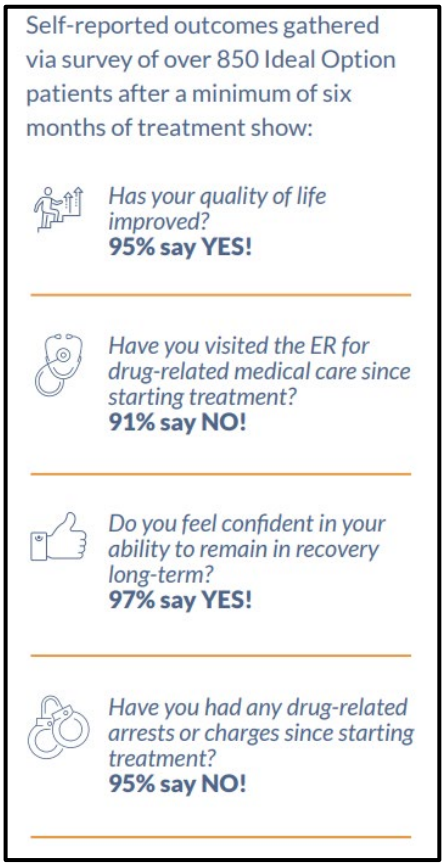
This intentional use of the CHA and CHP helped the Y build a strategic and evidence-based roadmap. Leaders explored strategies from the Robert Wood Johnson Foundation's "What Works for Health" database, cited throughout this CHP, and began implementing those that matched both community priorities and the Y's capacity. As a result, mental health is now a core organizational priority. The Y has successfully launched several evidence-based initiatives, including a community-wide physical activity campaign (the 100-Mile Swim Challenge), created in partnership with Willamalane, the City of Eugene, and River Road Parks & Recreation; and the 5-2-1-0 Healthy Habits Program, delivered in collaboration with PeaceHealth.

The Eugene Family YMCA continues to use the CHA and CHP as living guides, returning to them regularly to ensure their programs evolve with community needs. Their example demonstrates what is possible when organizations use these shared, community-created tools to inform strategy, strengthen partnerships, and advance collective action for health. By grounding internal decision-making in the CHA and CHP, the Y is not only supporting the well-being of its members, but also helping build a healthier, more connected community.

## *Ideal Option*

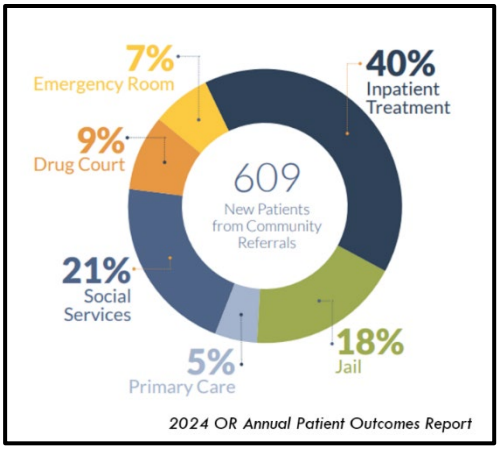
Ideal Option is a national leader in outpatient medication-assisted treatment for opioid, alcohol, and stimulant (including methamphetamine) use disorders – a particular strength in our local context. In Lane County, they have expanded access through clinics in Eugene and Springfield, with seven other clinics across Oregon, offering a low-barrier model built on rapid access and ***continuity of care***. Their "no penalties" policy means a person is not kicked out of treatment for a failed urine analysis test but instead activates a reassessment of supports and treatment plan.

A major innovation is Ideal Option's "instant intake" which reduces barriers during the transition from detox to ongoing care. Virtual intake appointment can be completed while a person is still in detox, supported by peers who help ensure treatment can begin quickly and seamlessly. Ideal Option also continues to introduce evidence-based alternatives to film-form medications by offering long-acting injectables. In response to patient feedback about pain associated with larger needles, they now provide Brixadi, an option available in weekly or monthly doses with easier administration.




Ideal Option is a core partner in the Lane County Behavioral Health Deflection Program, working with the Sheriff's Office to provide peer navigation and coordinate access to detox and treatment. Their model ensures people are not turned away, can walk in, and receive urgent referrals without delay, meeting people where they are in their recovery journey.

Their 2024 Oregon Patient Outcomes Report reflects this commitment, offering one of the only statewide datasets of its kind. With over 6,000 patients included, the report highlights trends related to social determinants of health, mental health outcomes, and treatment progress. For Live Healthy Lane's goals of improving access, reducing barriers, and advancing health equity and inclusion, Ideal Option remains a critical partner in our community.



## *The Arc Lane County*

What began as an emergency response during the COVID-19 pandemic has grown into one of Springfield's largest and most inclusive food pantries. The Arc Lane County's CARE Center provides a lifeline for more than 52,000 adults and children each year. Helping families, especially those with mobility limitations, transportation challenges, access consistent healthy and culturally familiar foods. With strong partnerships with Food for Lane County, United Way of Lane County, and local farmers, the CARES Center brings fresh, nutritious food directly to those who need it most, including Latine households across the community.


But the need is growing. With the reduction of food stamps and limited Oregon Food Bank resources, higher demand is surfacing at a time when food supplies are tightening. In fall 2025, the CARES Center experienced a 25% surge in visitors. Despite the scale of its impact, the Arc Lane County receives no grant funding to staff the pantry's daily operations; a critical gap that volunteers have stepped in to fill with extraordinary dedication. Through ongoing food drives, Amazon Wishlist, donation bins, and the True Joy Campaign, volunteers help keep shelves stocked year-round, deliver gifts to children with disabilities and their siblings, and distribute more than 300 holiday food boxes each winter.

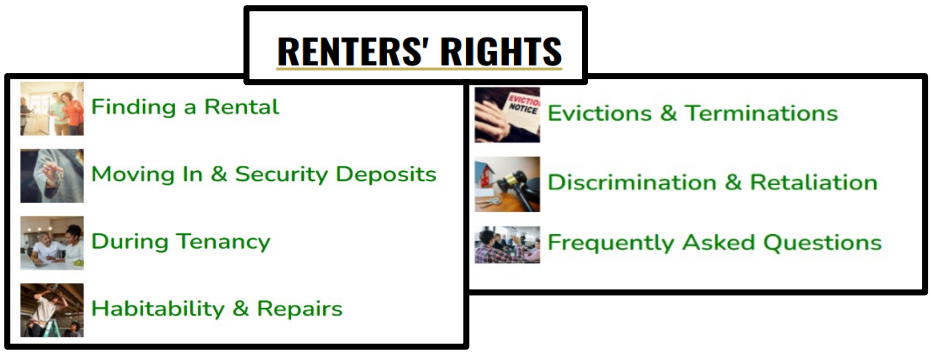
Behind these efforts are stories of resilience and testament to CHA findings that "people in Lane County want to work together to creatively solve problems and achieve health equity" ('Working Together' CHA Issue Profile). People like Tamara, who found stability while living in her car; Elbi, who relies on the pantry for ingredients that maintain her family's cultural traditions; and John, whose health depends on the fresh produce he receives. Their experiences mirror those of hundreds of families across Lane County who depend on this support to be well.

The Arc Lane Couty's work directly advances our community's shared goals for health and well-being, aligned with the CHPs vision of ensuring every person has access to nutritious food, culturally responsive resources, and the dignity of reliable support. As we look toward a healthier, more connected Lane County, everyone has a role to play. Community members can make a meaningful difference by donating, volunteering, or helping spread the word about the CARES Center and its mission. Every act of generosity helps turn hunger into hope and ensures no family is left behind.

## *Springfield Eugene Tenant Association*

Springfield Eugene Tenant Association is a 501(c)(3) nonprofit dedicated to advocating for renters' rights, preventing homelessness, and supporting housing navigation across Lane County. Primarily serving low-income households at risk of homelessness. As the only nonprofit in the area focused solely on tenants, Springfield Eugene Tenant Association offers free, expert guidance on landlord-tenant law through its Tenant Support Hotline, which can be reached at (541) 972-3715. Renters Rights guides can also be found on their website (see below).

