

# Oregon's Healthy Future

September 2013

A Plan for Empowering Communities



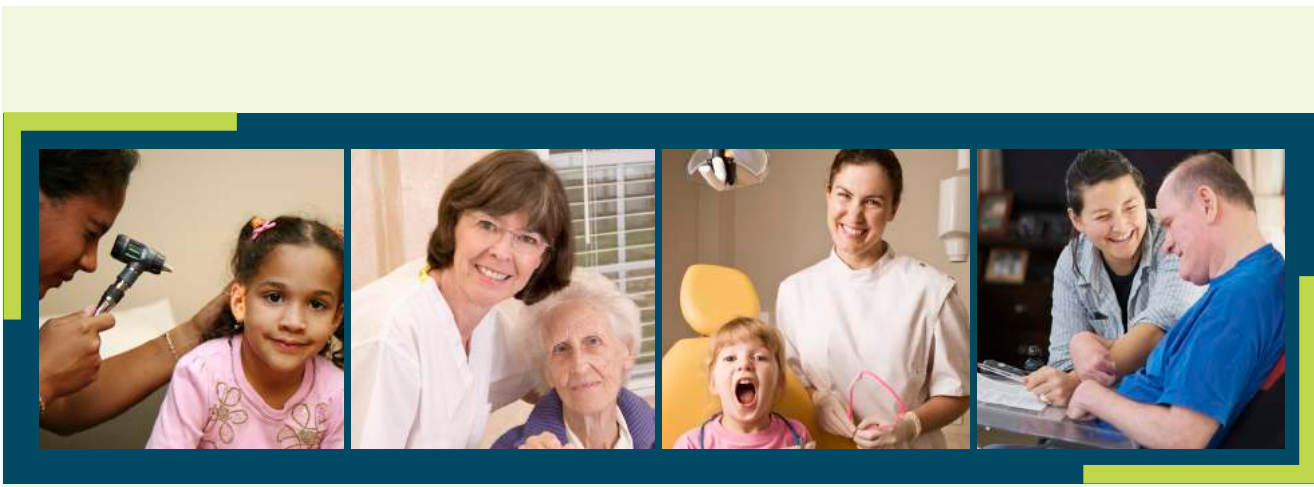
# Welcome to Oregon's Healthy Future!

This statewide community health improvement plan is a collaboration between the public, public health stakeholders and key leaders. It builds on work started in 2010 with the Oregon Health Improvement Plan Committee. In 2010, that committee completed the Oregon Health Improvement Plan, which acknowledged chronic diseases as the major driver of health care costs and outlined strategies for the prevention and management of chronic diseases.

The 2012 Oregon's Healthy Future Advisory Group consisted of representatives from a variety of sectors and groups, including populations experiencing health inequities, and public health officials from county and state levels (see page 3 for list of advisory group members). The advisory group reviewed the results of community engagement processes from 2010 and 2012 and Oregon's Community Health Assessment and deliberated to recommend health priorities based on need and strategic advantage. Additional representatives served as subject matter experts in advisory groups for each priority area, developing strategies to help us meet our goals.

This plan outlines strategies for our communities to work together to improve health. Oregon's Healthy Future is a living document. While the priorities are clear, the methods for addressing each of them will evolve and grow over time. Groups are coalescing to better understand and outline ways to achieve health equity and to support lifelong health.

We envision an Oregon where every community is empowered to improve the lifelong health of all people in Oregon. Oregon's Healthy Future incorporates strategies for taking the most timely and critical steps to realizing that vision.



# Acknowledgements

Members from private and public sector groups worked together on the Oregon's Healthy Future plan. Their time, dedication and efforts are greatly appreciated.

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# Acknowledgements

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# Executive summary

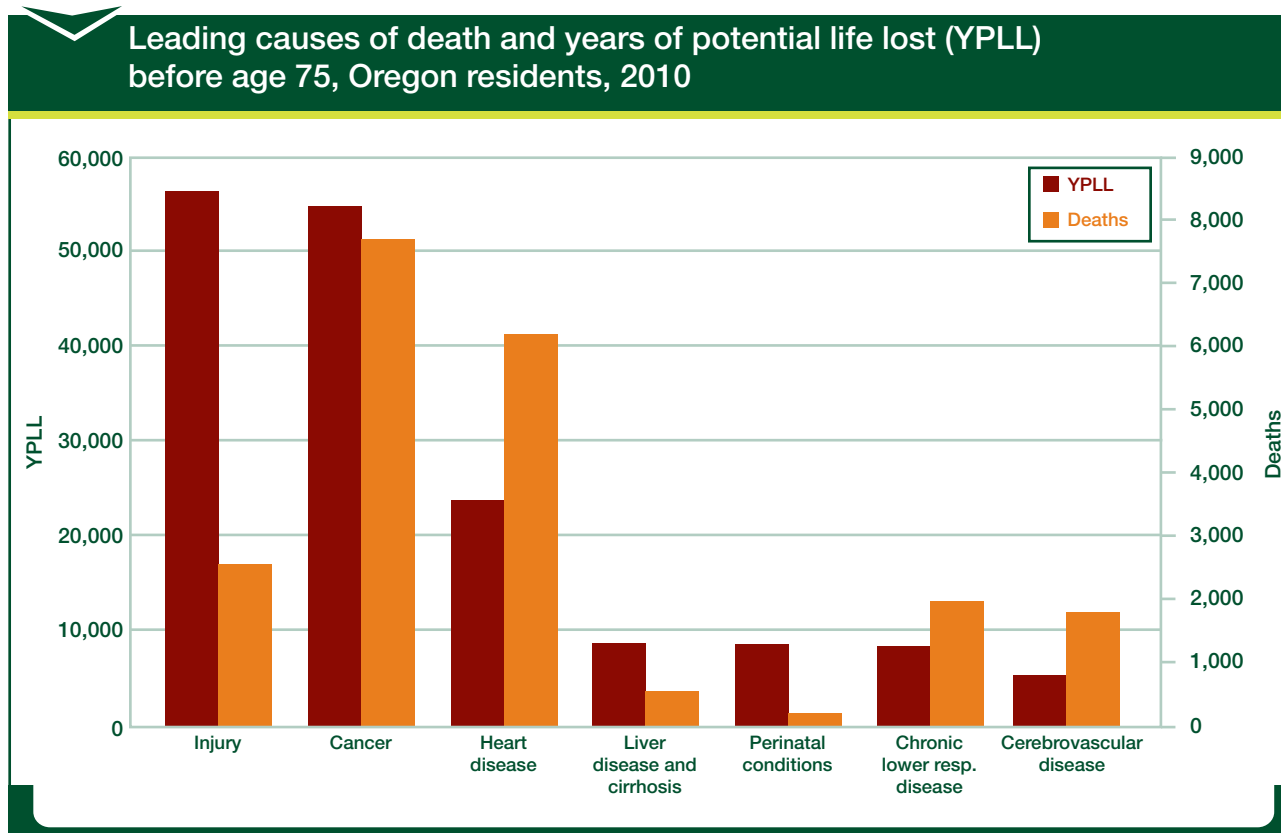
Oregon has a tradition of healthy communities built around abundant natural resources, hard work, caring for our neighbors and a spirit of innovation. We are proud that Oregon ranks 14th among U.S. states for overall health (America's Health Rankings, 2011). Yet, we realize that more must be done to improve the health of all people in Oregon.

Oregon's low smoking rates notwithstanding, tobacco-use continues to be the leading preventable cause of death and disease in the state; rates of obesity and diabetes affect many of us; and oral health outcomes among Oregon's children are some of the worst in the nation. Additionally, health inequities persist for communities of color, low-income populations, sexual minorities and incarcerated people. These are complex challenges. Addressing them successfully requires resources, effort, innovation and participation from everyone.

## Leading causes of death and social impact of premature death in Oregon

Because leading causes of death vary by age, mortality rates by underlying cause alone do not reflect the full social impact of premature death. Estimating years of potential life lost (YPLL) is a way of quantifying the cost of early death by measuring the number of years between age at death and a specific standard age. For instance, if the standard is set at 75 years, a death at age 21 results in 54 years of potential life lost.

The figure below compares causes of death by YPLL before age 75 years with the number of deaths.



DATA SOURCE: OREGON DEATH CERTIFICATE DATA

In order to create a healthier Oregon, stakeholders and key organizations collaborated to review critical health indicators and strategic issues. *Oregon's Healthy Future* identifies five priority objectives for improving health and quality of life in Oregon over the next five years:

- Improve health equity
- Prevent and reduce tobacco use
- Slow the increase of obesity
- Improve oral health
- Reduce substance abuse and other untreated behavioral health issues

These priorities were chosen based on which accomplishments would offer the greatest improvements in lifelong health, advance health equity, and promote equal access to conditions in which people can be healthy.

Based upon the strength of collective impact, this plan outlines improvement strategies that will address each of these priorities and allow us to advance toward our vision.



# Vision statement



Communities are empowered to improve the lifelong health of all people in Oregon.



# Introduction and background

During this time of unprecedented change with national health reform and Oregon's health system transformation, Oregon needs a bold vision for improving the health of its residents. Oregon's Healthy Future is a plan for ensuring the lifelong health for all people of Oregon, regardless of where they live, no matter their income, education, race or ethnicity.

Most of a person's health is determined by social and economic factors rather than by the health care he or she receives. According to the World Health Organization (1948), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The underlying determinants of health include our health behaviors, environments in which we live, health care settings, educational attainment and social support systems around us.

Oregon's Healthy Future focuses on helping communities and individuals make policy, systems and environmental improvements that put healthy options and health-promoting services within reach for everyone in Oregon. The health priorities and improvement strategies in Oregon's Healthy Future are the foundation and scaffold for improving health in Oregon over the next five years. These outcomes will be achieved by forming strong community connections and being part of a transformed health system.

## Health in Oregon: Challenges and opportunities

While Oregon is the ninth largest U.S. state geographically, its 3.8 million residents make it the 29th most populous state. About two-thirds of the state's population lives west of the Cascade Mountains in the Willamette Valley — the rest of the state is more rural. Traditionally, Oregon has been a state of farmers, loggers, ranchers and fishermen. While we are proud of our heritage, some aspects of Oregon's demography, geography and economy present challenges to achieving optimum health for the majority of our population. The rural nature of vast areas of the state requires some Oregonians to travel long distances to health care appointments. Others face similar challenges to maintaining good health due to unemployment, inadequate income and food insecurity. These factors adversely affect a disproportionate number of children. Like many other states, Oregon is dealing with shifting causes of disease, rising burden of chronic diseases, and changes in the way we access and pay for health care. Never before has Oregon faced such significant risks to its health budget and at the same time had such promising opportunities to improve health and lower costs through the prevention of the leading causes of death, disease and injury in the state.

## Challenges

### Changing demographics

Oregon's population is growing, aging and becoming more diverse. The total population grew by 12% between 2000 and 2010; in contrast, the national average for the same period was 9.7%. In 2010, approximately 14% of Oregon's population was over 65 years; by 2020, this is projected to increase to 20%. In 1990, Oregon's population was 90% white non-Hispanic, and in 2010 it was less than 80% white non-Hispanic. In 2010, 11.7% of the population was Hispanic; 3.7% Asian; 1.8% African American; 1.4% American Indian; and 3.8% more than one race. As Oregon's population becomes increasingly diverse, we must develop a health system that effectively meets the needs of Oregon's diverse populations.

### Shifting causes of disease

In the last century, the causes of morbidity and mortality have shifted from infectious diseases to chronic disease and injuries. Tobacco, obesity and heart disease/stroke are the three leading causes of premature death in Oregon, and injury is the single leading cause of death in people under the age of 40. Oregon has made significant progress in reducing tobacco use and promoting healthy environments. However, more than 7,000 Oregonians die each year as the result of tobacco use, and more than 80 cents of every health care dollar is still spent on treating chronic diseases. Each biennium, smoking costs Oregon \$4.8 billion, including \$748 million from the Oregon Health Plan. Obesity accounts for one-third of the recent increase in Oregon's medical costs. The U.S. Centers for Disease Control and Prevention estimate that annual medical costs for individuals with obesity are \$1,429 higher than for non-obese people.

Among children, dental decay is the most common chronic condition — five times more common than asthma. Children with poor oral health often have poor academic performance and are three times more likely to miss school. Preventing decay in childhood increases the likelihood that an individual can avoid dental disease and other health-related consequences throughout adulthood.

Furthermore, mental illness and substance abuse have significant negative effects on individual and family health and the broader social and economic environment, including public safety and worker productivity. Suicide is the eighth leading cause of death for Oregonians overall. The number of Oregon eighth graders who have had a drink in the past 30 days is twice the national average, and Oregon has one of the highest rates of prescription drug misuse in the nation. This proves that in addition to preventing chronic diseases and reducing injury, Oregon must focus on successful strategies to improve mental well-being, prevent suicides, and address alcohol and drug addictions. Only by addressing all of these health issues, while also continuing to control infectious diseases, can we improve the overall population's health and reduce future health care costs.

## Health disparities

These health issues have significant disproportionate effects on communities based on population characteristics such as race/ethnicity, geography, income, educational attainment, language spoken, sexual orientation, disability status and other characteristics. For example, adult obesity rates are higher for communities of color compared to non-Latino whites, and Oregon's African American diabetes and stroke mortality rates are among the highest in the nation. Eliminating health disparities and promoting health equity — attaining the highest level of health for all people — is essential to truly improve the lifelong health of everyone in Oregon.

