Community Health Improvement Plan (CHP)

Coos County, Oregon

In 2023 Advanced Health, in conjunction with ORPRN (Oregon Rural Practice-Based Research Network) submitted a Community Health Assessment (CHA) to the Oregon Health Authority (OHA). The result found that Coos County while it is doing well in some categories such as Air Quality and Community

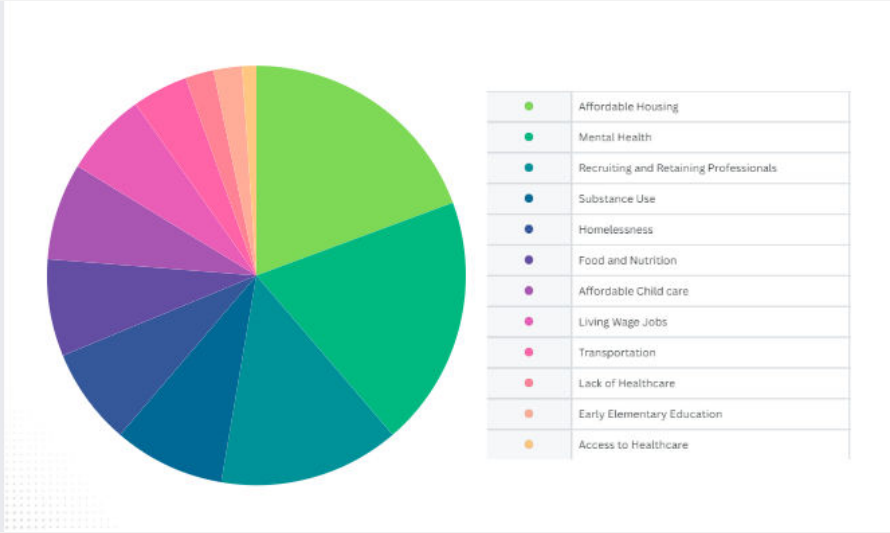
Involvement, however, it is worse off in many other categories than the rest of Oregon when it comes to a healthy community.

A list of the findings from the CHA will be listed at the end of this document.

Identifying issues.

Through the process of focus groups, questionnaires, and other data gathering, we identified 12 major priorities. In early 2024 (February – May) the Twelve (12) concerns were taken to eleven (11) total public meetings, where community members were asked to vote on the items that they were most concerned with. Below are the results of what individuals thought ranked by order of importance.

- Affordable Housing
- Mental Health
- Recruiting and Retaining Professionals
- Substance Use
- Homelessness
- Food and Nutrition
- Affordable Childcare
- Living Wages Jobs
- Transportation
- Lack of Healthcare
- Early Elementary Education
- Access to Healthcare



As you see many issues were discussed, and an initial plan was put together based on feedback from the focus group. One topic of conversation kept coming up in each category. For example, when we talked about Affordable Housing, and Mental Health as the number one priority it was stated the cost of housing was a contributing factor to the growing homelessness issue. When we discussed Mental Health, a similar discussion took place about a lack of Mental Health, and Substance Use Disorder professionals was leading to the increase in law enforcement interactions with individuals facing houselessness issues. Unresolved Behavioral Health (both Mental Health and Substance Use Disorder) issues are a major contributor to individuals living on the streets. As we further discussed these issues, we found similar overlaps in the homeless and all the other categories.

https://advancedhealth.com/members/your-benefits/behavioral-health/

Executive Summary

The Coos County Community Health Improvement Plan (CHP) is a strategic roadmap developed to address homelessness and its underlying causes, with a particular focus on behavioral health, healthcare access, housing, employment, and early intervention and prevention. Driven by a collaborative effort between community organizations, healthcare providers, local government, and residents, this plan is rooted in the belief that homelessness is a community-wide issue that requires comprehensive, coordinated action to create lasting change.

Vision and Objectives:

Our vision is a community where every individual and family has access to stable housing, essential healthcare services, and economic opportunities. This CHP outlines a set of goals and strategies designed to achieve the following key objectives:

- Addressing Behavioral Health
- Addressing the basic needs of individuals.
- Expanding access to housing and sheltering
- Addressing Workforce issues
- Early intervention and prevention

1. **Addressing Behavioral Health** in the homeless population – Improve mental health and addiction support services to meet the unique needs of homeless individuals and those at risk of homelessness, addressing stigma and barriers to treatment.
2. **Addressing Basic Needs of individuals** – ensure Individuals can get the basic needs metthrough network partners, increasing access to resources, and health navigators to match needs with partners.
3. **Expanding access to housing and Supportive Housing Options** – Develop pathways to permanent housing, focusing on increasing affordable housing units and expanding supportive services that enable residents to maintain long-term stability.
4. **Addressing Workforce issues** – Promote job training and employment programs that create opportunities for individuals experiencing or at risk of homelessness to achieve financial independence.
5. **Strengthen Early Intervention and Prevention Programs** – Identify at-risk individuals and families early on and connect them with resources, reducing the likelihood of homelessness through timely support and financial assistance.

Strategies and Action Steps:
To achieve these objectives, the CHP recommends expanding intervention services, coordinating housing and healthcare support, providing tele-health services, and establishing one-stop centers where individuals can access food, clothing, employment assistance, and other essential services. Building protective factors in youth and families, promoting community-based education on homelessness, and identifying key partners committed to long-term collaboration are additional focal points of the plan**.**

Expected Outcomes and Impact:
The CHP envisions measurable improvements in the health, housing stability, and overall well-being of individuals affected by homelessness. Success will be measured by reductions in homelessness rates, increased access to behavioral health services, improved housing stability, and stronger community support for at-risk individuals and families. By addressing social determinants and building pathways to stability, Coos County aims to reduce homelessness and create a supportive, inclusive community.

Conclusion:
The Coos County Community Health Improvement Plan provides a structured, collaborative approach to addressing homelessness by focusing on prevention, intervention, and support. With the commitment of community members, local organizations, and stakeholders, we can create a healthier, more resilient Coos County where everyone has the opportunity to thrive in a safe and supportive environment.