Amid Oregon's ongoing housing crisis, Springfield Eugene Tenant Association works to keep people housed by empowering renters with education, resources, and advocacy tools. With only 3% of tenants in Lane County having access to legal support during eviction proceedings, Springfield Eugene Tenant Association fills a critical gap by helping renters understand and assert their rights.




Springfield Eugene Tenant Association also serves as Oregon's primary resource hub for renters, coordinating over 70 partners, including local governments, nonprofits, and service providers to strengthen homelessness prevention efforts. The organization collects real-time, aggregated data on tenant experiences, eviction causes, and resource access. This information is not tracked elsewhere and informs systems change and policy work.

| Top 4 Monthly and Yearly Break Down of Call Topics** | | | | |
|---|---|---|---|---|
| **Call Topics** | **October** | **Monthly Call %** | **Year-to-Date** | **Yearly Call %** |
| Termination Notices | 62 | 27.1% | 684 | 28.1% |
| Habitability/Repairs | 43 | 18.8% | 567 | 23.3% |
| Financial Assistance/Late Rent | 43 | 18.8% | 391 | 16.1% |
| Housing /Resource Navigation | 20 | 8.7% | 225 | 9.3% |

** The percentage will add up to more than 100 and the number of calls will be more than the monthly calls because a call can have multiple topics.

## *Tobacco Prevention and Education Workgroup*

Tobacco Prevention and Education Program partners across Lane County continue to play a key role in advancing the CHP's goals for a healthier, tobacco-free future. Building on the findings of the previous CHA, the CHP Tobacco Workgroup was created to bring together local expertise, align strategies, and drive coordinated policy action. This workgroup will continue into the 2026-2030 CHP and is supported by Lane County Public Health's Prevention team, who provide technical assistance, staffing, and policy experience needed to keep the work moving. Members represent a strong cross-section of health systems, researchers, advocates, and community voices; including PeaceHealth, University of Oregon, Oregon Research Institute, American Cancer Society, the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians, Quit Tobacco and Vape in Pregnancy program, and community members.

Over the past few years, this collective effort has helped Lane County make measurable progress. Highlights include the passage of Lane County's Retail Tobacco Licensure policy, successful Oregon Indoor Clean Air Act advocacy, and a tobacco-free parks resolution in the city of Florence. The workgroup also lent local support to statewide efforts such as the proposed Tobacco Flavors Ban, and other bills aimed at reducing access and exposure among young adults.

In addition to policy work, Tobacco Prevention & Education Program and the workgroup administers the Tobacco and Alcohol Retail Assessment, a tool used to monitor retail environments and identify risk factors that contribute to youth and community exposure to harmful products. Findings from the 2025 Tobacco & Alcohol Retail Assessment highlight persistent concerns in the retail landscape. These data underscore the ongoing need for coordinated policy strategies, enforcement, and focused prevention efforts.


Tobacco Prevention & Education Program's impact is strengthened through deep partnerships across the county. Be Your Best Cottage Grove have been champions for transformative early policy work, including Tobacco 21, and continues to support new initiatives. With education from the Tobacco Prevention & Education Program, the Florence Area Community Coalition supported smoke-free park policies for Florence and remains engaged in ongoing policy exploration. The

Helping Hands Coalition, serving Western Lane County, provides essential, non-medical support for people navigating housing instability, low incomes, and substance use disorder treatment. Ensuring people receiving services also have access to tobacco prevention and cessation resources.

Regional and statewide partners amplify this work even further. The Tobacco-Free Coalition of Oregon, help align local, county, and state advocacy. The Lane County Public Health Advisory Committee continues to elevate tobacco policy on its agenda, providing guidance to Lane County leadership and offering a formal venue for ongoing updates and discussion. And importantly, the Lane County Youth Advisory Council brings critical perspectives to the table, helping share priorities and ensure policy solutions reflect experience and concerns of young people. To learn more about the Lane County Youth Advisory Council email Marissa.Lovell@lanecountyor.gov.

Looking ahead, the 2025-2027 TPEP Workplan includes the following activities aligned with the goals of the CHP:

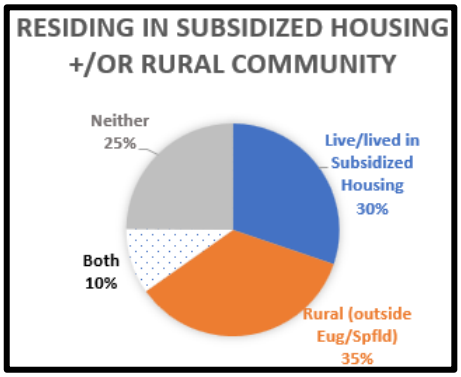
- **Youth Internship Tobacco Prevention Communications Program**
  Engaging youth in creating peer-informed tobacco prevention messaging in response to higher local youth tobacco and vaping rates.
- **Smoke-and Vape-Free Outdoor Community Spaces**
  Establishing smoke-and-tobacco-free parks and partnering with cities on interactive outdoor education installations.
- **Increased Access to Tobacco Education and Cessation Services**
  Supporting clinics in implementing community centered cessation programs and assisting organizations in offering tobacco education, cessation services, and Nicotine Replacement Therapy.
- **Strengthened Regional Tobacco Prevention Collaboration**
  Participating in a four-county regional collaboration (Lane, Linn, Marion, and Benton) to share learning, align approaches, and groundwork in equity-focused, relationship-driven practices.

If you are interested in supporting this work, joining the workgroup, or learning more, please contact Margaret.Mcnamara@lanecountyor.gov.

PUBLIC HEALTH
PREVENTION

## *Lane County Transportation and Equity Assessment Workgroup*

During the 2024-25 CHA, community members shared major challenges related to transportation, especially people living outside the Eugene-Springfield metro area and people living with disabilities. The CHA revealed a significant gap in local transportation data, making it difficult to fully understand how mobility barriers affect daily life, health, and access to essential services. In response to this, Lane County and Live Healthy Lane launched the Lane County Transportation Equity Assessment to ensure the voices and experiences of rural residents, low-income households, and people living with disabilities shape future solutions. The Lane County Transportation Equity Assessment is designed to learn directly from community members about what is and isn't working in the current transportation system. The project will explore how people are moving through their communities, what barriers limit mobility, and what types of micromobility (e.g. shared bikes, adaptive devices, or on-demand services) could improve access to health care, employment, education, and social connection. This work is rooted in the understanding that transportation is fundamental to community health.




To gather this input, the project team will host nine community forums across Lane County and conduct a community survey, followed by eight feedback sessions where participants can see the findings and help interpret results. Funded by the Oregon Department of Transportation's Innovative Mobility Program, the assessment began in August 2025.

From the start, the Lane County Transportation Equity Assessment has centered community leadership. An open interest form was shared widely through partner networks, resulting in more than 30 submissions from community members wanting to join the team, with outreach to Reedsport and Harrisburg communities as well. 16 individuals now serve on the advisory committee, meeting twice a month and with available stipends for their time. The figure on the left illustrates the make-up of the advisory committee members' experience with respect to some of this project's target communities. One community member was also hired as temporary project staff to support outreach and event coordination. The advisory committee includes residents with diverse transportation experiences alongside representatives from key local partners, including Community Advisory Council, Lane Council of Governments, Lane Transit District, Shift Community Cycles, Arc Lane County, and Mainstream Housing. Together, they are co-designing the assessment tools that will be used during community forums beginning Spring 2026.

By engaging community members directly, the Lane County Transportation Equity Assessment will help the community build a transportation system that supports health, independence, and equitable access; advancing the goals of the 2026-2030 CHP and ensuring that mobility solutions reflect the needs of the people who rely on them most. For more information contact, Joanna.Rodgers@lanecountyor.gov

## *Early Childhood Hub of Lane County*

The Early Childhood Hub of Lane County is launching an innovative Resource Navigation Project, known as the Parent Resource Directory, to strengthen how families and providers connect with supports. The navigation system will serve families with children perinatal to six years old. Some parenting classes will also be available for families with children up to 18 years old. This initiative was shaped through eight months of focus groups with 25 parents and 30 providers as well as community organizations, ensuring that work reflects experience and local expertise. Modeled after Pollywog Family Organization and integrated with the Unite Us closed-loop referral platform, the directory will help families, home visitors, health care providers, and social service partners make timely, coordinated referrals. Two bilingual coordinators will staff phone lines to help families navigate education, basic needs, and community services. An important feature given that families who speak Spanish are among Lane County's fastest growing population groups and face well-documented barriers in accessing interpreters, culturally responsive care, and reliable information.

