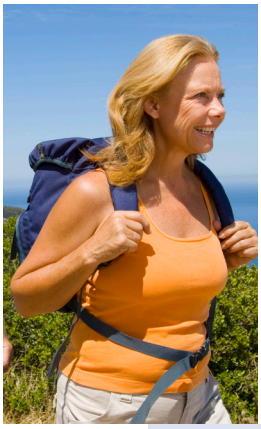
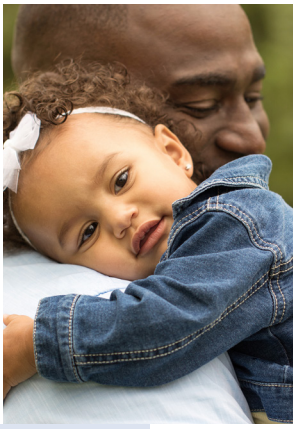
2018

Oregon's State Health Assessment







Oregon Health Authority
PUBLIC HEALTH DIVISION

Acknowledgements

The State Health Assessment (SHA) would not have been possible without the efforts of many individuals, including the SHA Steering and Subcommittee members, Public Health Division staff, and hundreds of people across our state who attended community meetings, completed an online survey, and provided public comment.

Core, Steering and Subcommittee Membership

Core Group – Public Health Division, Oregon Health Authority

Isabelle Barbour
Policy Specialist

Sara Beaudrault
Public Health Modernization Lead

Cara Biddlecom
Director of Policy and Partnerships

Danna Drum
Strategic Partnerships Lead

Julia Hakes
Executive Support Specialist

Katrina Hedberg
State Public Health Officer and State Epidemiologist

Nita Heimann
Research Analyst

Christy Hudson
Policy Analyst

Tim Noe
Administrator, Center for Prevention and Health Promotion

Angela Rowland
Executive Support Specialist

Steering Committee

Caroline Cruz
Confederated Tribes of Warm Springs

Julia Delgado
Urban League of Portland

Dawn Emerick
Clackamas County Health Department

Erin Fitzpatrick
PacificSource Central Oregon CCO

Katrina Hedberg
Oregon Health Authority

Holden Leung
Asian Health and Human Services Center

Kelle Little
Coquille Indian Tribe

Rebecca Tiel
Oregon Association of Hospitals and Health Systems

Roberta Riportella
Oregon State University Extension Services

Alejandro Queral
United Way of the Columbia Willamette

James Setzer
Umatilla County Health Department

Amanda Singh Bans
Health Care Coalition of Southern Oregon

Paul Virtue
Intercommunity Health Network Community Advisory Council

Health Status Assessment Subcommittee

Jen Coleman
Oregon Environmental Council

Mandy Davis
Trauma Informed Oregon

Dawn Emerick
Clackamas County Health Department

Erin Fitzpatrick
PacificSource Central Oregon CCO

Frank Franklin
Multnomah County Health Department

Tom George
Early Learning Division

Colt Gill
Chief Education Office

Katrina Hedberg
Oregon Health Authority
Public Health Division

Kelle Little
Coquille Indian Tribe

Joe Marek
Clackamas County Department of Transportation and Development

Alison Martin
Oregon Center for Children and Youth with Special Health Needs

Rebecca Tiel
Oregon Association of Hospitals and Health Systems

Alejandro Queral
United Way of the Columbia Willamette

Roberta Riportella
Oregon State University Extension Service

Josh Roll
Oregon Department of Transportation

Jane Savage
AARP Oregon

Jim Setzer
Umatilla County Health Department

Rick Treleaven
BestCare Treatment Services

Paul Virtue
Intercommunity Health Network Community Advisory Council

Kweku Wilson
Oregon Health Authority
Office of Equity and Inclusion

Themes and Strengths Assessment Subcommittee

Mary Apple
InterMountain Education School District

Tamara Bakewell
Oregon Center for Children and Youth with Special Health Needs

Emily Berndt
211 Info

Megan Bolton
Oregon Housing and Community Services

Royce Bowlin
Oregon Health Authority
Health Policy and Analytics

Kay Brooks
Unite Oregon

Maria Castro
Oregon Health Authority
Office of Equity and Inclusion

Beth Crane
211 Info

Caroline Cruz
Confederated Tribes of Warm Springs

Shelley Das
Oregon Health Authority
Office of Equity and Inclusion

Julia Delgado
Urban League of Portland

Frank Franklin
Multnomah County Health Department

Meredith Guardino
Office of Rural Health

Becky Jones
Children First for Oregon

Heather Kaisner
Deschutes County Health Services

Holden Leung
Asian Health and Human Services Center

Alison Martin
Oregon Center for Children and Youth with Special Health Needs

Jennifer Mead
Department of Human Services: Aging and People with Disabilities

Stephanie Millar
Oregon Department of Transportation

Erin Schulten
Klamath County Public Health

Amanda Singh Bans
Health Care Coalition of Southern Oregon

Darrin Umbarger
Clearview Mediation and Disability Resource Center

Paul Virtue
Intercommunity Health Network
Community Advisory Council

OFFICE OF THE DIRECTOR
Kate Brown, Governor

Oregon Health Authority

500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

Dear Colleagues,

We know that the majority of what influences health happens outside of the doctor's office. Without a thorough understanding of the many factors that contribute to health and well-being, we will not significantly improve health outcomes for people in Oregon. To that end, I am pleased to share with you the 2018 State Health Assessment (SHA). This is the Oregon Health Authority's comprehensive resource for describing the opportunities and challenges that we face in our state to ensure that every person can achieve optimal health and well-being.