Introduction: Homelessness is a significant issue in Coos County, Oregon, affecting the well-being of individuals and the community at large. According to the 2024 Point in Time (PIT) count provided by the Rural Oregon Continuum of Care, (ROCC) Coos County has the second highest count of homeless individuals of all rural counties in the state.[1] This Community Health Improvement Plan (CHP) outlines a comprehensive strategy to address homelessness by focusing on behavioral health, access to healthcare, housing, jobs, and early intervention. The goal is to improve the overall health and quality of life for residents experiencing homelessness and to prevent future homelessness.

To identify homelessness and those at risk of homelessness we will use the U.S. Department of Housing and Urban Development (HUD) definitions for each. HUD defines homelessness in four categories: Literally homeless, Imminent risk of homelessness, Homeless under other federal statutes, and fleeing or attempting to flee domestic violence.[2]

Literally Homeless[3]: a lack of a fixed, regular, and adequate nighttime residence. This includes people who:

- Live in a place not meant for human habitation, such as a car, park, or abandoned building
- Live in a shelter or drop-in center that provides temporary living arrangements
- Are exiting an institution where they resided for 90 days or fewer and were homeless before entering
- Are within 14 days of losing their primary nighttime residence and lack the resources to obtain other housing
- Are fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening situations

Imminent Risk for Homelessness:[4] An individual or family who will imminently lose their primary nighttime residence, provided that:

1. Residence will be lost within 14 days of the date of application for homeless assistance;

2. No subsequent residence has been identified; *and*

[1] https://public.tableau.com/app/profile/shriyansh.sharma8515/viz/2024ROCCPIT/2024ROCCPITbyCounty
[2] https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/four-categories/
[3] https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/four-categories/category-1/
[4] https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/four-categories/category-2/

3. The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Note: Includes individuals and families who are within 14 days of losing their housing, including housing they own, rent, are sharing with others, or are living in without paying rent.

Homeless Under Other Federal Statutes:[5] Unaccompanied youth under 25 years of age, or families with Category 3 children and youth, who do not otherwise qualify as homeless under this definition, but who:

1. Are defined as homeless under the other listed federal statutes;
2. Have not had a lease, ownership interest in permanent housing during the 60 days prior to the homeless assistance application;
3. Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and
4. Can be expected to continue in such status for an extended period of time due to special needs or barriers

Fleeing/Attempting to Flee Domestic Violence[6]

Any individual or family who:

1. Is fleeing, or is attempting to flee, domestic violence;
2. Has no other residence; and
3. Lacks the resources or support networks to obtain other permanent housing

“Domestic Violence” includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual or family member that either takes place in, or him or her afraid to return to, their primary nighttime residence (including human trafficking)

HUD also defines "unstably housed" as a situation where someone is doubled-up or living in a self-paid motel. People who are unstably housed are not eligible for federal homeless assistance but may be referred to more general housing assistance.

At Risk of Homelessness:[7]

An individual or family who:

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[5] https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/four-categories/category-3/

[6] https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/four-categories/category-4/

[7]

1. Has an annual income below 30 percent of Median Family Income (MFI) for the area, as determined by HUD;
2. Does not have sufficient resources or support networks, (e.g., family, friends, faith-based or other social networks), immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "homeless" definition in this section; and
3. Meets one of the following conditions:
    1. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
    2. Is living in the home of another because of economic hardship;
    3. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
    4. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by Federal, State, or local government programs for low-income individuals;
    5. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 persons reside per room, as defined by the U.S. Census Bureau;
    6. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
    7. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.

McKinney-Vento information[8] in 2021-2022 shows Coos Bay School District had one of the highest amounts of Homeless students in the state at 13.6% of pk-12 enrolled students meeting the HUD definition of homeless.

The plan

To achieve a community focus on Addressing Homelessness in Coos County there are several categories that need to be addressed.

Homelessness does not have one definitive cause. For that reason, through the use of focus groups and community input, we have determined that focusing on the following five topics will not only help address the homeless issue in Coos County but will also tangentially help the overall health of other citizens in the County as well.

[8] https://www.oregon.gov/ode/schools-and-districts/grants/ESEA/Documents/Districts%20-%20High%20Counts%20and%20Percentages%2021-22.xlsx

These five action teams are as follows in no particular order.

- Addressing Behavioral Health
- Addressing the basic needs of individuals.
- Expanding access to housing and sheltering
- Addressing Workforce issues
- Early intervention and prevention

These action teams have worked on goal setting for each category and have been comprised of Community Based Organizations (CBO), Partners associated with the specific focus areas, members of our Community Advisory Council, and the general public.

BEHAVIORAL HEALTH

Get access to quality mental health and substance use treatment. Advanced Health pays for most mental health and substance use treatment services. If you're already enrolled in the Oregon Health Plan (OHP), your benefits include most mental health and substance use treatment services, including:

- Assessments
- Psychiatry and counseling/therapy
- Substance use treatment
- Medication-assisted treatment, also called medication-supported recovery
- Mental health crisis services

Addressing Behavioral Health:

Addressing behavioral health is a critical component in tackling homelessness in Coos County, Oregon. Behavioral health challenges, including mental health disorders and substance use, often contribute to an individual's risk of experiencing homelessness. Without access to adequate mental health services and support systems, individuals may struggle to maintain stable housing, employment, and social connections. By prioritizing behavioral health, Coos County can improve the quality of life for those experiencing or at risk of homelessness, reduce barriers to accessing essential services, and ultimately foster a more resilient community. Integrating behavioral health support into housing initiatives not only addresses immediate needs but also provides long-term solutions, helping individuals achieve stability and preventing future episodes of homelessness.

When addressing behavioral health in the homeless population, internal stigma and external stigma both present significant barriers, though they differ in origin and impact.

Internal Stigma

Internal stigma refers to the negative beliefs and feelings that individuals hold about themselves, often due to experiencing mental health or substance use issues. This self-stigmatization can lead to feelings of shame, low self-worth, and isolation. In the context of homelessness, internal stigma can discourage individuals from seeking help, engaging with support systems, or believing they deserve assistance. For example, a person struggling with both mental health and homelessness may feel unworthy of housing or healthcare services, hindering their recovery and stability.