This project is being launched through both PacificSource and Trillium incentive funds supporting social-emotional health metric work. Findings from the focus groups identified several systemic gaps the Hub aims to address. Parents and providers described fragmented resource information, long waitlists, and a lack of warm handoffs. Participants also highlighted significant health inequities in maternal health. Many bilingual and bicultural doulas also described barriers to advocating for their clients, underscoring the need for workforce strategies such as cross-training doulas as medical interpreters.

> Families who give birth on weekends cannot access in-hospital home visiting enrollment, and parents with limited English proficiency reported being asked to sign medical paperwork while in active labor.
>
> Parenting Education & Resource Assessment in Lane County 2024-2025

To further strengthen support for families, the Hub will release a request for applications in January 2026 for approximately $160,000 to expand parenting education offerings. This funding directly responds to what parents shared in the assessment: the need for more culturally responsive classes, evening and weekend options, and logistical supports such as childcare and transportation. These grants will be advertised through social media and community listservs.

The Hub also continues to center family voice through its Family Leadership Council, a diverse group of parents who provide guidance on program design and system improvements. Co-facilitated by two parent leaders, the council is actively seeking additional members and remains a critical partner in shaping equitable and family-centered early learning systems in Lane County.

## *Center for Family Development & the University of Oregon*

Center for Family Development is a nationally recognized, nonprofit, state-licensed clinic that has provided mental health and substance use services for children, adolescents, adults, and families for the past three decades. In keeping with nation-wide efforts to elevate the importance of perinatal and early childhood mental health care, Center for Family Development launched its Perinatal to Five Program in the Fall of 2020, placing an emphasis on supporting parenting success that begins in utero and extends through infancy and into early childhood (i.e., prenatal - 5 years old). Center For Family Development is a natural partner for Live Healthy Lane's goal to strengthen early intervention and prevention from pregnancy through age six. With its dedicated Perinatal to Five Program, Center for Family Development delivers comprehensive, developmentally informed mental health services that begin in utero and extend through early childhood, including early screening, diagnostic evaluation, and rapid referral for perinatal and early childhood mental health concerns.

Center for Family Development's evidence-based individual, dyadic, and family therapies; Child Parent Psychotherapy; psychiatric care; and specialized pregnancy, peripartum, and parenting groups directly promote caregiver resilience, secure attachment, and positive parent-child relationships. Through its training partnership with the University of Oregon to develop the next generation of perinatal mental health specialists, Center for Family Development not only expands Lane County's current capacity for high-quality early screening and intervention but also builds a sustainable workforce that will advance Live Healthy Lane's vision for healthy children and families from prenatal to age six.

# Strengthening the Foundation through Aligned Investment

This section highlights one of many investments Live Healthy Lane Resource Partners have made in the community, aligning with our shared mission of improved community health.


## *Kaiser Permanente's Spotlight on Care & Connect Partnership*

The Care & Connect partnership, launched in 2022 by Kaiser Permanente in partnership with Medical Teams International and community-based organization partners that host the mobile clinic van and recruit community members to receive services. The partnership brings no-cost mobile clinics to communities that experience significant barriers to care. Since its inception, these clinics have provided urgent dental services, health screenings for chronic conditions like hypertension and diabetes, mental health assessments, on-site health education and counseling, and insurance enrollment support.

In addition to these medical and dental services, the program helps connect people to social service and other resources tailored to their needs, helping them address social determinants of health such as food security, housing stability, and access to public benefits. A partnership with Plaza de Nuestra Comunidad brings these dental and medical services to the community, and brings patients access to X-rays, fillings, extractions, fluoride treatment, and sealants. This combination of medical and dental clinical care, preventative services, and resource navigation reflects Kaiser Permanente's commitment to whole-person well-being.

As of May 2025, Plaza de Nuestra Comunidad hosted 17 mobile dental clinics, serving 268 community members. Through this work, Kaiser Permanente continues to play a critical role in expanding equitable access to care, building trust within under-resourced communities, and fostering long-term connections to health and social services. Live Healthy Lane is deeply grateful for Kaiser Permanente's ongoing partnership, which strengthens our shared commitment to improving health outcomes.

## *Lane Community Health Council's Spotlight on Grow Lane County*

Grow Lane County is a community-led project that closely supports the Community Resilience & Basic Needs priority of the CHP. It is a 5-year project, launched and funded by Lane Community Health Council, with support from Food for Lane County, Upper Willamette Soil & Water Conservation District, and Ensoterra, LLC. Together, these partners manage the project, help guide the community and support local food system work. Their shared goal is to build a stronger and more fair food system by increasing access to healthy, locally grown food.

A key part of Grow Lane County is the Food Security Coalition, which invites community members, food producers, and organizations to help make decisions and share ideas about how to improve food access. Agricultural Producers, anti-Hunger organizations, food businesses, healthcare professionals, and anyone interested in food access and security across Lane County is encouraged to visit the website or contact info@growlanecounty.org for more information about supporting the work.

| Grow Lane County Working Groups | | | |
|---|---|---|---|
| **Farm & Food** | **Processing & Infrastructure** | **Health & Healthcare** | **Mapping Food Security** |
| Improve agricultural producer's workforce development and for anti-hunger organizations to learn how to better access locally grown food. | Increase coordination and investment in mid-scale processing, storage, and distribution. | Integrate consistent access to diet and nutrition resources to address hunger and reduce the prevalence of chronic disease. | Assist Food for Lane County and its partners to identify gaps in free food supply and demand. |

The project also offers two grant programs: Producer Grants, which help farmers use sustainable practices and grow more local food, and Partner Agency Grants, which help food pantries and other community organizations improve their ability to store, distribute, and provide healthy foods to residents. The Lane Community Health Council's investment in this work shows a commitment to addressing the non-medical factors that shape health. Their support helps build community strength, encourages collaboration across sectors, and advances strategies that align with the goals of the CHP.

## *Lane County Health & Human Services' Spotlight on Community Prevention*

Lane County is home to an innovative partnership supporting long-term community-based prevention and health promotion. Lane County Public Health (a division of Lane County Health & Human Services), Trillium Community Health Plan, PacificSource Community Solutions, and Lane Community Health Council recognize disease *prevention* is a shared goal. These organizations have built a partnership that targets significant community health problems and supports the long-term health of the community.

A workgroup of the Community Advisory Council prioritizes evidence-based primary prevention strategies that align with the CHP. Lane County Public Health works with CCO partners, and 15 community organizations to support implementation. Efforts currently include 13 strategies focused on tobacco cessation, empowering healthy kids, mental health promotion, or adolescent health.

One example that highlights the commitment to partnership is Sources of Strength. Sources of Strength is a national evidence-based suicide prevention program usually implemented in schools. The program focuses on engaging trained peer leaders and adult advisors in building a culture of hope, health, and strength and normalizing asking for help. The program has been studied and students engaged as peer leaders increase healthy coping strategies, which is valuable even if they never have personal experience with suicide. In the school body there are increases in help-seeking acceptability and the perception that adults can help a suicidal friend. Both among students actively engaged as peer leaders and the broader school community the biggest impact is among students who felt the least connected or with a history of suicide attempts. Sources of Strength focuses on building resilience in a variety of situations and researchers have seen positive impacts beyond suicide including reductions in substance use, violence, and mental illness.

Sources of Strength also highlights the value of strong partnerships. Lane County Public Health works with CCOs to offer training for staff and students, provides start-up funding in the first year, covers materials costs for three years, and coordinates with statewide implementation partners (Oregon Health Authority and Matchstick Consulting) for data collection and analysis. In 2021, only 3 school districts were participating in the program, and in 2024, 10 school districts, 35 schools, and one community partner site are involved.