The development of the SHA was led by the SHA Steering Committee and the Health Status Assessment and Themes and Strengths Assessment subcommittees. These groups were made up of people representing a variety of perspectives related to health: culturally-specific organizations, coordinated care organizations and community advisory councils, tribes, local public health authorities, and organizations involved with transportation, education, housing, social services, health care, and more. I am grateful for the time and leadership of our partners who are committed to the SHA process. I also thank the people in Oregon who devoted their time to provide additional perspectives on what it takes for communities to be healthy and achieve well-being for everyone.

As we move forward to shape the priorities for health in Oregon from 2020 to 2024, we want to continue to hear from you. We want your ideas for how the Oregon Health Authority should develop goals and strategies to advance work across the state that addresses the social determinants of health and creates health equity. We also need you to work with us to make these efforts successful, whether you're from Baker or Yamhill County, or anywhere in between.

Thank you for your partnership.

Sincerely,

Patrick M. Allen
Director

OREGON STATE PUBLIC HEALTH DIVISION
Office of the State Public Health Director
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon Street, Suite 930
Portland, OR 97232
Phone: 971.673.1229
Fax: 971.673.1299

Dear Colleagues,

I am happy to share Oregon's 2018 State Health Assessment (SHA). Conducted every five years, Oregon's SHA provides a detailed description of the health of people in Oregon; our values, strengths, and needs; and the availability of critical public health protections that keep everyone safe and healthy.

I want to thank our many partners and community members who led the development of the SHA and contributed their perspectives through community meetings and surveys. The SHA includes qualitative and quantitative information gathered over the latter half of 2017, including; population health statistics, feedback from communities through an online survey, regional meetings, and focus groups with partner organizations; as well as data from the statewide public health modernization assessment conducted in 2016. The SHA highlights the strengths of our communities and the areas where persistent disparities are holding people back from achieving optimal health.

The Oregon Health Authority will use the SHA to identify priorities and strategies for the 2020 – 2024 State Health Improvement Plan. We also hope the SHA will be a tool for every organization in Oregon that is involved with local community health assessments so they have information they need to describe the health of people in their communities.

I look forward to continuing our work together on the next State Health Improvement Plan to help everyone in Oregon be as healthy as possible, regardless of race, ethnicity, ability, gender, sexual orientation, socioeconomic status, nationality, and geography.

Respectfully,

Lillian Shirley

Lillian Shirley, BSN, MPH, MPA
Public Health Director
Oregon Health Authority

Vision and Values

In September 2017, the SHA Steering Committee set out to express the vision for the 2018 SHA and the forthcoming State Health Improvement Plan (SHIP), which will be developed based on the 2018 SHA. The vision articulates what Oregon would like to achieve in the future, as a result of the strategies laid out in the 2020 – 2024 SHIP. The values are what the SHA and SHIP should collectively support.

Vision:

Oregon will be a place where optimal health is achieved for everyone, throughout the lifespan, regardless of race, ethnicity, ability, gender, sexual orientation, socioeconomic status, nationality, and geography.

Values:

Equity, Accountability, Empowerment, Transparency, Inclusion

Contents

Executive Summary

Every five years, the Oregon Health Authority, Public Health Division (OHA-PHD) describes the health of our state through the State Health Assessment (SHA). The SHA provides a data-driven resource that describes Oregon's health-related strengths as well as its leading health challenges. The SHA also attempts to illustrate Oregon's health as a state, compared to the rest of the country.

Vision:

Oregon will be a place where optimal health is achieved for everyone, throughout the lifespan, regardless of race, ethnicity, ability, gender, sexual orientation, socioeconomic status, nationality and geography.

Since Oregon published its last SHA in 2012, our state has made progress on many important measures, including:

- Reduction in opioid-related deaths;
- Reduction in rates of HIV infection;
- Increasing rates of immunization among 2-year-olds;
- Lower rates of teen pregnancy and births;
- Lower smoking rates among adults and teenagers.

