Lane County's Healthy Future

Version 1.0

A Plan for Empowering the Community

A Community Health Improvement Plan for

Lane County, Oregon

April 2013

Prepared by Jennifer Jordan, MPH

Lane County Public Health

HEALTH EQUITY

TOBACCO FREE CAMPUS

We CARD because we CARE

VACCINE

LANE COUNTY OREGON

PeaceHealth

Trillium Community Health Plan

LIVE UNITED

United Way

United Way of Lane County

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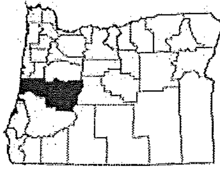


Lane County, Oregon

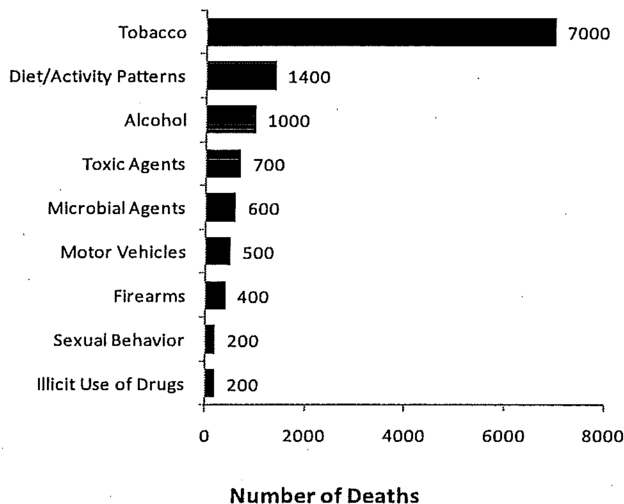
Executive Summary

WELCOME TO LANE COUNTY'S HEALTHY FUTURE!

Lane County has a strong foundation as a healthy community built around abundant natural resources, collaboration across organizations, hardworking residents, caring neighbors, and innovation. We are proud of these assets, but we know there is still much work to be done.

Even though there has been decades of progress in reducing disease and early death, tobacco use continues to be the leading preventable cause of death and disease in Lane County; obesity and diabetes affect more people every year; rates of substance abuse and poor mental health are of serious concern; and access to health care remains a challenge for many. Additionally, health inequities persist for communities of color, low-income populations, sexual minorities, and others. These are complex challenges. Addressing them successfully requires resources, effort, innovation and participation from everyone.

Actual Causes of Death in Oregon*



*Risk factors or the **actual** reasons people die. For example, tobacco smoking is the most common actual cause of death from lung cancer. These data are crucial for monitoring the reasons why people die and for targeting where, when, and how health resources should be expended to reduce morbidity and early mortality.

This Lane County wide community health improvement plan is the product of a collaborative effort by Lane County community members, Lane County Public Health, PeaceHealth, Trillium Community Health Plans (Lane County's Coordinated Care Organization coordinating health care for local Medicaid beneficiaries), and the United Way of Lane County. In order to collaboratively develop this community health improvement plan, the team led an extensive community health assessment and community health improvement planning process over the last year (May 2012-April 2013). Please see the companion document, Lane County's Community Health Assessment Version 1.0, for further details on the process and data collected.

Based on the review of local public health data, it was found that there are more similarities than differences in the health of Lane County residents and that of the rest of the state. For this reason, and in order to align efforts at the state and local level to increase impact, the local team has worked to closely match our community health improvement plan priorities and strategies with those included in the State of Oregon's health improvement plan. We would like to thank the state's community health improvement planning team for their leadership in this work. In addition to aligning priority areas and strategies, much of the background language for each of the five health priority areas in this plan was pulled directly from the State of Oregon's Health Improvement Plan (The 2012 Oregon's Healthy Future, Version 1.0; A Plan for Empowering Communities). We would also like to credit the state team for the work they have done in drafting that and other language we have borrowed from their plan.

Based upon the review of local community health data from a variety of sources, these five priority areas are offered to focus the attention and work of policy-makers and public, private and nonprofits organizations over the course of the implementation of this three year plan (July 2013 – June 2016):

1. Advance and Improve Health Equity
2. Prevent and Reduce Tobacco Use
3. Slow the Increase of Obesity
4. Prevent and Reduce Substance Abuse and Mental Illness
5. Improve Access to Health Care

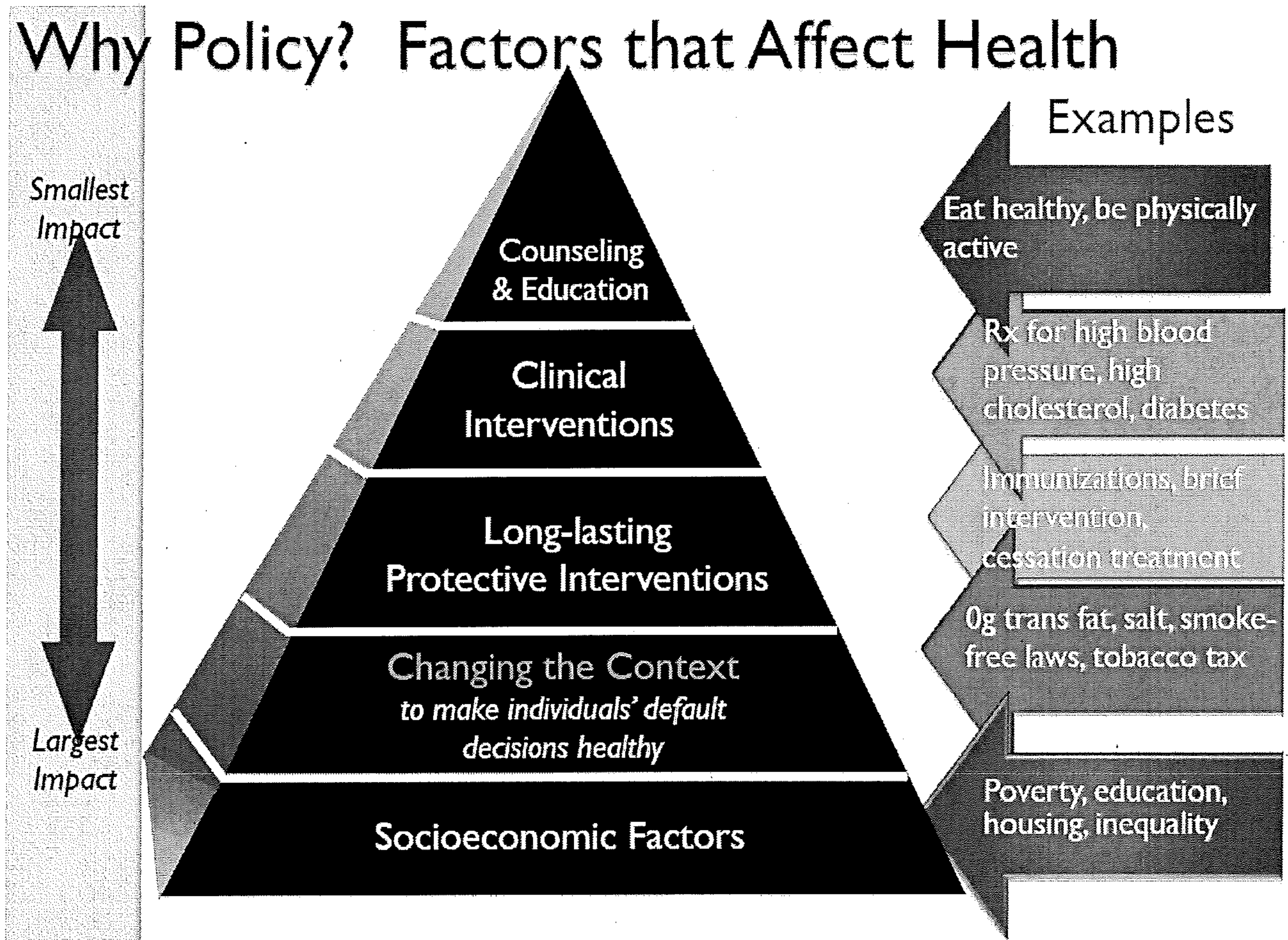
These priorities were chosen based on which accomplishments would offer the greatest improvements in lifelong health, advance health equity, and promote equal access to conditions