> *Our peer leaders learn a lot about growing in their own strengths and this is contagious to others. My students greatly enjoyed participating in this and they were even able to work with one of our 9th grade health classes for this work.*
>
> *Teacher at Churchill High School*

This partnership is a key part of our work to support mental well-being and respond to community priorities. If you are interested in learning more about partnering with Lane County Public Health on prevention initiatives, please contact Teresa.Roark@lanecountyor.gov.

## *PacificSource's Spotlight on McKenzie Valley Long-Term Recovery Group*

PacificSource Community Solutions has played a meaningful role in helping McKenzie River communities rebuild, reconnect, and regain stability after the Holiday Farm Fire in 2020. By partnering directly with McKenzie Valley Long-Term Recovery Group, PacificSource Community Solutions has helped move recovery projects from concept to reality, supporting affordable housing, on-the-ground recovery service, and community gatherings that restore connection and resilience.

PacificSource Community Solutions funding has supported Mckenzie Valley Long-Term Recovery Group's work on the Rose Street housing project, a permanently affordable community land trust development in Blue River. This project brings fire wise, energy-efficient homes to families recovering from wildfire displacement. With PacificSource Community Solutions' support, Mckenzie Valley Long-Term Recovery Group has been able to advance construction, coordination, and community readiness efforts; translating CHP housing priorities into real, lived stability for McKenzie Valley residents.

PacificSource Community Solution's partnership with Mckenzie Valley Long-Term Recovery Group demonstrates how health plans can invest in place-based recovery that is community-led and equity-centered. Investments like this show what is possible when recovery efforts, community priorities and health system partners move forward together: stronger families, stronger neighborhoods, and a community with the conditions it needs to heal and thrive.

## *Trillium Community Health Plan's Spotlight on Homes for Good*

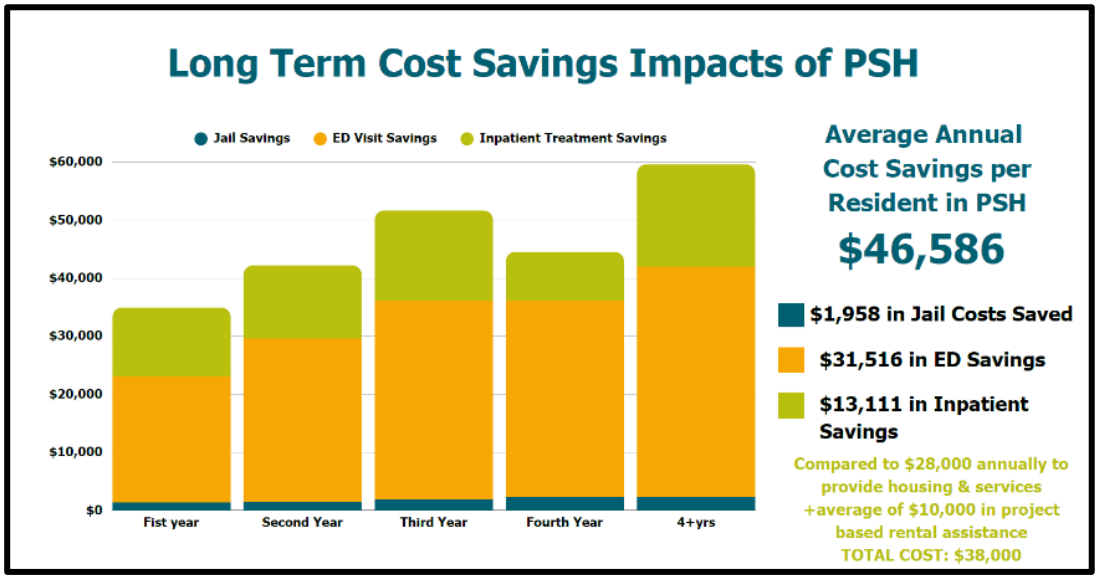
Trillium Community Health Plan is a key partner in expanding Permanent Supportive Housing in Lane County, supporting Homes for Good as they create safe, stable housing for people experiencing homelessness. Through investments in buildings, services, and resident wellness, Trillium is helping advance CHP priorities around stability, health, and community well-being.

Trillium helped fund Homes for Good's Bridges on Broadway project, converting the former Red Lion Hotel into 56 Permanent Supportive Housing units, including six accessible homes. This investment accelerated one of Lane County's most significant new housing developments and ensures residents have permanent, safe homes with onsite supports.

Beyond new development, Trillium has provided capital improvements and operational support at multiple Homes for Good sites, including repairs, building upgrades, uncollectable rent coverage, and essential staffing. These investments strengthen long-term housing stability and ensure residents have the resources needed for health and self-sufficiency.

Through deeply coordinated community partnerships and evidence-based Permanent Supportive Housing, Homes for Good's work is demonstrating measurable reductions in crisis-system use and improvements in health, safety, and quality of life.

Permanent Supportive Housing and Homes for Good is guided by a simple principle: when people have a safe, permanent place to live, and the support needed to stabilize their health, community health outcomes improve dramatically. Below are costs saving for residents of MLK Commons, a Homes for Good Permanent Supportive Housing complex, housing people who are frequent utilizers of jail, emergency departments, and inpatient treatment. Six months after moving into MLK Commons, residents saw jail time drop by over 60%, ER visits cut in half, psychiatric inpatient days reduced by more than 60%, and 94% remained housed for at least a year. For a population with long histories of homelessness, these results demonstrate remarkable stabilization.



# Live Healthy Lane Equity Tool

Looking at our work through an equity lens  requires us to ask important questions and means making sure we think about fairness and access for everyone in our community. It asks important questions. Using this approach from the start of implementation helps make sure our plans and actions work for everyone.

During implementation of the 2026-2030 CHP, Live Healthy Lane will use the Equity Tool, adapted by the Community Health Improvement Coalition from previous Live Healthy Lane versions. This tool will guide decisions and action plans and is available for anyone to access online through the Live Healthy Lane website. Using the tool helps spot challenges and barriers early, make better decisions about resources, and ensure that all voices are heard and valued. This approach builds trust, strengthens partnerships, and helps make sure that our programs truly support the health and well-being of the whole community. If you are interested in a poster or desk version of this tool, please reach out to Health@LiveHealthyLane.org.

LiveHealthy LANE

# EQUITY LENS - POCKET GUIDE

The 2024-25 Community Health Assessment (CHA) showed inequities and gaps in access for people in poverty, people with disabilities, rural communities, and culturally specific groups.

This tool, developed by subcommittee partners, helps ensure every strategy created to support the 2026-2030 Community Health Improvement Plan (CHP) is fair and inclusive.
Ask the key questions and think about ways to create positive outcomes for all.

## PARTNERS: WHO IS AFFECTED & ENGAGEMENT

- Which groups* will this strategy impact?
- Where can power be shifted to those impacted?
- Have we meaningfully engaged each group and invited their input?
- Who's been missed and why? Is there an opportunity to include them?

## PURPOSE: CHA DATA-DRIVEN SOLUTIONS

- What are we trying to achieve? Why are we trying to change things?
- How could this strategy reduce disparities?
- Are there other ways to work toward this goal? Who could we ask to learn more? *Lane County Public Health may provide technical assistance or a data party!*
- Are we able to create actions with our own identities? Are there biases we may hold as a group? *May indicate need to invite others to the table to co-create.*

## INEQUITIES

- How would this strategy affect groups differently? *Consider at least two communities and sovereign Tribal Nations.*
- If we don't know, how could we find out?

## NEGATIVE EFFECTS: AVOIDING HARM

- What negative effects or consequences might occur for different groups?
- How can we prevent or reduce these negative effects?

## POSITIVE EFFECTS: ENHANCING EQUITY

- How could this strategy increase positive outcomes for all groups?
- What could we add or change to strengthen positive effects?
- Are we assuming what impacted groups want? *Consider inviting input.*

## ROOT CAUSES: ASK 'WHY' FIVE TIMES

- What underlying inequities could cause unequal effects?
- How can this strategy address these root causes?

*Note: Throughout this tool, the term "groups" is meant to be inclusive of communities broadly, including culturally specific communities and Tribal Nations. We encourage you to consider these groups individually and reflect on potential impacts for each.