## Opportunities

### Health system transformation in Oregon

To address these challenges, federal health reform in the United States has recently motivated an unprecedented investment in prevention and wellness activities. This movement is also reflected in Oregon's pioneering health reform efforts. Governor Kitzhaber played a key role in the creation of the Oregon Health Plan in 1994 and now has made Oregon's health system transformation one of his top two priorities. This reform upholds Oregon's proud tradition of improving health through innovation and ingenuity with a focus on the Triple Aim:

- Improving the lifelong health of Oregonians;
- Increasing the quality, reliability and availability of care for all Oregonians;
- Lowering or containing the cost of care so it's affordable to everyone.

With the support of the Oregon Legislature and under the direction of Governor Kitzhaber and the Oregon Health Policy Board, the Oregon Health Authority has led the formation of regional coordinated care organizations (CCOs). As of November 2012, CCOs served an estimated 90% of Oregon's Medicaid population. CCOs aim to bend the cost curve on health care by integrating physical, mental and oral health care, public health, and community level health improvement efforts. The goal is to achieve a high standard of overall health for all Oregonians, regardless of income, race, ethnicity or geographic location.

### Education reform in Oregon

Optimal health is critical for addressing Governor Kitzhaber's other top priority: education reform. Oregon's four-year high school graduation rate (67% in 2011) is the 46th worst in the United States. Younger students are increasingly dropping out of school, and youth of color and youth from low-income families drop out at higher rates than their white and higher-income counterparts. Health is positively associated with regular school attendance, academic achievement and increased likelihood of high school graduation. Health system transformation is essential to meeting Oregon's 40/40/20 goal to improve the number of adults who graduate from high school and complete post-secondary education.

## 10-Year Plan for Oregon

In August 2011, Governor Kitzhaber created the 10-Year Plan for Oregon initiative. Health and education are two of the five cross-cutting priority areas identified. The Healthy People objective for the state seeks to ensure that Oregonians are healthy and have the best possible quality of life at all ages. Health is also an important prerequisite for the Education objective in the plan. The combined emergence of health system transformation, education reform, and the Governor's 10-Year Plan for Oregon provide a window of opportunity to achieve sustainable and measurable improvements in the state population's health.

## Oregon's Statewide Community Health Improvement Plan

In order to improve the lifelong health of all people in Oregon and support education and health system transformation priorities, the public health community must identify and address health priorities, including persistent disparities in health outcomes and the social, economic, educational and environmental inequities that contribute to them. Oregon's Healthy Future is Oregon's plan for ensuring the lifelong health for all people of Oregon, regardless of where they live, and no matter their income, education, race or ethnicity. The plan focuses on helping communities and individuals, in collaboration with local public health departments and other community partners, make policy, systems and environmental improvements that put healthy options and health-promoting services within reach for everyone in Oregon.

“Health does not occur in the doctor's office or hospitals alone ... It also occurs where we work, where we learn, where we play.”

Dr. Regina Benjamin,  
U.S. Surgeon General

This plan builds upon the work of prior state health improvement plans — most notably the Oregon Health Improvement Plan (December 2010), which was legislatively directed to focus on the prevention and management of chronic diseases. In 2012 the Oregon's Healthy Future Advisory Group, a multi-sector group of representatives from populations experiencing health inequities and local and state public health officials, sought additional community feedback from over 300 participants; reviewed the full spectrum of public health issues, including data from Oregon's State Health Profile of key health indicators; and synthesized the findings to create this five-year statewide community health improvement plan.

## Leadership and implementation

Statewide and community-level leadership is essential to achieving this vision of lifelong health for all people in Oregon. Full achievement of the goals and progress on the priorities in this health improvement plan can only be achieved through partnership with state, local and tribal public health departments, coordinated care organizations, health care organizations, government agencies, educational institutions, employers, nonprofit and community-based organizations, faith communities, the private sector, community members, and many others. This plan is also intended to guide and support the work of the Oregon public health system. Oregon needs a strong public health system to achieve better health outcomes at lower costs and to transform health care delivery.

## Oregon public health system

The Oregon public health system works daily to prevent disease and injury and promote and protect health. Oregon's system is comprised of state, local and tribal public health departments and public and private partnerships. Some key public health activities and programs are administered by the state component of the system, the Oregon Health Authority Public Health Division. Others are delivered in collaboration with 34 local health departments, which have statutory authority to protect the public's health in their counties. The public health system serves three main functions: 1) assessment of the public's health in Oregon through data collection and investigations of disease; 2) the development of policies and programs that support improved health outcomes; and 3) the assurance that those policies and programs are achieving the intended purpose. Public health programs reduce costs by promoting healthy options, creating safe and healthy communities, and preventing the need for acute medical care.

## National public health accreditation

In September 2011, the Public Health Accreditation Board officially launched national public health accreditation. Accreditation provides public health departments an opportunity to measure their performance under a set of standards. Accreditation prerequisites include a community health assessment, community health improvement plan and agency strategic plan. As Oregon's Statewide Community Health Improvement Plan, Oregon's Healthy Future is a resource to inform the development of local community health improvement plans and the Oregon Health Authority Public Health Division Strategic Plan.



## Priority areas

Oregon's Healthy Future identifies five priority objectives for improving health and quality of life in Oregon. These priorities were chosen based on which accomplishments would offer the greatest improvements in lifelong health, to advance health equity and achieve more equal access to conditions in which people can be healthy.

The selection of priorities was influenced by more than 300 planning participants around the state and shaped by knowledgeable teams based on trends affecting population health.

### Priority areas:

- Improve health equity
- Prevent and reduce tobacco use
- Slow the increase of obesity
- Improve oral health
- Reduce substance abuse and other untreated behavioral health issues

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

World Health Organization

### Improvement strategies

Oregon's Health Future Advisory Group and subgroups collaborated to develop specific improvement strategies for each of the five priority objectives. These groups of experts and stakeholders carefully selected strategies based on evidence of potential for effect, political feasibility, timing and opportunity for change, and potential to reduce health disparities.

The health priorities and improvement strategies in Oregon's Healthy Future are the foundation and scaffold for improving health in Oregon over the next five years.



# OREGON HEALTH PRIORITIES



# Health priorities

These five priority objectives are offered to focus the attention and work of policy makers and organizations, including state, local and tribal government agencies, educational institutions, employers, health care organizations, nonprofit and community-based organizations, faith communities, and others:

- Improve health equity;
- Prevent and reduce tobacco use;
- Slow the increase of obesity;
- Improve oral health;
- Reduce substance abuse and other untreated behavioral health issues.

## IMPROVE HEALTH EQUITY

### Background

The vision for Oregon's Healthy Future is that "Communities are empowered to improve the lifelong health of all people in Oregon." A key principle in this vision is that all people have the opportunity to attain their full health potential. The values of fairness and justice should spur action to ensure that the community conditions to improve health are available across the state.

Health disparities are population-specific differences in health outcomes. Examples of health disparities are when a specific population (defined by race/ethnicity, income, education or other factors) has an increased likelihood of using tobacco, having heart disease or dying prematurely. Some health disparities cannot be eliminated, for example, older adults are more likely to have heart disease than younger adults.

Health inequities are the unfair, avoidable and unjust social and community conditions that lead to disparities in health outcomes. Examples of health inequities include neighborhoods with less access to healthy food options, areas with higher air pollution, communities with lower-achieving schools, and populations that have less access to appropriate health care.

Achieving health equity requires structural, social and political changes to equalize the conditions that promote health for all people, especially populations that have experienced historical injustices or face socioeconomic disadvantages.

The first and most important health priority in Oregon's Healthy Future is improving health equity. Populations experiencing health inequities can be defined by a number of characteristics, including but not limited to race/ethnicity, income, educational attainment, occupation, geography (e.g., rural or urban), mental and physical disability status, language spoken, country of origin, immigration status, sexual orientation, and gender identity.

According to the most recent U.S. Census, Oregon's population is becoming more racially and ethnically diverse. From 2000 to 2010, the total population of Oregon increased 12%, while the population of Oregon's communities of color increased 46%, almost four times as fast. Communities of color now comprise 22% of the total state population, up from 16% in 2000. This trend is likely to continue, as 34% of Oregon youth under 18 years old are members of communities of color. Among the population receiving services from the Oregon Health Plan (Medicaid), 40% are from communities of color.

## Effects of health inequities

Health inequities result in unnecessary loss of life and also increase the costs of the health care system. A national study by Johns Hopkins University and University of Maryland researchers found that almost one-third of the medical care expenditures for African Americans, Asians and Hispanics were excess costs due to health inequities.<sup>1</sup>

Data from Oregon's State Health Profile show the extent of some current health disparities. For example, adult obesity rates are higher for Latinos (31%), American Indian/Alaska Native (30%), and African Americans (29%) compared to non-Latino whites (24%). The prevalence of asthma is twice as high for economically disadvantaged adults (defined by educational attainment and household income) compared to non-economically disadvantaged adults. Compared to the overall adult smoking prevalence of 20%, the smoking prevalence is higher for adults who are economically disadvantaged (33%), American Indian/Alaska Native (38%), and African American (30%).

## Factors that influence health equity

There are many causes for the adverse health outcomes experienced by certain communities. Populations experiencing health disparities may be less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive the appropriate care when seeing a health care provider. Equity must be considered in all health issues, spanning from preconception to the end of life.

<sup>1</sup>LaVeist TA, Gaskin DJ, Richard P. The Economic Burden of Health Inequalities in the United States. 2009. [www.jointcenter.org/hpi/sites/all/files/Burden\\_Of\\_Health\\_FINAL\\_0.pdf](http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf)

Health outcomes are also strongly influenced by factors that are not always seen as directly related to health. Such factors include housing, transportation, economic development and educational opportunities. It is critical to address equity in all the areas that affect a person's health. And, it should be recognized that health affects a person's ability to succeed in other areas. For example, a healthy youth is more likely to do well academically, and a healthy adult can be a more productive worker.

## Equity lens

An equity lens process is a method for identifying and addressing health inequities. The equity lens is used to assess policies and programs for disproportionate effects on specific populations. Then, necessary modifications can be made that would improve health equity. The equity lens process is an intentional method for making more informed decisions and moving toward the goal of achieving health equity. An equity lens can be applied to any policy or program that affects health.

For example, the equity lens was used to review the improvement strategies for the four other health priorities in this plan relating to tobacco, obesity, oral health and substance abuse/behavioral health. Among the improvement strategies developed for these four health priorities, the following strategies have the greatest potential to promote health equity, although they are not strategies that have been adopted into the identified health equity priority strategies.

### Priority: Prevent and Reduce Tobacco Use

**Strategy:** Increase the price of cigarettes by a \$1/pack excise tax (and a proportionate amount on other tobacco products), and dedicate 10% (\$40 million) to comprehensive and effective efforts at the state and local levels to reduce tobacco use and exposure in adults and children, especially in populations experiencing disparities, including implementation of best and emerging practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations.

Increasing the price of tobacco and funding comprehensive tobacco control efforts lead to reduced tobacco use. It is important to dedicate funding to community-based organizations representing populations that are currently experiencing a disproportionate share of the tobacco-use burden and ensure that these communities have lead roles in the decisions about how resources are allocated to reduce tobacco-related disparities. Diverse communities must be engaged throughout the planning, implementation and evaluation processes in order to most effectively eliminate health inequities.

## Priority: Slow the Increase of Obesity

Strategy: Adopt and implement nutrition standards for foods and beverages sold in cafeterias, stores and vending machines in state agencies, schools and universities, including eliminating the sale of sugar-sweetened beverages.

Strategy: Support legislative efforts to fund the Farm to School and School Garden, and the Farm to Institution programs through Oregon State Lottery funds.

Access to healthy foods, especially for youth, can improve nutrition and build lifelong good eating habits. Many youth with limited access to nutritious foods, such as those from low-income families, eat many of their meals at school. To ensure the effectiveness of nutrition programs, diverse community members need to be engaged so that foods offered through such programs are both desirable and healthy for all populations. Farmers and food processors that benefit economically from these programs should represent the socioeconomic and racial/ethnic diversity of Oregon, and maintain growing and labor practices that promote health.

## Priority: Improve Oral Health

Strategy: Encourage public water districts to fluoridate water based on CDC recommendations to reduce tooth decay.

Optimally fluoridated water is the most effective method for reaching all populations to improve oral health. Implementation of water fluoridation will improve the oral health of populations experiencing oral health disparities. This does not eliminate the need to increase access to oral health services, such as every child having an oral health screening or preventive dental visit by age 1.

## Priority: Reduce Substance Abuse and Other Untreated Behavioral Health Issues

Strategy: Collect and analyze baseline data on the availability of culturally and language-competent behavioral health providers.

The availability of culturally and language-competent behavioral health providers is essential to assure that diverse populations in Oregon can access effective services. Conducting an assessment of the current behavioral health providers is just the first step to assuring access to these important services.

## Cross-cutting objectives and strategies for health equity

The table on pages 22 and 23 includes a cross-cutting set of measurable objectives and strategies that outline the equity lens process and are applicable to any health issue. Diverse community perspectives are necessary for the equity lens process to be effective. The strategies throughout Oregon's Healthy Future are not meant to override a particular community's plans or priorities for improving health. Community-driven initiatives are critical to improving health equity, and the equity lens is designed to help identify and support these initiatives.