External Stigma

External stigma involves negative stereotypes and discrimination directed toward individuals from others, including society at large or service providers. In the case of behavioral health and homelessness, external stigma often manifests as judgments that individuals are responsible for their own homelessness or behavioral health issues, leading to less compassionate and equitable treatment. This can affect access to resources, as individuals may be denied housing, healthcare, or employment opportunities due to biases against those experiencing mental health challenges or homelessness.

Together, internal and external stigma create a cycle that reinforces barriers to support, making it essential to address both in efforts to improve behavioral healthcare and housing for the homeless population.

Goal one addresses Internal Stigma while goal two addresses external stigma.

GOAL #1: Increase/improve mental wellness literacy (Reduce internal stigma for individuals)

The terms mental health, behavioral health, substance use, and related terms often used in the mental health world may have different meanings from a medical, mental, and other social services provider as well as consumers/individuals specifically the at risk/homeless population in Coos County.

The purpose of this goal is to ensure the basic terms associated with behavioral health are identified, as standard use of terminology and definition. This is the assumption that when all are speaking the same language and can be understood, we will improve mental health literacy and services purpose and expectations.

Purpose:

Improving mental wellness literacy among individuals is crucial for enhancing community health, particularly when addressing homelessness.

Reduces Stigma and Encourages Empathy
Increasing mental wellness literacy helps reduce the stigma surrounding mental illness, especially for those experiencing homelessness. Many people living without stable housing struggle with mental health conditions such as depression, anxiety, or substance use disorders. When community members understand these issues, they are less likely to marginalize or criminalize those affected. Instead, they are more likely to support compassionate, solutions-focused approaches that improve the well-being of individuals and the community as a whole.

Promotes Early Intervention and Prevention
Mental wellness literacy equips individuals with the knowledge to recognize early signs of mental health issues, both in themselves and others. This can prevent the escalation of mental health problems that might lead to or exacerbate homelessness. People who can identify mental health concerns early are more likely to seek help, support from peers, or connect others to services. Early intervention reduces the need for costly emergency care and can help prevent homelessness by addressing mental health challenges before they spiral out of control.

Increases Access to Resources and Services
When individuals are educated about mental wellness, they are more aware of the resources available

to them. Communities with higher mental health literacy are more likely to advocate for and use available services such as counseling, addiction treatment, and housing programs. In the context of homelessness, this can lead to better resource utilization, helping individuals transition out of homelessness and into more stable environments, ultimately reducing homelessness rates in the community.

Improves Public Safety and Reduces Strain on Public Systems
Mental health crises often contribute to public safety issues, with individuals experiencing untreated mental illness have a higher risk of interactions with law enforcement. By improving mental wellness literacy, communities can focus on supportive responses rather than punitive ones. Understanding mental health conditions leads to more humane interventions, reducing the burden on emergency services, law enforcement, and hospitals. This creates a safer, more cohesive community where mental health issues are managed with care rather than criminalization.

Fosters Resilience and Community Cohesion
A mentally healthy population is more resilient, both individually and collectively. By improving mental wellness literacy, individuals can better manage stress, trauma, and other life challenges, including housing instability. Communities that understand the importance of mental health are better equipped to come together in times of crisis, offer support to vulnerable members, and work collaboratively to find long-term solutions to homelessness. A well-informed community is a stronger, healthier one, where individuals are empowered to support both themselves and others.

Enhancing mental wellness literacy is a proactive approach that not only benefits individuals but also strengthens the overall health and cohesiveness of the community. By fostering understanding, early intervention, and appropriate resource use, it directly addresses some of the root causes and consequences of homelessness, ultimately leading to a healthier, more resilient society.

Action Step:

- Reduce internal stigma by the dissemination of Guidebooks, resource manuals, and other distributed information and six (6) Café model presentations per year on an ongoing basis. Through December 2029

GOAL #2: Increase/improve mental wellness literacy (reduce external stigma for health care providers, community members and partners)

Improving Behavioral Health for individuals is only part of the solution. improving mental wellness literacy for healthcare providers and community members, and how better understanding of mental health can positively impact homelessness.

For Healthcare Providers:

Enhances Early Diagnosis and Intervention
Mental wellness literacy for healthcare providers leads to earlier recognition and treatment of mental health issues, which can help prevent homelessness. Providers who understand the nuances of mental illness can offer timely, holistic care that addresses both physical and mental health needs. This reduces

the likelihood of patients slipping through the cracks and becoming homeless due to untreated mental health conditions.

Improves Patient Outcomes and Continuity of Care
Healthcare providers who are well-versed in mental wellness are more equipped to connect individuals with comprehensive services, including mental health support, housing assistance, and addiction treatment. This integrated approach can stabilize individuals at risk of homelessness by addressing root causes, such as untreated mental illness or substance use disorders, ultimately improving long-term health outcomes.

Reduces Strain on Emergency Healthcare Services
Homeless individuals with untreated mental health conditions often rely on emergency care, placing a heavy burden on hospitals and urgent care facilities. Providers who understand mental wellness are better positioned to offer preventive care, reducing the need for costly emergency interventions. This not only alleviates the strain on healthcare systems but also ensures that patients receive consistent, appropriate care before their conditions become critical.

Supports Trauma-Informed Care and Reduces Burnout
Healthcare providers who are literate in mental wellness can offer trauma-informed care, particularly to patients experiencing homelessness, who often have a history of trauma. By recognizing and addressing mental health issues with compassion and appropriate interventions, providers reduce frustration and stress for themselves and their patients, leading to better care and less provider burnout. This results in a more effective healthcare system that can handle the complex needs of vulnerable populations.

For Community Members:

Fosters Understanding and Reduces Stigma
Mental wellness literacy among community members helps demystify mental health conditions that contribute to homelessness, such as addiction or schizophrenia. When community members understand the challenges faced by people experiencing homelessness, they are more likely to respond with empathy rather than judgment. This reduces social stigma, creating a more supportive environment where individuals feel encouraged to seek help.

Increases Advocacy for Supportive Services
When community members are educated about mental wellness and its connection to homelessness, they become advocates for expanding local services. They can push for better mental health services, affordable housing, and early intervention programs that address the underlying causes of homelessness. Community-driven advocacy is essential for influencing policy and securing funding for programs that reduce homelessness.