Learn about the 2026-2030 CHP

www.LiveHealthyLane.org

# Next Steps: Implementing and Tracking Progress

The 2026-2030 CHP is more than a set of priorities, it reflects our community's shared commitment to learning, adapting, and working together. Guided by the principles of Mobilizing for Action Through Planning and Partnership 2.0, we recognize that improving community health is an ongoing, collective practice. It requires us to revisit our strategies, reflect on what is working, and evolve our approach as our community grows and changes. The CHP is a roadmap, but it is our relationships, collaboration, and sustained engagement that will bring it to life.

As we move into implementation, this next phase offers new opportunities for deeper partnership and shared leadership. In 2026, Live Healthy Lane will launch two workgroups designed to support continuous improvement.

- The Live Healthy Lane Policy Team will convene partners to identify, assess, educate, and elevate policy opportunities that advance the priorities in this plan. By bringing together diverse community voices we can align local, organizational, and regional policies that strengthen the conditions for health and wellbeing.
- The Community Health Assessment Team will play a critical role in shaping how we track progress and learn as a community. Members will help develop meaningful, community-driven indicators that reflect experiences and the upstream drivers of health. This will allow us to better understand where change is happening, where disparities persist, and where added focus or new strategies may be needed.
- The Community Health Improvement Coalition will also reconvene in 2026, providing additional opportunities for others to join and provide guidance, reflection, and adjustments as the work unfolds. This ensures the CHP remains dynamic, relevant, and responsive to emerging needs.

Both teams and the coalition represent the next step in building a learning system that centers equity, honors community expertise, and supports accountable, transparent progress. The 2026-2030 CHP is an invitation: to be driven by data, to collaborate intentionally, and to come together around a vision of health where every person can thrive.

# Community Health Assessment Team

## *CHP Indicators*

These are potential indicators. Final indicators will be determined by the Community Health Assessment Team.

### Improve access to affordable, inclusive health services

| | |
|---|---|
| Percent of adults with had a routine check-up | Percent students with unmet mental health needs |
| Percent adults delayed care due to cost | Percent students with unmet physical health needs |
| Percent adults had a flu shot | Percent students without dental visit |

### Improve community resilience and access to basic needs

| | |
|---|---|
| Percent owner-occupied homes | Percent able to access clean air during a smoke event |
| Percent of households experiencing poverty | Percent agree Lane County is a safe place to live |
| Percent of households receiving SNAP | Percent thriving |
| Percent of adults delaying care due to cost | Percent with adequate social support |
| Percent of students experiencing hunger | Percent of students who reported being bullied |

### Improve mental health and well-being for everyone

| | |
|---|---|
| Percent adults use any tobacco | Percent students who had depression symptoms |
| Percent students who drank alcohol | Percent students who contemplated suicide |
| Percent students used tobacco | Percent students who made a suicide attempt |

**The Community Health Design Team** will work on identifying the final indicators and monitoring and evaluating this CHP with guidance from the Oregon Health Authority and 2024 CHA. If you are interested, please contact Olatorera.Adeniji@lanecountyor.gov

# Stay Involved

Stay up to date at www.LiveHealthyLane.org/Get-Involved. Find ways to engage, celebrate organizations advancing the CHP, and join community gatherings to share our progress. As Live Healthy Lane reflects on this incredible body of work and commitment to hearing and helping our community, we sincerely thank the following partners for their vital support in creating this CHP.


American Cancer Society, Community Organizations Active in Disaster, Charlie Health; Early Childhood and Mental Health Workgroup; Early Childhood Hub of Lane County; Lane County Community Advisory Council, Lane County Behavioral Health(Lane Care); Lane County System of Care; Lane County Veteran Services; Lane Education Service District; NAMI Lane; Quality Care Connections; Relief Nursery; ShelterCare, Suicide Prevention Coalition of Lane County; Veterans Mental Health Advocacy Council; Western Lane Mobile Crisis

# Appendix A: Live Healthy Lane Service Areas

Trillium Community Health Plan extends its Medicaid coverage beyond its core base in Lane County to include Reedsport (western Douglas County) and Harrisburg (western Linn County). This expansion helps Medicaid members living outside major urban centers access the care and services they need closer to home, addressing gaps in healthcare and promoting equity in areas often challenged with transportation and limited provider networks. Live Healthy Lane's CHP includes outreach to and representation from these communities, including Lane County. Overall, Live Healthy Lane's service area represents over 387,000.

## *Reedsport, Douglas County*

Reedsport is a small coastal community nestled on the banks of the Umpqua River in Douglas County. According to the United States Census Bureau, as of 2024, the population sits at about 4,310 and is majority White. The median age is higher than many places in Oregon, reflecting a larger share of elders. Reedsport sits in a geographic region shaped by diverse ecosystems and Indigenous history.

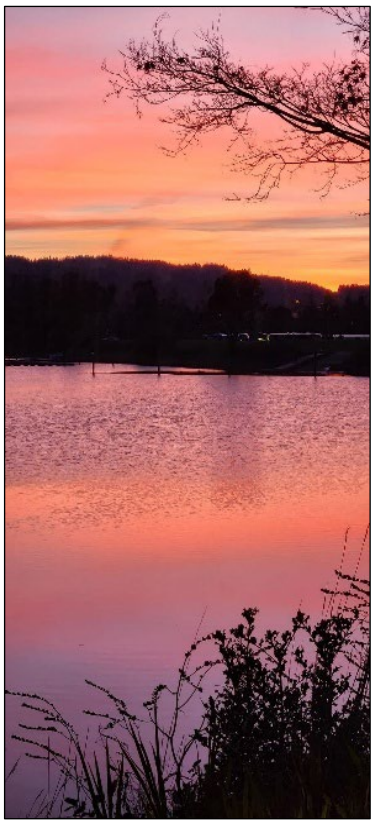


*Photo of Reedsport by Bobette Morrison*

Originally home to the Lower Umpqua Tribe (Kuitsh) and the Siuslaw-speaking people, now known as the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (Oregon Encyclopedia, Keith Tymchuk). Federal termination in the 1950s striped the tribe of federal status but together tribal members worked to protect their culture and way of life resulting in restoration in 1984. Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians is now one of the nine Federally Recognized Tribes of Oregon. To share in the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indian's mission to renew place of abundance and to support curiosity about the history of the place that is part of Reedsport, you are invited to journey through Abundance, a story map giving voice to Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians stories and culture in Oregon (*Tribal government of Confederated Tribes of Coos, Lower Umpqua and Siuslaw*).

| | Percent of Population |
|---|---|
| **Reedsport, Oregon** (Douglas County) | Census ACS 2022 5-year estimate |
| Population | 4310 |
| **Race and Ethnicity** | |
| Asian | 1.1% |
| American Indian or Alaska Native | 1.0% |
| African American or Black | <1.0% |
| Native Hawaiian or Pacific Islander | <1.0% |
| Latine/x/o/a or Hispanic (any race) | 2.8% |
| Some other race | 2.7% |
| White | 86.9% |
| Two or more races | 7.4% |
| | |
| **Age** | |
| Under 5 | 6.7% |
| 5 to 19 | 13.7% |
| 20 to 44 | 20.5% |
| 45 to 64 | 27.7% |
| 65 and over | 31.4% |
| | |
| **Language** | |
| English only | 96.2% |
| Spanish | 2.6% |
| Another Indo-European Language | <1.0% |
| An Asian or Pacific Island Language | <1.0% |

Photo of Reedsport by Elvis Proc

Photo of Reedsport by Carrie Galster

## *Harrisburg, Linn County*

Harrisburg is a small city in Linn County and sits on what was historically Kalapuya land. Live Healthy Lane invites you to learn more about the Indigenous peoples of this and other areas, by visiting Native Land, an Indigenous-led organization whose mission is "to strengthen the spiritual bonds that people have with the land, its people, and its meaning".

According to the United States Census Bureau, as of 2024, the population sits at about 3,717. Harrisburg's population is relatively young, with a median age in the low 30s and continued growth. The community is majority White, with Hispanic/Latine residents making up the largest non-White ethnic group and followed by smaller shares of multiracial or other racial groups.