The measurable objectives in the table were chosen because disparities in these areas are the result of multiple inequities. For example, whether a child graduates from high school can be influenced by factors ranging from environmental asthma triggers to smoking status to the quality of the neighborhood school.

The available data for some objectives also shows some of the current difficulties in monitoring disparities. For example, data on incarceration rates are available for only three racial/ethnic groups, and the most recent data are for 2005. Additionally, appropriate analysis is also difficult when data for certain ethnic or cultural populations are combined into one group, which can hide significant differences among subpopulations. For example, while Asian and Pacific Islander (API) communities share some cultural similarities, there are important historical, social, educational and economic differences among the various ethnic groups; more than 100 languages are spoken by people of API descent in Oregon. While API groups typically have very low smoking rates, smoking rates among Vietnamese-American and Korean-American men can be much higher than smoking rates among both the general population and other API groups. Care should be taken in the collection and analysis of data so that institutions and policymakers can develop, implement and evaluate appropriate solutions for the health issues facing diverse communities.

Performance measures for the health equity strategies can be specifically designed within any health priority. Here's an illustration using Health Equity Strategy 7: Ensure that health information systems include specific data on race/ethnicity and other characteristics necessary to monitor health equity. Looking at the health priority of reducing tobacco use, studies have shown that people who identify as lesbian/gay/bisexual/transgendered (LGBT) are more likely to use tobacco. Therefore, this strategy could have a performance measure: the number of tobacco use surveys that include questions on sexual orientation and gender identity. The responsible parties for implementing a health equity strategy will include the groups responsible for working on the underlying health priority (reducing tobacco use, in this example).

## Achieving health equity

The time frame is five years for implementing Oregon’s Healthy Future strategies; its goal is to significantly improve health equity in that time period. However, the struggle to achieve full health equity will continue. We need to take the steps that could improve the health of someone today, such as ensuring that the tobacco quit line has services tailored to specific communities. Also, we need to continue the efforts that have longer timelines, such as diversifying the health work force. Through all this, we must focus on the goal of eliminating the poor health outcomes and premature deaths that unnecessarily occur in communities confronted by health inequities. We must continue to empower communities to improve the lifelong health of all people in Oregon, ensuring that all people have the opportunity to attain their full health potential.

# Health Priority 1: Improving Health Equity

Health outcomes



Age adjusted death rates by race/ethnicity

Measurable objectives



High school graduation rates by race/ethnicity – baseline data (2010)

- African American -----49.8%
- American Indian/Alaska Native-----59.3%
- Asian/Pacific Islander -----76.1%
- Hispanic-----55.2%
- White-----69.9%

Percentage of babies with low birth weight by race/ethnicity – baseline data (2010)

- African American -----10.9%
- American Indian/Alaska Native----- 7.4%
- Asian ----- 7.8%
- Hawaiian/Pacific Islander -----11.1%
- Hispanic----- 6.1%
- White----- 6.0%

Incarceration rates per 100,000 by race/ethnicity – baseline data (2005)

- African American ----- 2,930
- Hispanic----- 573
- White----- 502

1 Strategy



Create and disseminate a health equity lens tool that can help assess policies and programs for disproportionate impacts on specific populations and recommend modifications that would improve health equity.

| Performance measures  | Target                                  | Responsible parties  |
|---|---|--|
| The creation of a health equity lens tool and the number of organizations that have adopted its use | Health equity lens tool created (2014). | <ul style="list-style-type: none"> <li>• Health Equity Policy Review Committee</li> <li>• Oregon Health Authority</li> <li>• Regional equity coalitions</li> <li>• Coordinated care organizations and community advisory councils</li> <li>• Culturally diverse community-based organizations</li> <li>• Health advocates</li> <li>• Policy makers</li> <li>• Elected officials</li> </ul> |



**2 Strategy** ▶ Provide resources to increase the capacity of Oregon's diverse populations to improve community health.

**3 Strategy** ▶ Meaningfully engage diverse communities to ensure that the effects on health equity are considered when developing, implementing and evaluating policies and programs.

**4 Strategy** ▶ Collaborate with K-12 and higher educational institutions and employers to diversify the health work force and ensure that workers from diverse background have the educational and employment opportunities to move up the career ladder.

**5 Strategy** ▶ Increase the cultural competency of the health work force to more effectively work with diverse populations.

**6 Strategy** ▶ When determining priorities for improving health, set measurable goals for reducing health disparities.

**7 Strategy** ▶ Ensure that health information systems include detailed data on race, ethnicity, language, and other characteristics necessary to monitor health equity.

**8 Strategy** ▶ Disseminate lessons learned from initiatives to improve health equity in order to help replicate successful efforts.

| Performance measures   | Target  | Responsible parties  |
|--|---|--|
| For each health area, performance measures should be defined for these health equity strategies. | Targets defined for each health area's health equity strategies (2017). | All people and organizations working on the underlying health area |

# PREVENT AND REDUCE TOBACCO USE

## Background

Tobacco use remains the number-one cause of preventable death in Oregon and nationally. Tobacco use kills approximately 7,000 Oregonians each year, and secondhand smoke causes an additional 650 deaths. Oregon's public health system has made powerful inroads into addressing the harm caused by tobacco use, but much remains to be done.

In 2011 in Oregon:

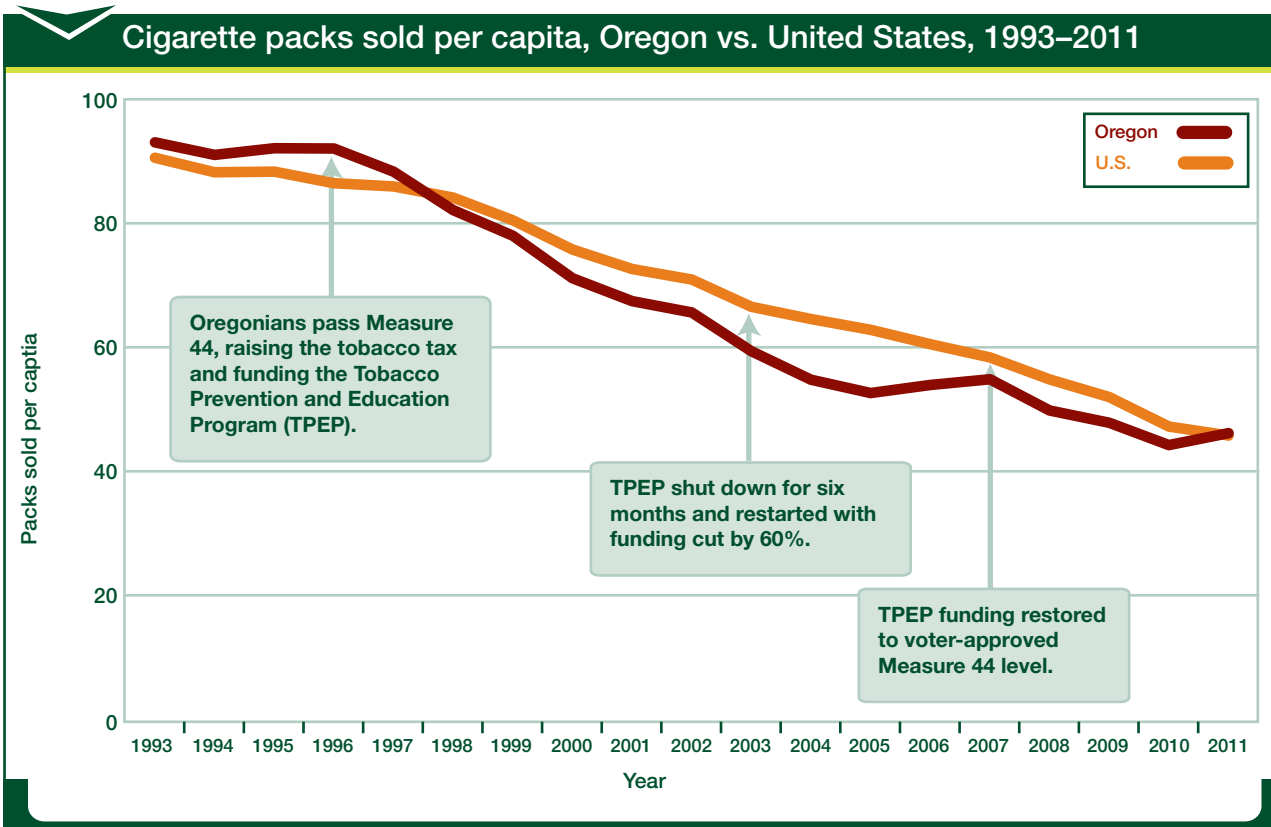
- 20% of adults smoked cigarettes.
- 12% of 11th graders smoked cigarettes.
- 7% of eighth graders smoked cigarettes.
- 4% of adults used smokeless tobacco.
- 12% of 11th-grade boys used smokeless tobacco.

Smoking costs Oregon more than \$2.5 billion annually in direct medical expenditures and indirect costs due to premature death. Treating smoking-related disease costs Oregon Medicaid \$374 million per year. In 2011, Oregon smokers paid an average of \$5.41 per pack, in contrast with the true cost to society of \$13.94 per pack (Oregon Tobacco Facts & Laws, 2011).

Tobacco use causes or worsens almost every chronic disease. Chronic diseases account for approximately 85 cents of every \$1 spent on health care costs. For Oregon to achieve success with health system transformation and the Triple Aim of better health and better health care at lower cost, Oregon must reduce tobacco use and exposure to secondhand smoke.

To reduce tobacco use, Oregon must take a comprehensive approach, addressing tobacco use from every angle. Implementing hard-hitting messages and warnings, providing advice and assistance to quit, increasing the price of tobacco products, improving access to and affordability of cessation services, enacting restrictions on where tobacco can be used, and restricting how tobacco can be promoted are all necessary components of an effective and comprehensive tobacco control strategy.

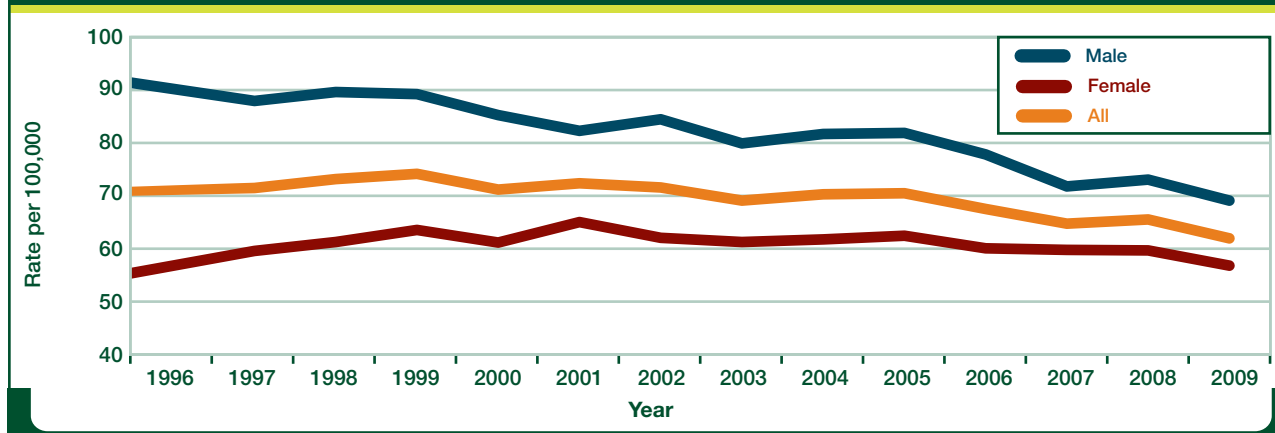
Oregonians voted in 1996 for Measure 44, which raised cigarette taxes and funded the Tobacco Prevention and Education Program. As shown in the chart below, cigarette consumption has declined in Oregon during the past 15 years.



RESEARCH TRIANGLE INSTITUTE (1993–1998); ORZECZOWSKI AND WALKER (1999–2009) POPULATION – U.S. CENSUS BUREAU

Lung cancer is the third most common cancer and the number-one leading cause of cancer deaths in Oregon; almost 90% of lung cancers are related to smoking. Lung cancer diagnosis rates among men have dropped markedly during the past decade due to decreases in smoking. Rates among women are slightly lower than rates among men but have remained relatively flat. Lung cancers among men and women can be expected to decline if smoking rates fall further.

## Age-adjusted rate of invasive lung and bronchial cancer diagnoses per 100,000 Oregonians, 1996–2009



SOURCE: OREGON STATE CANCER REGISTRY

## Tracking and monitoring policy, systems and environmental change

Several of the performance measures recommended in the table below will be assessed by a policy database developed by the Oregon Health Authority Public Health Division's Health Promotion and Chronic Disease Prevention Section. Oregon's public health system routinely collects and analyzes data on the prevalence of diseases and risk factors across the population and among sub-populations, and monitors state and local policies that prevent disease and support healthy living. To capture local and state policies, the Health Promotion and Chronic Disease Prevention Section established a policy database to track local and state policies to prevent tobacco use, obesity and related chronic diseases and promote tobacco-free living, healthy eating and active living. Components of the database include, but are not limited to:

- Type of policy;
- Date policy adopted and implemented;
- Population-reach;
- Jurisdiction;
- Contact information.