Encourages Early Identification and Peer Support
Educated community members are better able to recognize early signs of mental health issues in themselves, friends, or neighbors. This can prompt early intervention, helping individuals access support

before their mental health deteriorates to the point where they risk becoming homeless. Peer support and informal networks of care can prevent isolation, which is often a precursor to homelessness.

Builds a More Inclusive and Safe Community

Mental wellness literacy fosters a culture of care and inclusion, where community members support those who are struggling rather than marginalizing them. When the community understands mental health, people are less likely to resort to criminalizing homelessness and more likely to support rehabilitation and housing initiatives. This leads to a safer, more cohesive community, where resources are directed toward helping people rebuild their lives instead of perpetuating cycles of poverty and homelessness.

Improving mental wellness literacy among both healthcare providers and community members has a ripple effect throughout the entire community. For healthcare providers, it leads to better patient outcomes, more integrated care, and a reduction in the use of emergency services. For community members, it creates a more empathetic, supportive, and proactive environment, where people are empowered to support each other and advocate for necessary services. Ultimately, both groups play a critical role in addressing homelessness by fostering understanding, early intervention, and community resilience.

Action Step

- Create a Guidebook for the general population to help individuals identify general signs and symptoms in friends, family, and other community members. And hold 6 training sessions per calendar year.

GOAL 3: Help individuals feel safe in seeking immediate help with mental health or SUD treatment quickly

Importance of integration of services

The creation of a physical space or drop-in location for individuals in need of immediate support offers a vital lifeline to those facing crises, especially those at risk of homelessness or struggling with mental health challenges. Such spaces provide more than just a temporary shelter; they offer a safe, welcoming environment where individuals can access essential services, feel supported, and begin to stabilize their lives. By providing a physical location where people can connect with healthcare, mental health professionals, housing resources, and peer support, these spaces foster a sense of security and belonging that is critical to recovery and long-term stability. In essence, a drop-in center becomes a cornerstone for both immediate relief and the building of long-term resilience, addressing urgent needs while also offering a path forward. Examples of Drop-in centers have shown a reduction in Emergency Department (ED) admissions of up to 96% in some communities in Oregon.[9]

[9] Compass House in Medford saw a reduction of 96%– Research done in partnership with Asante Rogue Regional Medical Center Behavioral Health Unit. Pathfinder Clubhouse in Corvalis saw a reduction of 75% - research in partnership with Good Samaritan Regional Medical Center Behavioral health unit.

Action Step: create a drop-in location for those in need of support by Dec 2026.

- Create a physical space such as a drop-in type of center for those who need immediate support or a place to feel safe by Dec 2026
- Create a Mobile Safe space to visit out areas of Coos County by Dec 2026

To create a plan for Behavioral Health we included several Behavioral health professionals, and agencies focused on Behavioral Health as well as organizations and community partners that focus on Behavioral Health (Mental Health and Substance Use Disorder) issues as part of their organizational structure.

Addressing Basic Needs:

Addressing basic needs is fundamental to promoting overall well-being and stability within Coos County. Access to essentials like food, clean water, clothing, and healthcare provides a foundation upon which individuals can build healthier, more stable lives. When basic needs are unmet, individuals are more likely to face hardships such as housing instability, poor health outcomes, and decreased access to opportunities for self-sufficiency. By ensuring that all community members have access to these necessities, Coos County can create a more equitable environment that supports the health and resilience of its residents.

GOAL 1: Build a network of partners to provide services to individuals facing homelessness by December of 2025

A key goal in addressing homelessness is to identify and build partnerships with organizations and individuals who are willing to collaborate in meeting the basic needs of those facing housing instability. Collaboration is essential because homelessness is a complex issue that spans multiple areas, including healthcare, mental health services, housing, employment, and social support. By identifying and working with diverse partners—such as local government, nonprofit organizations, healthcare providers, businesses, and community leaders—we can create a more coordinated, holistic approach to addressing the root causes of homelessness. Collaborative efforts ensure that essential resources and services are accessible and effective, ultimately helping individuals transition out of homelessness and into stable, healthier lives. Partnerships strengthen the collective impact, ensuring no one faces homelessness alone and that all available resources are maximized to create meaningful change.

Action step

- Identify Partners that provide services to individuals that are either homeless or at risk of Homelessness
- Prepare information to distribute to individuals.
- Distribute Information and list of identified partners to the public in informational meetings

GOAL 2: Increase the amount of Traditional Health Workers in Coos County by 5% per year

Identifying and training Traditional Health Workers (THWs) to assist homeless individuals in navigating complex support systems is crucial for improving outcomes and ensuring that those in need can access essential services. THWs, often trusted members of the community, serve as invaluable bridges between vulnerable populations and the various healthcare, housing, and social service systems designed to help them. Given the challenges that homeless individuals face—ranging from navigating healthcare appointments to accessing mental health support and housing programs—THWs can provide personalized guidance, advocacy, and education, empowering individuals to make informed decisions and effectively utilize available resources. By training THWs to address the unique needs of homeless individuals, we create a more accessible, compassionate system where people receive the support they need to transition out of homelessness and regain stability in their lives.

The five types of THWs we would like to increase in Coos County are

- Community Health Workers (CHW)
- Peer Support Specialists (PSS)
    - PSS Mental Health
    - PSS Substance Use Disorder (SUD)
    - PSS Family Support
    - PSS Youth Support
- Peer Wellness Specialist (PWS)
    - PSW Mental Health
    - PWS SUDs
    - PWS Family Support
    - PWS Youth Support
- Personal Health Navigator
- Doula

Action Step:

- Identify and train Traditional Health Care workers to help navigate individuals through the system.
- Offer training opportunities for individuals to get certified as a THW.

GOAL 3: Create a Safe place for people to come to receive help and information

Similar to the idea of a one stop drop-in location identified in the Behavioral Health section. A one stop location focused on helping individuals connect with community partners and basic needs will be crucial in addressing individual needs.

Creating a **one-stop location** to meet the basic needs of individuals experiencing homelessness or instability is a transformative solution that fosters dignity, efficiency, and long-term self-sufficiency. Such a location provides a centralized hub where individuals can access critical services in one place, reducing the burden of navigating multiple systems and agencies scattered across the community. This holistic approach is essential in breaking down the barriers that often prevent people from obtaining the support they need.