that allow people to be healthy. This plan outlines improvement strategies that will address each of these priorities and allow us to advance toward our vision.

While this plan outlines key areas for action over the next 3 years, Lane County's Healthy Future Version 1.0 is a living dynamic document. While the priorities are clear, the details of the means of addressing them will be further developed and evolve and grow over time.

We envision a Lane County where everyone in the community is empowered to participate in efforts to improve the lifelong health of all people in the community. Through this effort, we will work to raise awareness that working toward better health is not just the job of the individual. There are many things we can do at the community and organizational level to ensure that, when residents decide to live healthier, the systems and people around them support and encourage that decision. These changes to the environments where we live, learn, work, and play will make it easier for everyone in the community to achieve better health and improve health equity.

Background & Introduction/Framework



Socioeconomic Factors:

The community health assessment and community health improvement team was encouraged by the level of community interest expressed in efforts that focus on the "social determinants of health". Work in this area would fall into the bottom and most impactful level of the pyramid above – Socioeconomic Factors. Work in this area – e.g. poverty reduction, ensuring access to affordable housing, increasing formal educational attainment at the community level – has generally been outside the purview of public health interventions. The community health assessment and community health improvement plan leadership team looks forward to supporting and coordinating community efforts to engage in work in this area. Our top priority - advancing and improving health equity - an element in this work plan still at a very early stage of development, will be a place to focus work in this area. Work in each of the four other priority areas will also be prioritized to focus community energy on efforts with the greatest potential to improve health equity.

Changing the Context to Make Individuals' Default Decisions Healthy:

The majority of the strategies in this plan focus on efforts to encourage public and organizational policy adoption and implementation here in Lane County. As depicted in the visual above developed by Dr. Thomas Frieden, MD, MPH, the Director of the U.S. Centers for Disease Control and Prevention (CDC), it is at the lower levels of the pyramid where we can expect the greatest impact for the effort exerted. This is true both in terms of the resources necessary to lead the intervention and on the impacted community members.

According to CDC Director Dr. Thomas Frieden:

> "Public action and interventions represented by the base of the pyramid require less individual effort and have the greatest population impact."..."Interventions at the top tiers are designed to help individuals rather than entire populations, but they could theoretically have a large population impact if universally and effectively applied. In practice, however, even the best programs at the pyramid's higher levels achieve limited public health impact, largely because of their dependence on long-term individual behavior change"(A Framework for Public Health Action: The Health Impact Pyramid, *American Journal of Public Health,* April 2010, Vol 100, No 4, pages 590-595). [A complete PDF of this article is available online free of charge].

Because public health is inherently political, unless we build community understanding and support for work at the lower levels of the pyramid, we cannot expect to gain the level of support necessary to encourage the policy changes needed to get ahead of health problems of this

complexity. It is not the intent of this plan to devalue or ignore the importance of working at all levels, in fact Dr. Frieden argues that implementing interventions at each of the levels can lead to maximum sustained impact. This plan instead works to direct limited community attention and resources to efforts where we can expect to achieve the greatest community health benefit. Interventions at the top of the pyramid are better understood and don't require as much leadership support to implement.

To quote Dr. Frieden again: "The biggest obstacle to making fundamental societal changes is often not a shortage of funds but lack of political will; the health sector is well positioned to build the support and develop the partnerships required for change".

HEALTH PRIORITY ONE:

ADVANCE AND IMPROVE HEALTH EQUITY

Background

Health equity has been identified as the first and most important health priority in this plan. In addition to stand-alone work in this area, health equity is to be incorporated into each of the other four health priorities in this plan- tobacco, obesity, substance abuse/behavioral health and access to health care. Impacts on health equity were considered in the selection of health improvement strategies for these other four priorities. When data are available, each of the measurable objectives, performance measures, and health outcomes should be analyzed by race/ethnicity, geography, income, educational attainment, language spoken, sexual orientation, disability status, and other population characteristics that can be associated with health disparities. This workplan will also support efforts to improve data collection efforts in this area so that we are better able to demonstrate health equity improvements.

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.

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.[1]

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 Indians/Alaska Natives (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.

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.

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[1] LaVeist TA, Gaskin DJ, Richard P. The Economic Burden of Health Inequalities in the United States.2009.http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf

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.

Over the first six months of implementation of this plan, a community-wide Health Equity Advisory Group will be established. During this time, the team will also participate in related training and a facilitated process to further develop improvement strategies, performance measures and targets in this area for the remaining two and a half years of this three-year plan (through June of 2016).