# Health Priority 2: Prevent and Reduce Tobacco Use

## Health outcomes

Reduce the prevalence of asthma attacks, arthritis, cancer, diabetes, heart disease and stroke among children and adults.

## Measurable objectives

Reduce the percentage of adults who smoke to 15% or less (2011: 20%).

- This decline would result in 148,000 fewer adult smokers and a cumulative savings of \$2.2 billion in future health costs.

Smoking prevalence will be reduced among:

- 11th graders to 7.5% or less (2011: 12%);
- 8th graders to 5% or less (2011: 7%).

Reduce the number of packs of cigarettes sold per capita each year to less than 22 (2009: 48).

## 1 Strategy

Increase the price of cigarettes by a \$1/pack excise tax (and a proportionate amount on other tobacco products).

Dedicate 10% (\$40 million) to comprehensive and effective efforts at the state and local levels to reduce tobacco use and exposure.

Note 1: Efforts are geared to adults and children, especially in populations experiencing disparities.

Note 2: Strategies include implementation of best and emerging practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations.

Note 3: This was identified by the Health Equity Advisory Group as the tobacco prevention and reduction strategy that provides the greatest opportunity to affect health equity.

| Performance measures                                     | Baseline                            | Target  | Responsible parties  |
|--|-------------------------------------|---|--|
| The amount of state tax on a pack of cigarettes          | \$1.18 (2012)                       | \$2.18 tax/pack (2017)  | Tobacco control advocacy partners:   |
| Secured allocations to the Tobacco Use Reduction Account | \$12.5 million (2009–2011 biennium) | Approximately \$20 million annually allocated to the Tobacco Use and Reduction Account (2017) | <ul style="list-style-type: none"> <li>• American Heart Association</li> <li>• American Cancer Society</li> <li>• American Lung Association</li> <li>• Campaign for Tobacco-Free Kids</li> </ul> |

## 2 Strategy

Ban free sampling of tobacco products, tobacco coupon redemption, and other tobacco price reduction strategies.

| Performance measures   | Baseline      | Target   | Responsible parties                                |
|--|---------------|--|--|
| <p>Number of laws passed at the local and statewide levels banning tobacco sampling</p> <p>Note:<br/>Policy database is being developed to monitor this measure.</p> | Not available | Tobacco sampling banned in five additional jurisdictions (2017). | Tobacco-Free Coalition of Oregon (to be confirmed) |

## 3 Strategy

Increase the number of environments where tobacco use is prohibited including:

- Publicly owned multi-unit housing;
- City, County, tribally owned or operated campuses, parks and outdoor recreational spaces;
- Schools;
- Community colleges;
- Universities;
- Coordinated Care Organizations and hospitals.

| Performance measures   | Baseline  | Target  | Responsible parties  |
|--|---|---|--|
| <p>Number of environments where tobacco use is prohibited</p> <p>Note:<br/>Policy database is being developed to monitor this measure.</p> | <ul style="list-style-type: none"> <li>• Counties, 8% (2012);</li> <li>• tribes, 0% (2012);</li> <li>• community colleges, 29% (2012);</li> <li>• public universities, 29% (2012);</li> <li>• public housing authorities, 91% (2012)</li> </ul> | Number of environments where tobacco use prohibited increased by 100% (2017). | <ul style="list-style-type: none"> <li>• OHA Public Health Division</li> <li>• Tribal health organizations</li> <li>• County health department's tobacco control programs</li> </ul> |



## 4 Strategy

Adopt and implement tobacco-free campus policies in all state agencies, hospitals and addictions and mental health facilities contracting with OHA.

| Performance measures  | Baseline  | Target   | Responsible parties   |
|---|-----------|--|---|
| Number of agencies and organizations that have adopted tobacco-free campus policies | 2% (2012) | Rules adopted and policy implementation guidance issued in 100% of organizations (2017). | <ul style="list-style-type: none"> <li>OHA Public Health Division</li> <li>County health department's tobacco control grantee programs</li> </ul> |

## 5 Strategy

Ensure that evidence-based, comprehensive tobacco cessation benefits are available and promoted to Oregonians.

| Performance measures   | Baseline   | Target   | Responsible parties  |
|--|--|--|--|
| <p>Essential benefit package tobacco cessation coverage for the Oregon Health Insurance Exchange</p> <p>Note:<br/>These measure benefit availability, not promotion. The promotion of benefits cannot be measured with current data systems.</p> | <p>Not available</p> <hr/> <p>Not available</p> <hr/> <p>Not available</p> | <p>The essential benefit package for the Oregon Health Insurance Exchange includes evidence-based, comprehensive tobacco cessation (2017).</p> <hr/> <p>100% of coordinated care organizations provide evidence-based tobacco cessation benefits to their members (2017).</p> <hr/> <p>75% of insured adult smokers in Oregon report their health insurance coverage pays for the cost of any smoking cessation assistance (2017).</p> | <p> OHA Medical Assistance Programs </p> |

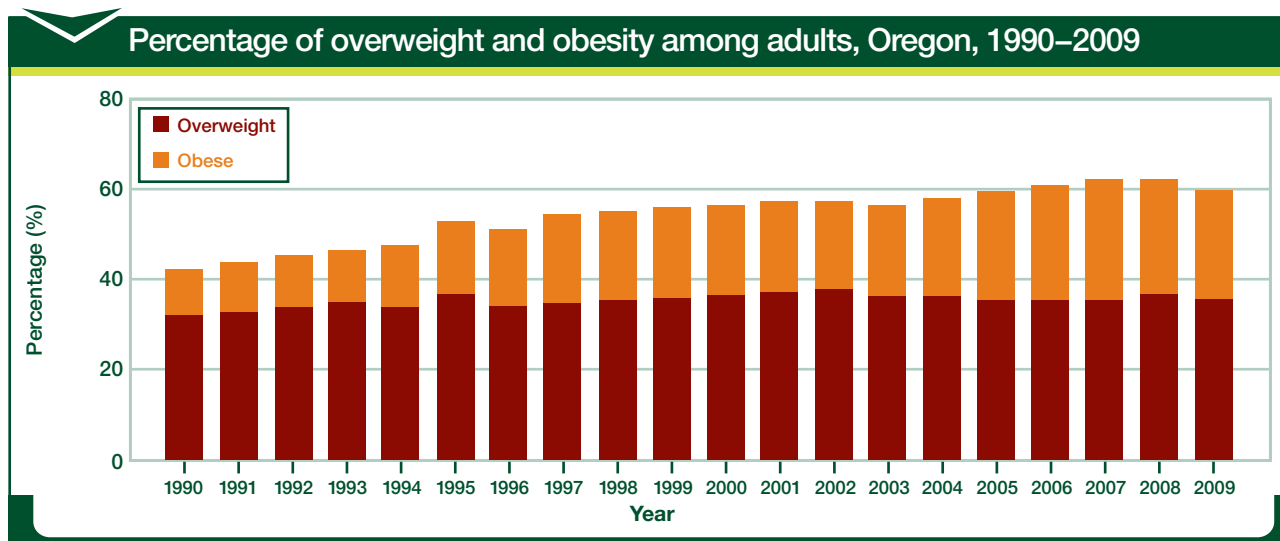


# SLOW THE INCREASE OF OBESITY

## Background

Obesity is the number-two cause of preventable death both in Oregon and nationally, second only to tobacco use. Obesity-related illnesses annually account for approximately 1,500 deaths in Oregon. Between 2001 and 2009, the percentage of Oregon students who were obese increased 53% for eighth-graders and 55% for 11thgraders. Since 1990, Oregon's adult obesity rate has increased 121% (Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012).

Preventing obesity among Oregonians lowers the risk of diabetes, heart disease, stroke, high blood pressure, stress and depression. Children and adolescents who are obese are at increased risk for becoming obese as adults and face a lifetime of health consequences.

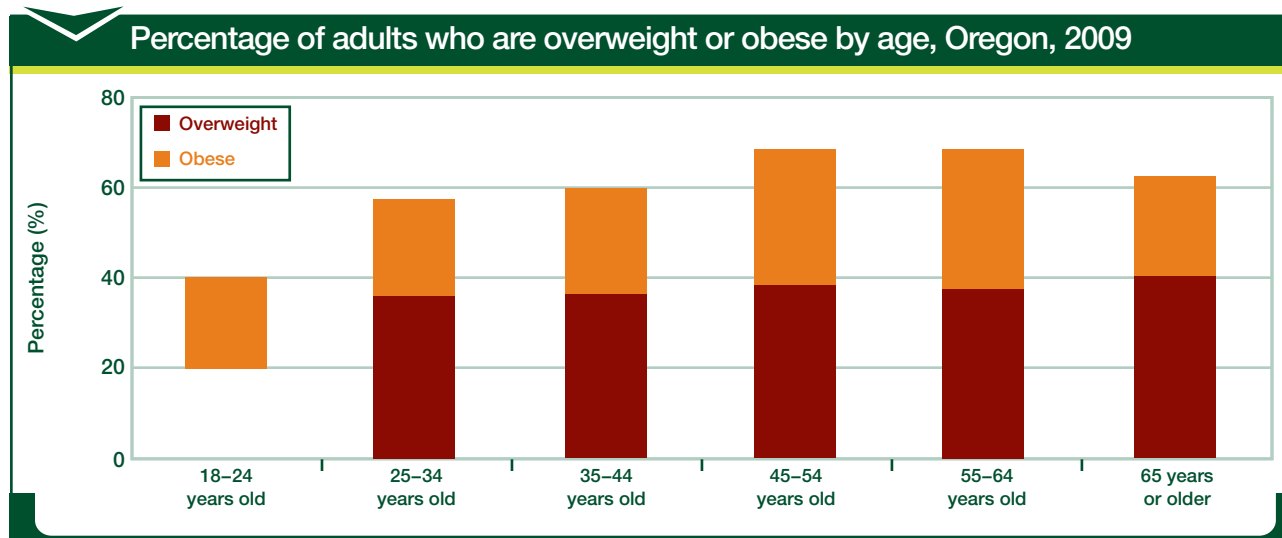


SOURCE: OREGON BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

In Oregon in 2009:

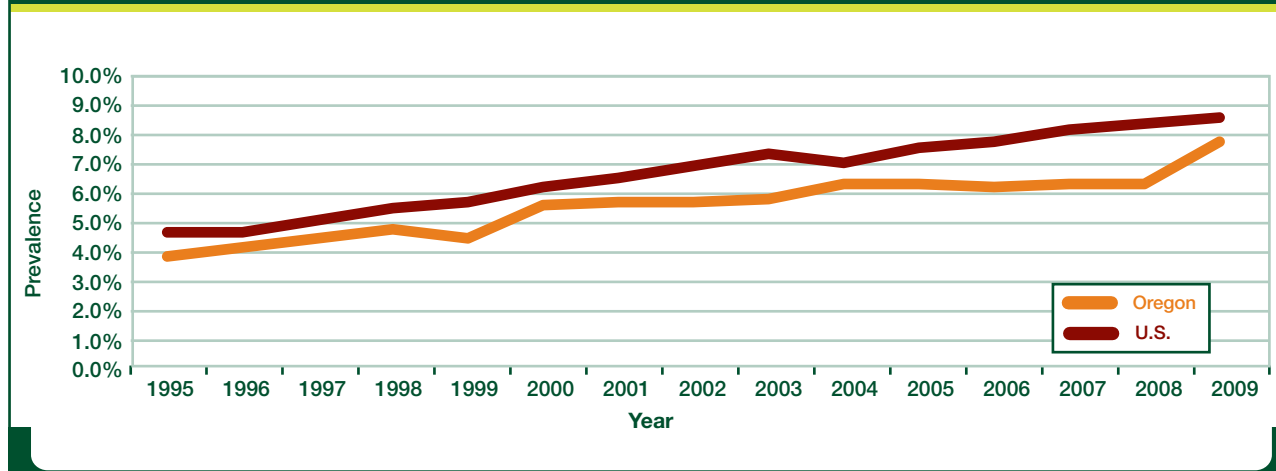
- 60% of adult Oregonians were overweight or obese.
  - 26% of adults met recommendations for fruit and vegetable consumption.
  - 57% of adults met minimum recommendations for physical activity.
  - 73% of adults with a history of heart attack were overweight or obese.
- 27% of eighth-graders were overweight or obese.
  - 21% of eighth-graders drank seven or more soft drinks a week.
  - 27% of eighth-graders played video games, computer games or used the Internet for non-schoolwork for three or more hours in an average school day.
- 24% of 11th-graders were overweight or obese.
  - 19% of 11th-graders drank seven or more soft drinks a week.
  - 12% of 11th-graders participated in daily physical education.

(Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012)



SOURCE: OREGON BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

## Age-adjusted diabetes prevalence, Oregon and United states, 1995–2009



SOURCE: OREGON AND U.S. BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEMS

Each year, Oregon spends approximately \$1.6 billion (\$339 million paid by Medicaid) in medical expenses for obesity-related chronic diseases, such as diabetes and heart disease. Annual medical costs of persons who are obese are estimated to be \$1,429 higher per person than those of people who are not obese (Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012).

To slow the increase in obesity, Oregon must take a comprehensive approach. The same framework for addressing tobacco use also applies to obesity. Monitoring obesity, obesity-related diseases, and healthy eating and active living policies; promoting healthy eating and active living; raising the price of unhealthful foods and lowering the price of healthful foods; and offering support for people to manage their weight are all necessary components of an effective obesity prevention strategy.