One-Stop Location

The concept of a one-stop location allows individuals to meet multiple needs in a single visit, saving time, reducing stress, and increasing the likelihood that they will engage with services. By consolidating services such as healthcare, housing support, job assistance, and basic necessities like food, clothing,

and hygiene supplies, this space ensures individuals have a clear, accessible path to improving their lives. People experiencing homelessness often face overwhelming challenges, and simplifying access to services is crucial in helping them rebuild stability.

Telehealth Services

Offering tele-health as part of this one-stop location expands access to medical and mental health care, especially for those who may not have regular access to healthcare providers. Telehealth allows individuals to consult with healthcare professionals virtually, ensuring that they can receive timely care for both physical and mental health issues without needing to travel to different facilities. For those without transportation or in rural areas, this can be a game-changer, providing immediate support that might otherwise be unavailable. Tele-health also connects individuals with specialists who might not be available locally, further improving health outcomes.

Not a Day Shelter

It is important to distinguish this drop-in location from a day shelter. Unlike a day shelter, which may only offer a place to rest or sleep, this one-stop space provides access to a range of services focused on empowerment and long-term solutions. The goal is not just to provide temporary relief but to offer the tools and resources individuals need to move toward stability and independence. This makes it a proactive space for change rather than simply a place for short-term respite.

Drop-In Location for Basic Needs

A drop-in location means individuals can access services without extensive barriers, appointments, or requirements. This flexible approach is particularly valuable for individuals' experiencing homelessness, who often face unpredictable challenges that make scheduling regular appointments difficult. By allowing them to drop in as needed, the location becomes a reliable resource for immediate help, whether it's healthcare, job support, or access to food and clothing.

Food and Drink

While many organizations provide food to those in need, access to drinks is often overlooked. This one-stop location would ensure that individuals have access to both food and drink, addressing a critical gap in services. Hydration is a basic human need and ensuring that people have access to water or other beverages, in addition to food, is essential to supporting their health and well-being.

Clothing

Providing clothing is another key element of this one-stop location. Homeless individuals often lack access to clean, appropriate clothing, which not only affects their comfort and health but also their ability to secure employment or maintain a sense of dignity. Offering clothing at this location ensures individuals have access to basic necessities and can present themselves confidently, whether for job interviews, social services, or personal well-being.

Job Opportunities

Creating a connection to job opportunities at the one-stop location further empowers individuals to regain independence. Job assistance could include job postings, resume help, interview preparation, and even partnerships with local businesses willing to hire individuals facing homelessness. Employment is

one of the most important factors in overcoming homelessness, and offering this support in a familiar, accessible space helps remove some of the barriers to re-entering the workforce.

Access to Donations

Finally, the one-stop location could serve as a centralized place for community donations, where individuals can access not just clothing, but also other essentials like hygiene products, blankets, and household items. Many people in the community are eager to donate, but without a clear, centralized space to do so, these resources often go unused or are difficult for individuals to access. Having a structured donation system in place ensures that the needs of those experiencing homelessness are met in a more organized, consistent manner.

In summary, a one-stop location designed to meet the basic needs of individuals—by providing food, drink, clothing, healthcare, telehealth services, job support, and access to community donations—would be a powerful resource in addressing homelessness. By simplifying access to these critical services in a welcoming, non-restrictive environment, this location can help individuals not only meet their immediate needs but also build the foundations for long-term stability and success.

Action steps:

- Create a one-stop location for community partners to provide support and give information to those in need of services, by Dec 2026.

Housing:

Stable and affordable housing is a cornerstone of community health and well-being. In Coos County, the lack of safe, permanent housing options directly contributes to the challenges faced by individuals experiencing homelessness. Without a stable place to live, it becomes significantly harder to address other issues like physical and mental health, employment, and education. Investing in housing solutions, such as affordable housing development and supportive housing services, is key to reducing homelessness and creating a community where every resident has the opportunity to thrive.

GOAL 1: Community Involvement and Education.

Community involvement and education are essential when addressing homelessness and housing because they foster empathy, break down stigmas, and create a collaborative approach to solutions. Here's why community involvement and education are particularly important:

1. **Building Awareness and Reducing Stigma**: Educating the public on homelessness issues, including its causes, such as mental health struggles, economic hardship, and lack of affordable housing, can help reduce negative stereotypes. When people understand the complex factors involved, they're more likely to support initiatives.
2. **Increasing Community Buy-in**: Solutions to homelessness often require policy changes, resource allocation, or even physical space in the community. By involving the public early in the process, it's possible to gain support and reduce opposition that might arise from misconceptions or fear.
3. **Fostering Collaborative Solutions**: Addressing homelessness often requires coordinated efforts from multiple sectors, such as health services, housing authorities, and local businesses.

Community involvement helps identify local needs and resources that can lead to innovative and effective strategies.

4. **Empowering Individuals and Building Social Capital:** When community members are involved, they feel empowered to contribute to change. This involvement also builds social capital, creating a stronger, more connected community that can provide support networks for those transitioning out of homelessness.
5. **Enhancing Sustainability**: Community-supported solutions tend to be more sustainable because they're rooted in local needs and have the ongoing support of residents. This makes it more likely that initiatives will be maintained and adapted over time to meet changing needs.
6. **Preventing Future Homelessness**: Education can lead to a broader understanding of preventative measures, such as policies that support affordable housing, mental health resources, and job training. Early education and intervention can help reduce homelessness rates over the long term.

Involving and educating the community helps create a shared vision and a commitment to effective, compassionate solutions to homelessness.

Action Steps:

- Increase support around housing and shelter needs in Coos County by providing information.
    - Offer a minimum of 6 community presentations per year highlighting the need for housing and shelter options throughout the county.
    - Create materials to be distributed by December 2025

GOAL 2: Create safe places for individuals to get information

Creating one-stop locations for housing support offers multiple benefits, making it easier for individuals experiencing homelessness or housing instability to access essential services efficiently and effectively. Here are some key advantages:

1. **Increased Accessibility**: A single location where various services are centralized reduces the need for individuals to travel between different agencies, which is especially beneficial for those who lack reliable transportation or have mobility challenges.
2. **Streamlined Services**: Coordinating housing services, mental health support, medical care, job placement, and financial assistance in one place simplifies the process for clients, allowing them to receive comprehensive support without navigating complex systems or redundant processes.
3. **Holistic, Integrated Care**: By housing multiple services under one roof, providers can address a range of client needs holistically. For example, a person seeking housing might also need job assistance, addiction counseling, or mental health services, which can be immediately accessible on-site.