Health Priority #1: Improving Health Equity	
Health outcomes	Age-adjusted death rates by race/ethnicity
Measurable Objectives	A few examples of baseline data the state is considering and which we might also consider (additional work in this area to be completed by to-be-established Health Equity Advisory Group) **High school graduation rates by race/ethnicity – baseline state data (2010), targets to be determined** 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 birthweight babies by race/ethnicity – baseline state data (2010), targets to be determined** 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 state data (2005), targets to be determined** African American 2,930 Hispanic 573 White 502		
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
Strategy 1: Examine the implementation of all Community Health Improvement Plan strategies through an "equity lens" to assess any disproportionate impacts on specific populations and make any necessary modifications to improve health equity	TBD by Health Equity Advisory Group	TBD by Health Equity Advisory Group	CHIP Leadership Team, Health Equity Advisory Group, all people and organizations working on the underlying health priority

Health Priority #1: Improving Health Equity

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
Strategy 2: Increase CHIP Leadership Team's and other community leaders and stakeholders understanding of health disparities in order to build capacity to address disparities	TBD by Health Equity Advisory Group	TBD by Health Equity Advisory Group	CHIP Leadership Team, Health Equity Advisory Group, all people and organizations working on the underlying health priority
Strategy 3: Engage diverse communities in policy initiatives to help ensure that the impacts on health equity are considered when implementing policies			
Strategy 4: Increase the capacity of Lane County's diverse populations to participate in community health improvement activities			
Strategy 5: Collaborate with educational institutions and employers to diversify the workforce in health-related fields			

Health Priority #1: Improving Health Equity			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
Strategy 6: Increase the level of cultural competency of the workforce in health-related fields	TBD by Health Equity Advisory Group	TBD by Health Equity Advisory Group	CHIP Leadership Team, Health Equity Advisory Group, all people and organizations working on the underlying health priority
Strategy 7: When determining priorities for improving health, set measurable goals for reducing health disparities			
Strategy 8: Ensure that health information systems include data on race/ethnicity and other characteristics (e.g. rural, urban, income and educational attainment) necessary to monitor health equity			
Strategy 9: Disseminate lessons learned			

HEALTH PRIORITY TWO:

PREVENT AND REDUCE TOBACCO USE

Background

Tobacco use remains the number one cause of preventable death in Lane County, in Oregon and the nation. Tobacco kills about 7,000 Oregonians each year and nearly 700 people a year in Lane County alone. About 800 additional deaths are caused by secondhand smoke each year across the state.

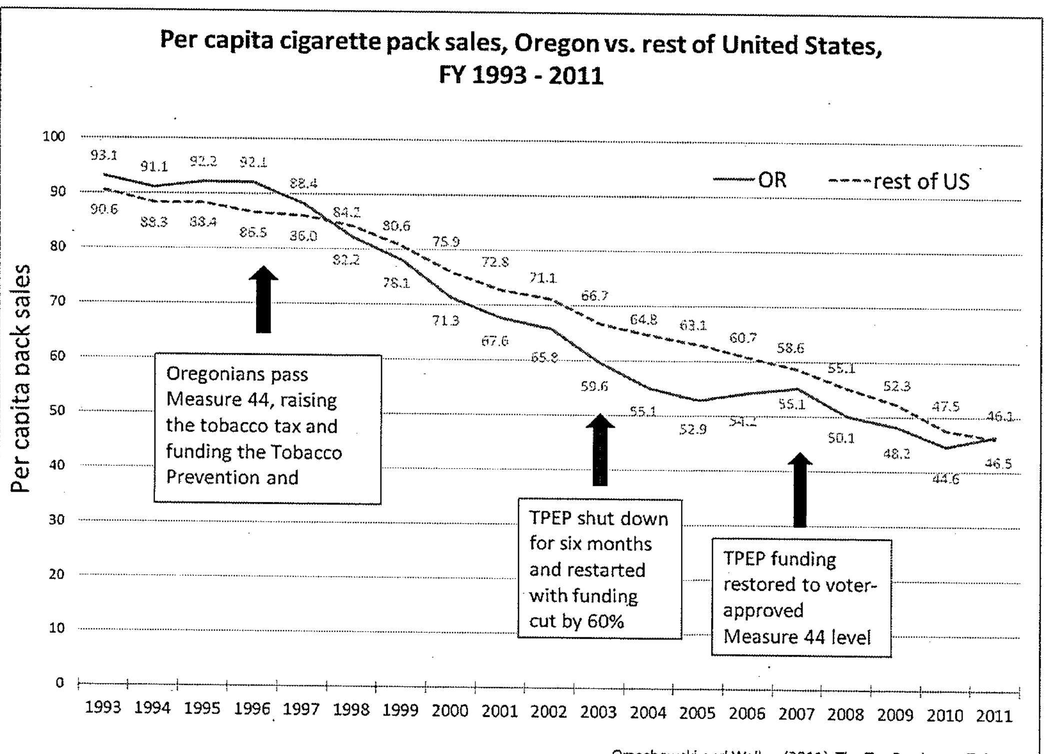
In order to get a sufficient sample size, it is often necessary to combine multiple years of county-level data. Data availability can also lag behind a few years depending upon sample size, participation levels, and data analysis resources. The data below were the most recent data available at the drafting of this report. All data are either from the 2011 Oregon Tobacco Facts & Laws report or the Oregon BRFSS County Combined Dataset for 2008-2011

- 18.1% of Lane County adults smoked cigarettes 2008-2011 (state rate during this period was 16.3%)
- 15% of Lane County 11th graders reported smoking during the 2007-2008 school year
- 8.4% of 8th graders reported smoking during the 2007-2008 school year
- 14.3% of pregnant women reported prenatal tobacco use in 2003-2007 (state rate during this period was 12.2%)
- 47% of Lane County adults reported trying to quit each year from 2008-2011

Tobacco use costs Oregon more than $243 million annually in direct medical expenditures and indirect costs due to premature death. At the state level, treating smoking-related disease costs Oregon Medicaid $374 million per year. In 2011, Oregon smokers paid an average of $5.41 per pack, in contract with the true cost to society of $13.97 per pack (Oregon Tobacco Facts & Laws, 2011).
Almost every chronic disease is either caused, or worsened, by tobacco. Chronic diseases account for approximately $0.85 of every $1.00 spent of health care costs. For Lane County to achieve success with health system transformation and the Triple Aim components of better health and health care at lower cost, Lane County must reduce tobacco use and exposure to secondhand smoke.

To reduce tobacco use, Lane County must take a comprehensive approach. To provide a framework for a comprehensive tobacco control program, the World Health Organization created the MPOWER framework. The US Centers for Disease Control and Prevention and the Oregon Public Health Division have adopted and provide technical support to local jurisdictions in the implementation of this framework. The strategies below represent the application of this framework to Lane County's current status.

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.



The MPOWER framework is not well known or broadly understood by community leaders in Lane County. Over the first six months of the implementation of this plan the community health assessment and community health improvement leadership team will organize a series of training events to build community leaders and decision makers understanding of this framework.