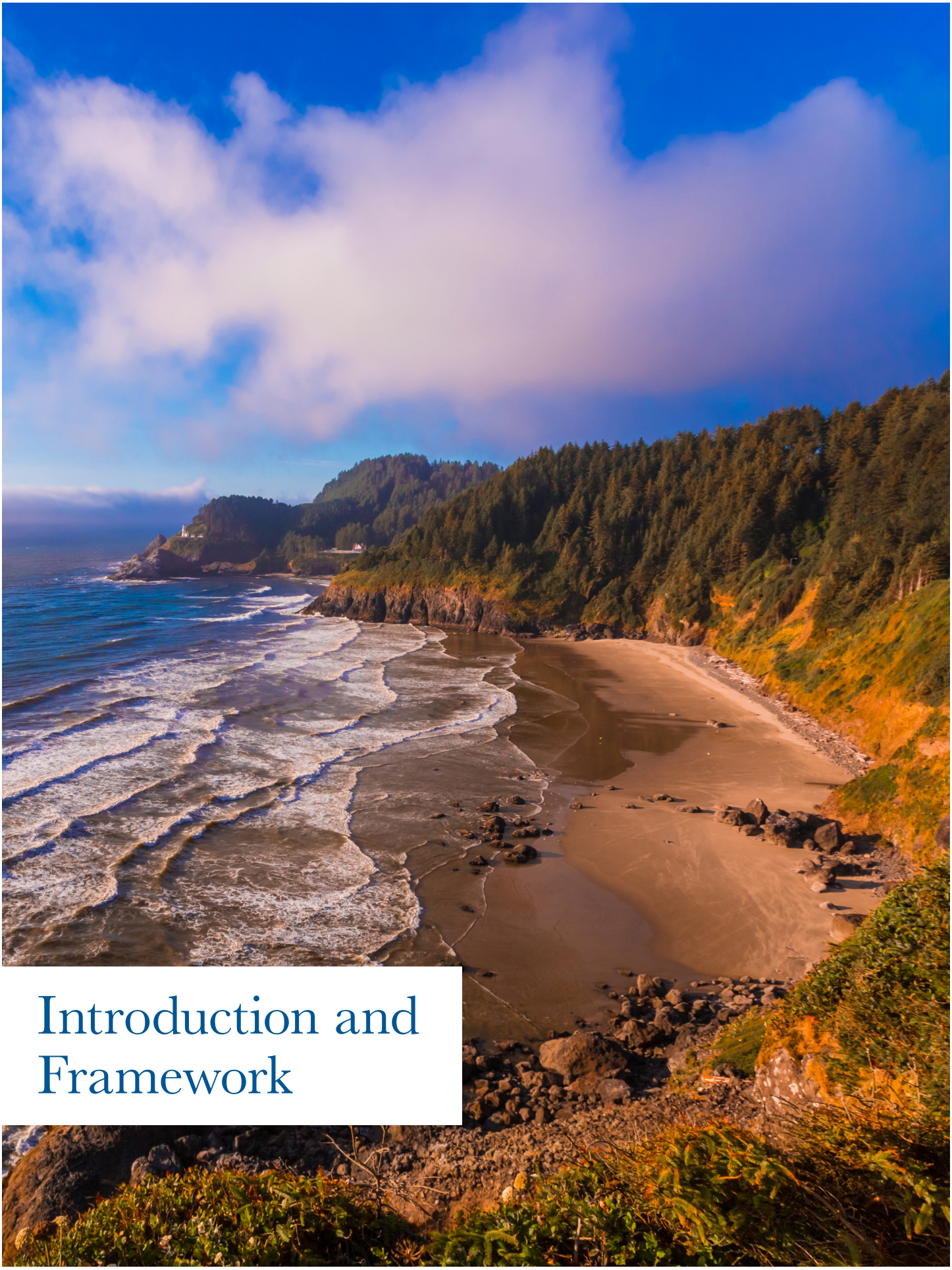
Oregon has also experienced gains in access to health insurance with the start-up of coordinated care organizations (CCOs) and the passage of the Affordable Care Act. However, some measures of health in Oregon have worsened, including rates of obesity, diabetes and suicide. In addition, Oregon's low standing in education, housing affordability and food insecurity have contributed to a decline in the state's relative standing in national scorecards of health measures. According to the United Health Foundation's Annual Health Rankings, Oregon was the 20st healthiest state in the country in 2017 (Massachusetts is 1st and Mississippi is 50th).* This is down from 13th in 2012 and 8th in 2011.† Many factors could be contributing to this relative worsening of health outcomes.

Oregon has a lot to be proud of: beautiful landscapes that provide boundless recreation, an ideal growing season that provides an abundance of local fruits and vegetables, and a rapidly growing population that is spurring economic growth in some parts of the state. However, many people in Oregon do not enjoy the benefits of educational attainment, economic opportunity and good health. This situation has created dramatic differences in health outcomes among people in Oregon, called health disparities, which are unacceptable.

The SHA is the result of many people from across Oregon who came together to describe what is needed for everyone in their community to be healthy. More than 900 people participated in community meetings or responded to an online survey.This information helps to illustrate the health disparities seen in quantitative data. Key findings include:

- People in Oregon want everyone to have their basic needs met, including affordable and quality housing, healthy foods, healthy environments, convenient transportation, education, economic stability, and child care. Only when these needs are met can we all be as healthy as possible.
- Some communities are disproportionately affected by health disparities.
- Communities are coming together, despite differences, to address health disparities and eliminate systems of oppression such as racism and classism.

The SHA is designed to help inform the health priorities of the 2020 – 2024 SHIP, a roadmap for helping Oregon realize the vision of a place where optimal health is achieved for everyone, throughout the lifespan, regardless of race, ethnicity, ability, gender, sexual orientation, socioeconomic status, nationality, and geography.



Introduction and Framework

Introduction and Framework

The World Health Organization* defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." There is not one single measure which describes how healthy Oregon is, but rather a constellation of factors that provide the overall picture. The SHA describes the health of people in Oregon, including their strengths, weaknesses, and areas for improvement. The SHA uses quantitative and qualitative data to share how people across Oregon describe the health of people in our state and what is needed for everyone to be healthy. The SHA will help to inform the strategic priorities for the 2020 – 2024 State Health Improvement Plan (SHIP).