Chronic diseases account for approximately 85 cents of every \$1 spent on health care costs. For Oregon to achieve success with health system transformation and the Triple Aim of better health and better health care at lower costs, Oregon must reduce and prevent obesity.

# Health Priority 3: Slow the Increase of Obesity

## Health outcomes

Reduce the prevalence of asthma attacks, arthritis, cancer, diabetes, heart disease and stroke among children and adults.

## Measurable objectives

- Obesity prevalence will be maintained or reduced among:
- Adults to 30% or less (2010: 28%);
  - 11th graders to 10% or less (2009: 10%);
  - 8th graders to 11% or less (2009: 11%).

## 1 Strategy

Adopt and implement nutrition standards for foods and beverages sold in cafeterias, stores and vending machines in state agencies, schools and universities. This includes eliminating the sale of sugar-sweetened beverages.

Note: This was identified by the Health Equity Advisory Group as the obesity reduction strategy that provides the greatest opportunity to affect health equity.

| Performance measures  | Baseline                  | Target   | Responsible parties              |
|---|---------------------------|--|----------------------------------|
| Percentage of state agencies, schools and universities with written nutrition standards adopted or improved | State agencies, 0% (2012) | <ul style="list-style-type: none"> <li>• 100% of state agencies and universities have adopted nutrition standards for food sold or served (2017).</li> <li>• Schools improve their nutrition standard policies to include sports drinks and juices at school events (2017).</li> </ul> | Oregon Nutrition Policy Alliance |

## 2 Strategy

Reduce consumption of sugar-sweetened beverages by raising the price through a \$0.005 per ounce excise tax (going to \$0.01 per ounce).

Dedicate a portion of proceeds to reach recommended funding (\$22 million) for comprehensive efforts to reduce obesity and chronic diseases in adults and children, especially in populations experiencing disparities.

Note: Strategies include media campaigns and implementation of best and promising practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations.

| Performance measures                                 | Baseline      | Target   | Responsible parties              |
|--|---------------|--|----------------------------------|
| The amount of state tax on sugar-sweetened beverages | Not available | <ul style="list-style-type: none"> <li>• Sugar-sweetened beverages taxed (2017).</li> <li>• Funding allocated to obesity prevention (2017).</li> </ul> | Oregon Nutrition Policy Alliance |

### 3 Strategy

Secure dedicated funds to support active transportation projects, such as public transit, inter-city rail, and bicycle and pedestrian projects.

| Performance measures   | Baseline      | Target  | Responsible parties   |
|--|---------------|---|---|
| Secure \$50 million each biennium in dedicated funds to support active transportation projects outside of the road right of way, such as public transit, inter-city rail, and bicycle and pedestrian projects. | Not available | \$50 million (in state budget) dedicated annually (2017). | <ul style="list-style-type: none"> <li>• Oregon Department of Transportation Safe Routes to Schools program</li> <li>• Oregon chapters of the American Planning Association, American Institute of Architects and American Society of Landscape Architects</li> <li>• Sustainable Communities (HUD, EPA, USDOT) and Smart Growth Organizations</li> <li>• Local and statewide planning departments</li> </ul> |

### 4 Strategy

Promote and support physical activity throughout the work and school day for employees and students including accessible stairs, breaks for stretching, walking meetings, recess, physical education and after-school play time.

| Performance measures  | Baseline      | Target   | Responsible parties |
|---|---------------|--|---------------------|
| Note: Policy database is being developed to monitor this measure. | Not available | Number of institutions with policies promoting physical activity throughout the day increased by 100%. | To be determined    |

### 5 Strategy

Support efforts to fund the Farm to School, Farm to Institution and School Gardens Nutrition Programs through State Lottery funds.

Note: This was identified by the Health Equity Advisory Group as the obesity reduction strategy that provides the greatest opportunity to affect health equity.

| Performance measures                                       | Baseline      | Target   | Responsible parties    |
|--|---------------|--|------------------------|
| Amount of significant and/or sustaining legislation passed | Not available | <ul style="list-style-type: none"> <li>• Farm to School funding legislation renewed (2017).</li> <li>• Farm to Institution legislation developed.</li> </ul> | Upstream Public Health |

# IMPROVE ORAL HEALTH

## Background

Oral health affects overall health and can have a significant effect on the quality of life. Oral diseases can affect our ability to eat well, our appearance, how we communicate, and our productivity at work and school. Oral diseases, which can range from cavities to oral cancer, cause needless pain and disability.

Evidence shows that oral health complications lead to or worsen many general health conditions. Recent studies have linked infections in the mouth with heart disease, diabetes and autoimmune disorders. Among pregnant women, oral infections can increase the risks for premature delivery and low birth weight babies.

Healthy mouths are very important to child development. Poor oral health among young children affects speech, nutrition, growth, social development and quality of life. Dental decay is the most prevalent chronic condition among children — five times more common than asthma. Children with poor oral health have worse academic performance and are nearly three times more likely to miss school. Nationally, more than 51 million school hours are lost each year due to dental illness.

In Oregon:

- 58% of third graders had dental decay.<sup>1</sup>
  - 20% had untreated decay.
  - 10% had decay in permanent teeth.
  - 14% had decay in seven or more teeth.
- 76% of 11th graders had dental decay.<sup>2</sup>
  - 28% did not visit a dental provider in the previous year.
- 37% of adults had permanent tooth loss.<sup>3</sup>
  - 31% did not have a dental visit the previous year.<sup>4</sup>
  - 14% of those over age 65 had no teeth.
- 51% of women did not have a dental visit during pregnancy.<sup>4</sup>
  - 52% did not receive information about oral health during their pregnancy.
- 78% of toddlers (1 to 3 years of age) did not have a dental visit in the previous year.<sup>4</sup>
  - 60% did not receive fluoride.
  - 27% used bottles filled with something other than water

Most recent data available from:

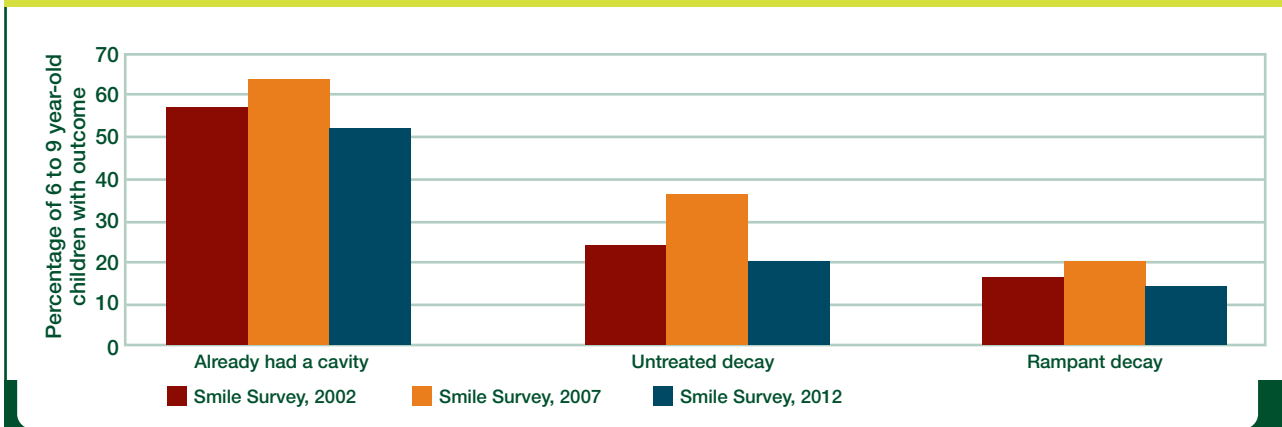
<sup>1</sup>2012

<sup>2</sup>2011

<sup>3</sup>2010

<sup>4</sup>2007

## Oral health status, \*6 to 9 year-old children, Oregon 2002–2012 Smile Surveys



SOURCE: OREGON SMILE SURVEY, 2002, 2007 AND 2012

Timely access to preventive dental care can reduce health care costs, while lack of care can lead to costly hospital emergency care. The number of dental-related emergency visits by Oregon’s Medicaid enrollees was 31% higher in 2010 than in 2008. Research shows that hospital care for a Medicaid enrollee costs nearly 10 times more than preventive care in a regular dental office (Pew Center on the States, 2012).

Oral health diseases are largely preventable. Effective behavioral interventions, such as good dental hygiene and regular visits to a dentist, and policy interventions, such as policies that increase access to fluoridated water, can help reduce the suffering and costs of oral diseases.

Early behavioral interventions include:

- Scheduling a child’s first dental visit by 12 months of age;
- Receiving oral health and nutrition education based on the child’s developmental needs (also known as anticipatory guidance), beginning prenatally;
- Reducing at-will consumption of liquids, beverages and foods containing fermentable carbohydrates (e.g., juice drinks, soft drinks, milk and starches), including no sugary liquids while a child is in bed and infrequent use of a training cup;
- Implementing proper oral hygiene as soon as the first tooth erupts;
- Checking the child’s teeth for white spots (evidence of beginning cavities);



- Ensuring access to fluoridated water and preventive dental sealants.

Effective interventions that do not rely on behavioral changes include:

- **Public water fluoridation:**  
Fluoridation produces a median decrease in caries<sup>2</sup> of 29.1% to 50.7% among children ages 4 to 17 years. In 2010, only 23% of Oregon’s water supplies were fluoridated to optimum levels.
- **School-based dental sealant programs:**  
School-based dental sealant programs produce a median 81% decrease in cavities in children (The Guide to Community Preventive Services, 2013). Dental sealant programs currently service approximately 69% of the eligible schools in Oregon.

<sup>2</sup>Early childhood caries is defined as the presence of one or more decayed, missing (due to caries) or filled tooth surfaces in any primary tooth in a preschool-age child between birth and 71 months of age. The American Dental Association (ADA) recognizes that “early childhood caries is a significant public health problem in selected populations and is also found throughout the general population” (ADA, 2013).

# Health Priority 4: Improve Oral Health

## Health outcomes

- Reduce the prevalence of decay in permanent teeth among third graders.
- Reduce the prevalence of older adults who have lost all their natural teeth.

## Measurable objectives

- Reduce the percentage first-grade through third-grade children with untreated tooth decay to 30% (2007: 36%).
- Increase the percentage of adults with any dental visit in the past year to 75% (2010: 70%).

1

### Strategy

Expand school-based dental sealant programs to reach more children.

| Performance measures   | Baseline   | Target  | Responsible parties   |
|--|------------|---|---|
| <p>Percentage of eligible schools with a dental sealant program</p> <p>Note: Eligible schools have at least 50% of students receiving free or low-cost school meals.</p> | 61% (2011) | 75% of eligible schools have a dental sealant program (2017). | <ul style="list-style-type: none"> <li>Schools</li> <li>Local organizations</li> <li>OHA Public Health Division Oral Health Unit</li> </ul> |

2

### Strategy

Encourage public water districts to optimally fluoridate water to reduce tooth decay.  
 Note: This was identified by the Health Equity Advisory Group as the oral health improvement strategy that provides the greatest opportunity to affect health equity.

| Performance measures   | Baseline     | Target  | Responsible parties  |
|--|--------------|---|--|
| Percentage of population residing in optimally fluoridated communities | 22.6% (2010) | 30% of the population reside in optimally fluoridated communities (2017). | <ul style="list-style-type: none"> <li>Local municipalities</li> <li>Local water districts</li> <li>General public</li> <li>County health departments</li> </ul> |

**3 Strategy** > Ensure that children have a preventive dental visit by age 1.

| Performance measures  | Baseline     | Target  | Responsible parties   |
|---|--------------|---|---|
| Percentage of children under 4 years old with a fluoride varnish application by a medical provider      | 1.6% (2009)  | 10% have a fluoride varnish application (2017).     | <ul style="list-style-type: none"> <li>• Family medical providers</li> <li>• Dental care organizations</li> <li>• Dentists</li> <li>• Caregivers</li> </ul> |
| Percentage of children under 4 years old receiving preventive oral health services by a dental provider | 17.6% (2009) | 25% receive preventive oral health services (2017). |   |

**4 Strategy** > Increase public knowledge about oral health by promoting accurate and consistent messages, including the link between oral health and overall health.

| Performance measures   | Baseline     | Target  | Responsible parties   |
|--|--------------|---|---|
| Percentage of women who received information on dental care during pregnancy             | 55.4% (2010) | 60% of women will receive information on dental care during pregnancy (2017). | <ul style="list-style-type: none"> <li>• Dental health providers</li> <li>• Oregon Dental Association</li> <li>• OHA Public Health Division Oral Health Unit</li> </ul> |
| Percentage of women who received advice on preventing child tooth decay                  | 33.5% (2010) | 50% of women receive advice on preventing child tooth decay (2017).           |   |
| Data developed for performance measure related to knowledge among the general population |              |   |   |

## 5 Strategy

Enhance oral health services provided through Federally Qualified Health Centers and School-Based Health Centers.

| Performance measures   | Baseline      | Target  | Responsible parties   |
|--|---------------|---|---|
| Percentage of Federally Qualified Health Centers with onsite dental services                   | Not available | Data to come.   | <ul style="list-style-type: none"> <li>Federally Qualified Health Centers</li> <li>School-Based Health Centers</li> </ul> |
| Percentage of School-Based Health Centers with a dental provider (dentist or dental hygienist) | 4.7% (2010)   | 15% of School-Based Health Centers have a dental provider (2017). |   |

## 6 Strategy

Within health systems, promote the inclusion of oral health in chronic disease prevention and management models.

| Performance measures   | Baseline      | Target  | Responsible parties   |
|--|---------------|---|---|
| Percentage of overweight children with untreated decay   | Not available | Oregon Smiles & Healthy Growth Survey data available (December 2012).                   | <ul style="list-style-type: none"> <li>Health systems</li> <li>Health care providers</li> </ul> |
| Percentage of adults with diabetes who visited the dentist, dental hygienist or dental clinic within the past year | 65.6% (2008)  | 70% visited the dentist, dental hygienist or dental clinic within the past year (2017). |   |

# REDUCE SUBSTANCE ABUSE AND OTHER UNTREATED BEHAVIORAL HEALTH ISSUES

## Background

According to the Substance Abuse Mental Health Services Administration (SAMHSA), behavioral health issues, including substance abuse and mental illness, substantially contribute to disease and premature death in Oregon. Behavioral health is a general term that encompasses the promotion of emotional health; the prevention of substance abuse and mental illness. The Oregon State Health Profile shows that Oregon's death rates are higher than those of the overall U.S. death rates for liver disease (28% higher) and suicide (36% higher). Suicide kills more people in Oregon than motor vehicle crashes. The majority of Oregon suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death. Efforts to treat behavioral health and reduce the abuse of alcohol, opioids (painkillers) and other drugs, will decrease deaths from liver disease and suicide and improve Oregonians' overall health.