Tracking and Monitoring Policy, Systems and Environmental Change

The performance measures recommended in the table below will be tracked by Lane County Public Health's Tobacco Prevention and Education Program staff and shared with the local community health improvement plan leadership team, the community and the Oregon 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 active living. Components of the database include, but are not limited to:

- Type of policy
- Data policy adopted and implemented
- Population-reach
- Jurisdiction
- Contact Information

Health Priority #2: Prevent and Reduce Tobacco Use	
Health outcomes	Reduce the prevalence of asthma, arthritis, cancer, diabetes, heart disease, and stroke among children and adults
Health equity focus	Ensure that policy, systems and environmental strategies are prioritized to address specific populations (e.g. racial and ethnic minorities, pregnant women, people with mental illness, low income people, LGBT community) and reduce health disparities

Measurable Objectives	**Reduce the percentage of adults who smoke** • **Baseline:** 18.1% (2008-2011 BRFSS) **Reduce the percentage of 8th and 11th graders who smoke** • **Baseline:** 8th graders: 8% (2007/2008, OHT) • **Baseline:** 11th graders 15% (2007/2008, OHT)		
Strategy 1: Build community leaders and decision makers understanding of the WHO MPOWER framework for tobacco control, the history of tobacco control in Lane County and the strategies below	Key community leaders and decision makers understand and support local implementation of the WHO MPOWER framework for tobacco control	Key leaders and decision makers participate in a process to build understanding of the WHO MPOWER framework	CHIP leadership team
Strategy 2: Engage in efforts to encourage support for statewide legislation to increase the price of cigarettes by $1/pack excise tax (and 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	• The amount of state tax on a pack of cigarettes • Allocations to the Tobacco Use Reduction Account are secured	• $2.18 tax/pack **Baseline:** $1.18 (2013) • Approximately $20 million annually allocated to the Tobacco Use Reduction Account **Baseline:** $12.5 million (2009-2011 Biennium)	CHIP leadership team, Tobacco-Free Lane County Coalition, new community leader champions to be developed, Statewide tobacco control advocacy partners: American Heart Association, American Cancer Society, and American Lung Association, Campaign for Tobacco Free Kids

Health Priority #2: Prevent and Reduce Tobacco Use			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
Strategy 3: Increase the number of environments where tobacco use is prohibited: • City & county operated campuses • Parks and outdoor recreational spaces • Early through higher education campuses • Places where people connect with physical and mental health services and support services • Worksites	• Number of local government entities that adopt and implement tobacco-free campus policies • Number of public places that are tobacco-free including parks and recreational properties • Number of early through higher education properties that are tobacco free • Number of places where people connect with physical and mental health services and support services that are tobacco-free • Number of other worksites that are tobacco-free	• All Lane County worksite properties are tobacco-free **Baseline:** All Lane County Health and Human Services Department properties will be tobacco-free by June 30th, 2013 • Increase the number of cities in Lane County that adopt and implement tobacco-free campus policies **Baseline:** No cities in Lane County have adopted tobacco-free campus policies • Increase the number of local park jurisdictions in Lane County that adopt	CHIP leadership team (Lane County, PeaceHealth, Trillium, United Way), Lane County Public Health's Tobacco Prevention and Education Program Team, parks district staff, county and city government officials, education officials, large employers, physical, mental, dental and social service providers, Tobacco-Free Lane County Coalition, new community leader champions to be encouraged

Health Priority #2: Prevent and Reduce Tobacco Use			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
		and implement tobacco-free parks policies **Baseline:** No park jurisdictions in Lane County are tobacco-free; assessment of recreational properties policies needed • Increase the number of places where people connect with physical and mental health services and support services that adopt and implement tobacco-free campus policies **Baseline:** All four PeaceHealth hospitals in Lane County are tobacco-free, Planned Parenthood is tobacco-free but may not have a written policy, McKenzie-Willamette	

Health Priority #2: Prevent and Reduce Tobacco Use			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
		hospital allows smoking in designated areas, all state-funded residential addictions and mental health facilities are required to be tobacco-free by June 30th, 2013 but may need support, assessment of policies at other places where people connect with physical and mental health services and support services needed • All early through higher education properties are tobacco-free **Baseline:** All K-12 schools in Oregon are tobacco-free, the University of Oregon adopted a tobacco-free campus policy in September of 2012, Lane	

Health Priority #2: Prevent and Reduce Tobacco Use

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		Community College allows smoking in designated areas, Head Start campuses are tobacco-free, assessment of other properties needed • Increase the number of other worksites that adopt and implement tobacco-free campus policies **Baseline:** Assessment of current policies needed	
Strategy 4: Support adoption and implementation of tobacco-free multi-unit housing complex policies (indoors)	• Number of multi-unit housing properties that are tobacco-free	• Increase number of multi-unit properties that adopt tobacco-free indoor policies **Baseline:** The Housing and Community Services Agency of Lane County implemented a tobacco-free policy banning smoking inside all of their complexes in 2010;	CHIP leadership team, Lane County Public Health's Tobacco Prevention and Education Program, Tobacco-Free Lane County Coalition, new community leader champions to be developed

Health Priority #2: Prevent and Reduce Tobacco Use			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
		assessment of other multi-unit property policies needed	
Strategy 5: Promote the Oregon Tobacco Quitline as part of every local tobacco-free initiative	• Number of calls to the Oregon Tobacco Quitline from Lane County residents • Number of Lane County residents using the Quitline's web-based service	• Increase the number of tobacco users from Lane County who call the Quitline to at least 2% **Baseline:** In FY 11/12 1.2% of tobacco users in Lane County called the Quitline	Lane County Public Health's Tobacco Prevention and Education Program, CHIP leadership team, new community leader champions to be encouraged, physical, mental, dental and social service providers through referrals
Strategy 6: Promote the Oregon Tobacco Quitline and incorporate Healthy Communities, Healthy People messaging developed by the state Public Health Division's media contractor into all earned media and other communications	• Number of times Healthy People, Healthy Communities messaging appears in local media • Number of times Oregon Tobacco Quitline messaging appears in local media	• Increase the number of times Oregon Tobacco Quitline messaging appears in local media **Baseline**: System to track messaging needed • Increase the number of times the Healthy Communities, Healthy People messaging appears in local media **Baseline:** Messaging has not yet been used with	CHIP Leadership Team, local and statewide advocacy organizations, community members