The SHA Steering Committee identified a framework that relies on the four foundational programs for public health in Oregon, plus a fifth category, the social determinants of health. The SHA categorizes data within these five areas:

- **Social determinants of health** – Social conditions that influence health, like employment and education
- **Environmental health** – Factors in the natural and built environment that affect health, like air and water, transportation, housing, and occupation
- **Prevention and health promotion** – Behaviors and policies that affect health, like tobacco and alcohol use, and access to healthy food
- **Access to clinical preventive services** – Health care services that are critical to preventing long-term problems, like immunizations and cancer screening
- **Communicable disease control** – Transmissible diseases such as food borne diseases, sexually transmitted infections, HIV, pertussis, and health-care associated infections

* http://www.who.int/about/mission/en/

Health Equity and the Social Determinants of Health

Health equity is defined as the absence of unfair, avoidable, or remediable differences in health among social groups.* Health equity exists when all people can reach their full health potential and are not disadvantaged because of their social and economic status, social class, race, ethnicity, religion, age, disability, gender identity, sexual orientation or other socially-determined circumstance.† Achieving health equity requires a fair and just distribution of resources and power that eliminates gaps in health outcomes between and within different social groups.

To ensure health equity, OHA-PHD must examine the root causes of health inequity. These root causes are collectively called the social determinants of health. Social determinants of health (SDOH) include access to healthy food, safe neighborhoods and housing, transportation, and education.

Social determinants and the places people live, work, learn and play, have the most significant effect on individual and population-level health. People of color and those living with fewer financial resources are more likely to bear the burden of unsafe neighborhoods, substandard housing, lack of transportation, and low-quality schools. As a result, some people and communities with less or no access to these resources experience worse health outcomes, poorer quality of life, and shorter lifespans.

Community members shared:

"Eradication of institutional racism…fair systems that treat everyone with respect and dignity"

"Equity and equal access to resources. It also requires an ability to understand that not everyone's needs will be met in the same way."

"To realize that in most cases people that are not healthy did not make the choice to be that way."

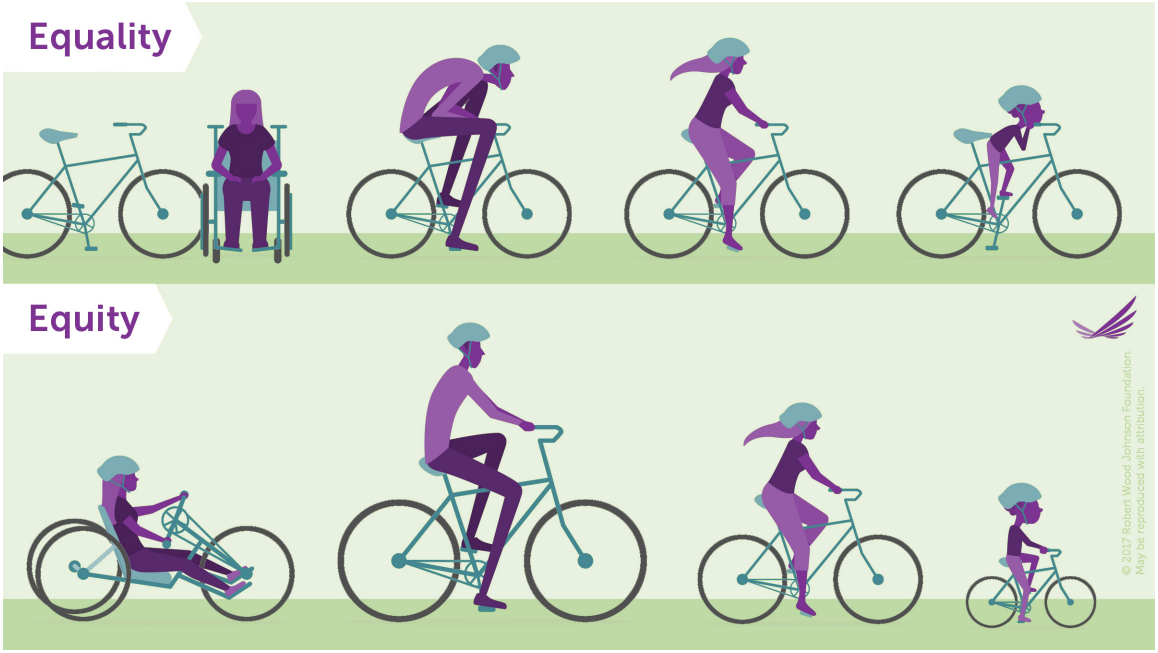
"Holding oppressive structures accountable for inequitable practices, changing antiquated processes for more equitable policies and more diverse representation in decision-making arenas."

"Community health looks at the experience of EVERY person and creature in the environment. If institutions of care, service and education are not addressing/ dismantling the areas of systematic oppression of marginalized people then the community is not healthy."

* World Health Organization, Commission on Social Determinants of Health, (2007). A Conceptual Framework for Action on the Social Determinants of Health.

