Lane County Community Health Assessment 2018-2019

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100% Health
Community Coalition

LiveHealthy LANE

Community Health Assessment

2018-2019

EXECUTIVE SUMMARY

United Way
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Trillium
Community Health Plan

LANE COUNTY OREGON
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Acknowledgements

This report was developed by the 100% Health Executive Committee and Live Healthy Lane (LHL), which is comprised of Lane County, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, and other organizations invested in the Lane County's 2018-19 Community Health Needs Assessment. LHL gratefully acknowledges the participation of community members in Lane County's Health Assessment including those who shared their important experiences with health, and those who engaged in facilitating assessments. A full list of individuals who led each assessment is listed in each assessment report found at www.livehealthylane.org.

Please contact Senna L. Towner at United Way of Lane County (541-741-6000 X163, stowner@unitedwaylane.org) or Jennifer Webster (541-682-4280; jennifer.webster@lanecountyor.gov) with questions about this document.

INTRODUCTION

Creating a healthy community is a shared responsibility. By working together, we have the potential to create a caring community where all people can live a healthier life. Live Healthy Lane (LHL) brings together Lane County, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, local organizations, and community members to contribute to improving the lives of everyone in Lane County.

LHL uses the Mobilizing for Action through Planning and Partnerships (MAPP; NACCHO, 2018) model as the strategic framework for prioritizing community health issues and developing strategies to improve health outcomes. There are six phases of MAPP:

1. Organize for Success & Partnership Development;
2. Engage in Visioning;
3. Conduct a Community Health Assessment;
4. Identify Strategic Issues;
5. Formulate Goals & Strategies; and
6. Engage in the Action Cycle.

The final three steps together comprise creating and implementing the Community Health Plan (CHP). Step three, conducting a Community Health Assessment (CHA), includes four assessments[1]: 1) Community Themes and Strengths Assessment, 2) Local Public Health Systems Assessment, 3) Community Health Status Assessment, and 4) Forces of Change Assessment.

MAPP: Mobilizing Action through Planning and Partnerships

This report is a summary of the four assessments that were conducted between April 2018-September 2019. The assessments were approved by the 100% Health Executive Committee, who steers LHL's work, on November 20, 2019. The CHA reports, including this summary report, can be found on LHL's website at www.livehealthylane.org. Community members are also invited to provide feedback on the CHA here.

[1] Live Healthy Lane also conducted a fifth assessment called the Care Integration Assessment, which is not included in this Executive Summary and can be found at Live Healthy Lane's website www.livehealthylane.org.

COMMUNITY THEMES AND STRENGTHS

The Community Themes and Strengths Assessment (CTSA) asks the questions:

- *What is important to our community?*
- *What is important to our quality of life and well-being?*
- *What assets do we have in our community?*

The CTSA conducted in 2015 provided such a wealth of information from a variety of individuals and organizations that LHL partners built upon rather than replicated the efforts. Thus, the 2019 CTSA focused on learning whether the community health issues identified in 2015 continue to be priorities in Lane County, and whether those priorities resonate specifically with people from groups and populations that were not as well-represented in the 2015 CTSA.

Broadly, the findings from the 2019 CTSA are as follows:

- Populations targeted for participation were reached.
- There are some slight, but not significant, differences in perception about the barriers to health or access to facilitators of health among these populations compared to the county overall.
- The priorities identified in 2015 remain relevant and important to the community.

The strategic priorities, in order of ranked importance by community members[2] (with overall ranking score, on a scale of 1-7 with 1 being most important) are:

1. The ability to access affordable housing (2.05)
2. The ability to access living wage jobs (2.76)
3. The ability to access affordable, healthy food (3.73)
4. The ability to access mental health and addiction services (3.88)
5. The ability to access affordable, high-quality childcare (4.34)
6. Efforts to promote healthy behaviors (5.51)
7. The ability to access dental care (6.61)

Based on data from 2015 and comments on the 2019 survey, community members identified **collaboration, policy work**, and **general understanding of the social determinants of health** as assets for continuing the work on community health improvement.

[2]Based on the survey of over 500 members of the Lane County Community.

LOCAL PUBLIC HEALTH SYSTEMS

The Local Public Health System Assessment (LPHSA) asks the question:

- *What are the activities, competencies, and capacities of our local public health system?*

The 2018 LPHSA focused on the four essential public health services most relevant to current and future Community Health Plan (CHP) work:

- Essential Service 3 (ES 3): Inform, educate, and empower people about health issues
- Essential Service 4 (ES 4): Mobilize community partnerships to identify and solve health problems
- Essential Service 5 (ES 5): Develop policies and plans that support individual and community health efforts
- Essential Service 7 (ES 7): Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Compared to 2015, **the local public health system has improved** in all these areas:

Essential Service	2015 Score	2018 Score
Educate/Empower (ES 3)	39.8%	66.7%
Mobilize partnerships (ES 4)	55.2%	61.5%
Develop policies/plans (ES 5)	52.1%	75.0%
Link to health services (ES 7)	53.1%	62.5%

Scoring	
Optimal Activity (76-100%)	*No room for improvement*
Significant Activity (51-75%)	*Room for minor improvement*
Moderate Activity (26-50%)	*Room for improvement*
Minimal Activity (1-25%)	*Room for substantial improvement*
No Activity (0%)	*Significant improvement needed*

The following areas of focus were identified for continuing the work of improving the community's health:

- Effective and appropriate data sharing and communications
- Communication about the broad and integral nature of public health
- Engagement with community partners, especially the business community, to better integrate and understand each other's contributions to community well-being
- Communicate with and engage the community to increase understanding of housing as a public health issue and the importance of addressing mental health needs as a piece of improving access to housing
- Continue to focus on health promotion and health education

COMMUNITY HEALTH STATUS

The Community Health Status Assessment (CHSA) asks the question:

- *How healthy are our community members?*

The assessment covers a range of health outcomes, health behaviors, and social determinants of health. In 2015, a subcommittee of LHL came together to select indicators for the CHSA. Those indicators were updated in 2018-19 with the most recently available data.

The major CHSA findings, listed below, are categorized into those that contribute to "A Healthy Community" and those that are "Potential Priority Areas:"

A Healthy Community

- Lane County's population is growing more slowly than Oregon's overall and is becoming increasingly racially/ethnically diverse.
- Lane County's environment is generally clean, with good air and water quality.
- Thanks to the Affordable Care Act, Lane County's uninsured population is decreasing and preventive health screenings are increasing.
- Lane County residents are slightly more physically active and eat more servings of fruits and vegetables than the state overall, however, both are still well below CDC recommendations.
- Rates of chronic disease have remained stable in Lane County in the past few years.

Potential Priority Areas

- Despite recovery from the 2008 recession, Lane County continues to struggle economically:
    - 20% of Lane County's population lives in poverty;
    - 40% of Lane County residents pay more than 30% of their income on housing; and
    - About 50% of Lane County's elementary school children participate in the Free/Reduced Lunch program.
- The four-year cohort graduation rate for Lane County's high school students is 74%, lower than the state overall.
- Lane County residents use tobacco, alcohol and marijuana at slightly higher rates than the state overall.
- Rates of depression and/or 'poor mental health days' appear to be increasing in Lane County.
- Rates of sexually transmitted diseases are increasing at an alarming rate in Lane County.

Although Lane County remains moderately healthy on the whole, there are **several health conditions and social determinants of health that vary dramatically based on race, ethnicity, and geography**, creating significant inequities in health and in the conditions necessary to create health.

FORCES OF CHANGE

The Forces of Change Assessment (FOCA) asks the questions:

- *What is occurring or might occur that impacts the community's health or local public health system?*
- *What specific threats or opportunities are generated by these occurrences?*

Five primary forces were identified, as well as the threats they pose and opportunities they offer.