Health Priority #2: Prevent and Reduce Tobacco Use			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
		media	
Strategy 7: Support and encourage the City of Eugene to conduct annual compliance inspections of all licensed tobacco retail outlets and ensure enforcement action is taken against those outlets out of compliance.	• Number of licensed tobacco retail outlets in Eugene receiving an unannounced site inspection • Number of licensed tobacco retail outlets in Eugene that received enforcement action taken against them for being out of compliance	• 100% of tobacco retail outlets will be inspected **Baseline:** None • Enforcement action will be taken against 100% of tobacco retail outlets found out of compliance **Baseline:** None	CHIP Leadership Team, Lane County Tobacco Prevention and Education Program, City of Eugene

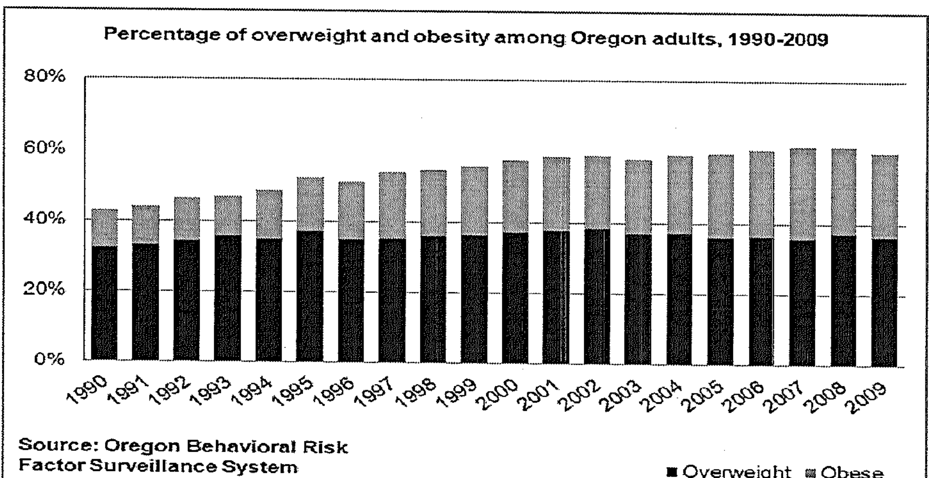
HEALTH PRIORITY THREE:

PREVENT AND REDUCE OBESITY

Background

Obesity is the second cause of preventable death in Lane County, in Oregon and the nation, second only to tobacco use. Obesity-related illnesses annually account for about 1,500 deaths in Oregon. Between 2001 and 2009, the percentage of Oregon students who were obese increased 53 percent for 8th graders and 55 percent for 11th graders. Since 1990, Oregon's adult obesity rate has increased 121 percent (Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012).The increasing trend can be seen in the chart below. The goal is to decelerate this upward trend in obesity.

Preventing obesity among Lane County residents 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 negative health consequences.



A public health approach to obesity prevention is not well known or broadly understood by community leaders in Lane County. Over the first six months of the implementation of this plan the community health assessment and community health improvement leadership team will organize a series of training events to build community leaders and decision makers understanding of this work.

Oregon the State Public Health Division, Health Promotion and Chronic Disease Prevention Section compiles and combines 4 years of county-level data on many chronic disease risk factors, including obesity.

Among Lane County adults for the 2008-2011 combined years:

- 60 percent of adults living in Lane County were overweight or obese
- 27 percent of adults met recommendations for fruit and vegetable consumption
- 60 percent of adults met minimum recommendations for physical activity

Among Lane County eighth-graders for the 2007-2008 school year:

- 26 percent of eighth-graders were overweight or obese
- 18 percent of eighth-graders drank seven or more soft drinks a week
- 22 percent met minimum recommendations for fruit and vegetable consumptions
- 53 percent participated in daily physical education
- 23 percent of eighth-graders played video games, computer games or used the Internet for non-school work for three or more hours in an average day

Among Lane County eleventh-graders for the 2007-2008 school year:

- 25 percent of eleventh-graders were overweight or obese
- 18 percent drank seven or more soft drinks a week

- 23 percent participated in daily physical education

Each year, Oregon spends about $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 persons who are not obese (Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012).

Chronic diseases account for approximately $.0.85 of every $1.00 spent on health care costs. For Lane County to achieve success with health system transformation and attain better health and reduce health care costs, Lane County must reduce and prevent obesity.

Health Priority #3: Prevent and Reduce Obesity	
Health outcomes	Reduce the prevalence of asthma, arthritis, cancer, diabetes, heart disease, and stroke among children and adults
Health equity focus	Ensure that policy, systems and environmental strategies are prioritized to address specific populations (e.g. racial and ethnic minorities, pregnant women, people with mental illness, low income people) and reduce health disparities
Measurable Objectives	**Adoption and implementation of public and organizational policies:** • Type of policy • Date policy adopted and implemented • Population-reach • Jurisdiction • Contact Information **Decelerate the increase in obesity:** • Adults to 30% or less (2008-2011: 27%) • 11th graders to 11% or less (2009 11%) • 8th graders to 10% or less (2009: 10%)

Health Priority #2: Prevent and Reduce Obesity

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
Strategy 1: Build community leaders and decision makers understanding of a public health approach to obesity prevention and the history of obesity prevention efforts in Lane County and across the nation and of the obesity prevention strategies below	• Key community leaders and decision makers understand a public health approach to obesity prevention and support local implementation of this plan	Key leaders and decision makers participate in a process to build understanding of obesity prevention and this plan	CHIP leadership team
Strategy 2: Support adoption and implementation of healthy meetings and events policies for food and beverages **provided** to staff, partners and the public at local government agencies, schools, health care facilities, social service organizations, community organizations and worksites at meetings and events including eliminating the provision of sugary drinks	• Percentage of local government agencies, local school districts, universities, community colleges, health and social service agencies, community organizations and other worksites with written policies requiring that foods and beverages served meet certain criteria	• At least one of each of the categories of organizations listed will have adopted a policy regarding the food they provide to staff, partners and the public at meetings and events including eliminating the provision of sugary drinks **Baseline:** In 2011 Lane County Public Health	CHIP Leadership Team, local and statewide advocacy organizations, old and new local obesity prevention champions

Health Priority #2: Prevent and Reduce Obesity			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
		adopted a policy with nutrition standards for food and beverages served at meetings and events for items that are purchased using any public health funds	
Strategy 3: Support adoption and implementation of healthy food and beverage policies for items **sold** in vending machines, in on site restaurants cafeterias and cafes, and in on site stores at local government agencies, schools, health care facilities, social service organizations, community organizations, and other worksites including eliminating the sale of sugary beverages on site	• Percentage of local government agencies, local school districts, universities, community colleges, health and social service agencies, community organizations and other worksites with written policies requiring that foods and beverages **sold** served meet certain criteria	• At least one of each of the categories of organizations listed will have adopted a policy regarding the food available for sale to staff, partners and the public at their worksites including eliminating the sale of sugary drinks **Baseline:** All K-12 schools in Oregon are required to sell only items that meet nutrition standards outlined in HB 2650/Oregon Law	CHIP Leadership Team, local and statewide advocacy organizations, old and new local obesity prevention champions