† Winnipeg Regional Health Authority. (n.d.). Winnipeg Regional Health Authority's Position Statement on Health Equity. Available at http://www.wrha.mb.ca/about/healthequity/statement.php

Health equity means we all have the basics to be as healthy as possible



Racism and Discrimination Affect Health

In all the places where people live their lives, racism, classism, and other systems of oppression negatively affect people's health. These systems create barriers to resources like education, safe homes and neighborhoods, jobs, and health care. Racism has played a powerful role in Oregon's history, despite the state's current reputation for accepting differences. For example:

- When Oregon was first recognized as a state in 1859, it was the only state in the country that forbade people of color from living in the state.
- In 1862, an annual tax was levied on people of color to help maintain white settlers' access to land that had been taken from Oregon tribes.
- Oregon's legislature refused ratification of the 14th and 15th U.S. constitutional amendments (until 1973 and 1959, respectively), which aimed to grant citizenship to all persons born or naturalized in the United States, including former slaves, and give black men the right to vote.
- Redlining policies and other discriminatory loan practices enacted by the real estate industry prevented black families from purchasing homes in white neighborhoods through the 1990s.

The impact of Oregon's racist history remains starkly evident in the health disparities described in the SHA. Racism, whether overt,* implicit,† institutional,‡ or structural,§ continues to be a powerful force in our state and American society. Yet racism is not the only form of discrimination that people experience. People who are seen as different due to difference in ability, sexual orientation, gender, socioeconomic status, or geographic location also experience health disparities. Racism often compounds these challenges.

Discrimination causes stress. Likewise, trauma is a common experience for many people, especially communities of color. When these traumas are transmitted from one generation to the next, they can lead to epigenetic changes, or changes in our genes, which fuel health disparities. Neuroscience now paints a clear picture of how these factors of toxic stress and trauma can negatively affect brain development and lifelong outcomes in education, socioeconomic status, and health.

Throughout the SHA, OHA-PHD presents data that illustrates how systems of oppression and social determinants of health contribute to health outcomes and disparities. The SHA explores health disparities among specific groups, including:

- People of color
- People with disabilities
- People with low income
- People who identify as lesbian, gay, or bisexual
- People who live in rural or frontier areas of our state

* Overt racism against an individual, as in prejudicial comments or discriminatory actions.
† Implicit racism can occur when a person's attitudes influence their behaviors, but they are unaware of their bias.
‡ Institutional racism involves policies, practices, and procedures that work better for white people than for people of color; it can be unintentional or inadvertent.
§ Structural racism includes historical and current racism across all institutions, which results in an entire system that negatively affects people of color.

Key Findings of the SHA

I. How healthy is Oregon?

Oregon has made significant strides in many health outcome measures, health insurance coverage and access to medical care. Yet, our state's standing in national health rankings has declined, largely due to health factors that occur outside the doctor's office. These factors are often referred to as 'social determinants of health' and they include issues such as education, housing and transportation. According to the United Health Foundation's Annual Health Rankings, Oregon was the 20st healthiest state in the country in 2017 (Massachusetts is 1st and Mississippi is 50th).* This is down from 13th at the time the last SHA was published in 2012, and 8th in 2011.†

II. What is important to people in Oregon?

People in Oregon value self-determination, independence, and choice. They want to ensure that everyone has their basic needs met, including affordable and quality housing; access to healthy foods; convenient transportation; education; economic stability; and child care.

People in Oregon also recognize important factors that keep people healthy, such as a connection to family, friends, and community. However, they appreciate that not everyone is able to be healthy in their communities, often for reasons beyond their control. People in Oregon recognize that the best way to make sure that every person in our state can be healthy is to make our leadership reflect Oregon's increasingly diverse population.

III. What contributes to the health disparities that exist in Oregon?

People in Oregon recognize that systems of oppression, such as racism and classism, affect access to opportunities and resources that influence our health. They are aware that people in positions of authority and decision-making in Oregon usually represent white, dominant culture. People in Oregon recognize that until minority populations share decision-making authority in our state and American society more broadly, the decisions that get made will tend to favor the dominant culture, further contributing to health disparities.

---

* National Health Rankings. For all national rankings identified in this document, 1 is best and 50/51 (when Washington D.C. is counted as a state) is worst.

† http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/Americas-Health-Rankings-2012-v1.pdf

IV. What assets does Oregon have that can be used to improve health?

People in Oregon have abundant state pride, particularly in two assets: our distinct communities and our plentiful natural resources. People across the state reported high levels of civic engagement in their cities and towns, and considerable hope for a better future. Many also mentioned pride in the laws that have recently come out of the Oregon Legislature, such as Cover All Kids and the Reproductive Health Equity Act. A diverse mix of people attended community meetings across the state to contribute their perspectives to the SHA, yet these common themes emerged from all of the meetings.

Process for Development of the SHA

To develop the SHA, OHA-PHD used the Mobilizing Action through Planning and Partnership* (MAPP) framework, an evidence-based tool developed by the National Association of County and City Health Officials. This framework directed us to conduct four unique assessments in order to paint a complete picture of health in Oregon:

- **Public Health System Assessment** – Findings from the 2016 Public Health Modernization Assessment informed this assessment.
- **Health Status Assessment** – This assessment examined quantitative health indicators to describe the health status of people in Oregon.
- **Themes and Strengths Assessment** – This assessment was designed to capture community members' experiences with health.
- **Forces of Change Assessment** – This assessment identified external threats and opportunities, including political and social issues that could affect the health of people in Oregon.