*Harrisburg Riverfront by Lisa Dames*

| | Percent of population |
|---|---|
| **Harrisburg, Oregon** (Linn County) | Census ACS 2022 5-year estimate |
| Population | 3663 |
| **Race and Ethnicity** | |
| Asian | <1.0% |
| American Indian or Alaska Native | 1.2% |
| African American or Black | <1.0% |
| Native Hawaiian or Pacific Islander | <1.0% |
| Latine/x/o/a or Hispanic (any race) | 7.8% |
| Some other race | 4.3% |
| White | 83.2% |
| Two or more races | 10.1% |
| | |
| **Age** | |
| Under 5 | 9.9% |
| 5 to 19 | 21.3% |
| 20 to 44 | 39.9% |
| 45 to 64 | 21.5% |
| 65 and over | 7.4% |
| | |
| **Language** | |
| English only | 99.6% |
| Spanish | <1.0% |
| Another Indo-European Language | <1.0% |
| An Asian or Pacific Island Language | <1.0% |

## *Lane County*

Lane County is the 4th largest county in Oregon by population and the 6th largest by geographic area. Spanning from the crest of the Cascade Range to the Pacific Ocean, the county is diverse in both its population and ecosystems. Lane County includes the city of Eugene, the 2nd largest city in Oregon with over 178,000 residents. Due to Oregon's history of exclusion and "termination", Lane County's population is majority white; however, people of every race and ethnicity live here, and racial and ethnic diversity continues to grow. (Community Health Assessment Summary, 2024-25 CHA).

*Salt Creek Falls by Shayna Higashi*

Long before Lane County existed, this region was home to diverse Indigenous peoples who stewarded the land, waterways, and ecosystems. Much of present-day Lane County sits on the ancestral homelands of the Kalapuya, whose many bands lived throughout the Willamette Valley, including Long Tom watershed, the Eugene-Springfield area, the Mohawk Valley, and surrounding prairies, wetlands, and oak savannas. These lands were and, in many areas, continue to be actively managed through cultural practices such as seasonal burning, harvesting camas, tule, and other traditional foods and materials.

In addition to the Kalapuya, several coastal and western Oregon tribes historically lived in, traveled through, or maintained close cultural ties to the lands that are now part of Lane County. These relationships reflect the fluid and overlapping ways Indigenous peoples used and cared for the region long before county boundaries existed. Today, five of Oregon's nine federally recognized tribes have ancestral, historical, or connections to Lane County:

- Confederated Tribes of Grand Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians

During the mid-1800s, through a series of treaties and forced removal policies, many Kalapuya and other western Oregon tribal members were displaced and relocated to the Grand Ronde and Siletz reservations. Later federal "termination" policies further disrupted tribal governance and land stewardship. Several tribes including Grande Ronde and Siletz regained federal recognition in the decades that followed and hold annual gatherings to celebrate "restoration" with all.

Recognizing this history is essential to understanding community health today. Indigenous community members continue to contribute to the region, and tribal nations remain important partners in health, cultural preservation, land stewardship, and community well-being. To learn more about Lane County's history, the Community Context Assessment: Forces of Change report examines the historical, cultural, and structural context of Lane County to better understand how past and present events, systems, and social conditions shape efforts to improve health and equity.

At the time of publishing this CHP, two Coordinated Care Organizations serve Medicaid members in Lane County: Pacific Source Community Solutions and Trillium Community Health Plan. In early 2026, PacificSource Community Solutions will be transitioning out of Lane County and Trillium Community Health Plan will be the sole Coordinated Care Organizations serving over 110,000 Medicaid members, including residents in Reedsport and Harrisburg. According to the Oregon Health Authority Medicaid enrollment dashboard, as of October 2025, 34.1% of Lane County residents are covered by Medicaid, consistent with the state average.

As Medicaid members represent a large portion of the community, we are grateful for our strong partnership with the Lane County Community Advisory Council, who has provided leadership and guidance throughout this CHP cycle.

| | Percent of Lane County population (CSA) |
|---|---|
| **Race and ethnicity** | |
| Native Hawaiian/Pacific Islander (NHPI) | 0.2% |
| American Indian/Alaska Native (AIAN) | 0.9% |
| Black/African American (B/AA) | 1.1% |
| Asian | 2.6% |
| Two or more races (Multiracial) | 8.5% |
| Latine/a/o/x (Latine) | 10.8% |
| White | 83.5% |
| **Age group** | |
| Under 5 | 4.4% |
| 5 to 19 | 16.8% |
| 20 to 44 | 34.9% |
| 45 to 64 | 23.9% |
| 65 and over | 20.0% |
| **Language** | |
| English only | 91.5% |
| Spanish | 4.8% |
| Another Indo-European language | 1.7% |
| An Asian or Pacific Island language | 1.7% |

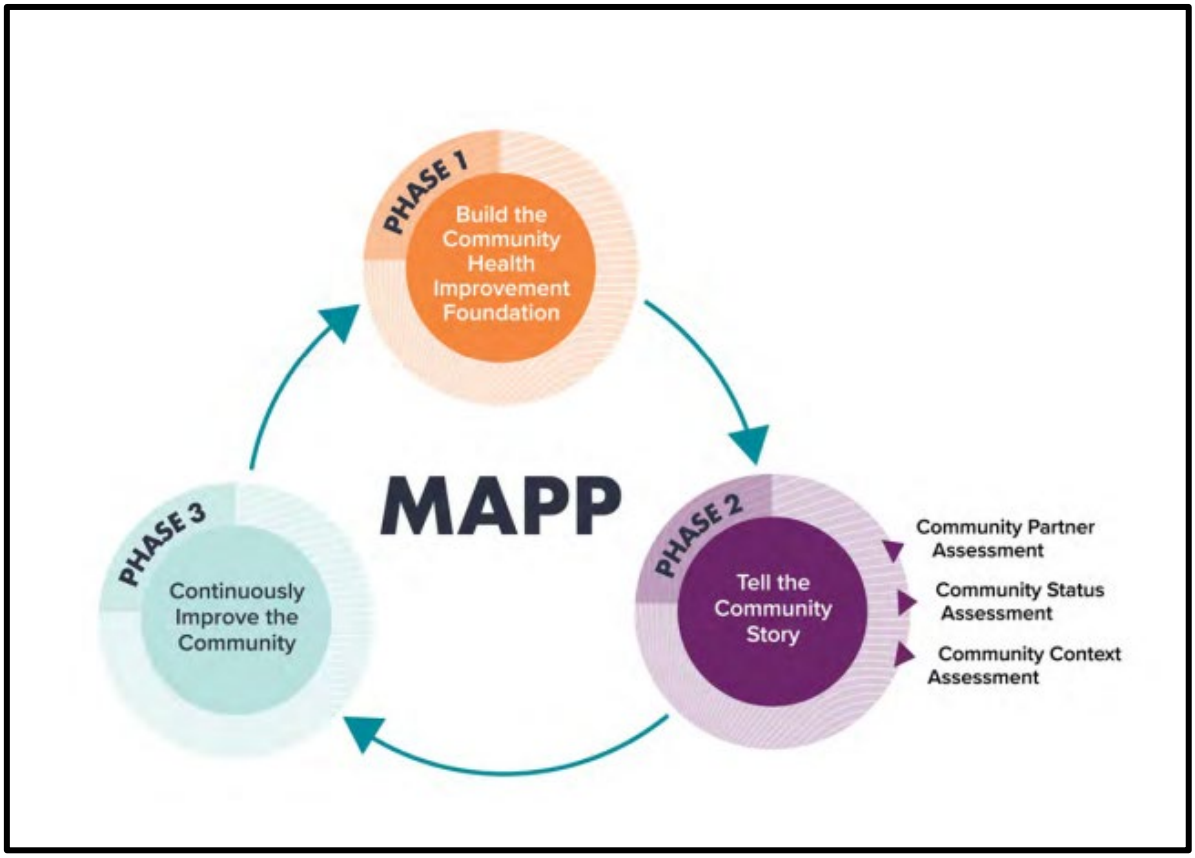
*Community Status Assessment (CSA), 2024-25 CHA*

# Appendix B: Definitions & Clarifications

## *Mobilizing for Action Through Planning and Partnerships 2.0*

The Live Healthy Lane CHA and CHP were guided by Mobilizing for Action Through Planning and Partnership 2.0, a nationally recognized framework designed by the National Association of County and City Health Officials. Mobilizing for Action Through Planning and Partnership 2.0 helps communities build strong partnerships, understand the conditions that shape health, and create action plans rooted in shared power and aligned resources. It looks at social, economic, environmental, and political systems that influence community well-being.