Threats	Opportunities
Housing	
Pricing and inventory	Housing 1st
Lack of housing at different levels of affordability	More local control
Increasing number of people navigating homelessness	Multi-generational pairing options
Gentrification	Supportive housing
	More flexibility in land use
Federal/State politics	
Loss of the Affordable Care Act	Innovations to funding
Cuts to social safety net	Proactive engagement of communities
Immigration policies	More local collaboration
Immigration	
Fear of accessing services	Opportunities to strengthen cultural competence
Hate crimes	Integration of services
Loss of federal funding due to sanctuary status	Advocacy for better policies
Increased health disparities	
Technology	
Social isolation	Integration and sharing of data
Privacy/PHI issues	Rural access/telemedicine
Generational knowledge gap	Strengthen privacy protections
Silos within systems of care	Internet as a public utility
Public Discourse	
Deep racism	Teaching to assume good intentions
Lack of objective news sources	More interagency cooperation
Lack of accuracy, honesty, and accountability	Engaging more community-based organizations
Equity seen as a negative	

Of note is the **interrelatedness of the primary forces** identified and the way the **threats and opportunities intersect**. Also of note, three of the primary forces, Housing, Immigration, and Technology, were also identified in the 2015 FOCA.

ASSESSMENT THEMES

From the four assessments, the following themes emerged:

- A significant proportion of Lane County residents **lack access to affordable housing, living wage jobs, healthy food**, and **quality childcare**, all of which are key social determinants of health.
- There are **significant disparities** in both health outcomes and the social determinants of health in Lane County **based on race/ethnicity**.
- There is a concerning trend of **worsening mental health** among Lane County residents, especially youth.
- The **above conditions stem from and contribute to social and environmental conditions** that are detrimental to healthy behaviors and healthy outcomes for Lane County residents.

NEXT STEPS

Guided by the 100% Health Executive Committee and LHL, the 2018-19 CHA is used to identify and prioritize health needs in Lane County, and informs the development of a Community Health Plan (CHP). Effective community health improvement is a continuous process that includes strengthening and building new partnerships, leveraging resources, and implementing and evaluating evidence-based approaches. More information about how Lane County's community works to improve its health and how to engage with this work can be found at www.livehealthylane.org.

Community Health Assessment, Executive Summary

2018-2019

Care Integration Assessment

May 4, 2018

Acknowledgements

This document was developed by *Live Healthy Lane*, which is comprised of Lane County Public Health, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, and other organizations invested in the Lane County's 2018 Community Health Needs Assessment. Lisa Ladendorff, the Training and Development Director for Northeast Oregon Network, was instrumental in planning the assessment, and Dr. Rick Kincade from Lane County Health and Human Service's Community Health Centers, facilitated it. Committees working to advance the health of Lane County were pivotal in completing this assessment and include:

100% Health Executive Team
Live Healthy Lane Core Team
Trillium Community Health Plan's Community Advisory Council

The participants who engaged in this assessment include:

Susan Ban
Susan Blane
Amanda Cobb
Jane Conley
Tara DeVee
Susie Dey
Leah Edelman
Cynthia Fisher
Caity Hatteras
Dawn Helwig
Rick Kincade
Linda Mann
Holly Mar Conte
Tara McCullers
Milo Mirro
Shawn Murphy
Chris Parra
Kristina Payne
Char Reavis
Lisa Roth
Matthew Sinnott
Cindy Shirtcliff
Senna Towner
Jocelyn Warren
Kayla Watford
Trevor Whitbread
Lucy Zammarelli

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INTRODUCTION

Live Healthy Lane

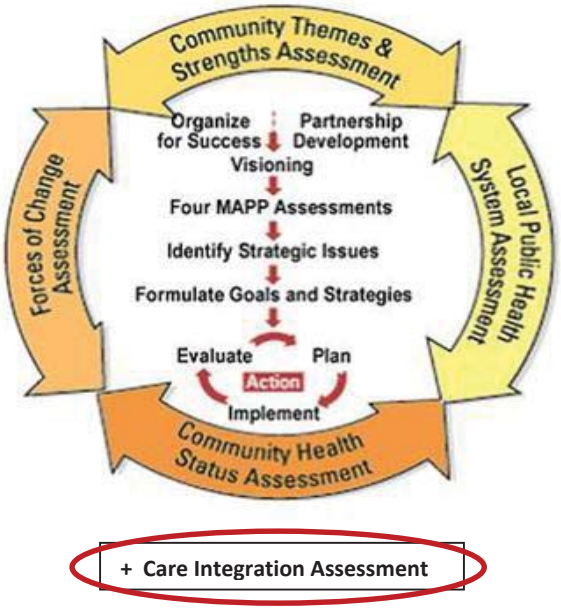
Creating a healthy community is a shared responsibility. By working together, we have the potential to create a caring community where all people can live a healthier life. *Live Healthy Lane* brings together Lane County Public Health, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, local organizations, and community members to contribute to improving the lives of everyone in Lane County.

Live Healthy Lane uses the Mobilizing for Action through Planning and Partnerships (MAPP; NACCHO, 2018) model (see Figure 1) for collecting data that informs how we as a community can improve our health. Specifically, Lane County's Community Health Improvement Plan (CHIP) is shaped by data collected by the Community Health Needs Assessment (CHNA), which uses MAPP as its strategic planning process.

Care Integration Assessment

Not a standard part of MAPP, the Care Integration Assessment (CIA) is a supplement to Lane County's 2018 CHNA, as mandated by House Bill 2675. The Bill passed during Oregon's 2017 Legislative Session as an amendment to ORS 414.627[1]. It calls for Coordinated Care Organizations (CCO), or the collaborative healthcare provider network charged with supporting the health of individuals covered by Medicaid/the Oregon Health Plan (Oregon Health Plan, 2018), to implement a CHIP that includes an integration strategy. *Integration*, by definition, is the coordination of physical and behavioral healthcare (SAMHSA, 2018), thus, the strategy is required to include an approach to *integrating* services, activities, and responsibilities related to physical, behavioral, and oral health care services.

Figure 1



The ultimate goals of an integration strategy are to improve patient outcomes, patient experience, provider experience, and reduce total cost of care. This assessment examined how well domains of care are currently integrated in Lane County.

Specifically, the purpose of the CIA is to *identify service areas with integration opportunity expected to influence the health and quality of life of people living in Lane County, Oregon*. The objectives of the assessment are to:

a) determine existing integration in Lane County,
b) explore opportunities to integrate services, and
c) identify the associated barriers to and resources for integration.

This report that summarizes the CIA is intended to assist the *Live Healthy Lane* planning teams (i.e., Core Team, 100% Health Executive Team) in shaping the 2020-2023 CHIP strategy. The report includes the CIA's:

1) methods,
2) key findings,
3) strengths and limitations, and
4) an appendix with detailed data.

2. **ORS 414.627**: In Oregon, a Coordinated Care Organization (CCO) is required to have a community advisory council, which shall meet every three months, and will ensure the healthcare needs of the consumers and the community are being addressed.

METHODS

On May 4, 2018, Lane County held its first Care Integration Assessment (CIA) at Oregon Research Institute in Eugene, Oregon. Facilitated by Dr. Rick Kincade from Lane County's Health and Human Service's Community Health Centers, the brainstorming session convened 29 leaders from diverse sectors including housing, healthcare, behavioral health, oral health services, public health, education, and social services.