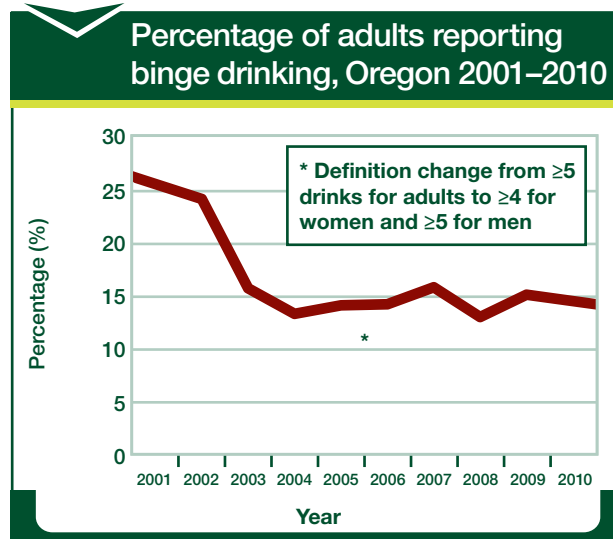
## Alcohol use

Age of first use of alcohol and alcohol dependency are closely related. Supporting youth to delay first use could yield immediate and long-term health benefits. Research shows that approximately four in 10 youth who first used alcohol by age 14 were diagnosed with alcohol dependency at some time in their lives. Only one in 10 people who first use alcohol at age 21 had that same risk.

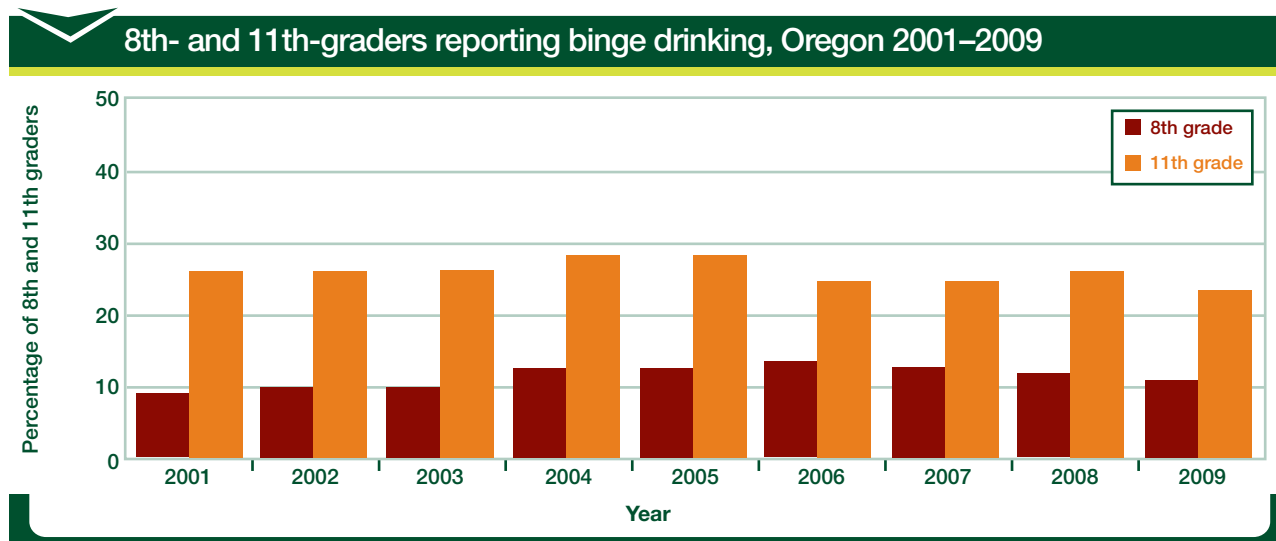
Alcohol use during pregnancy increases the risk of fetal alcohol spectrum disorder (FASD), the leading preventable cause of mental retardation. In Oregon, 51.7% of new mothers reported drinking alcohol before they knew they were pregnant and 8.7% consumed alcoholic beverages during their last trimester (Oregon Pregnancy Risk Assessment and Monitoring System, 2007). Pregnant women were advised to abstain from any alcohol use.

## Binge drinking

Binge drinking is a significant risk factor for injury, violence and chronic substance abuse. During 2010, 14.4% of adults reported binge drinking on at least one occasion during the past 30 days. Self-reported binge drinking declined from 2001 to 2004 but has not changed appreciably since that time. Males, in general, report binge drinking more frequently than women. Male binge drinking peaked (29.5%) in the 25–34-year age group; female binge drinking peaked (18.1%) in the 18–24-year age group.



SOURCE: OREGON BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

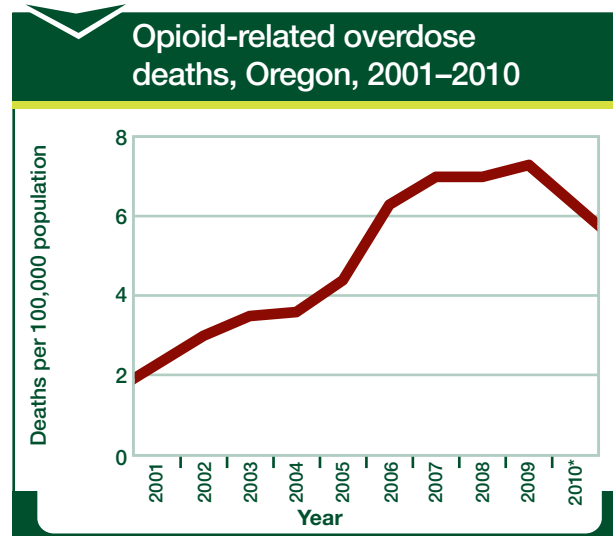


SOURCE: OREGON HEALTHY TEENS SURVEY

Among youth in 2009, 10.7% of Oregon eighth-graders and 23.4% of Oregon 11th-graders reported binge drinking in the past 30 days. Levels of binge drinking were similar among boys and girls (Oregon State Health Profile, 2012).

## Opioid-related overdose

Unintentional opioid-related overdose is one of the leading causes of injury mortality in Oregon, and has increased three- to four-fold during the past decade (from 69 total deaths during 2001 to 225 during 2010). The numbers of Oregonians killed in motor vehicle crashes have declined substantially during the past decade, but the numbers dying from opioid overdoses have been steadily increasing. Efforts targeted at patients who use opioids as well as clinicians who prescribe them are needed to address this emerging public health problem.



SOURCE: OREGON DEATH CERTIFICATE DATA  
NOTE: 2010 DATA ARE PROVISIONAL

Untreated mental illnesses cost the United States at least \$105 billion in lost productivity annually, including 35 million lost workdays each year, according to Harvard University Medical School research. In 2010 alone, 678 Oregonians died by suicide; the estimate of total lifetime cost of suicidal deaths was nearly \$680 million. Annual health care expenditures associated with fetal alcohol spectrum disorder totaled \$78 million (Oregon Department of Human Services, 2009).

Effective approaches to promote positive behavioral health include primary care screenings of substance use and mental health issues; culturally appropriate mental health care; population-based surveillance such as Oregon's Prescription Drug Monitoring Program; and policy interventions, including increased alcohol taxes and enhanced enforcement of laws prohibiting sales to minors.



# Health Priority 5: Reduce Substance Abuse and Other Untreated Behavioral Health Issues

**Health outcomes**

Reduce the prevalence injuries, suicide deaths, opioid overdose deaths and alcohol-induced diseases.

**Measurable objectives**

- **Alcohol-induced diseases** — Baseline: 14 per 100,000 (2012). Targets to be determined.
- **Reduction in underage binge drinking** — Baseline: 23% 11th Grade (2009), 11% 9th Grade (2009), 17.9% 18-24 (2010), targets to be determined
- **Alcohol-related motor vehicle transportation injuries** — Baseline: 44% of all MVT injuries (2004). Targets to be determined.
- **More behavioral health providers with language and cultural competency skills** — Baseline: 26.0% of Oregon physicians speak more than one language (2009); 93.2% of substance abuse treatment services provide counseling in Spanish, 8.1% in American Indian/Alaska Native languages and 16.2% in other languages. Targets to be determined.
- **Reduce opioid overdose mortality** — Baseline: 6 per 100,000 (2010). Targets to be determined.
- **Any reported alcohol use during pregnancy** — Baseline: 53.6% first trimester, 6.9% third trimester (2010). Targets to be determined.

**1 Strategy**

Start a formal, cross-sectoral (including representatives from behavioral health, public health, education and youth groups) planning process to develop a unified policy/systems change agenda for alcohol abuse prevention with emphasis on:

- Adolescents (aged 10 to 24) and young adults (ages 18 and older);
- Alcohol prevention in pregnant women;
- Community-school climate.

| Performance measures   | Baseline             | Target                            | Responsible parties   |
|--|----------------------|-----------------------------------|---|
| <p>Diverse and representative group of key stakeholders (including clients and survivors) convened to develop the action plan.</p> <hr/> <p>Actionable plan developed.</p> | <p>Not available</p> | <p>Plan complete (June 2013).</p> | <ul style="list-style-type: none"> <li>• OHA Public Health Division</li> <li>• OHA Addictions and Mental Health</li> <li>• Oregon Department of Education</li> <li>• Oregon Health &amp; Science University</li> <li>• Oregon Research Institute</li> </ul> |

## 2 Strategy

Conduct political feasibility assessments to determine the overall political feasibility of increasing beer and wine taxes with funding for law enforcement, treatment and prevention.

| Performance measures | Baseline      | Target                          | Responsible parties                  |
|----------------------|---------------|---------------------------------|--------------------------------------|
| Completed study      | Not available | Study complete (December 2014). | Drug and alcohol prevention partners |

## 3 Strategy

Collect and analyze baseline data on the availability of culturally and language-competent behavioral health providers.

Note: This was identified by the Health Equity Advisory Group as the substance abuse and untreated behavioral health issues reduction strategy that provides the greatest opportunity to affect health equity.

| Performance measures | Baseline     | Target        | Responsible parties              |
|----------------------|--------------|---------------|----------------------------------|
| Completed study      | January 2015 | Not available | OHA Addictions and Mental Health |

## 4 Strategy

Support CCOs in maximally integrating substance abuse, behavioral health and physical health; screening and brief intervention at the primary care level; provider training on resources and education.

| Performance measures  | Baseline      | Target               | Responsible parties  |
|---|---------------|----------------------|--|
| Percentage of members over 12 years of age with routine visits screened and referred as necessary | Not available | 10% increase (2014). | <ul style="list-style-type: none"> <li>• OHA Addictions and Mental Health</li> <li>• OHA Transformation Center</li> <li>• Coordinated care organizations</li> <li>• OHA Medical Assistance Programs</li> </ul> |

## 5 Strategy

Establish and promote statewide best practices for the treatment of chronic non-cancer pain; promote wellness activities for health and wellness.

| Performance measures            | Baseline      | Target   | Responsible parties   |
|---------------------------------|---------------|--|---|
| Establishment of best practices | Not available | Decrease in number of opioids prescribed (2014). | <ul style="list-style-type: none"> <li>• Oregon Prescription Drug Monitoring Program</li> <li>• Oregon Medical Association</li> <li>• Lines for Life</li> <li>• Board of Medical Examiners</li> </ul> |

# Conclusion and special thanks

## CONCLUSION

This plan outlines strategies for our communities to work together to improve health. Oregon's Healthy Future is a living document. While the priorities are clear, the methods for addressing each of them will evolve over time. Groups recognize this potential collective effort as a powerful means to improve critical health indicators. Across the state, diverse stakeholders are working together to better understand and outline ways to achieve health equity and to support lifelong health.

As the numbers of those engaged in this effort grow, we envision a future where *every* community is empowered to improve the lifelong health of all people in Oregon.

