# Public Notice

## Crook County Community Health Advisory Council

## Special Meeting

Crook County Community Health Advisory Council will hold its scheduled Special Meeting on Monday, March 2nd, 2026, beginning at 11:00 AM, at the HEDCO Conference Room, located at 375 NW Beaver St. The principal subject(s) anticipated to be discussed are: Present draft vision and mission statement, review workplan session 1 information, review proposed topics for new workplan, create an objective for each proposed topic and discuss possible activities for each topic category. . Additional items may be discussed that arise too late to be included as part of this notice. For complete agenda and scheduled times, please see the website www.co.crook.or.us. For information on remote attendance, or to request assistance due to disability or for assistance with language interpretation or communications aids, please contact the Crook County Health Department at 541-447-5165 or Eric Blaine at Eric.Blaine@crookcountyor.gov or 541-416-3919. Assistance to disabled individuals or persons needing language interpretation is provided with advance notice.

Members of the public and media are welcome to attend in person or via Zoom:
Meeting ID: 912 0199 6778 0; Passcode: 982409
https://crookcountyor.zoom.us/j/91201996778pwd=wQyOrWezXgmK0BaM6Zae0fibleBbTa.1

# Vision & Mission Statement DRAFT 2026

## Vision Statement

### Option 1 (Balanced: formal + community-centered)

A healthy, connected community where all people in Crook County have fair access to coordinated, high-quality supports, basic needs, and lifelong opportunities to achieve mental, physical, and emotional well-being.

### Option 2 (More community-forward and aspirational)

A community where partners are united for health, basic needs are met, supports are accessible across the lifespan, and individuals and families feel safe, connected, and able to thrive

## Mission Statement

### Option 1 (Balanced: formal + community-focused)

Crook County Community Health Advisory Council brings together community voices and partners to identify and prioritize local health needs, strengthen collaboration across sectors, and provide informed recommendations to the Board of Commissioners that advance holistic, prevention-focused solutions so people across the lifespan in Crook County can access basic needs, responsive supports, and opportunities to thrive.

### Option 2 (More community-forward and plain language)

The Crook County Community Health Advisory Council unites community partners to listen, identify health priorities, and shape collaborative solutions that improve mental and physical well-being, ensure basic needs are met, and support people of all ages in living safe, healthy, and connected lives.

| CHAC: From Workplan Session 1 | | | | | |
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| **Dreams for This Community** | **Problems Not Previously Identified** | **Problem Details** | **Populations w/ Greater/Specific Needs** | **CHAC Influence** | **Other (That Didn't Fit in Another Bucket)** |
| Temporary housing/shelters for youth & elderly | Lack of community readiness for change | Rides – families with small kids | Juniper Canyon or any outskirt area | Invitation to more entities/community to join or support – families, end users, etc. Have ads or combo meetings | Specialists/services come to Prineville vs the cost of travel for patients & organizations that pay for transportation (St. Charles, Mosaic) |
| Having a community center | Community engagement vs. Opinions about what is happening | Specialist appointments in Bend | Respite/Stabilization Center | | |
| More family-wage jobs | | Community Health | Houseless and mentally ill | | |
| Affordable groceries | Expand on distrust/community attitudes towards health services/education and accepting assistance | Worker (CHW) assistance for OHP clients with transportation assistance availability | Special needs – especially adults and caretakers | | |
| Resources for mental and behavioral health, treatment, food, childcare, transportation and domestic violence | | | | Increase CHW in all areas of "Health" to address issues before crisis level = health care costs decrease and health literacy increases | WRAP services – existing models: CCO |
| Warming shelter/save spaces for people in need | Any issues in the schools? | Stakeholders engaged – includes concerned community members and general public | Foster youth and those in shelter | | |
| People knowing/education on how to access and have opportunity for resources within Crook County | Language barriers | | Under employed/Financially strained | Engage with Coordinated Care Organization (CCO) innovator agent directly | |
| Start working within the socioeconomic status level of issues and work from there | Community togetherness/kindness | Transpiration – is there still bus service for outskirt areas? | Language | Early identification of a problem before it becomes a problem? | |
| Affordable and accessible childcare | Resources for mothers/children | Small town mentality | Single parents/guardians | Plan progress sharing | |
| Having more holistic approaches to overall health | | | Those with adverse childhood experiences (ACEs) | | |
| Mental Health counselors at each school OR a school-based health center at each school | | | Domestic violence survivors | | |
| Focus and improve the financial burden | | | Those with combined needs | | |
| Medical providers for life-long access, specifically for specialist doctors | | | | | |
| Increased youth activities | | | | | |
| Decrease stigma around mental health | | | | | |
| Sober adult activities | | | | | |
| Decrease stigma around social-emotional learning | | | | | |
| Increase activity/use of the community garden | | | | | |