To complete the four assessments, OHA-PHD established three groups according to the MAPP process: a Core Group, a Steering Committee and Subcommittees, and the Community at Large.

Core Group

The Core Group was comprised of Public Health Division staff who provided support to the steering and subcommittees and managed the assessment process. The Core Group met every few weeks throughout the SHA process to ensure that it aligned with the MAPP framework, prepare agendas and materials for the steering committee and subcommittees, and draft the SHA. Core Group members also attended community meetings around the state. They also reviewed other health assessments from around Oregon, including:

- Community health assessments produced by CCOs and local public health authorities
- Community health needs assessments produced by hospitals

* https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

- Assessments conducted by the Oregon Health Authority such as the CCO Listening Session Summary Report (https://bit.ly/2u6A9MV) and the Behavioral Health Collaborative Report (https://bit.ly/2KJRGVd)
- Assessments completed by other agencies including the Oregon Rural and Frontier Health Facility Listening Tour Report (https://bit.ly/2N3Puob), Oregon Areas of Unmet Health Care Need Report, Oregon's Children and Youth with Special Health Care Needs (https://bit.ly/2KS97T3), Oregon's State Plan on Aging (https://bit.ly/2J71lzJ), and the State of Our Health 2015 (https://bit.ly/2N26wDq).

Steering Committee and Subcommittees

Many individuals provided direction and guidance throughout the SHA development process. Steering Committee members had experience in assessment and were representative of the public health system. Members represented culturally-specific organizations, local and tribal public health authorities, CCOs and CCO Community Advisory Councils (CACs), hospitals, regional health equity coalitions, and academia. The Steering Committee was responsible for developing the SHA and SHIP vision and values, identifying key findings, and completing the Forces of Change Assessment. Steering Committee members also participated on one of two subcommittees: Themes and Strengths Assessment or Health Status Assessment.

Themes and Strengths Assessment Subcommittee

More than 20 subcommittee members met three times between August and November 2017 to identify previous community engagement efforts; review themes across those efforts and local community health assessments; develop the strategy for community engagement; and provide input into the agenda, key questions, locations, and invitees for the SHA community meetings that were held in October 2017. Members also reviewed feedback collected during the SHA community engagement process, which included the community meetings, an online survey, and facilitated discussions with partner organizations. Many subcommittee members assisted with outreach to communities to encourage participation in the SHA process.

Health Status Assessment Subcommittee

Twenty subcommitee members met three times between August and November 2017 to recommend the framework for the SHA, review existing state health indicators; recommend additional indicators based on national frameworks; determine criteria by which indicators would be selected; and provide feedback on proposed indicators. This group was advised by subject-matter experts within the OHA-PHD. The final set of health indicators were prioritized based on criteria that included the following:

- **Magnitude** – Proportion of the population affected
- **Seriousness** – Issue is associated with death, severe disease, disability, or suffering
- **Trend** – Ability to track health indicator over time
- **Comparison** – Measure is comparable to national and local data
- **Alignment** – Measure aligns with national or local priorities
- **Data Quality** – Existence of an annual statewide data set

Community at Large

Broad community input was sought in the SHA development process. More than 900 individuals responded to the invitation to attend community meetings, complete an online survey, or participate in a facilitated conversation with an existing community group. More than 110 people attended one of seven community meetings in La Grande, Portland, Eugene, Grants Pass, Medford, Newport, and Madras in October 2017. An additional 788 people responded to an online survey that was available in English and Spanish and shared widely across the state. Direct quotes from these efforts are included in the SHA to further illustrate the health-related needs identified by participants. Finally, additional feedback was contributed by the following community groups:

- Hood River County Alcohol, Tobacco and Other Drug Prevention Coalition;
- Jackson County Substance Abuse Prevention Coalition;
- Senior and Disability Services Advisory Councils for Lane Council of Governments;
- Disability Services Advisory Council of Multnomah County;
- Willamette Valley Community Health CAC;
- The Alliance of Culturally-Specific Behavioral Health Providers and Programs;
- Linn Benton Regional Health Equity Alliance; and
- Cow Creek Band of Umpqua Tribe of Indians.

Demographics of the Community at Large

While the SHA process defined and sought a "community at large" that was racially and geographically representative of Oregon, the people who attended the seven community meetings and responded to the survey were less diverse.

Demographics of community meeting attendees:

- Nineteen counties were represented: Baker, Benton, Clackamas, Coos, Deschutes, Harney, Jackson, Jefferson, Josephine, Lane, Lincoln, Malheur, Multnomah, Tillamook, Umatilla, Union, Wasco, Washington, and Wallowa.
- Many attendees identified a professional affiliation with a health care or social service provider.
- A majority were female (77% female, 20% male, 3% other/non-binary).
- A majority had a college degree or higher (93% college degree,* 7% high school diploma or GED).
- Attendees were representative of Oregon by race and ethnicity (83% white, 13% Latina(o), 8% American Indian and Alaskan Native, 2% African American, 5.5% Asian, 1% Native Hawaiian and Pacific Islander).†

Demographics of survey respondents:

- All Oregon counties were represented. In the online survey, 68% of respondents lived outside of the Portland metro area.
- A majority (79%) had a professional affiliation with a health care or social service provider.
- A majority were female (78% female, 19% male, 1.8% other/non-binary, 0.9% transgender).
- A majority had a college degree or higher (78% college degree, 20% high school diploma or GED, 1% less than high school graduation).
- Respondents were representative of our state by race and ethnicity (84.5% white, 15.4% Latina(o), 4.4% American Indian and Alaskan Native, 5.0% African American, 2.8% Asian, 1.4% Native Hawaiian and Pacific Islander).‡

* Also includes those with some college and/or certificate degrees.
† Percentages don't total 100% because people identified multiple races.
‡ Percentages don't total 100% because people identified multiple races.