4. **Improved Collaboration and Communication**: One-stop centers encourages greater communication and collaboration among service providers. This ensures that clients receive coordinated care, preventing gaps and redundancies in services and enabling case managers to work together on comprehensive support plans.
5. **Reduced Wait Times and Bureaucracy**: With multiple services available in one location, individuals may experience shorter wait times and less paperwork, as agencies can share information and resources more easily. This leads to faster interventions and reduces the risk of clients falling through the cracks.
6. **Enhanced Privacy and Dignity**: A centralized location can help reduce the stigma associated with seeking help by providing a space where individuals can receive support discreetly and without needing to go from place to place, which can feel exposing or stigmatizing.
7. **Efficient Use of Resources**: Centralizing services can lower operational costs, as agencies can share physical space and resources. This can also reduce duplication of efforts, allowing more funding and staff time to go directly to client support.
8. **Improved Client Outcomes**: With easier access to comprehensive support, individuals are more likely to achieve stable housing and improve their overall well-being. Accessing multiple services together can help address the root causes of homelessness, including mental health, addiction, and financial instability.

A one-stop location creates a welcoming, supportive environment where individuals can efficiently access the resources needed to stabilize their lives, which ultimately supports long-term success and reduces the barriers that often keep people trapped in cycles of homelessness.

Action items:

- Create a framework for a navigation center
- Create permanent locations where individuals can receive help
- Create a mobile center to give access to individuals to information and needed items.

Goal 3: Transition 60 households through at least one step of the housing continuum per year

Creating a pathway from homelessness to permanent housing involves a series of coordinated steps that address immediate needs, build stability, and support long-term success.

Housing continuum:

- Homelessness
- Emergency Shelter
- Transitional Housing
- Supportive Housing
- Community Housing
- Affordable housing
- Market Housing

Here's an outline of key steps in developing this pathway:

1. Conduct Initial Assessment and Outreach

- **Street Outreach and Engagement**: Engage with homeless individuals through outreach workers to assess needs, build trust, and offer immediate support. This helps bring people into the system and understand each individual's unique circumstances.
- **Needs Assessment**: Identify barriers to housing, such as health issues, lack of income, or unmet mental health needs. A thorough assessment allows providers to tailor services to each person's situation.

2. Provide Emergency Shelter and Basic Necessities

- **Emergency Shelter Access**: Offer safe shelter options for individuals, providing immediate relief and security. Shelters often serve as the entry point for further support services.
- **Access to Food, Hygiene, and Medical Services**: Ensure basic necessities are available to build a foundation of health and well-being, creating a more stable environment for addressing long-term needs.

3. Connect to Transitional Housing or Rapid Re-Housing Programs

- **Transitional Housing**: Offer temporary housing solutions that provide stability while individuals work toward finding permanent housing. Transitional housing often includes support services aimed at improving life skills and work readiness.
- **Rapid Re-Housing**: Use rapid re-housing programs to provide short-term rental assistance and case management, helping individuals transition directly into housing with financial and service support to help them stabilize.

4. Provide Supportive Services for Stability

- **Case Management and Life Skills Training**: Case managers, such as Traditional Healthcare Workers (THW), work closely with individuals to set goals, build life skills (such as budgeting and job readiness), and navigate service systems.
- **Behavioral Health Services**: For individuals struggling with mental health or addiction, access to behavioral health services is crucial. Support in these areas helps address underlying causes that might otherwise prevent successful housing.
- **Healthcare and Substance Abuse Treatment**: Access to primary healthcare and substance abuse treatment promotes physical well-being and supports people in staying housed.

5. Facilitate Employment and Income Support

- **Employment and Job Training Programs**: Work readiness programs can help individuals find sustainable employment, allowing them to afford housing. This may include vocational training, resume building, and job placement services.
- **Financial Assistance**: Assist individuals in accessing income support programs, such as disability benefits, Supplemental Security Income (SSI), or Temporary Assistance for Needy Families (TANF), to help meet basic living costs.

6. Develop Access to Permanent Supportive Housing

- **Subsidized and Permanent Housing Solutions**: Connect individuals with housing vouchers or subsidized housing options, such as Section 8 vouchers, which reduce rent costs and help people afford permanent housing.
- **Permanent Supportive Housing (PSH)**: For individuals with chronic homelessness or disabilities, PSH offers stable housing combined with long-term supportive services, like case management and health services, tailored to maintaining housing stability.

7. Promote Community Reintegration and Long-term Support

- **Community Support Networks**: Connect individuals with local support networks, such as peer groups, mentorship programs, and community resources, to create a sense of belonging and reduce isolation.
- **Tenant Education and Landlord Mediation**: Provide education on tenant rights and responsibilities to foster positive landlord-tenant relationships and reduce housing-related conflicts. Mediation services can help prevent evictions.

8. Establish a System for Monitoring and Follow-Up

- **Ongoing Case Management and Support**: Once individuals are in permanent housing, continued case management or check-ins can help them maintain stability, preventing a return to homelessness.

- **Data Collection and Program Evaluation**: Track progress and outcomes to assess the effectiveness of the pathway and identify areas for improvement, helping adapt services as needed for future individuals.

9. Strengthen Prevention Measures

- **Early Intervention Services**: Develop systems for early identification of those at risk of homelessness, offering support before housing instability occurs.
- **Community Education and Resources**: Educate the public and increase awareness around resources and preventive support to reduce the need for emergency interventions.

Each of these steps requires strong partnerships across service providers, community organizations, housing authorities, and local government to ensure that services are accessible, effective, and integrated.

Action steps

- Transition 60 households through steps of the continuum per year.
- Create county wide low barrier shelter options.
- Increase the number of beds in Coos County by 10% each year.