Health Priority #2: Prevent and Reduce Obesity			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
		336.423 during school hours; PeaceHealth Oregon Region adopted a healthy vending machine policy in 2013; the City of Eugene's Library, Cultural and Recreation Services Department is on the cusp of adopting a similar policy; some baseline assessment conducted recently, but additional assessment needed	
Strategy 4: Build local support for legislative efforts to raise the price of sugary drinks through a statewide excise tax. Dedicate a portion of proceeds to reach recommended funding ($22 million/year) for comprehensive efforts to reduce obesity and chronic disease in adults and children, especially in	• The amount of state tax on sugary beverages	• Sugar sweetened beverages taxed and funding to obesity prevention allocated • **Baseline:** No current tax	CHIP Leadership Team, local and statewide advocacy organizations, old and new local obesity prevention champions

Health Priority #2: Prevent and Reduce Obesity			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
populations experiencing disparities including implementation of best and promising practice interventions by the county, schools, coalitions, and community-based organizations			
Strategy 5: Build local support for implementation of the 2017 legislative PE mandate	• Participate in local and statewide efforts to ensure that the overall health and academic contributions of physical education are recognized, valued and supported	• All school districts in Lane County are on track to meet minimum PE requirements (grades K-5 = 150 minutes/week grades 6-8 225 minutes/week) outlined in ORS 329.496 by 2017 deadline **Baseline:** Statewide data from 2011-2012 school year suggests that schools have a long way to go before meeting mandates, local assessment needed	CHIP Leadership Team, local Superintendents, parents, PE champions, local and statewide advocacy organizations, old and new local obesity prevention champions

Health Priority #2: Prevent and Reduce Obesity			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
Strategy 6: Support statewide efforts to secure funds to support active transportation projects, such as public transit, inter-city rail, and bicycle and pedestrian projects	• Participate in statewide efforts to 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	$50 million (in state budget) dedicated annually	CHIP Leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions
Strategy 7: Promote and support physical activity throughout the work and school day for employees and students including accessible stairs, breaks for stretching, walking meetings, recess, and after school play time	• Number of workplaces and schools that consistently promote and support physical activity throughout the work and school day for employees and students	• Increase the number of worksites and schools that consistently promote and support physical activity throughout the work and school day for employees and students • **Baseline:** Unknown, assessment needed	CHIP Leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions

Health Priority #2: Prevent and Reduce Obesity			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
Strategy 8: Support statewide legislative efforts to fund the Farm to School, Farm to Institution, School Gardens Nutrition Programs and similar legislative efforts	• Legislation passed and/or sustaining legislation passed	• Farm to School funding legislation renewed and Farm to Institution legislation developed and passed	CHIP leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions
Strategy 9: Explore feasibility of healthy food zoning policies near schools	• Conduct local political feasibility assessment	• Assessment summary document	CHIP Leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions
Strategy 10: Incorporate Healthy Communities, Healthy People messaging developed by the state Public Health Division's media contractor into all earned media and other communications	• Number of times Healthy People, Healthy Communities messaging appears in local media	• Increase the number of times the Healthy Communities, Healthy People messaging appears in local media • **Baseline:** need to develop tracking system	CHIP Leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions

HEALTH PRIORITY FOUR:

PREVENT AND REDUCE SUBSTANCE ABUSE AND MENTAL ILLNESS

Background

Untreated 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; and treatments and services for substance abuse and mental illness, according to the Substance Abuse Mental Health Services Administration (SAMHSA). The Oregon State Health Profile shows that Oregon's death rates were 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.