- Among Latina(o)-identified respondents, 64% were of Mexican or Mexican American descent, 9% were Chicano(a), 9% were Puerto Rican, and 25% identified another ethnicity.
- Among Asian-identified respondents, 39% were of Chinese descent. Other respondents identified as Filipino, Japanese, Korean, Vietnamese, or another ethnicity.

Data Limitations

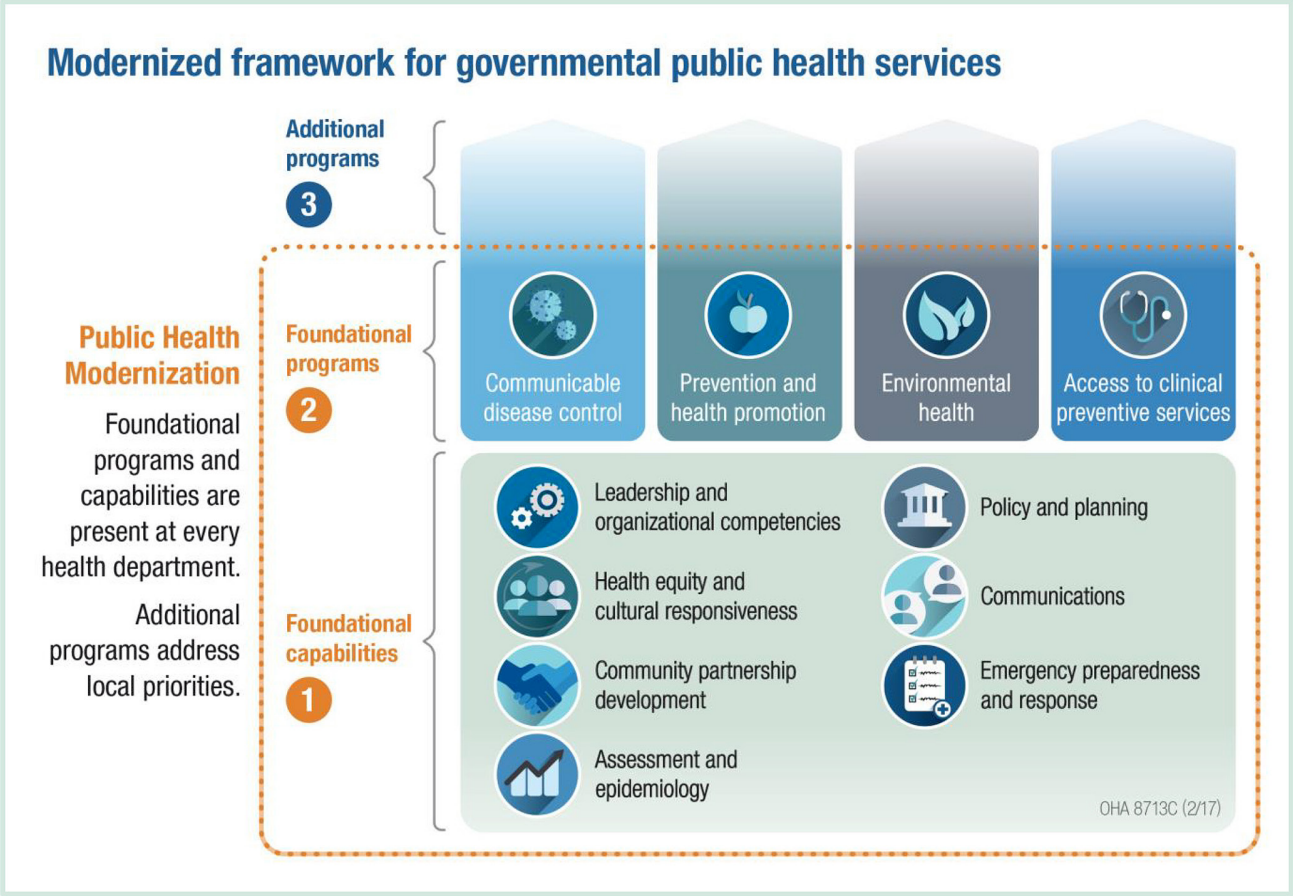
Despite a comprehensive effort to engage communities in the SHA process, there are some limitations to the data OHA-PHD collected. Educated women with a professional affiliation with a health care or social service provider are overrepresented in the responses gathered from the community meetings and the online survey. Also, people who have experienced health disparities may have faced barriers to participation, including time and location of meetings and distrust of state government.