Integration Opportunities, Barriers, and Needed Resources

Using the snow card technique (Bryson, 2004), which is a straightforward and effective approach for generating a list of information from a group of people, participants were asked to consider opportunities in which *integration of services could improve efficiency and quality of care* for the following nine domains:

- Housing
- Food
- Education
- Income
- Oral Health
- Physical Health
- Substance Use Treatment
- Public Health
- Mental Health

Participants were encouraged to consider broad and all-encompassing or narrow and very specific ideas. The following six questions guided the discussion:

1) What are the points of contact?
2) What gaps in services could have been addressed if available?
3) What systems of care would need to interact to improve efficiency in care delivery?
4) What are the barriers to more effective integration?
5) In what areas of the previous CHNA/CHIP did integration improve outcomes? Could these be leveraged in the next CHIP?
6) What opportunities or resources could be available over the next CHIP cycle that could improve the chance of meaningful integration?

After participants generated a list of *opportunities* for integration, they divided into small groups to explore and discuss related *barriers*, defined as *obstacles to moving forward with integration efforts,* and the related *resources* needed for more effective integration, defined as *necessary fiscal or human-power needs to accomplish enhanced integration.*

Integration Perception

Community Integration Planning Grid: Participants shared their perceptions of the levels of integration (i.e., minimal, moderate, significant) of various services. Further, using this same scale, participants explored their perceived value to integrating services. The purpose of this exercise was to identify the level of integration existing today and, in areas where integration needs development, where the next CHIP can focus its related attention. The grid/tool used for the integration perception exercise allowed participants to recognize opportunities for improving integration in the listed service environments. Ultimately, the tool can help plan intentional initiatives using community collaborative arrangements across and between service providers.

Focused CCO Services Integration Evaluation Grid: Finally, participants explored their perceptions of the levels of integration within the core CCO Services (i.e., primary care, oral health, mental health, substance abuse treatment) by using the following measures: Coordinated Care, Co-located Care, Fully Integrated Care, or No Integrated Care. Because it is the CCO's responsibility to coordinate Medicaid services, this assessment approach can help inform planning for intentional service integration.

KEY FINDINGS

Integration Opportunities, Challenges, and Existing Approaches
Participants identified a broad array of *opportunities* that have the potential to support and improve integration. Related themes and subthemes emerged and are listed in Table 1. It is clear from participants' conversations that Lane County has the foundation for an efficient, integrated system. This is evidenced by the current collaborative approaches, many of which have resulted in positive outcomes including a move towards an upstream approach to addressing health outcomes.

Table 1. ***Opportunities for Healthcare Integration in Lane County***

	Themes	Subthemes
Opportunities	**Collaboration**	• Resource shortage ⟶ creative and non-traditional collaborations (e.g., substance abuse treatment and housing systems) • Community partnerships
	Resources	• PCPCH* funding and incentives • Advocacy efforts ⟶ increased funding for integration efforts • Emerging technology (e.g., tele-health) • Empty buildings for housing
	Positive Outcomes	• A focus on prevention • Reduced mental health stigma • Equity efforts • Wrap-around services • Food insecurity addressed in traditional healthcare settings • A shift towards trauma-informed care

* Patient-Centered Primary Care Home Program

Barriers to and *needed resources* for integration, as well as related themes and subthemes, were also explored and are described in Table 2. Generally, participants want to see current partnerships and in turn integration efforts expanded, and one of the primary barriers to increasing integration is needed funding. Although Table 2 lists funding as separate from the other barriers and needed resources, without question funding (or lack thereof) informs all other barriers and needed resources. For example, with more funding, accessible, affordable, low-barrier housing would be easier to address. (Funding is not the only needed resource, however; collaborative efforts, access, etc. are also needed.) Further, and perhaps unsurprisingly, housing is the only domain that was listed as a prominent needed resource, which speaks to housing as a basic need that informs all other systems and determinants of health. Specifically, housing is a requirement for health and wellness, and it lays the foundation for all other basic needs (CDC, 2009). In sum, funding and housing are interrelated with and inform all other needs for integration.

Table 2. ***Barriers to and Resources Needed for Healthcare Integration in Lane County***

	Themes	Subthemes
Barriers	**Access**	• In rural areas • For the homeless • 42CFR Part 2: Substance use disorder treatment confidentiality
	Payment Systems	• Shifts in the payment system • Getting mental health providers on insurance panels • Trillium Community Health Plan billing support • Social determinants are inconsistently coded, but billed when included
Needed Resources	**Funding**	• For health certifications • For supportive technology • Needs further shift towards prevention • More money to replicate existing, successful efforts (e.g., Veggie Rx) • To address all other barriers
	Education/Training	• Workforce development of doctors/psychiatrists • General professional development • Trauma-informed care training • Related incentives • Health systems navigation/literacy
	Housing	• Subsidies • Accessible, affordable, low-barrier access • Expansion • Youth/transitional housing

Despite the barriers to and needed resources for integration, participants generated an extensive list of existing approaches to integration in Lane County, and agreed that these approaches should inform future integration efforts. Table 3 lists these approaches by the nine service domains discussed. The approaches listed do not, by nature of integration, strictly belong in only one of the service domains. For instance, food integration approaches are listed only under the food domain, but this approach could also be listed under the physical health domain, because it is an example of the current integration between food and traditional physical healthcare. To simplify the table, however, Table 3 lists each approach under one service domain only.

Table 3. ***Existing Integration Approaches***

Service Domain	Existing Integration Approaches
Housing	**1)** Utilization of Traditional Health Workers and Community Health Workers **2)** Better Housing Together **3)** Implementation of education, couching, and resource/assistance development **4)** Newly implemented housing projects (e.g., Square One Emerald City) **5)** Renters' education
Food	**1)** Food for Lane County Programming (e.g., accessible gardens, community education, Extra Helping) **2)** Food integration in housing, social services, and healthcare settings (e.g., Veggie Rx, food provided at crisis service sites such as the Emergency Department, food boxes at churches) **3)** K-12 integrating food education (e.g., school gardens)
Education	**1)** Parenting classes (e.g., Relief Nursery, Parenting Now) **2)** Private sector involvement in schools **3)** Career and Technical Education (CTE)
Income	**1)** Goodwill Industries **2)** Incubator businesses **3)** Regional Accelerator and Innovation Network (RAIN) **4)** Financial mentorship **5)** Job share opportunities **6)** Lane Workforce partnership
Oral Health	**1)** Dental screenings held at WIC, Headstart, and middle schools **2)** United Way's dental kits disseminated in schools, clinics, and housing support projects **3)** Whitebird's resource list including oral healthcare options
Physical Health	**1)** Embedded dental screenings in education settings **2)** PCPCH* **3)** Nutritional education at schools and clinics **4)** Centro Latino Americano **5)** Sheltercare **6)** Legal aid offered at traditional healthcare appointments

Table 3. *Existing Integration Approaches* (continued)

Mental Health	**1)** Screening, Brief Intervention, and Referral to Treatment (SBIRT) **2)** Medication assisted treatment for opioids **3)** Looking Glass **4)** Resource collaboration (e.g., 211) **5)** Whitebird **6)** Rapid access program **7)** Lane Pain Guidance **8)** Safety Alliance **9)** Suicide prevention in schools (k-12 and higher education) **10)** Behavioral health assessments and referrals in k-12 schools
Substance Abuse Treatment	**1)** Skill building and health education in K-12 education **2)** Community Health Workers and Peer Support Specialists are supporting patients **3)** ElRod – encouraging artistic expression for healing **4)** Christian-based services (e.g., Christians as Family Advocates) **5)** Naloxone at community partners **6)** Willamette Family Treatment Services
Public Health	**1)** Wellness Clinics **2)** Focus on social determinants **3)** Accessible vaccinations **4)** Education/outreach **5)** Tobacco prevention **6)** Safer sex kit distribution **7)** Effective STI treatment **8)** Non-traditional locations

* Patient-Centered Primary Care Home Program

Integration Perception

Community Integration Planning Grid: Opportunities for increasing the level of integration were identified using the Community Integration Planning Grid. Overall, participants noted that integration across most domains needs improvement. Importantly, *physical health* and *public health* were the only care environments with current *significant* integration and value. *Food* was not integrated well with any of the domains except income, but even in this case, food and income have only moderate integration. That said, participants identified moderate or significant value in integrating most domains. For instance, participants perceived significant value in integrating almost all domains with mental health, substance abuse treatment, and public health. (This is not to suggest that these domains are currently integrated, only that there would be value to integrating them.) In sum, participants perceived the need to improve integration across all domains where integration is possible, and that there is significant value to integration of many domains. The grid detailing participants' perceptions of integration level and value can be found on page 9.