To ensure this process was responsive to the needs of our community, a group called the Community Health Organizing Meeting was formed. The group was made up of Community Advisory Council members and resource partner staff. The Community Health Organizing Meeting worked to adapt the Mobilizing for Action Through Planning and Partnership 2.0 phases (see below) to our community context, ensuring each step from gathering input to identifying priorities and strategies reflected community voices and responded to local needs. Working through this process helped ground the CHA and CHP process in the community, emphasizing root causes, and focusing on strong relationships and the structures needed to achieve lasting change.



## *Mental Health v. Behavioral Health*

| **Mental health** | **Behavioral health** |
|---|---|
| Refers to a person's emotional, psychological, and social well-being. It includes how people think, make decisions, manage emotions, and relate to others.<br>Mental health covers mood disorders (e.g. depression and anxiety), thought disorders (e.g. schizophrenia), and the everyday experience of wellness and resilience. | A broader, clinical term commonly used in health care systems. It includes mental health conditions but also substance use disorders, health-related behaviors (e.g. sleep, nutrition, physical activity), and the range of clinical and community interventions that address those conditions and behaviors. |

The Community Health Improvement Coalition has adopted the intentional use of "mental health" throughout the CHP because it reflects what we heard directly from community members. People told us that "mental health" feels familiar, welcoming, and centered on well-being not on labels or diagnoses. Mental health describes how we think, feel, make decisions, manage stress, and stay connected with others. It is language that invites people into the conversation rather than pushing them away.

Healthcare systems often use the broader term "behavior health", which includes mental health conditions, substance use disorders, and health related behaviors. While this term is useful in clinical settings, many community members shared it can feel technical, confusing, or even stigmatizing, and sometimes interpreted as referring only to "behavior problems".

Because this plan is built with the community and for the community, the Community Health Improvement Coalition chose to honor language that people are most comfortable with. To support clarity, trust, and participation, the CHP uses "mental health" as the primary term. At the same time, the CHP recognizes the importance of being inclusive of the full scope of needs. For this reason, one of the CHP priorities is named "Mental Health, Substance Use Disorders, and Well-Being". This phrasing preserves community language while clearly acknowledging substance use disorders as a critical part of the work.

By grounding the priority in community language and explicitly naming substance use disorders, the CHP bridges community voice with system-level inclusiveness. This approach strengthens engagement, reduces stigma, and ensures that everyone, not just service providers and professionals, sees themselves in the work to improve health.

## *What We Mean by 'Local Community Resource Hubs'*

To develop a shared definition of "local community resource hubs" the Community Health Improvement Coalition drew on community feedback, existing local efforts, and lessons learned during recent emergencies. Members looked at what makes a hub truly accessible, not just physically, but culturally, linguistically, and operationally. They emphasized the importance of meeting basic needs while strengthening community resilience and social connection. Through this collaborative process, the coalition decided on a definition that highlights equity, adaptability, and coordination across neighborhoods, ensuring that hubs can serve as welcoming, connected points of support for everyone.

**Local community resource hubs** are accessible, community-based spaces that are shaped by community and neighborhoods rather than formally designated or state-recognized. They connect people to essential services, like food, housing, transportation, and economic opportunity, and serve as places where neighbors can meet, build relationships, and support one another. These hubs strengthen social connection and foster a sense of belonging while also contributing to equitable emergency preparedness and disaster response. Local community resource hubs reflect neighborhood needs by offering culturally and physically accessible services, adaptable hours during major events, and intentional outreach to people who face barriers. They operate as part of a coordinated network that identifies community assets, connects neighbors to each other, addresses service gaps, and strengthens collaboration. This ensures everyone can reliably access basic needs, community support, and opportunities to build community with one another.

## *What Does It Mean to 'Thrive'?*

The definition of "thrive" aligns with the Mobilizing for Action Through Planning and Partnership 2.0 framework and the core domains of public health. It centers community well-being in the conditions that shape health, not only in health outcomes. Mobilizing for Action Through Planning and Partnership 2.0 highlights achieving health equity through shared power, addressing root causes, and strengthening the social, economic, environmental, and political systems that influence whether people can reach their full potential. Public health practice reinforces this approach by measuring well-being through areas such as access to care, economic stability, social connection, safety, and environmental quality.

By connecting these principles, Live Healthy Lane's definition of "thrive" reflects both community experience and the measurable conditions that determine whether people and neighborhoods have what they need to be healthy, secure, and supported at every stage of life.

To **thrive** means that everyone has equal access to the conditions that support optimal health. Thriving is made possible by fair equitable systems, strong community voice, and shared power. It includes having basic needs met, feeling safe and connected, having meaningful opportunities to participate and succeed, and living in environments that support well-being across the lifespan.

## *Trauma-Informed/Healing Centered*

**Trauma-informed/healing centered** care is an approach that recognizes the effects of trauma and emphasizes healing. Adapted from the Trauma Healing Project, it supports individuals and communities in building resilience and focuses on creating environments that feel safe, empowering, and supportive for those receiving services and for the staff providing them.

## *Traditional Health Worker*

**Traditional Health Workers** are people you can trust from your community. Someone who often shared similar life experiences, language, or culture with you. Traditional Health Workers:

- Connect people to care and community services
- Help with navigation of the healthcare system
- Support ongoing care and wellness (see Continuity of Care)
- Advocate for fair treatment
- Provide culturally appropriate care and support

The Oregon Health Authority recognizes that Traditional Health Workers help make healthcare more accessible, fair, and effective. In Oregon, Traditional Health Worker is a group name that covers a few different kinds of roles. These include:

- Community Health Worker – public-health workers who are deeply connected to and trusted by their community
- Peer Support Specialist – People who, based on their own experience with addiction or mental health recovery, provide support to others going through similar experiences.
- Peer Wellness Specialist – people with experience of mental health challenges who help others access services and build wellness.
- Patient Health Navigator – people who help patients make informed decisions about their health, life circumstances, and goals.
- Birth Doula – a trained companion who offers personal, non-medical support to a person and their family during pregnancy, childbirth, and after birth.
- Tribal Traditional Health Worker – for Indigenous communities, a Traditional Health Worker who brings specific cultural and community understanding, helping to bridge tribal traditions and the health system.

## *Continuity of Care*

**Continuity of care** means having a connected network of support and services that helps people at every stage of their health journey. This network makes sure people can move smoothly from one service to another without gaps in care. Moving from early intervention to treatment, recovery, and long-term support can be complex, a continuity of care network promotes consistent, comprehensive, and person-centered care.

## *Collective Impact*

**Collective Impact** is a structured approach to addressing complex community challenges through cross-sector collaboration. This CHP aims to bring together organizations, community members, and partners around a community vision, shared goals, and coordinated strategies, using continuous and accessible communication and shared measurement to achieve long-term, systemic change. In public health terms, collective impact supports communities in aligning resources and actions to improve health outcomes, reduce disparities, and advance the priorities identified in the CHA and CHP.

## *Systematically Marginalized*

The 2024 CHA was led by the CHA Design Team, a community-based team convened by Lane County Public Health in March 2024. CHADT members were recruited from a wide range of communities and organizations across Lane County to ensure diverse perspectives were represented. The team included representatives from **systemically marginalized** communities, rural areas, the health and education systems, disability services, programs serving people with low incomes, and services for individuals who are homeless or at risk of becoming homeless.

The CHA defines **systemically marginalized** as people who face additional barriers to accessing resources due to one or more parts of their identity. People who identify as Black, Indigenous, Asian, Latine/a/o/x, Native Hawaiian/Pacific Islander, people who identify as LGBTQA+, and people living with a disability are considered systemically marginalized in this document.

## *What Does It Mean to Improve 'Access'?*

In past CHPs, "improving access" has been identified as a strategy for addressing community priorities. However, the term "access" was not clearly defined. For the 2026-2030 CHP, the Community Health Improvement Coalition developed a shared definition that reflects both local context and state-level guidance.