| Categories of Themes from Above |
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| Access to Care |
| Prevention & Recovery |
| Social Drivers |
| Community Readiness |

| From COHC RHIP: | | | | |
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| Alcohol, Tobacco and Other Substances | Mental Health | Transportation | Access & Quality of Healthcare | Nutrition & Physcial Activity |
| Strategy 1, Objective 1: | Strategy 1, Objective 1: | Strategy 3, Objective 1 | Strategy 2, Objective 1 | Strategy 2, Objective 1 |
| By December 2029, we will create cross-sectional and multi-cultural coalitions (schools, youth, parents, healthcare and public health systems) to guide communities' substance use prevention educatinoal priorities. | By December 2029, establish community-based accountability processes that prioritize marginalized voices in assesing the quality of care provided by finded entities, including the use of exit feedback forms for program evaluations. | By December 2029, we will provide quarterly opportunities to reform and create regional, county and community transportation policies and procedures while ensuring inclusivity by including individuals from marginalized populatins and underserved areas while providing transportation and stipends, as needed. | By December 2029, we will develop a coordinated and equitable healthcare career pathway program in high schools in Jefferson and Crook Counties to place at least 50 students from historically marginalized communities in rotating mentorship healthcare sites. | By December 2029, we will collaboratively map and optimize existing nutrition resources, empowering 1,000 users to find and access what they need. |
| Strategy 2, Objective 2: | Strategy 2, Objective 1 | Strategy 4, Objective 1 | Strategy 3, Objective 1 | Strategy 2, Objective 2 |
| By December 2029, we will increase the number of collaborations between medical and mental health visits by 40%,aiming to achieve this increase across all community and SBHC. | By December 2029, we will build upon efforts of the 2019-2023 RHIP Behavioral Health Workgroup to assess existing coalitions, collaborative partnerships and integrative services across Central Oregon-identifying facilitator organizations, barriers and service gaps to addresing mental and behavioral health disparities experienced by marginalized and underserved communities. | By December 2029, we will use quantitative data to create incentives, guidelines, tecnology and funding for needs-based non-emergency medical transportation programs for seniors, desaled communities and underserved communities. | By December 2029, 75% of physical, dental and mental health providers will be enrolled in a health information exchange. | By December 2029, community collaborations will obtain equipment for harvest and pickup of rural food donations to deliver to a central kiten for prep and distribution to those most in need. |
| Strategy 3, Objective 1: | Strategy 3, Objective 2 | Strategy 4, Objective 2 | Strategy 4, Objective 1 | |
| By December 2029, we will integrate family-based prevention programs within exisiting provider networks and community settings. We will measure their effectiveness by a reduction of adolescent substance use initiation, with an intentional focus on groups experiencing disproportional burden. | By December 2029, we will mandate trauma-informed care and diversity, equity and inclusion skills-based training for any organization or individual receiving public funds. | By December 2029, we will determine the gaps betwee current and desired medical transportation conditions for seniors, disabled and undersevered residents, By surveying the stakeholders and analyzing the results, we will create a data-driven impact statement based on two years of medical data and publish the findings. | By December 2029, we will convene a regional group led by culturally specific and community-representative organizations, advocates and others. This group will encourage written support from ten legislators who will create and/or fight for bills that mandate autonomously chosen and alternative covered services through the 1115 demonstration waiver (or create their own). We will provide incentives to encourage the participation of 60% of underserved communities. | |
| Strategy 3, Objective 2: | Strategy 4, Objective 1 | | | |
| By December 2029, w ewill develop a task force for legislative advocacy to increase awareness and expand funding for preventative practices. | By December 2029, we will ensure that each SBHC has at least one mental health provider from a BILAPOC background, with the cultural competence and values necessary to be culterally responsive to the student population served. | | | |
| | Strategy 4, Objectve 2 | | | |
| | By December 2029, we will implement routine mental health screening and services at all SBHC, achieving a 25% increase in the number of BILAPOC students receiving needed health services by the end of your two. | | | |