Focused CCO Services Integration Evaluation Grid: Levels of CCO service integration were also identified by participants. Of note is the perception that *mental health* and *primary care* are thought to be fully integrated while *substance abuse treatment* and *oral health* are thought to have no integration. A grid illustrating participants' perceptions of CCO service integration can be found on page 10.

STRENGTHS AND LIMITATIONS

The qualitative nature of this assessment provides opportunity for exploration and discovery of integration opportunities expected to influence the health and quality of life for people living in Lane County, Oregon. For instance, participants generated a list of existing integration approaches, which can inform future integration efforts in the county.

Respondents were recruited from myriad different healthcare sectors in Lane County, and as a whole provided substantial contributions to assessing service domain integration in Lane County (Polkinghorne, 2005). This report provides a snapshot of healthcare integration in the county. Nevertheless, the assessment results are based only on respondents' perceptions, experience, and knowledge. In turn, they are meant to inform the 2020-2023 Community Health Improvement Plan, but should be considered in conjunction with the results from other data collected during Lane County's 2018-2019 needs assessment MAPP process. Further, future integration assessments should replicate and extend this assessment to uncover details and nuances related to healthcare integration in Lane County, Oregon.

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APPENDIX
Data Collected During the May 4 Assessment

To follow is a detailed report of the findings from the May 2018 Lane County Care Integration Assessment. First, the two planning grids (i.e., Community Integration Planning Grid and the Focused CCO Services Integration Planning Grid are provided) are included. Next, each service domain is detailed as it is positioned and operates in Lane County, and the related opportunities, resources, and barriers for integration are bulleted. The sum of these analyzed data can be found in the "Key Findings" section of this report.

Assessment Grids

Community Integration Planning Grid

Service Area	Housing		Food		Education		Income		Oral Health		Physical Health		Mental Health		Substance Use Tx		Public Health	
Integration Level, Value	Lev	Val	Lev	Val	Lev	Val	Lev	Val	Lev	Val	Lev	Val	Lev	Val	Lev	Val	Lev	Val
Housing																		
Food																		
Education																		
Income																		
Oral Health																		
Physical Health																		
Mental Health																		
Substance Use Tx																		
Public Health																		

Note. The table reads such that service domains on the Y axis are integrated into service domains on the X axis (e.g., how well food is integrated into housing, education into food, income into education, etc.).

Key

- **Minimal integration**
- **Moderate integration**
- **Significant integration**
- Integration is **not appropriate or possible**
- **Minimal value**
- **Moderate value**
- **Significant value**

Focused CCO Services Integration Planning Grid

Service Area	Primary Care	Oral Health	Mental Health	Substance Use Tx
Primary Care				
Oral Health				
Mental Health				
Substance Use Tx				

Key

Coordinated Care
Co-located care
Fully Integrated Care
No Integrated Care

Service Domains: Descriptions and Data

1. Housing

Numerous concerns exist over the trend of decreasing availability of affordable housing in Lane County. The rising cost of housing and relatively flat wage levels have created increasingly vulnerable families in our community. Childcare remains another high cost driver for vulnerable families, which can negatively impact their ability to access secure, long-term housing. Integration efforts have primarily been centered around the development of strong supportive housing entities, leveraging community relationships to bring services directly to residents. Integration of services, including job development training and legal services, have improved the chances of stability for many families.

Existing approaches to integration:

- Cornerstone, Homes for Good, and St Vincent de Paul utilizes Traditional Health Workers and Community Health Workers
- Willamette Family Treatment Services – developing all further given housing crisis
- FHC, Coordinated Entry Central Waitlists, St Vincent de Paul
- Renter's education
- Better Housing Together collaboration/partnerships for communitywide housing shortage
- Neighborhood Economic Development Corporation is creating integration opportunities through its education, coaching, & resources
- Recovering houses, city housing project, tiny houses (e.g., Square One Emerald Village), South Lane, Housing First
- Assistance for the first time home buyers with NEDCO and others
- MLK – Housing First project

Opportunities/Resources identified:

- Education: budgeting, more ADA housing.
- Strengthen local partnerships and identify local resources
- Culturally and Linguistically accessible programs
- Funding more paneled mental health Providers Trillium Community Health Plan billing support
- Certification billing demands/education shortage of MH providers
- Client centered housing space
- City planners/ incentives for contractors/ money back

- Mental health supportive housing
- Expanding housing opportunities in rural
- Embedded services at housing sites
- Diagnosis documenting social determinants no consistently used/billed on claims
- Better use of empty buildings
- Rent prices are very high, consider expanded subsidies
- Providing services/education/training at housing
- Network of private property managers tools to entice property managers to rent
- Accessory dwelling units
- Youth housing – Transitional Housing
- Pro-social housing communities

2. Food

Adequate and easy access to local fresh foods is a focus with multiple programs in Lane County. Food for Lane County, in particular, has been the primary vehicle for integrating food availability and nutritional education into housing environments and into primary care clinics. Programs have enhanced Supplemental Nutrition Assistance Program (SNAP) dollars (FNS, 2018) for fruits and vegetables through collaboration with Willamette Farm and Food Coalition, an effective way to increase healthy food purchases. SNAP is a USDA-run program that provides nutrition assistance to low-income individuals and families (FNS, 2018).

Existing approaches to integration:

- Food for Lane County (FFLC) – more accessible gardens, education/ foods healthy choices, extra helping
- GR gardens, food boxes (more central list of options), summer lunches, saving food collaboration, SNAP (farm double-up, extra bucks)
- Integration in housing, social services, and health care settings
- Produce school program, food in EDs/clinics
- Churches that provide food boxes
- Healthy food access development within Double Up Food Bucks & FFLC
- Food distribution/expansion near crisis services sites (Emergency Department, Hourglass Crisis, etc.)
- K-12 schools (e.g., students growing food via school gardens)
- Veggie pilot/Trillium Veggie Rx

Opportunities/Resources identified:

- Improve school lunches
- Homeless camps need access
- Food deserts still exist in many areas of the county
- Maps/lists of where to get food boxes/ meal sites
- Funding knowledge – place skills – how to access, budget, make
- Increased collaboration/ integration between Double-Up Food Bucks & SNAP
- How to distribute food (e.g., how to get healthy choices to SNAP-eligible families)
- Transportation/ delivery
- Overcome barrier related to “for profit” organizations reselling food boxes for distribution.
- Expand community garden spaces
- Head start/ school collaborative efforts with students and parents and screen/intervene
- Produce plans in health care settings
- Promote plant-based diets, cooking classes (options for those with full schedules, off site participation)

3. Education

State funding challenges, current low funding for education, and the privatization of education are significant concerns for the education sector. Optimistically, there is an increased focus, especially locally, on investing in early childhood and the related impact on long-term public health outcomes. A particular example is the well-established Lane Early Learning Alliance. Integration has been done well in school-based clinics, providing both physical health and behavioral health services.