WORKFORCE

A robust and well-supported workforce is essential for the economic vitality and health of Coos County. For individuals experiencing or at risk of homelessness, access to meaningful employment can be a critical step towards achieving stability and self-sufficiency. Strengthening workforce development through job training, education, and support services can empower residents to secure stable employment and build pathways out of poverty. By addressing barriers such as skill gaps, transportation, and childcare, Coos County can foster a more inclusive labor market that benefits both workers and employers, ultimately contributing to a more resilient community.

Goal #1 Facilitate and enhance a collaborative Job resource management network,

It is critical to have access to the job listing and openings specific to entry-level job opportunities. Understanding the importance of maintaining control of the job listings and opportunities will require developing an in-house organization to actively seek out businesses to partner with centered around our specific population and work skill level.

For this program to succeed in its conceptual development, partnering with a nonprofit entity would require it to house this 'Work to Live' program. The objective is that as the program strengthens following the five-year CHP funding, this CHP-in-house program would then be sustained through grant funding and rolled into the existing nonprofit that we have partnered with in this initiative. This will provide immediate service to the unhoused community as a pathway to sustainable work, translating into additional job opportunities and self-sustainability.

To be successful we must do the following three things.

1. Meet People Where They Are

- **Understanding Barriers**: Recognize that individuals seeking employment, particularly those affected by homelessness, behavioral health challenges, or economic instability, often face unique obstacles. These might include lack of stable housing, access to transportation, and limited childcare.
- **Flexible and Trauma-Informed Approaches**: Emphasize the importance of trauma-informed support that addresses emotional, psychological, and situational needs. Use language that is accessible and nonjudgmental, and consider providing services in various formats—remote, on-site, or in community hubs.
- **Access to Supportive Services**: Implement programs that provide services or partner with supportive services—counseling, resume workshops, financial assistance, and job training—that allow individuals to engage on their terms.

2. Importance of Making Connections

- **Building Trust and Supportive Relationships**: Establish connections with community organizations, social service providers, and mentors who can provide guidance and support. Relationships build trust and create a safety net for people who may be hesitant to re-enter the workforce.

- **Networking Opportunities**: Host events, job fairs, and workshops with potential employers, community members, and peers to foster a sense of inclusion. Networking helps individuals build professional relationships and gain confidence.
- **Peer Support and Mentorship Programs**: Peer mentors can guide individuals through the reemployment process, share lived experiences and provide encouragement. Emphasize the value of peer-led support systems to foster resilience and accountability.

3. Rapid Reemployment

- **Definition and Objective**: Rapid reemployment programs aim to get individuals back into the workforce quickly, often within a set timeframe, through targeted job placement, skills training, and expedited hiring processes.
- **Benefits of Rapid Reemployment**: Reduces time spent unemployed, which can lessen financial strain, improve mental health, and minimize skill loss. This approach also benefits local businesses by filling positions faster, especially in sectors facing labor shortages.
- **Integration with Wraparound Services**: Highlight the importance of integrating wraparound services—such as mental health support, housing assistance, and childcare—to ensure individuals maintain employment once placed. This support can increase job retention and provide stability as they transition into their roles.

These sections can help communicate the multi-layered approach needed for workforce development, especially for a community like Coos County, where addressing specific local challenges is key.

Action step

- Build a collaborative job management resource by Dec 2026.
- Support Workforce navigators to assist individuals needing help

Goal #2 Facilitate a network of Employers engagement and development

For Coos County to fully address homelessness we must first create a sense of community to give individuals a second chance. It is critical that we have employers that are willing to take a chance on hiring individuals that may not have all the skills needed at the moment of hire.

Engage and provide an opportunity for employers to take the opportunity to develop jobs they normally would not.

Building partnerships with employers within our area and region that employ a workforce with potentially undeveloped skill sets. These partnerships include the trades community, state and county jobs, and forestry and food Co-op.

Creating an incentive for businesses to participate in this program would lead to a higher success rate in participation and willingness to work through the growing pain associated with this program's launch. Some of these incentives could include:

- Three to six months of employee pay to cover training and onboarding time, putting less risk on the individual businesses.
- Develop a partial housing payment directly from the employer. Direct housing payment would provide security and sustainability for both employer and employee.
- As part of this work-to-live program, possible drug screenings could be part of the condition.

Action items.

- Create conversations with employers in Coos County to build support with job creation.
- Identify Employers willing to hire homeless or individuals at risk for homelessness

Early Intervention and Prevention

Early intervention and prevention strategies are vital in breaking the cycle of homelessness and promoting long-term health outcomes in Coos County. Addressing challenges before they escalate—such as mental health concerns, substance use, and family instability—can prevent individuals from entering into a state of crisis that may lead to homelessness. By investing in programs that identify and support at-risk populations early, Coos County can reduce the burden on emergency services and provide more effective, cost-efficient care. This proactive approach not only saves resources but also empowers individuals to build healthy, stable lives.

GOAL 1: Expand the number of interventions and improve timeliness of intervention programs for individuals and families on the verge of becoming homeless by the end of 2029.

Expanding the number of interventions and improving the timeliness of intervention programs for individuals and families on the verge of becoming homeless is essential for preventing homelessness before it begins. Timely interventions can provide critical support—such as rental assistance, mental health care, financial counseling, and emergency aid—that helps stabilize individuals and families facing sudden or severe hardships. This proactive approach not only reduces the trauma and long-term challenges associated with homelessness but also lessens the strain on emergency shelters, healthcare facilities, and social services. By addressing housing instability early on, communities can create more effective, compassionate systems that promote long-term stability, reduce homelessness rates, and improve overall public health and well-being.

Action steps:

Organize a housing specific community partner meeting to increase communication and support by various organizations.

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This goal aligns with the central drop-in center goals created by other Action teams.

GOAL 2: Expand and improve prevention programs for youth and families that build protective factors to keep families in their homes or prevent future generations from being at risk of homelessness. Increase evidence-based prevention programing available in Coos County by 5% per year over current programming to meet the goal of 20% increase of programming by 2029.