To address these barriers, OHA-PHD staff reached out to agencies suggested by the Themes and Strengths Assessment Subcommittee. At OHA-PHD invitation, several agencies held internal discussions around the SHA's key community engagement questions and sent notes to the PHD to include in this report. OHA-PHD also purchased Facebook ads to reach populations that had not participated in the initial launch of the online survey. Additionally, the SHA incorporates findings from the OHA-Place Matters Oregon focus groups, which OHA conducted in 2014 with African Americans, Latina(o)s, American Indian and Alaska Native, and residents in rural areas of the state.

A lack of sufficiently granular data was also a challenge. Although OHA-PHD monitors a wealth of population data, many of the indicators do not allow for analysis by subgroup such as race, ethnicity or county. For some indicators, the data collection process does not encompass these and other subgroups. For example, it is difficult to capture health information about migrant workers or incarcerated populations. For other indicators, the number of people affected by a specific condition or behavior is not large enough to allow for meaningful analysis. In 2015, the Oregon Legislature enacted a statute related to the collection of data on race, ethnicity, language, and disability status. As this statute continues to be put into practice across the Oregon Health Authority and Department of Human Services, OHA-PHD expects the availability of granular data to improve.

Public Health System Assessment

The Oregon public health system is transforming through public health modernization. The model for public health modernization is built upon a set of 7 foundational capabilities and 4 foundational programs. Foundational capabilities are the knowledge, skills, and abilities needed to run effective public health programs like communicable disease control, prevention and health promotion, environmental health and access to clinical preventive services. Foundational programs, in turn, lead to better health outcomes.



In 2016, all state and local public health authorities completed a public health modernization assessment to learn about current capacity for providing foundational capabilities and programs. This assessment found:

- There are gaps in all areas across the public health system.
- Some public health authorities have more gaps than others.
- No foundational programs or capabilities have been significantly implemented across the state.
- The most significant gap was found in the health equity and cultural responsiveness capability. More than half of all people in Oregon live in an area where the public health authority does not have the capacity to sufficiently address health disparities.

In July 2017, members of the SHA Steering Committee and other community members participated in a webinar to learn about the 2016 public health modernization assessment and discuss how its findings could be applied to the SHA. This group highlighted the need for ongoing focus and reflection on what the public health system should be doing to reduce health disparities.

Public health authorities are already working to build capacity in the foundational capabilities, and this work will continue in coming years. The goal is a modern public health system – one where innovative public health agencies build upon their historic success at improving health with greater attention toward improving health equity.

Environmental Context

Forces of Changes Assessment

In order to describe the greater context of the SHA, the SHA Steering Committee identified the events, trends, and factors that affect health in Oregon or could affect it in the future.

Events – One-time occurrences, such as a natural disaster or passage of legislation

The committee identified the impact of changes in leadership at all levels of government, including federal, state, and government agencies, as the primary "event" affecting health in Oregon. While federal-level changes have threatened social and health services and protections such as the Affordable Care Act, Deferred Action for Childhood Arrivals (DACA), and the Indian Healthcare Improvement Act, state-level changes have created opportunities to improve population health, such as Cover All Kids, Tobacco 21, and the Reproductive Health Equity Act.

While the creation of CCOs has drawn national attention to Oregon's innovative approach to health care, challenges remain. People have reported facing barriers to accessing care because of a lack of health care providers, particularly in rural and frontier areas.

Other identified events of importance included natural disasters and other traumatic events, such as wildfires, earthquakes, tsunamis, and mass shootings.

Trends – Patterns over time, such as migration or gentrification

The primary trend that the committee identified was Oregon's quickly growing population. According to Census Bureau data, Oregon was the 6th fastest-growing state in the nation in 2016, and more than three-quarters of this growth came from people moving into the state. Oregon's Office of Economic Analysis (OEA) projects that the population will grow to 4.25 million people by 2020. Not only is the number of people in Oregon increasing, but the state is becoming more diverse.

This demographic change is fueling economic growth for some. However, it also exacerbates disparities, as seen in the current housing crisis affecting all parts of the state. A growing population also taxes health and social systems. The population of Oregon

is also growing older. An aging population places more demands on the medical system and long-term care facilities.

Committee members also expressed concern about the privatization of public health services as a result of declining resources for public health.

Other trends identified in the SHA include the potential negative impacts of climate change. The committee also noted the potential for climate-change solutions that could improve population health in Oregon, like greater consumption of locally-grown foods and increased use of active transportation options such as biking and walking.

Factors – Forces that are constant, such as geographic elements

The committee noted that people in Oregon are proud of the state's abundant natural resources, tremendous recreational opportunities, and strong tourist industry. However, outdoor opportunities are not accessible to everyone due to transportation and financial barriers. The tourism industry benefits many people in Oregon but has also reduced the affordability of housing in some communities. Finally, while beautiful, mountains create significant transportation barriers for isolated communities, particularly during winter.

The committee also highlighted Oregon's struggle to fund the high-quality state services that people expect the government to provide. For example, although most people agree that Oregon is a good place to raise a child, the state education system continues to be among the worst in the country. Until Oregon identifies a more sustainable revenue structure, basic services will be threatened.

The committee recognized that while the real estate market is thriving in some areas of the state, the experience of homelessness and housing instability is a reality for many people in Oregon. This is a growing problem as housing costs increase. Finally, while historical and current institutional and systemic racism contributes to segregation and gentrification, communities also report increased awareness of and conversations about racism in our state.