Existing approaches to integration:

- Adult education
- CTE program
- Oral health services (future) BH services (future) problem in schools
- More private sector involvement in health at schools
- Better serving of neighborhoods and families
- Future: training for career and technical education, breakfast after the bell
- Suicide prevention in schools k-12
- Behavioral health assessment and referral in k-12 schools
- Training for staff for crisis intervention has increased
- Mental health providers led skill building groups (intervention)
- Education of the direct link between behavior issues and behavioral health struggles to increase empathy within school systems
- Life – skill curriculum
- SUDS prevention/ education in schools
- Social determinants
- Peer driven/ led education
- Social services
- Broaden types of learning styles
- Centro Latino's Mental wellness classes
- Lane workforce partnership
- Food services – LCC

Opportunities/Resources identified:

- Future – more services in school based clinics
- Instruments/ equip
- Consents
- Disparate records
- LCC don't asst. pro.
- Alternative payment mythologies
- 0 access to state school fund for some services (PH/BH/OH)
- School policy
- FERPA
- Vision screening
- Gun violence
- $ for certification
- Education staff to identify social det. Of health – suicide, MH
- Relief nursery

- Need more family service integration
- More family planning integration
- Family education of ACES/ resiliency tools, vocab
- Cyber world crisis (impact) for our children
- ADA training and compliance
- Undocumented families – outreach?
- Barrier $$$ the cost of higher ed prohibits people in poverty from access
- Insure rural schools get services

4. Income

The ability of a resident to earn family-wage income is critical for long term personal and family stability. Although the healthcare industry has been a strong employer of residents of Lane County, and training programs continue to supply needed workers, integration of workforce development would assist in health stability at multiple levels and should be considered in future integration initiatives.

Existing approaches to integration:

- Goodwill Industries
- Entrepreneurial training
- Now: rain, coastal venture catalyst, small business, CTE
- Future: investment funnels, supportive eco system
- Micro enterprises
- Incubators – Sprout, Rain, net
- Supported employment
- Financial mentorship
- Standard minimum income
- Job share opportunities
- New requirements might divert energy or focus away from current priorities and traditional services; funds may be insufficient

Opportunities/Resources identified:

- Free higher ed.
- Better public – private partnerships
- Standard minimum income
- Technical skills training
- Older adult re-training
- Community health centers/South Lane/LCC/PH partnership in training
- Needs baseline level of education/degree – including entrepreneurship
- Community lack of affordable childcare
- Limited instruction opportunities/resources
- Incarceration to job market, more sponsors inc. workers program for felons through jail.
- Benefits ‘donut hole’
- More guild or apprenticeship opportunities
- Life cycle changes
- DHS partnership to help welfare recipients get training to re-enter workforce and Lane workforce partnership
- External sources of $$?

- Feds, VC, other?
- Paid 'volunteer' programs
- Living wage
- Disabled job programs
- Benefits offered for part time jobs
- Provide professionals in schools
- Expand school loan forgiveness programs

5. Oral Health

The lack of unified focus on oral health within medicine, inadequate local dental care access (including restorative), lack of coordination in care delivery, and low oral hygiene knowledge and instructions are significant factors affecting the local public health system and community. Recent efforts to improve integration within the Dental Care Organizations has improved overall access and several promising practices exist today and have the potential to be replicated.

Existing approaches to integration:

- On-site screenings in affordable housing and schools
- Physical health – control
- Immunizations
- Annual wellness
- Health and safety assessment (questionnaire)
- Substance abuse questionnaire
- Food assistance (e.g., produce pantry)
- WIC, head start
- HPV/ BP'V's/ Oral CA screening
- Free toothbrushes and incentives
- Screening for issues in BH and triage
- White bird – better developed resource list
- United Way of Lane County dental kits

Opportunities/Resources identified:

- BH – anxiety initiative (Yamhill co.)
- Ongoing anti-fluoride propaganda
- Link with Early Learning Alliance initiatives
- Tele-dentistry to serve rural areas
- Lack of education, intern skills (eg. Brush, floss, all ages)
- Partner with existing resources
- Barrier: limited professional resources and space
- The separation of oral, eye, behavioral from physical health is bad
- Not covered by most health insurances, separate insurance.
- Co-locate hygienists
- A lot of members have OHP
- Barrier: 'pain' associated with TX, 'fear', phobia, and 'intimacy'
- Can't get to dental office
- Water fluoridation
- No Medicare coverage for oral health
- Care centers transporting

- Capturing what's out there and up to date
- Shame reduction
- Opiate addiction – fear of being in pain
- Clinics being willing to support/ provide care
- Better coverage for adults
- Mobile dental van!
- Dental care in the ER (funnel to dental clinic on-site)

6. Physical Health

The Affordable Care Act (ACA) has substantially improved access to healthcare for almost 50,000 Lane County residents, which in turn has the potential to impact the physical health of the population (Simon, Soni, & Cawley, 2017). In addition, Cover All Kids has assured all children have access to health insurance. Driven by quality expectations and a Patient Centered Primary Care Home model, care delivery in Lane County has centered around integration with behavioral health services, some with limited oral health integration. Reverse integration, primary care into Behavioral Health settings has shown cost reduction primarily in emergency department use and hospitalizations.

Existing approaches to integration:

Embed dental health screenings, NPV, varnish, BP'V's , SD, Tobacco interventions

- Food Boxes at primary care sites
- Social, Community Health Worker, Peer appointment partner
- Group support visits
- Parenting classes
- PCPCH very effective in expanding integration
- Health Education
- Nutrition education (on health clinics and schools)
- Centro Latino as a support organization
- Legal aid
- Sheltercare center
- Cornerstone centers

Opportunities/Resources identified:

- Legal aid/ immigration
- Shower facilities
- Laundry facilities
- Pharmacy on site accessible to the younger generations; efficient way to reach more people
- Partner with organizations who represent and advocate for minority population
- Incorporating active means of transportation into city planning
- Transportation education flexibility in this reach
- Buy-in (patient and provider)
- Record sharing more common
- Space sharing
- Legal protection (i.e., slip and fall accidents)
- Barriers can be related to 'for profit' organizations, language and culture
- Rural, seniors, homeless
- System is too complicated, patients need navigation assistance
- 24-7 nurse line capacity could be increased

- 42 CFR is a barrier
- Substance use integration
- Immunizations
- Lane Independent Living Alliance
- Lane Transit District
- Share model being developed by 15th night alert system
- 211 needs improvement
- Being able to bill for integration (coding system is still in silos)
- Willamalane (Prioritizing public health) veggie Rx model
- Prescribing physical activity

7. Substance Use Treatment

The integration of substance use treatment (SUD) with more traditional health settings has been limited because of federal regulatory requirements (i.e., 42 CFR Part 2 – Substance Use Disorder Treatment confidentiality), but creative solutions, including more support in primary care offices, has been helpful to meet the large demand for SUD treatment, particularly problems with the use of opiates. Extensive efforts to educate the provider community have improved the level of collaboration, opening the door for more integration.

Existing approaches to integration:

- Looking Glass
- Community "211" clearinghouse
- White bird is working well & Willamette Family Treatment & Options
- Rapid access program
- Good behavior game as a prevention strategy
- Provider education with the Lane Pain Guidance and Safety Alliance

Opportunities/Resources identified:

- Incentives – education and outreach to younger ages
- Homeless individuals – outreach and engagement
- More providers doing Medication Assisted Treatment for opioid addiction
- Collaboration and innovation: broadening health care to include more than just medical care
- Economies of scale
- $2 billion prevention and public health fund will enable reach to upstream issues to advance prevention
- Educating households on tax credits to support affordability and stabilize cost
- CCO incentive metrics
- No opiates in ED
- Continuous follow ups a support after treatment
- Trauma-informed SUDS services needed
- Cultural & Linguistic inclusivity Rural and Youth treatment
- Regulatory restrictions regarding sharing of PHI in this category "confidentiality"
- IMD barriers
- Lack of teen treatment, law enforcement – move away from tertiary (or both)
- Residential higher level
- Meaningful integration
- Adjudicated youth have better access to significant treatment programs
- Cannabis – cultural perspective and value vs harm

- 42 barriers CFR
- Incentives – not enough beds available, teens need more support care
- Teen/ peer education
- Less prescribing meds = more alternative choices
- Primary care could be a more helpful partner! Screening, Brief Intervention, and Referral to Treatment (for process for identifying SUD's and depression)
- Community reduction in stigma
- Naloxone @ community partners
- SUD waiver will help eliminate some barriers & make integration easier
- Oral health rehab/ repair needed – needs partnership

8. Public Health

The impact of the current care delivery system could be enhanced with a more direct partnership with Public Health, particularly as strategies for population health are developed. Efforts in prevention have been very successful in Lane County, largely financed by Trillium Community Health Plan and led by public health experts. Integration of services could be best supported with a strong data system and a public health construct.