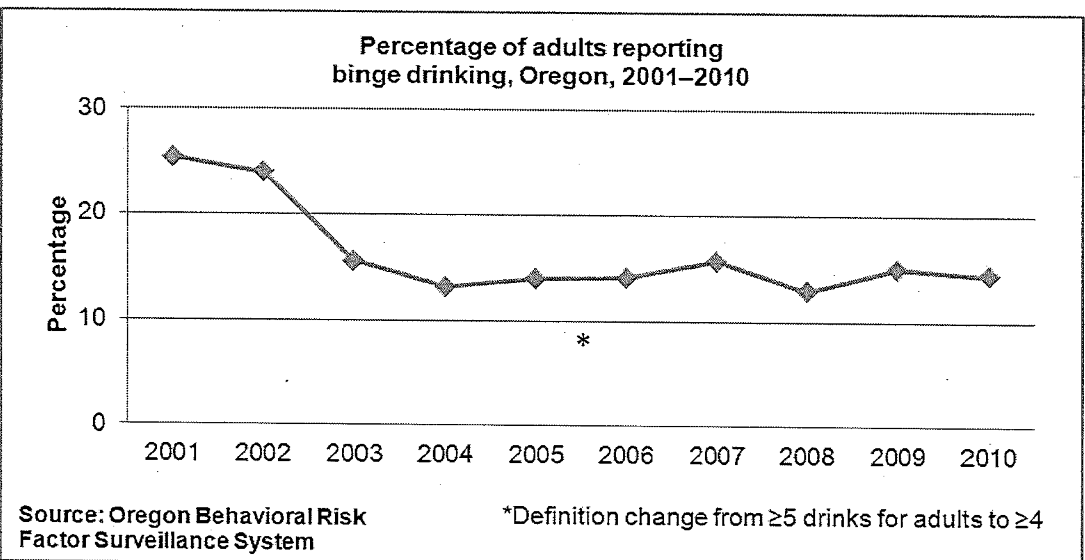
Alcohol use

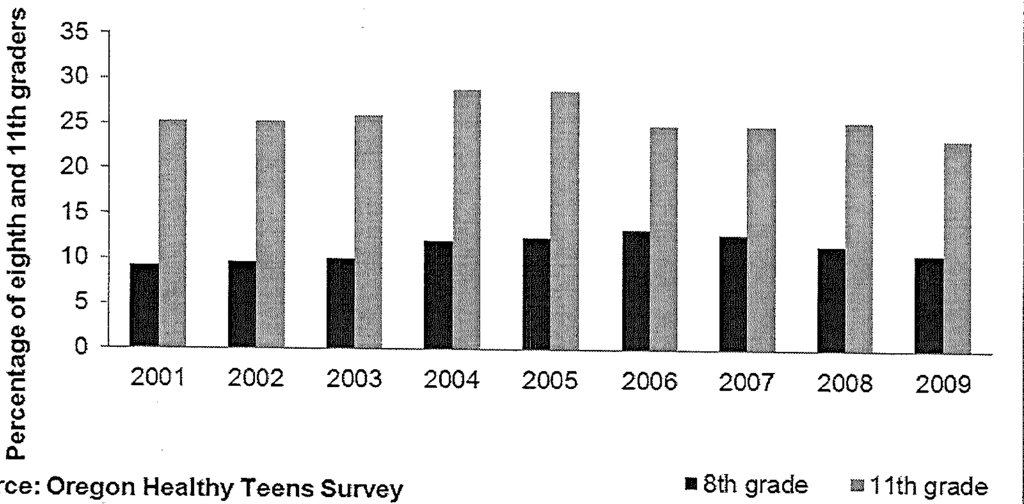
Age of first use of alcohol and alcohol dependency are closely related. Supporting youth to delay first use could yield immediate and long-term health benefits. Research shows that approximately four in 10 youth who first used alcohol by age 14 were diagnosed with alcohol dependency at some time in their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

Binge drinking

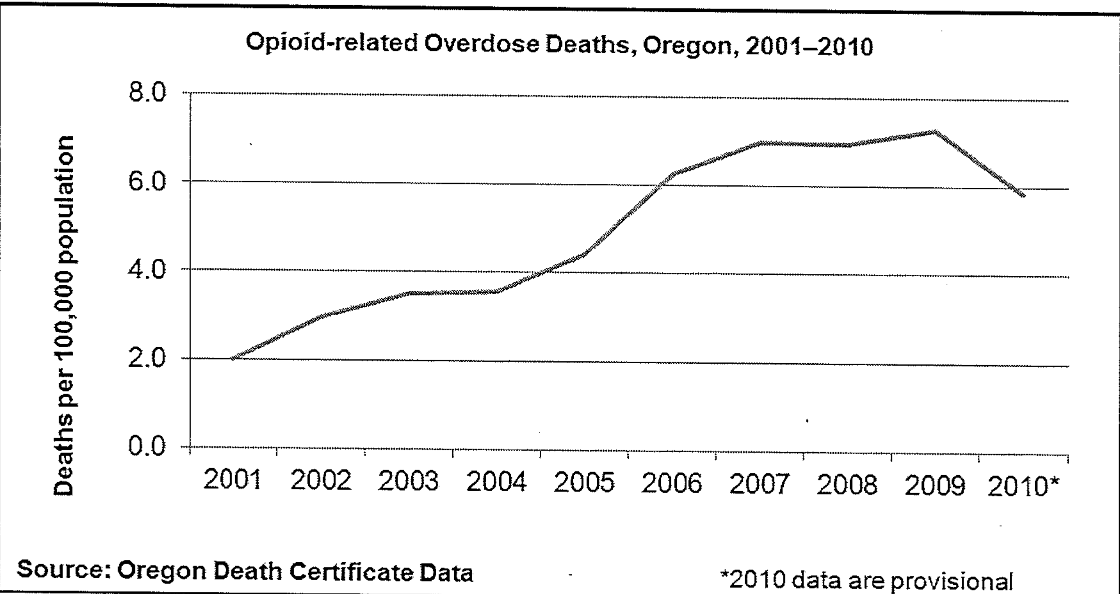
Binge drinking is a significant risk factor for injury, violence and chronic substance abuse. During 2010, 14.4% of adults reported binge drinking on at least one occasion during the past 30 days. Self-reported binge drinking declined from 2001 to 2004 but has not changed much since that time (see line chart below). Males, in general, report binge drinking more frequently than women. Male binge drinking peaks (29.5%) in the 25–34-year age group; female binge drinking peaks (18.1%) in the 18–24-year age group. 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 (see bar chart below). 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 has declined substantially during the past decade, but the numbers dying from opioid overdoses have been steadily increasing (see chart below). Efforts targeted at patients who use opioids as well as clinicians who prescribe them are needed to address this emerging public health problem.



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 total $78 million (Oregon Department of Human Services, 2009).

Health Priority #4: Prevent and Reduce Substance Abuse and Mental Illness	
Health outcomes	Prevent and reduce morbidity and mortality related to mental illness and alcohol and other drugs
Health equity focus	Ensure that systems and strategies are prioritized to address specific populations (e.g. racial and ethnic minority groups, pregnant women, people with mental illness, low income people, veterans, and adolescents ages 10-24) and reduce health disparities.
Measurable Objectives	**Reduce:** • **Rate of death from suicide:** 18 per 100,000 (2007-2011 Death Certificate Data) • **Rate of death from alcohol-induced disease:** 16 per 100,000 (2007-2011 Death Certificate *Data)* • **Rate of drug-induced death:** 18 per 100,000 (2007-2011 Death Certificate Data) • **Youth depression:** 24% 8th grade, 29% 11th grade (2012 Oregon Student Wellness Survey) • **Underage drinking:** 24% 8th grade, 38% 11th grade (2012 Oregon Student Wellness Survey) • **Adult binge drinking:** 11% females 18+, 20% males 18+ (2006-2009 Oregon Behavioral Risk Factor Surveillance System) • **Youth use of marijuana:** 11% 8th grade, 28% 11th grade (2012 Oregon Student Wellness Survey) • **Youth prescription drug abuse:** 6% 8th grade, 10% 11th grade (2012 Oregon Student Wellness Survey) • **Youth and Adult prescription pain reliever abuse:** 9% 12-17 years old, 17% 18-25 years old, 5% 26 or older (2008-2010 National Survey on Drug Use and Health) *All of the above information is found in the Lane County Epidemiological Data on Alcohol, Drugs and Mental Health 2000 to 2012 (Oregon Health Authority)

Health Priority #4: Prevent and Reduce Substance abuse and Mental Illness			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
Strategy 1: Increase public, educator and healthcare provider awareness and education of substance abuse and mental health, including: • Risk and protective factors; • Mental health promotion strategies • Adverse Childhood Experiences; • Stigma reduction; and • Positive social norms	• Number of trainings, awareness campaigns, and presentations related to substance abuse, suicide, and mental health • Percent of Lane County youth that recall hearing, reading, or watching an advertisement about prevention of substance abuse • Number of Lane County schools implementing evidence-based curricula specific to substance abuse and mental health	• Increase the number of substance abuse, suicide and mental health educational and awareness activities **Baseline:** Assessment needed—to be completed by December 2013 • Increase the percent of Lane County youth in 6th and 8th grade that recall hearing, reading or watching an advertisement about prevention of substance abuse **Baseline:** 48% 6th grade, 59% 8th grade (2012 Oregon Student Wellness Survey)	CHIP leadership team