Expanding and improving prevention programs for youth and families that build protective factors is essential for breaking the cycle of homelessness and creating stable, resilient communities. These programs strengthen the support systems around vulnerable families and equip young people with the skills and resources they need to overcome challenges that could lead to housing instability. By focusing on prevention, we not only keep families in their homes today but also reduce the risk of future generations experiencing homelessness. Protective factors—such as access to education, financial literacy, mental health resources, and community support—are key to building long-term resilience. Investing in these programs ultimately fosters healthier, more sustainable communities where individuals and families are better equipped to thrive and maintain stable housing.

Action Step

- Work with partners to gather and review data from agencies and community partners and identify critical needs to reduce risk for homelessness in populations served.
- Review evidence-based prevention programs for common issues that lead to homelessness and support the expansion of those prevention services in our community.
- To be assessed by the committee, tracking changes to show increase of services offered.
- Assess program efficacy and fit for the community through community conversations with individuals who utilize the services**.**

Goal 3 – Support and expand activities and services that focus on building a positive sense of community belonging. Prioritize buildings belonging to historically underserved populations. Community members show an upward trend in community belonging by 2029.

Supporting and expanding activities that build a positive sense of community belonging, particularly for historically underserved populations, is vital for fostering a resilient, inclusive society where everyone has a stake in their community. A strong sense of belonging connects individuals to each other and their community, which promotes mental health, reduces feelings of isolation, and encourages people to invest in local well-being. For populations historically excluded or underserved, the effects of belonging can be transformative, helping individuals feel valued and supported, and ultimately breaking down barriers to accessing resources such as housing, healthcare, and employment.

Prioritizing belonging for these groups not only enhances personal well-being but also strengthens the community as a whole by addressing inequality and promoting social cohesion. When people feel that they truly belong, they are more likely to engage in community life, seek and offer mutual support, and contribute to a positive community atmosphere. As we observe an upward trend in community belonging, we see the ripple effect: healthier, more engaged residents, reduced social and economic disparities, and a community that is better equipped to handle challenges together. Supporting initiatives that foster belonging is therefore an investment in a healthier, more equitable future, ensuring that all community members—especially those historically left out—feel safe, respected, and empowered to thrive.

Explore creating an annual community wide survey, or series of questions to include, for distribution in early 2026

Implementation and Evaluation: To ensure the success of this plan, it will be essential to:

- Establish a task force to oversee implementation.
- Monitor progress through regular data collection and analysis.
- Adjust strategies as needed based on feedback and outcomes.

By working together, we can make a significant impact on homelessness in Coos County and create a brighter future for all residents.

Partners:

- Coos County Community Advisory Council (CAC)
- Youth Era
- Coos Health and Wellness
- Coos Bay School District
- Columbia Care
- South Coast Early Leaning Hub
- ADAPT Oregon
- South Coast ESD
- Kairos
- Waterfall community Health Center
- Oregon Coast Community Action (ORCCA)
- Coos County Homeless Response
- NeighborWorks Umpqua
- Alternative Youth Activities (AYA)
- Coos County North Bend City Housing Authority
- South Coast Business (SCBEC)
- Southwest Oregon Workforce Investment Board (SOWIB)
- South Coast Health Equity Coalition
- Advantage Working Solutions
- Boys and Girls Aid
- Bay Area Hospital
- Nancy Devereux Center

Coos County CHA Summary of findings

CHA Findings

Demographics

Population growth is lower than the state average

Hispanic / Latino population lower than the state average

American Indian and Alaskan Native Higher than the state average

Aged 55 and older Higher than the state average

Age 18 and younger Lower than the state average

Veterans Higher than the state average

The prevalence of disability is Higher than the state average

Economic stability

Median and Average income is lower than state's average

People living in Poverty is higher than the state average

Children living at or below 200% federal poverty level is higher than the state average

Women in poverty Is higher than the state average

Students qualifying for free or reduced lunch is Higher than the state average.

Housing

Cost-burdened households in rentals and homes with mortgages are higher than the state average.

The median value of a house is higher than the state's average

Older housing stock is higher than the state average

Vacant housing stock is higher than the state average

Overall homelessness is higher than the state average

Homeless students are higher than the state average

Education

High school graduation rates are lower than the state average

Bachelor or advanced degree is lower than the state average

Food Environment

Adults and children living with food insecurities are higher than the state average

SNAP recipients are higher than the state average

People served by WIC is Higher than the state average

Health Behaviors

Tobacco use is higher than the state average

Adult binge drinking is lower than the state average

Heavy drinking is lower than the state average

Youth having their first drink (6^{th} and 11^{th} grades) is higher than the state average

Adult marijuana use (current) is lower than the state average

Adult marijuana use (ever) is higher than the state average

Youth using Marijuana is lower than the state average

2-year-old immunization rates are lower than the state average

Youth eating fresh foods is higher than the state average

Adults drinking 7 or more sodas a week is higher than the state average

Physical activity is lower than the state average

Adults with recent cholesterol checks are higher than the state average

Adults with recent blood sugar test is higher than the state average

Health outcomes

Crude Death rate is higher than the State average.

Cancer, heart disease, and COPD rates are higher than the state average

Tobacco related Mortality is Higher than the state average

The burden of chronic disease is higher than the state average

The Cancer rate (all) is higher than the State average

Adult suicide is higher than the state average

Attempted suicide in youth is higher than the state average

Mentally unhealthy days per month per adult is higher than the state average

Adult depression is higher than the state average

Youth depression is lower than the state average

Poor dental health is Higher than the state average

Adequacy of prenatal care is lower than the state average

Birth rate is lower than the state average

Low birth weight is higher than the state average

Teen birth rate is higher than the state average

Infant mortality is higher than the state average

Adults with obesity is higher than the state average

Health Care access and quality

- Public insurance (Medicaid, Medicare, VA) is higher than the state average
- Population without insurance is higher than the state average
- Access to primary care physicians is lower than the state average
- Access to mental health providers is lower than the state average
- Access to dental services is higher than the state average

Physical environment

- Air quality is higher than the state average
- The number of wildfires is higher than the state average
- Available recreational opportunities are lower than the state average
- Use of public transportation is lower than the state average
- Commute time of less than 15 minutes is less high than the state average
- Workers who drive alone to work is higher than the state average
- Workers who walk or bike to work are lower than the state average
- Social associations/memberships are higher than the state average
- Violent crimes are lower than the state average
- Children in foster care is higher than the state average