Existing approaches to integration:

- Wellness clinics – more available/ support to access
- Continued focus of social determinants (e.g., race, racism, etc.)
- Vaccinations = in more access, locations, ADA access
- Education/ outreach
- Tobacco prevention
- Safer sex kits distribution has been effective
- Cultural and linguistic inclusivity understanding poverty
- Non-traditional locations
- Cultural norm improved regarding value of public health
- STIs more effectively treated

Opportunities/Resources identified:

- HUB program for teens?
- Develop community-wide practice standards and protocols for treatment
- Primary Care Provider and psychiatry shortages
- Gun control/ safety/ data
- People need support accessing services filling out applications and forms
- Know what's available to who – some services are only for homeless or families, seniors are left out
- People afraid of being shamed – train providers
- Caregivers – training on cultural sensitivity and community services
- Sex education – open and inclusive and without shame
- Exploit social media platforms understanding of public behavioral health and primary care
- Extension for Community Healthcare Outcomes project in Oregon (enhances ability of primary care physicians to treat chronic and complex illnesses via live weekly video conferences)
- Telehealth expansion to rural areas
- Water fluoridation
- Flu shot clinics in neighborhoods
- Poverty stigma prevents access

- Stigma of public health (feel supported/ unpressured)
- Prevention coalition
- More social connections – reduce isolation
- Better knowledge of behavioral health
- Resource Navigator – google, craigslist, etc.
- Available alternative health modalities (acupuncture, chiropractic, massage)
- Integration of primary care
- Better public awareness of what is available
- Vaping teen use average
- Cannabis use/abuse
- Effective marketing okaying use but not abuse
- Aging and increasingly ill population further stresses the delivery system
- Lack of connection to minority communities both with resources and effective messaging

9. Mental Health

Lane County has a strong history of collaboration with community partners, and there is significant investment in collective impact approaches (CIF, 2014). In addition, there have been focused integration initiatives within the transformation efforts of Trillium Community Health Plan. Alternative payment models and organized collaborative projects have accelerated the integration of physical health into mental/behavioral health environments resulting in significant reduction in cost of care and improved outcomes. Mental health services have been integrated in primary care environments across the community, as evidenced by over 80% or primary care practices attesting to Tier 3 or higher with the Oregon Health Authority's (OHA) Patient Centered Primary Care Homes (PCPCH) program. That said, several additional opportunities have been identified for expanded integration of mental health services.

Existing approaches to integration:

- FQHC, school – based clinics, CCBHC & FRC's
- Skill building and health education, which supports mental health, exists in several schools
- Stigma has been reduced in regards to accessing mental health
- Fostering resiliency in communities has been emphasized
- Community Health Workers (CHWs) and Peer Support Specialists (PSSs) are supporting/engaging patients
- ELRod center – encourages artistic expression to heal
- Christian based services including Christians as Family Advocates

Opportunities/Resources identified:

- More education – destigmatize teens, early interventions, school services
- Development of non-traditional partnerships and coalitions with new strategies for managing cross sector collaboration and leadership
- Collaboration with multicultural organizations, local colleges and universities, and utilizing students as resources for impacts of change
- Tele behavioral health for supporting rural areas
- Need more health system navigation/literacy
- Privately insured families do not have same access to programming
- Southern Oregon for success model of community wide vocab and conversation/tools for clients
- More hands on interaction with peers
- Suicide hotline is available and needs to be marketed
- Cultural and Linguistic Inclusivity

- Wraparound services are working well, but they need to be expanded to all, not just youth
- Supported employment –people with mental health illnesses need to be supported and recruited into workforce
- We need to support workforce development of doctors/psychiatrists, as we have a shortage
- Warm hand-offs from Primary Care Provider to Behavioral Health Specialist
- Trauma-informed care needs to be the norm
- Integrated MH and Mental Health & Substance Use Disorders (SUDS) – Medication Assisted Treatement (MAT) for opiates

10. Transportation

Lane County's Community Advisory Council priorities include transportation as a fundamental barrier to access to care and to other services which could improve health. Discussion focused on opportunities to provider more integrated services using the current transportation platform and vendor.

Existing approaches to integration:

- Ride source – community partners training for clients
- LTD goes to cottage Grove, McKenzie, J. City
- Future – circle shuttles to get to Emx, set appointments with providers with consideration to bus schedules
- WFTS – provide transportation, food, housing, medical appointments, mental health, etc.
- Equitable options for rural, county residents
- Eugene pediatrics home visits
- White Bird STS service – for those who can't use other transportation due to BH
- Centro Latino Americano – discounted bus passes
- Bike Share Program

Opportunities created:

- More rural healthcare services needed
- Better integration with LTD
- Future – Expansion of transport sites (no transport to school sites), LTD & school bus integration to access healthcare, affordable passes (bus) for students
- Partner with medical facilities for reduced rate passes
- Ride sharing – include Uber and Lyft – allows much more flexible scheduling
- Expansion to rural
- Companies need to pay for cars, safety, insurance
- Ride source only for health appointments
- Coastal community is cut off
- Cost is a barrier for some for LTD
- Peers on the bus for assistance/coordination
- How to explore removing procedural barriers
- Wait times for outlying areas
- More collaboration between all providers - $ to increase efficiency
- Better driver training – people skills
- No address, no ride on LTD/ Ride Source

11. Legal Services

Not traditionally considered a service domain influencing health outcomes, this area was identified by the CAC as influencing several aspects of the social determinants of health. Lack of legal services increases evictions and other legal actions that threaten the stability of families. Integration of these services may help provide needed support and improve overall health.

Existing approaches to integration:

- Drug court, mental health court, and municipal court
- Many legal profession volunteer on non-profit and social service boards
- Fair housing council

Opportunities/Resources identified:

- Sponsors like legal/housing/employment services offered in other settings
- Money for legal barriers (grants/ scholarships for expungements, fines, forgiveness programs) Future – affordable legal aid (ex. DACA, Residency)
- Community court/ growth
- Employment
- Housing
- Financial
- Accessing services
- Lack of knowledge of resources
- Removing perceived barriers
- Educate employers on value propositions for giving people a second chance
- Reduce need for legal services… education and paperwork requirements
- Sponsors, legal aid (limited capacity), community court
- Cultural competency training (medical docs i.e., birth certificates)
- Space, employees, resources (i.e., community evolvement, collaboration with community programs, reduction)
- Free consultations – one hour
- Immigration law/ ATTY's/ SME's to with navigation and fear
- Active engagement of legal communication at meeting such as this session
- Education in high schools about legal issues, rights
- People, process, ideas, moving, info Ex, connections
- EA. Sector

Care Integration Assessment

May 4, 2018

100% Health
Community Coalition

LiveHealthy LANE

Forces of Change Assessment

June 13, 2018

United Way
United Way of Lane County

PeaceHealth

Trillium
Community Health Plan

LANE COUNTY OREGON

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100% Health Executive Team
Live Healthy Lane Core Team