Health Priority #4: Prevent and Reduce Substance abuse and Mental Illness			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
		• Increase the number of schools implementing substance abuse and mental health curricula **Baseline:** Assessment needed—to be completed by December 2013	
Strategy 2: Support the adoption and implementation of mental health- friendly workplace environments to promote mental health and reduce substance abuse.	• Number of Lane County employers who complete an assessment of their practices and policies related to mental health • Number of Lane County employers with stress management and other mental health friendly workplace policies	• Increase the number of Lane County employers that implement stress management and other mental health-friendly policies • **Baseline:** Assessment needed—to completed by June 2014	CHIP Leadership Team (Public Health, PeaceHealth, Trillium, United Way), healthcare and social service providers, local employers
Strategy 3: Implement policies to reduce access to lethal means of self-harm (firearms, poisons, prescription medications, alcohol and drugs)	• Number of healthcare and mental health providers counseling on access to lethal means	• Increase the number of healthcare and mental health providers counseling on access to	CHIP Leadership Team (Public Health, PeaceHealth, Trillium, United Way), healthcare and social service providers

Health Priority #4: Prevent and Reduce Substance abuse and Mental Illness			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
		lethal means. **Baseline:** Assessment needed	
Strategy 4: Implement policies that reduce the retail and social availability of alcohol and other drugs	• Number of alcohol retailers in compliance with not selling to minors • Conduct feasibility studies on 1. Social host liability laws in municipalities within Lane County, 2. Increasing the local beer/wine tax, 3. Local alcohol outlet density/saturation policies in Lane County municipalities 4. Prescription drop boxes, 5. Prescription medication tracking	Assessments completed by July of 2016	CHIP leadership team
Strategy 5: Support healthcare	• Number of healthcare and	• Increase the number of	CHIP Leadership Team (Public

Health Priority #4: Prevent and Reduce Substance abuse and Mental Illness			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
and social service providers in adopting evidence-based and trauma-informed mental health and substance abuse screening, assessment, and referral policies	social service providers that routinely screen, assess and refer using evidence-based tools and procedures	healthcare and social service providers that provide recommended policies and procedures **Baseline:** Assessment needed	Health, PeaceHealth, Trillium, United Way), healthcare and social service providers

Health Priority #5: Improve Access to Care	
Health outcomes	Improved health outcomes for people living with chronic conditions
Measurable Objectives	• Increase number of people with health insurance • Increase number of people with a primary care medical home • Increase number of people participating in chronic disease self-management programs • Increase immunization rates • Increase access to health care for rural residents • Reduce incidence of dental cavities • Improve connectivity for physical, behavioral and oral health care • Expand health care workforce

Health Priority #5: Improve Access to Care			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
Strategy 1: Increase the number of people enrolled in a health insurance plan	• Percentage of Lane County residents with health insurance • Percentage of eligible people enrolled in Medicaid	• Target for percentage of residents with health insurance: To be determined by Access to Health Care committee **Baseline:** 23% • Target for percentage of eligible people enrolled in Medicaid: To be determined by Access to Health Care committee **Baseline:** assessment needed	CHIP Leadership Team, Access to Care Advisory Group
Strategy 2: Increase the number of people with a medical home	• Percentage of Lane County Residents with a medical home	• Target: TBD by Access to Health Care committee • **Baseline:** Assessment needed	CHIP Leadership Team, Access to Care Advisory Group

Health Priority #5: Improve Access to Care

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
Strategy 3: Increase access to disease self-management programs	• Sustainable local program infrastructure with sufficient capacity to meet need • Systematic referrals of appropriate patients to self-management programs	• Number and breadth of disease self-management programs available **Baseline:** Assessment needed • Number of Lane County residents with one or more chronic conditions participating in a self-management program • **Baseline:** Assessment needed	CHIP Leadership Team, Access to Care Advisory Group
Strategy 4: Increase immunization rates	• Support statewide legislation to increase barriers to parents opting out of immunizations for their children • Support statewide efforts to remove legislative preemption that prohibits requiring any adult	• Increase the percentage of immunized children in Lane County **Baseline:** 94% of children in pre-school children's facilities; 94% in Kindergarten & 1st grade; 95% in 7th grade	CHIP Leadership Team, Access to Care Advisory Group

Health Priority #5: Improve Access to Care			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
	immunizations that are not required in federal legislation (ORS 416.133)	• Increase percentage of people classified as Health Care Workers (by CDC definition) that receive CDC recommended vaccinations (influenza, MMR, Varicella, Tetanus/Diphtheria and Meningococcal) **Baseline:** Assessment needed	
Strategy 5: Improve access to health care for rural Lane County residents	• Percentage of rural Lane County residents that have access to health care	• Increase access to affordable transportation options **Baseline:** Assessment needed • Expand telehealth, virtual visits and home monitoring initiatives **Baseline:** Assessment	CHIP Leadership Team, Access to Care Advisory Group

Health Priority #5: Improve Access to Care

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		needed	
Strategy 6: Improve oral health	• Percentage of children and adults with tooth decay, untreated decay and rampant decay	• Increase access to fluoride treatment **Baseline:** Assessment needed • Increase access to dental care **Baseline:** Assessment needed • Explore political feasibility of water fluoridation in Lane County and local cities **Baseline:** assessment needed • Decrease number of dental-related emergency room visits **Baseline:** Assessment	CHIP Leadership Team, Access to Care Advisory Group

Health Priority #5: Improve Access to Care			
Improvement Strategies	**Performance Measure**	**Target by July 2016**	**Responsible Parties**
		needed	
Strategy 7: Improve patient connectivity with physical, mental and behavioral health services	TBD by Access to Care Advisory Group	TBD by Access to Care Advisory Group	CHIP Leadership Team, Access to Care Advisory Group
Strategy 8: Expand health care workforce	Increase the number of health care providers in Lane County	TBD by Access to Care Advisory Group	CHIP Leadership Team, Access to Care Advisory Group

CONCLUSION

This plan outlines strategies for our community to work together to improve the health of Lane County residents. Lane County's Healthy Future is a living document. While the priorities are clear, the methods for addressing each of them will evolve over time. The community health assessment and community health improvement plan leadership team and the community recognize this collective effort as a powerful means to improve critical health indicators. Across the state of Oregon and Lane County, 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 everyone in Lane County is empowered to improve the lifelong health of all people in Lane County.