## SPECIAL THANKS

A special thank you goes to Mosbaek Consulting and Agnew::Beck, which provided consultation and direction to the Oregon's Healthy Future plan. The Oregon Health Authority and Rede Group appreciate and value the collaborative effort it took to create this plan.



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Engage Plan Implement



# Appendix

## APPENDIX 1: Planning process

The process for developing Oregon's Healthy Future was built upon the work of recent planning processes, most importantly the 2010 Oregon Health Improvement Plan. The Oregon Health Policy Board convened a 26-member Oregon Health Improvement Plan Committee (OHIPC) in January 2010 and charged it with developing a 10-year overarching plan to improve Oregonians' health through reducing chronic disease. OHIPC members represented schools, tribes, academia, government agencies, businesses and communities throughout the state. They were legislatively directed to focus on the prevention and management of chronic disease. The committee conducted a large-scale community feedback and engagement process, a detailed review of Oregon's public health data, and a rigorous review of the literature around evidence-based practices for improving population health.

### Overview of 2010 Oregon Health Improvement Plan planning process

- Committee appointments (January 2010);
- 10 committee meetings (from March 30 to Oct. 8, 2010);
- Eight community listening sessions (summer 2010);
- Website Community Input Survey for those not able to attend a listening session (summer 2010);
- Public input through a website for review of final draft (fall 2010);
- Presentation to Oregon Health Policy Board (Nov. 9, 2010);
- Final report (December 2010).

The 2010 Oregon Health Improvement Plan Committee used a set of guiding principles to direct its work throughout the development of the plan:

- Focusing on prevention;
- Using evidence and data;
- Advancing health equity;
- Addressing social, economic and environmental factors;
- Respecting cultures and traditions;
- Empowering local communities;
- Creating short- and long-term policy actions.

As a result, the plan focused on chronic disease prevention and outlined a broad spectrum of policies and interventions to improve lifelong health (available at <http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/OregonHealthImprovementPlan/Pages/index.aspx>).

## Overview of 2012 Oregon’s Healthy Future planning process

In developing the 2012 Oregon’s Healthy Future plan, The Oregon Health Authority Public Health Division and the planning advisory group sought to:

- Seek additional community feedback to ensure timeliness of information;
- Review the full spectrum of public health issues and problems; and
- Create a five-year Statewide Community Health Improvement Plan.

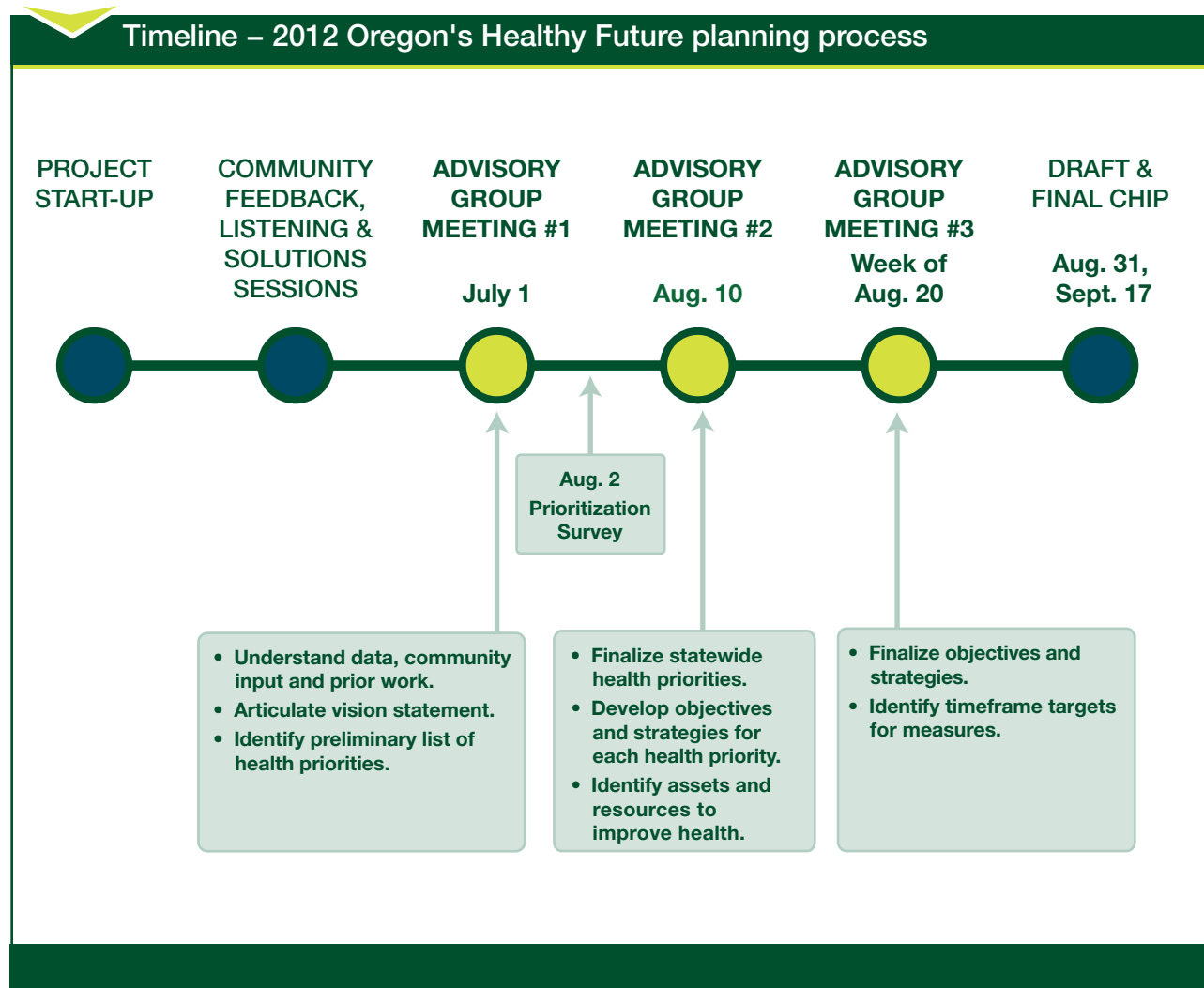
Two community listening, feedback and solutions work sessions were conducted in June and July 2012 as part of the community input process for Oregon’s Healthy Future. The purpose of these work sessions — held in Portland and La Grande — was to gather community perspectives on Oregon’s state of health. This outreach effort was intended to build upon the community input collected in 2010 for the Oregon Health Improvement Plan (OHIP). Approximately 300 people representing all regions of the state participated in the 2010 process through a series of statewide public meetings and an online survey; an additional 20 Oregonians took part in the 2012 work sessions.

Details of the community input from these engagement processes are summarized in appendices 2 and 3. The 2012 public engagement process requested feedback from communities on Oregon’s health indicators as well as on the health indicators from the World Health Organization’s Healthy Cities initiative.

Together, these community engagement processes were vital to following the Mobilizing for Action through Planning and Partnership (MAPP) process, which entails including a “community themes and strengths assessment [to] provide a deep understanding of the issues that residents feel are important.”

This input and state health indicators data were then summarized and shared with the advisory group. This data included a statewide community health assessment recently conducted by the Oregon Health Authority Public Health Division that included comprehensive Oregon Public Health Division System Assessment of state resources that can be mobilized to address identified health challenges; and a State Health Profile that presents information on selected health indicators and offers a snapshot of Oregonians’ health status. (Both the assessment and profile are available at [www.healthoregon.org/about](http://www.healthoregon.org/about).) The State Health Profile was a central focus of discussion and decision making.

In a series of three facilitated meetings and an in-depth online survey of advisory group members, health priority areas were identified and specific strategies and outcomes recommended.



# APPENDIX 2:

## Community engagement

### Themes from the 2010 OHIP process

Participants in the 2010 outreach process were asked the following questions in a public meeting and online survey:

- What are the issues in your community that have the greatest impact on your health and that of others in the community?
- What is happening in your community that promotes health and supports a thriving community?
- What three to five changes in policy would make your community healthier and thrive?

From these discussions, the following main themes were identified and used to shape recommendations in the 2010 OHIP:

- Access to nutrition;
- Access to health care;
- Good transportation;
- Adequate funding and programs;
- Improved physical activity.

Additionally, poverty, joblessness and homelessness were identified as pressing underlying socio-economic issues that negatively affected health.

### Themes from the 2012 community listening, feedback and solutions process

The main themes emphasized by participants in the 2012 work sessions are summarized below and illustrated in Appendix 3 and 4.

Themes repeated from 2010 included funding, access to health care, nutrition and addressing chronic diseases. New emphasis was placed on collaboration, mental health, providing for vulnerable populations, air quality, youth and teens, and promoting an overall healthy community and lifestyle.

### Broad understanding of health

Participants uniformly viewed health as more than health care. In their view, health considers not only primary care and behavioral health, but also active lifestyles and access to quality foods, jobs, shelter and safety. Social equity and equal access for all people to the conditions necessary for a healthy life were especially important.



## The importance of collaboration

The ability to remove barriers to collaboration was another major theme of the sessions. These barriers sometimes take the form of lack of communication or lack of knowledge sharing among programs and communities throughout the state. Participants felt that a forum for a better understanding of what other communities, providers and programs are doing would be very beneficial. But bureaucratic and funding barriers also exist. Likewise, who is responsible for what, concerns over sharing funding, and hesitancy to try new or experimental approaches to health were commonly cited as barriers to resolving pressing issues. Session participants strongly recommended identifying and removing these barriers, and involving communities in the developing solutions.

## Developing compassionate communities

Participants spoke about several programs, policies and practices that would contribute to — as one participant said — developing “compassionate communities.” Compassionate communities are ones in which fellow members of the community are encouraged to be concerned about, reach out to and care about one another. They are communities in which it is easy to find ways to volunteer, reach out to neighbors who are at risk and offer different levels of support.

## Health is severely underfunded

Nearly every participant commented on the level of public health funding that Oregon budgets. While participants recognized that funding is a common issue in the field of public health, nationally, Oregon’s funding level is particularly low. Participants felt strongly that a change in Oregon’s funding levels would result in significant improvement of public health throughout the state.

## Focus on youth

Session participants agreed that promoting and protecting the health of youth populations was a priority across the board, from pre-natal to infant to school-aged, teen and young adult groups. Participants discussed a number of specific programs and practices on this topic.

## Address chronic diseases

In addition to the new ideas noted above, participants strongly supported continuing to address issues of chronic disease, particularly the underlying health habits that increase its incidence.

Each theme identified in the 2010 and 2012 community engagement processes is addressed through one or a combination of the identified health priorities and strategies.

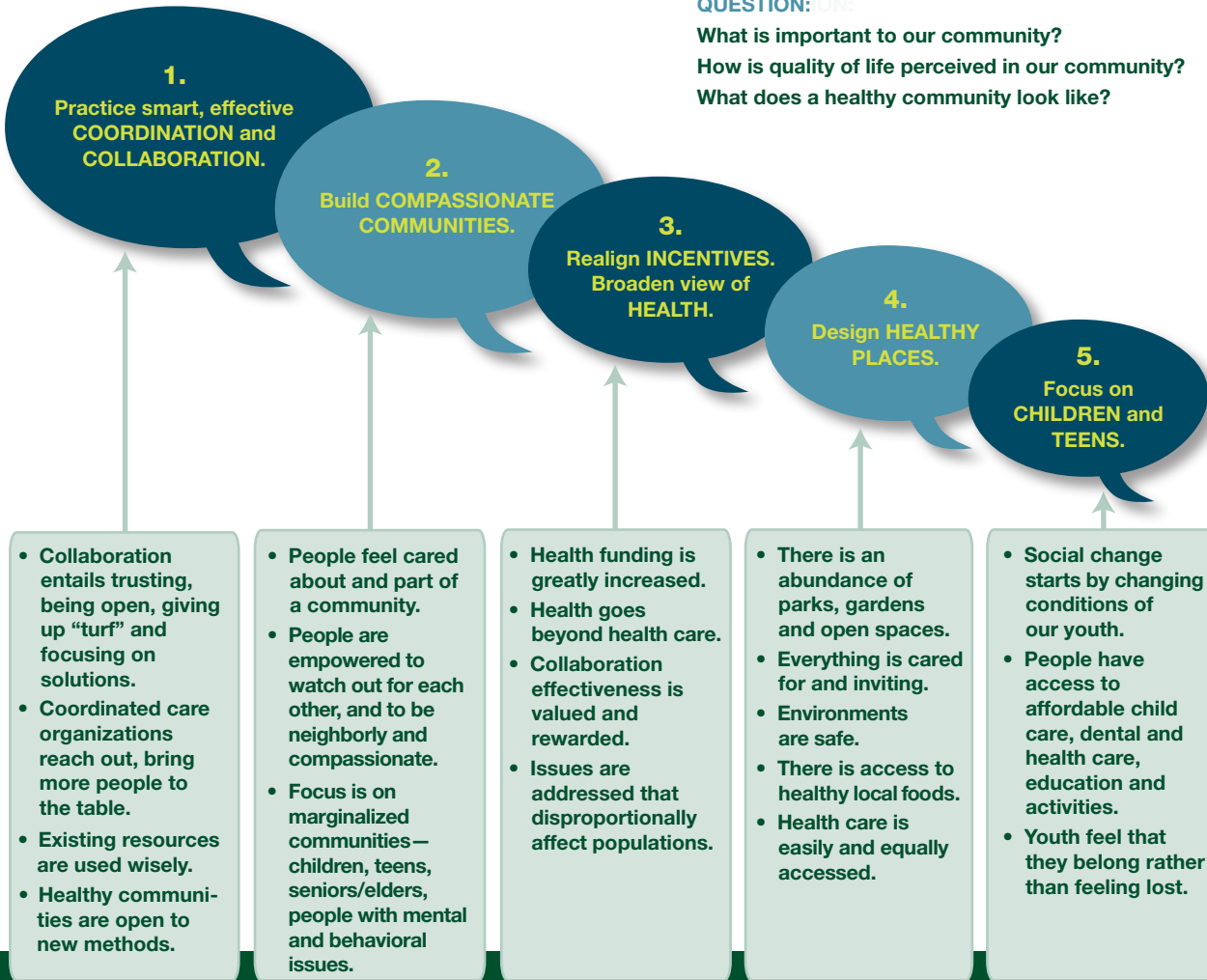
# APPENDIX 3: Portland community engagement themes

## Portland community feedback and solutions sessions

### VISION

**QUESTION: ON:**

What is important to our community?  
How is quality of life perceived in our community?  
What does a healthy community look like?