| St. Charles Community Health Needs Assessment (2026-2028) |
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| Sample size, 700 across the tri-region. Most respondents were likely 55yo+. |
| 19.5% of persons in Crook County are under the age of 18 |
| Second largest group of population is hispanic or Latino at 8% |
| Life expectancy in Crook County is 78yo |
| **Quality of Life** |
| 16% of residents with household incomes less than $50k are more likely to say the overall quality of life is less than "good." |
| 15% of residents with a high school education or less report a negative quality of life. |
| 17% and 28%, respectively, of residents of color and those who speak a language other than English at home report an overall negative quality of life. |
| **Overall, residents say affordable healthy food and affordable housing are the two factors that would most improve their quality of life.** |
| Residents were given a list of items that might improve their overall QOL. Asked to select the most important factor, residents most often chose affordable healthy food (24%) and affordable housing (19%), followed by living wage jobs (11%) and wellness and prevention programs (8%). |
| Access to affordable healthy food has increased significantly as the most important factor since 2022. |
| **Discrimination** |
| Central Oregon residents are equally likely to say that racial and economic/wealth & class discriminatin are the most common forms in their communities (22% and 11%/8%, respectively). However, it is likely that those feeling discriminated by for age and homelessness (both 3% in survey) were not included in the demogrpaphics of the survey (or very under represented). |
| **Health Care Quality** |
| From 208 to 2025, the rate at which residents view their health care quality in their communities has dropped by 12%. |
| 36% of Crook County has a negative perception of Health Care. |
| Positive rating for health are are lower amount residents of color (60%), those who are burdened by housing costs (58%) and residents who speak a primary language other than English at home (42%). |
| **Residents say that affordable housing is the single greatest factor that would most improve the health of their communities.** |
| Residents were provided a list of items that might improve their communities' overall health. Asked to select the most important factor, residents most often chose affordable housing (27%), followed by living wage job (15%), mental health and substance use programs (12%) and affordable healthy food (12%). |
| Affordable housing, living wage jobs, metnal health and substance abuse programs and affordable healthy food have remained top factors over the years. Access to affordable housing has increased as a key factor since 2016 (20% to 27% in past 10 years) and affordable healthy foods (5% to 12% in past 3 years - new metric in 2022). |
| **Residents say access to affordable health insurance is the number one physcial health concern for themselves and their families.** |
| When asaked to select their main physcial health concern, the primary selection was access to affordable health insurance (18%), followed by old age (7%). All other factors were in low single digits, including obesity (5%), mental health (5%), cancer (4%), eating healthy/nutrition (3%) and staying healthy/alive (3%). It should be pointed out that this is their perception of what they think will help. Managing some of the lower selections can help improve physical health without access to insurance, but also still rated highly as issues of concern throughout assessment. |
| Access to affordable health insurance has most often been cited as the main health concern for residents and their families and the concern has increase 11% since 2018 (7% to 18%). |