The participants who engaged in this assessment include:
Liz Bainter, PacificSource Health Plans
Gustavo Balderas, Eugene School District 4J
Susan Ban, ShelterCare
Susan Blane, PeaceHealth Oregon Network
Cheryl Boyum, Cascade Health
Jay Bosievich, Lane County Board of Commissioners
Michelle Cady, Cornerstone Community Housing
Tara DaVee, Trillium Community Advisory Council
Bess Day, United Way of Lane County, Early Learning Alliance
Noreen Dunnells, United Way of Lane County
Tom Ewing, Planned Parenthood of Southwestern Oregon
Pat Farr, Lane County Board of Commissioners
Mark Florian, PacificSource Health Plans
Brian Johnson, Lane County Public Health
Robert Killen, Springfield Area Chamber of Commerce
Richard Kincade, Community Health Centers of Lane County
Ela Kubok, Homes For Good
Grant Matthews, Lane Community College
Elizabeth McCrary, Trillium Community Health Plan
DeLeesa Meashintubby, Volunteers In Medicine
Steve Mokrohisky, Lane County Health and Human Services
Joshua Monge, Eugene Chamber of Commerce
Chris Parra, Bethel School District
Dianna Pimlott, PeaceHealth Oregon Network, Peace Harbor Medical Center
Kate Reid, Willamalane Park and Recreation District
Joel Rosenberg, United Way of Lane County, Board
Damien Sands, South Lane Mental Health
Kate Scott, Lane Council of Governments, Senior and Disability Services Division
Kara Smith, FOOD For Lane County
Paul Wagner, PeaceHealth Oregon Network
Michael Wargo, Williamalane Park and Recreation District
Jocelyn Warren, Lane County Public Health

Trevor Whitbread, Centro Latino Americano
Thomas Wuest, Trillium/Health Net of Oregon
Renee Yandel, HIV Alliance

Please contact Senna L. Towner at United Way of Lane County (541-741-6000 X163, stowner@unitedwaylane.org) with questions about this document.

INTRODUCTION

Live Healthy Lane

Creating a healthy community is a shared responsibility. By working together, we have the potential to create a caring community where all people can live a healthier life. *Live Healthy Lane* brings together Lane County, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, local organizations, and community members to contribute to improving the lives of everyone in Lane County.

Live Healthy Lane uses the Mobilizing for Action through Planning and Partnerships (MAPP; NACCHO, 2018) model (see Figure 1) for collecting data that inform how we as a community can improve our health. Specifically, Lane County's Community Health Improvement Plan (CHIP) is shaped by data collected by the Community Health Needs Assessment (CHNA), which uses MAPP as its strategic planning process.

In 2015-2016, LHL conducted an in-depth MAPP assessment (see Appendix B). Although the current assessment uses MAPP principles, it is meant to "refresh," or update, 2015-2016 data, and thus should be considered in conjunction with the prior full assessment when planning the 2020-2023 CHIP.

Forces of Change Assessment

A standard part of MAPP, the Forces of Change Assessment (FOCA) explores positive and negative forces predicted to influence health and health systems in the next five years (e.g., 2018-2023). Forces take into account, for example, those that are social, economic, political, geographic, environmental, technological, legal, ethical, and/or demographic in nature. These forces can be trends, factors, and events. *Trends* are patterns over time (e.g., increasing shortage of housing); *factors* capture a community's unique characteristics (e.g., Lane County's diverse geographical landscape); *events*

Figure 1

+ Care Integration Assessment

include one-time incidents (e.g., county-wide tobacco legislation). The FOCA also uncovers the opportunities and threats that predicted forces may of bring to Lane County (e.g., equity considerations as they impact immigration policy). In sum, the purpose the FOCA is to *identify trends, factors, and events that are expected to influence health and health systems in Lane County, Oregon*.

This report that summarizes the FOCA is intended to assist the *Live Healthy Lane* planning teams (i.e., Core Team, 100% Health Executive Team) in shaping the 2020-2023 CHIP strategy. The report includes the FOCA's:

1) methods,
2) key findings,
3) strengths and limitations, and
4) an appendix with detailed data.

METHODS

On June 13, 2018, Lane County held its second Forces of Change Assessment (FOCA) at the Willamalane Bob Keefer Center in Springfield, Oregon. (Lane County's first FOCA was held in May 2015). To best consider the foreseeable forces, participants included a broad range of community members who understand and influence policy development, and thus are systems-level thinkers (e.g., government officials, non-profit directors, medical directors, hospital administrators). Such individuals are positioned to best predict upcoming trends, factors, and events, and in turn consider related threats and opportunities. Specifically, participants included 35 individuals representing sectors in Lane County directly related to public health, medicine, government, social & human services, services, non-profit, education, law, environment, and technology.

Karen Gaffney, the Director of Lane County Health and Human Services, facilitated the assessment. First, Karen reviewed for participants the process and goal for the assessment. Next, participants engaged in a brainstorming session aimed at identifying forces. Specifically, they were asked to write down perceived forces of change (see Appendix B. Forces of Change Brainstorming Worksheet). Third, using the snow card technique (Bryson, 2004), which is a straightforward and effective approach for generating a list of information from a group of people, participants were asked to consider the five forces from their larger list of which they considered most prominent. Fourth, as a large group, the facilitator gathered primary forces (1-8, in order of prominence) from each participant and posted these forces to the front of the room. Next, the large group categorized the forces (e.g., housing, technology, etc.) and titled them as, "primary forces" under which myriad "sub-forces" were listed. Finally, the primary forces were noted on large sticky notes and, in small groups, participants discussed and then wrote on the sticky notes specific potential threats or opportunities generated by the primary forces. Finally, Karen summarized the key forces and shared next steps for the assessment process.

KEY FINDINGS

Primary Forces

The following five categories emerged as primary forces. The categories are listed in order of how many times they were noted by participants, with the number of times they were noted in parenthesis:

1. Housing (20)
2. Federal & State Politics (14)
3. Immigration (12)
4. Technology (9)
5. Public Discourse (9)

Furthermore, three other categories of forces, Access, Behavioral Health, and the Aging Population, emerged. Data from these additional forces, including related threats posed and opportunities created, are included in Appendix A.

Of note are that two primary force categories, Federal & State Politics and Public Discourse, did not emerge as themes in Lane County's 2015 Forces of Change Assessment. All other forces emerged in the prior assessment, although not necessarily in precisely the same way (e.g., "Technology" in 2019 and "Technology in Healthcare" in 2015). Highlights from the 2015 assessment are included in Appendix C.

Forces, Threats, and Opportunities

To follow, a brief narrative highlighting each primary force and how it influences health and health systems is provided, along with a table including related sub-forces, threats posed, and opportunities created. (Appendix A provides data from which these summary tables emerged.)

Of note is the interrelated nature of the five primary forces. For instance, housing is influenced by federal and state politics and public discourse, while politics and public discourse influence housing and immigration. Because of the interconnected nature of the forces, threats and opportunities are also naturally interconnected. For instance, fear is a threat to housing, immigration, and public discourse; and, equity, in some form, is an opportunity created for all five forces. Given the overlapping nature of forces, threats, and opportunities, information in all the tables should be considered together.

The social ecological model (SEM; CDC, 2018) is used to organize the threats and opportunities in each table, because this perspective demonstrates the interrelated nature between the factors listed. The SEM emphasizes people's interactions with their physical and sociocultural environments, and in turn, the multifaceted nature of those factors and how they influence health (NIH, 2005). Specifically, the model puts forward five factors of influence (McLeroy, et al., 1988) on health including *public policy factors* (e.g., educational systems, sanctioned prevention), *community factors* (e.g., neighborhood structure and economy), *institutional factors* (e.g., city-wide health services availability), *interpersonal factors* (e.g., cultural beliefs, attitudes, and behaviors), and *intrapersonal factors* (e.g., personal beliefs, attitudes, and behaviors).