The process began with a subcommittee reviewing key sources including guidance from the Oregon Health Authority, the Oregon Health Policy Board, prior CHA and CHP documents, and CCO metrics. From this review, access was understood as a multi-dimensional concept that includes the availability of services, affordability, and the degree to which care is reachable, appropriate, and culturally responsive.

From this work, the Community Health Improvement Coalition identified **six core dimensions of access** that align with both community experience and statewide health priorities:

- **Awareness:** People know about the services and understand how to use them.
- **Availability:** Services exist nearby.
- **Affordability:** Care can be paid for.
- **Accessibility:** Care can be reached.
- **Accommodation:** Systems fit people's needs.
- **Acceptability:** Care feels safe and culturally respectful.

The Community Health Improvement Coalition adopted the following definition for this plan: **Access** is the extent to which people can obtain care that meets their needs in ways that feel safe, respectful, and appropriate. It is understood through six main ideas: awareness, availability, affordability, accessibility, accommodation, and acceptability.

# Appendix C: CHP Alignment with Other Plans

The CHP does not exist in isolation. It builds upon and complements a wide range of local, regional, and state strategies that shape health and well-being in our communities. The following section highlights how the CHP aligns with other key plans, including county strategic plans, hospital community health needs assessments, and regional and local coalitions.

Live Healthy Lane encourages readers whose work intersects with any of the CHP's priority areas to explore these plans in detail. Doing so can help reduce duplication of effort, align resources, and strengthen partnerships across sectors. By coordinating strategies and leveraging existing initiatives, we can amplify impact, address shared priorities more effectively, and support one another in achieving equitable health outcomes for all community members.

## *State Health Improvement Plan*

The CHP aligns closely with the Oregon State Health Improvement Plan and strengthens shared statewide goals for health equity and well-being. The 2026-2030 CHP aligns with two priority areas from the state plan (Behavioral Health and Economic Drivers of Health, including housing, transportation, and living wage employment). Because this CHP was developed in parallel with the next Oregon State Health Improvement Plan cycle, it also reflects the most recently released concept areas and is expected to align with the proposed priority areas. The chart below shows the proposed areas and the ways the CHP aligns.

| | |
|---|---|
| **Healthy Environments**<br>• Tobacco-Free Air – advanced locally through the CHP Tobacco Workgroup<br>• Reduced exposure to poor indoor and outdoor air quality | **Emergency Preparedness and Response**<br>• Inclusive communication systems that reach all community members through Localized Community Resilience Hub trainings |
| **Health Across the Life Span**<br>• Sense of belonging and connection<br>• Policies and programs that improve health across all life stages (pregnancy through older adulthood, including people with disabilities)<br>• Access to preventative care through school-based health centers<br>• Responsive community-based care (Traditional Health Workers/home visiting/peer models) | **Physical, Mental, and Community Safety**<br>• Safe, clean, and well-maintained parks and neighborhoods that support connection (Tobacco Workgroup)<br>• Prevention and intervention related to Adverse Childhood Experiences through CHP strategies<br>• Home visiting for households with pregnant people, infants, and young children |
| **Disease Prevention and Health Promotion**<br>• Access to services delivered by trusted providers with lived experience<br>• Communities designed to meet residents' needs | **Equitable Social Conditions**<br>• People can participate in activities without barriers (see Lane County Transportation Equity Assessment)<br>• Economic and environmental conditions strongly influence health |

## *Alcohol and Drug Policy Commission 2026-2030 Comprehensive Plan*

This CHP also aligns with the goals of the Alcohol and Drug Policy Commission 2026-2030 Comprehensive Plan which are to: Reduce substance use and substance use disorders; Reduce substance use-related deaths; and Reduce substance use disparities and health inequities. The commission is focusing on six priority areas: Infrastructure; Youth; Prevention; Risk Reduction; Treatment; and Recovery.

## *PeaceHealth's 2025 Community Health Needs Assessment*

The 2026-2030 CHP intentionally aligns with PeaceHealth Sacred Heart Medical Center at Riverbend's community health findings and priorities described in "A Vital Bridge with the Community". PeaceHealth's findings center on improving health equity for vulnerable populations and strengthening supports for basic needs that shape health (e.g. housing stability, food access, childcare and other social supports) and behavioral/mental health. These shared focus areas create a strong basis for coordinated action between the CHP and PeaceHealth's stated community priorities.

Both hospital systems serving Lane County, McKenzie Willamette Medical Center and PeaceHealth, played an active role in building the Community Health Improvement Coalition and the early development of this CHP by participating In the CHP Implementation Workgroup (previously the Live Healthy Lane Steering Committee, which sunset prior to the Community Health Improvement Coalition's convening). This cross-sector participation helped surface health system highlights, local data, and priority areas that appear both in PeaceHealth's assessment and this CHP.

Live Healthy Lane remains committed to maintaining alignment with PeaceHealth's implementation strategies. This alignment makes it easier to coordinate complementary investments, reduce duplication, and pursue joint initiatives that address the social drivers PeaceHealth identifies as critical to community well-being.

## *Lane County Strategic Plan 2025 - 2027*

The CHP aligns with the 2025-2027 Lane County Strategic Plan, including both the "Safe & Health County" and "Vibrant Communities" priorities. This reinforces shared goals around health, equity, public safety, housing, and community well-being.

Lane County's "Safe & Healthy County" priority emphasizes the delivery of equitable, integrated services to support physical and behavioral health, housing stability, and public safety. These objectives directly reflect CHP priorities with focus on emergency response, health care access, and sustaining safe, healthy environments. Similarly, the County's "Vibrant Communities" priority aims to support communities through inclusive engagement, healthy environments, and strategies that foster economic and social resilience. This complements a CHP priority which centers on community well-being and social determinants of health.

Additionally, Lane County's leadership on initiatives such as the Transportation Equity Assessment, a direct result of 2024 CHA gap findings, strengthens alignment with the CHP's focus on access, mobility, and equitable community infrastructure. By coordinating with Lane County's strategic priorities, the CHP can leverage shared data, align programmatic efforts, and identify opportunities for joint initiatives that maximize impact reduce duplication, and support sustainable community health improvements.

## *Regional Health Equity Coalition*

The CHP also aligns with the findings and strategic direction of the Regional Health Equity Coalition for Lane and Douglas Counties known as the Regional Intersectional Systems-Change for Equity (R.I.S.E.) of the Umpqua and Willamette Valleys. Regional Health Equity Coalitions are coalitions established by the Oregon Health Authority to build community power and drive long-term policy, system, and environmental changes to increase health equity for all communities.

R.I.S.E. calls for improved access to culturally safe health care, affordable housing, community engagement, policies that reduce stigma, and strategies that treat housing and social needs as core drivers of health. The alignment and continued partnership with R.I.S.E helps ensure that CHP strategies are equity-grounded, community-informed, and responsive to systemic barriers identified by R.I.S.E. in their 2024 Community Needs Assessment.

## *Poverty and Homelessness Board Strategic Plan*

The Poverty and Homelessness Board serves as an action board combining elected officials, community representatives, and individuals with experience of poverty or homelessness. Its role is to represent concerns of low-income and unhoused people and to guide policy, programs, and funding decisions on homelessness and anti-poverty measures. The Poverty and Homelessness Board advises the Lane County Board of Commissioners and serves as the Continuum of Care for Lane County, coordinating funding and programs to re-house individuals and families experiencing homelessness.

The Poverty and Homelessness Board's 2025-2030 Strategic Plan "Coming Together: Taking Collective Action for All to Create a Stronger, Healthier Lane County" emphasizes revitalizing the housing crisis response system, scaling housing and shelter investments, and strengthening connection between housing supports and local health and community based services. The CHP's strategies for integrating health care, social services, and community supports complement Poverty and Homelessness Board's cross-sector efforts to prevent and end homelessness and stabilize families. Alignment with the Poverty and Homelessness Board also supports shared governance and inclusion through participation of people with poverty and homelessness experience in policymaking and coalition-building, a value that the CHP seeks to center by integrating community voice and equity in plan implementation and evaluation.

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