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| The primary physcial health issue that stands out by area is the concern about obesity. |
| **Dental and Vision Coverage.** |
| Overall, residents continue to have lower rates of coverage for dental (65%) and vision (54%) insurance. While 93% continue to have health insurance. |
| Younger residents ages 18-34 report lower health (85%), dental (55%) and vision (32%) coverage rates than residents aged 35-54 (93%, 64%, 59&, respectively) and 55+ (98%, 74%, 65%, respectively). |
| Among Central Oregon residents, dental and vision exams exceed dental and vision coverage. Health: 93% had coverage, 83% had exam. Dental: 65% had coverage, 71% had exam. Vision: 54% had coverage, 62% had exam. |
| **Access to Family Physcians or Nurse Practitioners (PCP)** |
| Some groups in Central Oregon are less likely to have a family physician or nurse practitioner: men (76%), those who need to travel for care (75%), those with a high school degre or less (68%), residents of color (69%) and younger residents ages 18-34 (61%). |
| Onlyabout 1 in 10 resdients would say they rely on telemedicine (may be skewed by age of those included in survey). |
| Jefferson and Crook county and Redmond/Sisters residents are more likely to need to travel outside their communities for primary care. |
| Crook County residents are 38% more likely to need to travel outside their communities for primary care. |
| Residents among the following groups are also more likely to travel outside their communities for care: women (25%) and families with children under 5 (35%). |
| **Telemedicine Visits** |
| Some residents are less likely than others to utilize telemedicine: residents with a high school education or less (31%) and those who primarily speak a language other than English at home (19%). |
| Of those that have relied on telemedicine fewer rely on it for specialty health (27%) or behavioral health (15%). |
| **Access to behavioral health care is limitedacross Central Oregon.** |
| First time asking about behavioral health care access, so no baseline data. When residents were asked whether they or their famlies have access to behavioral health or mental health care, 18% responded no and 10% were unsure. |
| Residents in Crook County are even less likley to have access to behavioral health acre. Only 64% of residents in Crook County have access to such care. |
| Residents of the following groups are also less likley to have such care (behavioral/mental): those of color (69%), younger residents 18-34 (61%), residents in households earning less than $50k annually (58%) or $50k-$75k annually (67%), those who are housing-burdened (63%), those with a high school degree or less (65%) and those who speak a primary language other than English at home (46%). |
| **The amount of time it takes to get an appointment (56%) and the cost of care (48%) are the two primary obstacles to obtaining medical care.** |
| Wait times as a perceived barrier to care are more common among certain groups: those who lack access to behavioral health care (72%), resdients who lack regular PCP or nurse practitioner (69%), those who need to travel for care (67%) and those who are housing burdened (64%). |
| Cost as a barrier to care is especially pronounced among certain groups: thos in households that are housing burdened (69%), those in households with children under age 5 (62%), those in households earning less than $50kannually (60%), |
| **Jefferson and Crook County residents are more likely to cite additional significant barriers to care.** |
| For Crook County residents, distance (28%), time away from work (25%), limited technology for virtual appointments (21%) and unstable housing (14%) are key additional barriers to care. |
| **Secondary Barriers to Care** |

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| Time away from work, lack of insurnace and location of where you need to go impact certain groups harder than others: residents ages 18-34 and 35-55, those in households earning $50k or less, those burdened by housing costs, those with a high school eductin or less and those of color. |
| **Other Factors of Barriers of Care** |
| While some factors were not significant in this survey, technology for virtual appointments, lack of transportation, unstable housing, fear or being scared, lack ofchlidcare and language barriers, it could be due to the demographics of those surveyed. |
| Residents rely most on health professionals for their health information, but this relieance has declined since 2016. |
| About 5 in 10 residents (495) say they get most of their health information from their doctor or health professional. About 4 in 10 (39%) primarily get their information online. Only 8% primarily get information from books, magazines or newspapers. |
| Those getting health information from health professionals are thos in households earning more than $150k per year (57%), those ages 55+ (55%) and college-educated residents (51%). Those who lack a regular PCP or nurse practitioner are the most likely to use the internet as their primary source of health information (54%). |

# CCHHS Fair Access to Health Plan - Assessment

## Community and Population Inclusion

### Populations and groups engaged in assessment:

- Residents of rural and frontier areas of Crook County outside of Prineville
- Latinx families and Spanish-speaking community members
- Tribal members and Indigenous residents
- Older adults and caregivers
- People experiencing poverty or unstable housing
- Veterans
- Representatives from community organizations and partners of CCHHS

## Foster Fair Access to Health

### Use of Data to Reveal Access Gaps:

- Residents in outlying areas reported difficulty accessing routine care due to travel distance and limited clinic hours.
- Spanish-speaking community members expressed a need for more consistent bilingual services, outreach and resources.
- Mental health care access was identified as a major unmet need, particularly for adolescents and older adults.

### Assessment of health Resources and Threats

- Lack of public transportation options is a critical barrier, especially for older adults and low-income individuals.
- Mobile health clinics have shown promise in reaching underserved areas but require more stable funding and staffing.
- Environmental threats - such as wildfire smoke - have increased in frequency and impact, particularly for those with pre-existing respiratory conditions and houseless or unstably housed individuals.

### Identification of Priority Populations and Geographies

- **Geograhic Gaps:** hosueholds in the Paulina, Post and Powell Butte areas reported dispropartionately high barriers to in-person care.
- **Cultural & Language Barrieers:** Latinx and Indigenous families often face cultural disconnects and a lack of translated materials or bilingual staff.
- **Veterans:** many face unique barriers to care, including limited access to specialized services, challenges navigating complex systems and gaps in mental health support.
- **Income-Based Disparities:** People experiencing poverty, especially those not connected to public assitance programs, face overlapping access barriers including cost, stigmaand transportation.