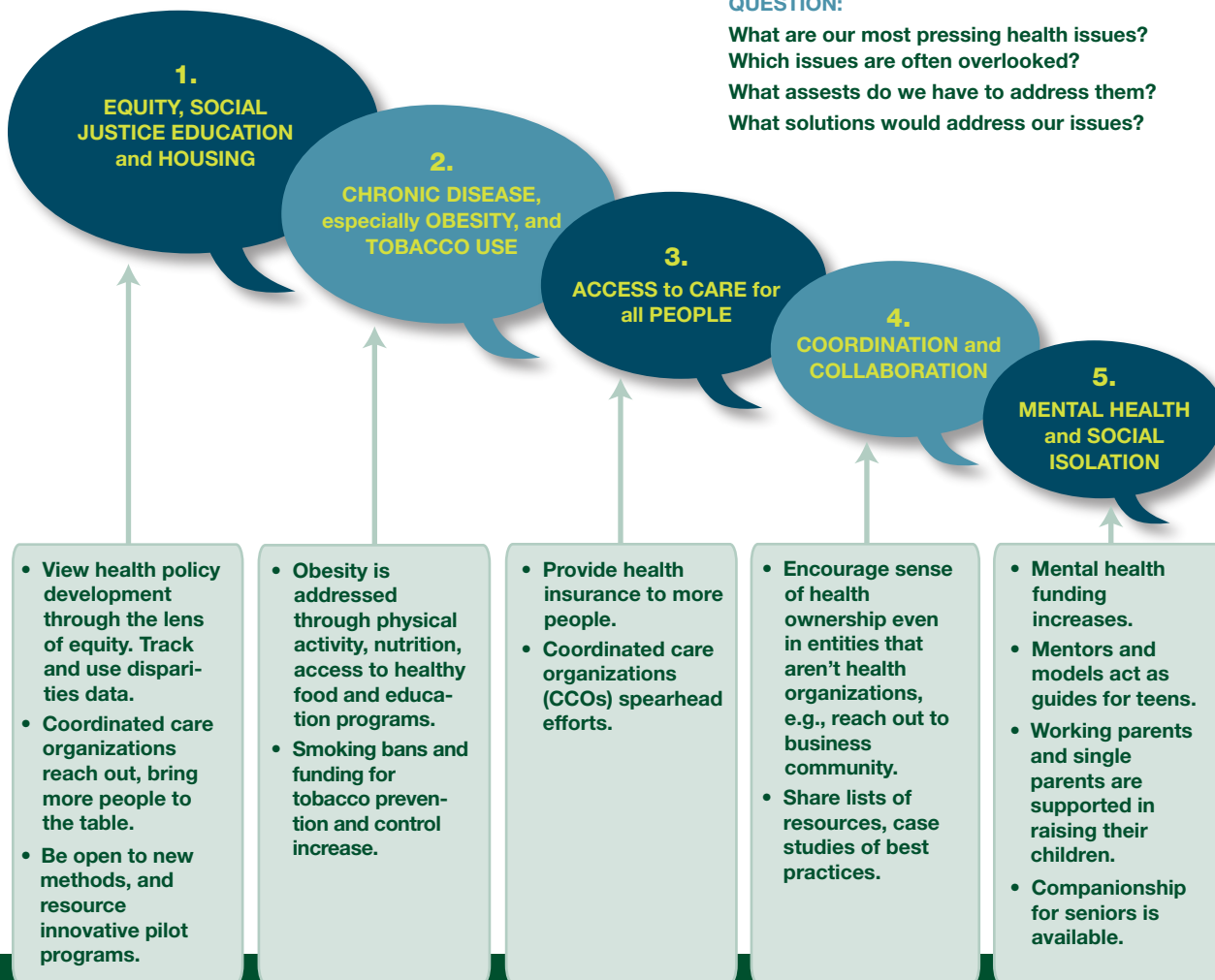


Statewide Community Health Improvement Plan 2012

## SOLUTIONS to KEY ISSUES

**QUESTION:**

What are our most pressing health issues?  
 Which issues are often overlooked?  
 What assets do we have to address them?  
 What solutions would address our issues?



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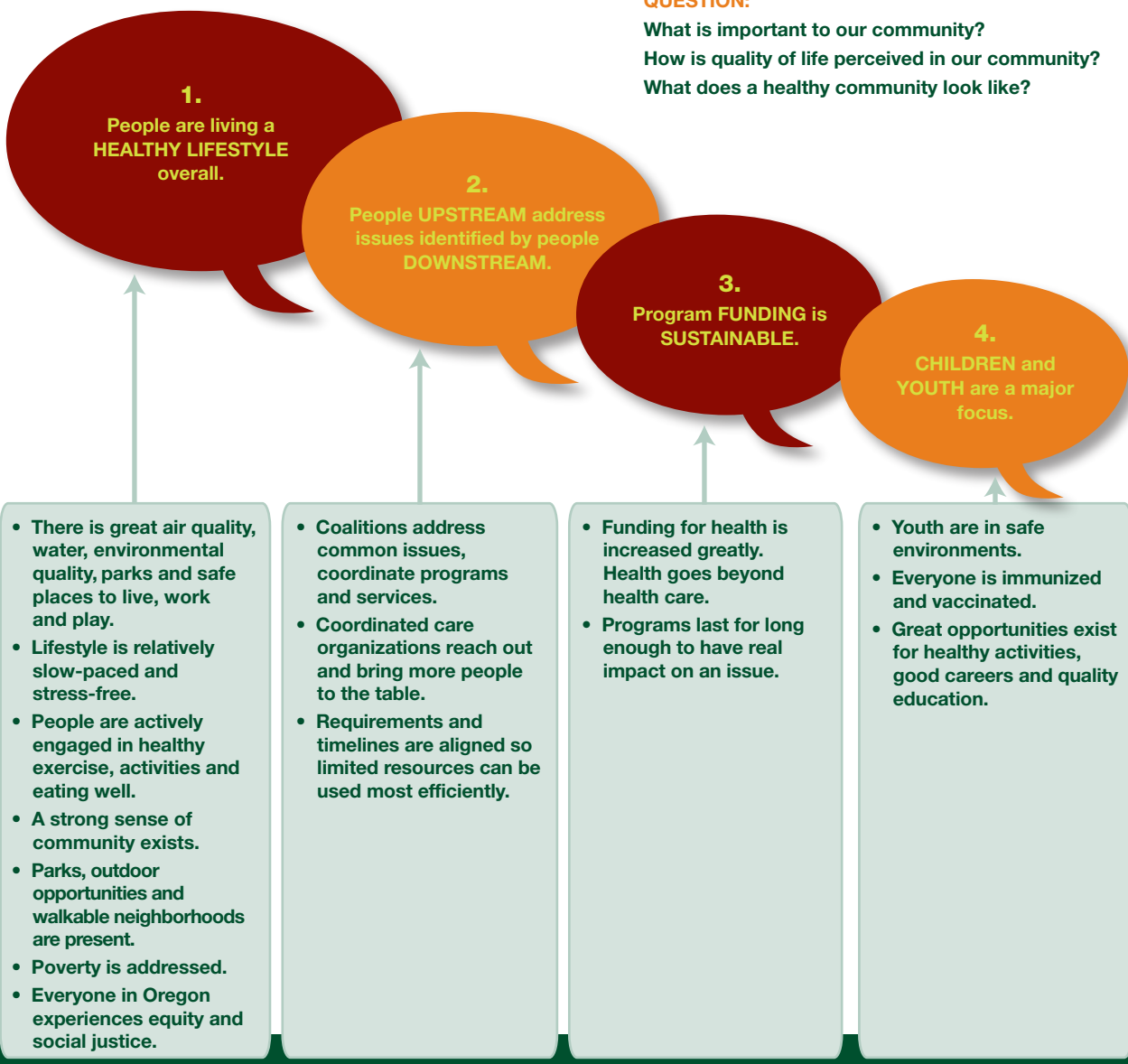
# APPENDIX 4: La Grande community engagement themes

## La Grande community feedback and solutions sessions

### VISION

**QUESTION:**

What is important to our community?  
How is quality of life perceived in our community?  
What does a healthy community look like?

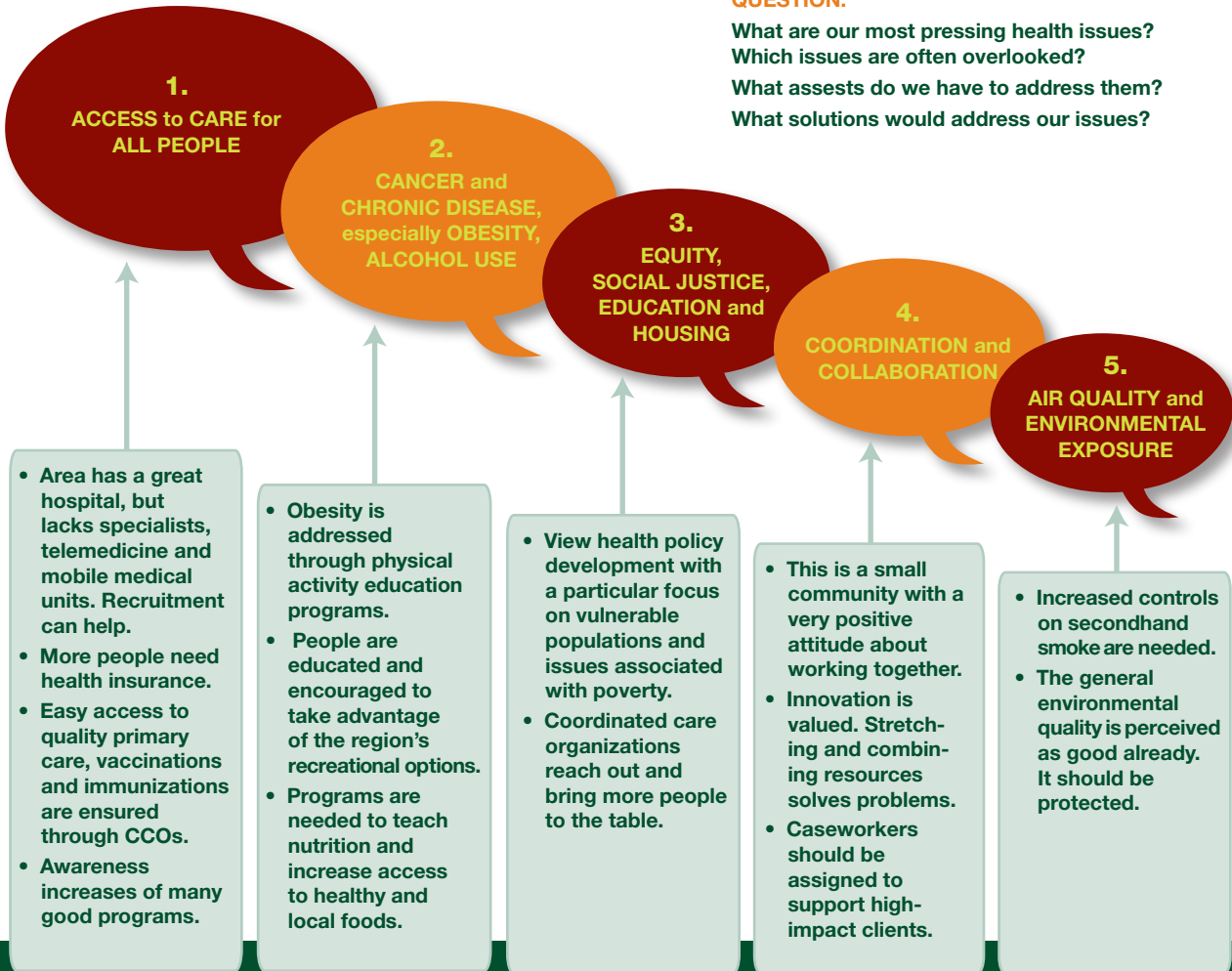


Statewide Community Health Improvement Plan 2012

## SOLUTIONS TO KEY ISSUES

**QUESTION:**

What are our most pressing health issues?  
 Which issues are often overlooked?  
 What assets do we have to address them?  
 What solutions would address our issues?



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