### Internal Assessment of Staff Capacity

- Staff are eager for further training in cultural humility and community engagement
- There is a growing recognition of the importance of working across sectors to address the root causes of health inequities.
- Current strengths include strong relationships with schools, adaptability in outreach models and a team culture that values service to all.

## Communicate and Engage Inclusively

### Stakeholder Identifications and Assessment

- Stakeholders expressed strong interest in collaborating around outreach, transportation and culturally responsive services.
- Many partners noted that they are asked to participate in health-related initiatives, but not always included in decision-making or follow-up.
- There are opportunities to more meaningfully involve community-based organizations in strategy development and to diversify which voices are at the table.

### Engagement with Impacted Communities

- Residents want more direct communication about available services, especially during times of crisis (e.g., extreme heat events, disease outbreaks).
- Many respondents expressed appreciation to mobile services and school-based outreach but requested that these be expanded and more consistently funded.
- There is a desire for public health to be more present in everyday community spaces - not just during emergencies.

### Root Causes of Health Inequities Identified with the Community

- **Transportation Barriers:** Lack of affordable or relieable transportation prevents timely access to care.
- **Housing Instability:** Many residents live in substandard housing or experience frequent moves, affecting continuity of care.
- **Language Access:** Spanish-speaking families shared that they often rely on their children to interpret at appointments, which limits understanding and autonomy.
- **Lack of Trust in Systems:** Past negative experiences with healthcare and government institutions lead to hesitancy in seeking servies.

# CCHHS Fair Access Plan - Action Plan

## Foster Fair Access to Health: Strategies and Objectives:

| Co-Created Strategies to Address Root Causes of Access Barriers | Ensure Programs Are Culturally Responsive and Understandable | Strengthen Cross-Sector Partnerships to Promote health Access | Build Organizational Capacity for Fair Access |
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| **Strategy:** Partner with community members and local organizations to expand mobile health access and culturally appropriate services. | **Strategy:** Improve the cultural responsiveness and health literacy of all public health services. | **Strategy:** Formalize partnerships with education, housing and transportation sectors to address access barriers. | **Strategy:** Develop internal systems that support sustained equity work. |
| **Objectives:** | **Objectives:** | **Objectives:** | **Objectives:** |
| Pilot a monthly mobile clinic route for underserved rural areas by Sumer 2026. | Translate core public health materials (including vaccine, nutrition and emergency communications) into Spanish and other needed languages. | Establish a quarterly cross-sector working group (public health, schools, transit, housing, etc.) by Fall 2026. | Allocate a portion of training and professional development funds specifically for cultural responsiveness and anti-bias education. |
| Strengthen our CHAC to include respresentation from Latinx, Tribal and low-income residents by early 2026. | Train all public health staff in cultural humility and plain language communication by the end of 2026. | Integrate health access priorities into county emergency preparedness plans. | Develop a Fair Access Implementation Plan with designated staff leads and timelines by Spring 2026. |
| Co-design outreach campaings for behavioral health resources using input from youth and seniors. | Incorporate client feedback loops into service areas (e.g., satisfaction surveys with demographic data). | Seek funding opportunities jointly with partners to sustain health-related transportation options. | Establish equity metrics as part of annual program review and performance measures. |

## Communicate and Engage Inclusively: Strategies and Objectives:

| Communicate Regularly and Transparently with the Community | Advance Workforce Equity and Representation | Influence Policy and System Change to Advance Fair Access |
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| **Strategy:** Build trust through consistent, multi-platform community communication. | **Strategy:** Make public health employment more inclusive and representative of the community. | **Strategy:** Engage with local leaders and policymakers to advocate for upstream solutions. |
| **Objectives:** | **Objectives:** | **Objectives:** |
| Collaborate with regional partners for the bilingual quarterly newsletter with updates on services, data and opportunities to engage. | Develop internship opportunities in partnership with local schools and community colleges. | Share assessment findings and commuity priorities with the Crook County Commissioners and other decision-makers annually. |
| Host annual community forums in both Prineville and outlying areas. | Conduct an annual review of recruitment and hiring practices to reduce barriers for underrepresented candidates. | Monitor and support local or state policies that promote housing stability, transportation equity and access to care. |
| Improve public health's social media presence with plain-language and accessible content. | Include community representatives on hiring panels for public-facing roles. | Participate in regional collaboratives focused on advancing fair access and health equity. |