Housing. A 2018 Point-In-Time count identified 1,641 unsheltered individuals living in Lane County, with over 80% being single adults. Moreover, approximately 138 individuals become homeless each month in Lane County (Technical Assistance Foundation, 2018). Individuals and families are homeless for myriad reasons including, but not limited to, housing and rent costs that rise faster than wages, the burden of childcare costs, increasing competition for a limited supply of affordable housing, behavioral health services that do not adequately support needs, domestic violence, and/or circumstance of abuse, personal trauma, and hardship (City of Eugene, 2018). There is widespread understanding that housing *is* healthcare (National Healthcare for the Homeless Council, 2011), and thus housing influences health and is a public health responsibility.

Table 1. *Housing*

Sub-Forces	Threats Posed	Opportunities Created
➢ Housing Insecurity ➢ Homelessness	➢ Public Policy ▪ Zoning and codes ▪ HUD funding ▪ Housing crisis ➢ Community/Institution ▪ Wage stagnation ▪ Low/no housing = barrier to recruiting healthcare providers ▪ Inward migration ▪ Lack of documentation = barrier to secure housing ▪ Increasing crime rates ▪ Poverty ➢ Intrapersonal/Interpersonal ▪ Housing instability ▪ Evictions ▪ Fear (e.g., Not In My Back Yard/Not In My Front Yard Either)	➢ Public Policy ▪ Zoning and codes ▪ Economic support ▪ Alternative housing support ▪ Equity regulations ➢ Community/Institution ▪ Housing first efforts ▪ Accessible housing for seniors ▪ Support for aging in place ▪ Education ▪ Community mobilizing and collaboration ➢ Intrapersonal/Interpersonal ▪ Widespread knowledge of housing crisis ▪ Widespread knowledge that housing is healthcare ▪ Support (e.g., Yes In My Back Yard)

Federal and State Politics. The current state of politics, both locally and nationally, is divided. Voters, including politicians, are driven by their "political tribe" rather than principles or ideology. Instead of beliefs determining political identity, political identity often determines beliefs (Liasson, 2018). At a state level, there is an urban-rural divide where urban communities are predominantly democratic and rural communities are predominantly republican. Given that the majority of Oregon's population is urban, the state remains predominantly democratic. In turn, democratic politics inform rural areas of the state despite the voters in those regions being primarily republican (Denning, 2019). Federal and state politics inherently influence policies that directly and indirectly influence health and health systems (e.g., Affordable Care Act, tax reform).

Table 2. ***Federal & State Politics***

Sub-Forces	Threats Posed	Opportunities Created
➢ Change in the use of executive power ➢ Policy and budget changes ➢ U.S. Congress ➢ Elected officials ➢ Public Discourse ➢ Budget changes	➢ Public Policy ▪ ACA repeal/reform ▪ Medicare changes ▪ Increasing mergers and acquisitions ▪ 340B Drug Discount Program ▪ Budget deficit ▪ Tax reform ▪ Social security cuts ▪ Hyperinflation = market crash ▪ EPA reform ▪ Trade policy changes ▪ Defense industry prioritization	➢ Public Policy ▪ Political term limits ▪ Local investments and control ▪ ACA improvements ▪ Opioid prevention funding
	➢ Community/Institution ▪ Rural communities not supported ▪ Safety Net erosion ▪ Decrease in women's health services/support ▪ Racism ▪ Nationalism ▪ Cultural and geographical divide ▪ Inequitable distribution of available funds ▪ Disengagement ▪ Opposition	➢ Community/Institution ▪ Creative budgets ▪ Media accountability ▪ Collaborative local funding ▪ Lack of funds = innovation ▪ Increased youth engagement ▪ Dysfunctional federal and state government = collaboration ▪ Equity efforts/training
	➢ Intrapersonal/Interpersonal ▪ Lack of knowledge about and distrust in science ▪ Government distrust	➢ Intrapersonal/Interpersonal ▪ Critical thinking ▪ Public official outreach ▪ Voting

Immigration. Throughout America's history, immigrants have been confronted with discrimination, being denied basic human needs such as healthcare, employment, housing, and social services (Alameda County Public Health Department, 2017) – services that directly influence health. National politics have recently taken a hyper-focus on immigration despite the number of undocumented immigrants in the United States decreasing over the past

several decades (Manuel Krogstad, Passel, & Cohn, 2018). And, the current national executive branch has focused on immigration as a threat. Contradictory to national politics, Lane County follows ORS 181A.820, which "prevents state and local law enforcement agencies from targeting people based on their race or ethnic origin when those individuals are not suspected of criminal activity" (Lane County, 2018). In sum, the aim of the ordinance is to protect personal information of citizens and undocumented immigrants. Immigration is a public health issue, and thus influences community health and health systems.

Table 3. ***Immigration***

Sub-Forces	Threats Posed	Opportunities Created
➢ Policy changes ➢ Fear	➢ Public Policy ▪ Immigration reform ▪ No funds for sanctuary cities ▪ Change to Oregon driver's licenses ▪ Detention = interrupted education ➢ Community/Institution ▪ Increased health disparities ▪ Decrease in workforce ▪ Lack of public safety ▪ Separation of families ▪ New diseases ▪ No cultural support ➢ Intrapersonal/Interpersonal ▪ Hate speech and crimes ▪ Trauma = fewer people accessing care, need for more specialized care ▪ Isolation ▪ Biased treatment ▪ Racism	➢ Public Policy ▪ Improved advocacy and policies ▪ Sanctuary cities ➢ Community/Institution ▪ Safe spaces ▪ Better communication of policies ▪ Workforce development ▪ Equity efforts/training ▪ Accurate demographic reporting ▪ Service integration ▪ Media accountability ▪ Equity efforts/trainings ➢ Intrapersonal/Interpersonal ▪ Critical thinking ▪ Public official outreach ▪ Voting

Technology. Over the past several decades, technological advancements including, for example, Electronic Health Records (EHR), data systems, and telemedicine, have significantly impacted health and health systems. EHR have, for the most part, replaced paper records and impacted medical billing, scheduling, ease of patients' access to information, and improved epidemiological reporting (Banova, 2018). In addition, systems are in place that better facilitate data holding, analyzing, and sharing, which can subsequently result in reduced healthcare costs, better predicting of epidemics, preventing deaths, improving quality of life, reducing healthcare waste, improving efficiency and quality of care, and informing new drug development (Banova, 2018). Furthermore, telemedicine can support individuals who are too sick to leave their home or who live in remote areas. Although there are multiple benefits to technological advancements, there are also disadvantages including, for instance, challenges with patient privacy (i.e., how to store safely patient data), and access issues (e.g., telemedicine is not universal nor do all people have access to the Internet; Banova, 2018).

Table 4. *Technology*

Sub-Forces	Threats Posed	Opportunities Created
➢ Smartphones ➢ Drones ➢ Healthcare technology ➢ Artificial intelligence ➢ Nano-technology ➢ Other advancements	➢ Public Policy ▪ Data privacy laws ➢ Community/Institution ▪ Lack of integration of healthcare ▪ Disconnected Electronic Medical Records ▪ Access inhibited by Socioeconomic Status ▪ Increased cost ▪ Low-skilled workers pushed out ➢ Intrapersonal/Interpersonal ▪ Advancements outpace knowledge ▪ Social isolation ▪ Psychological distress ▪ Dependence on smartphones ▪ Lack of data sharing ▪ Knowledge gaps	➢ Public Policy ▪ Improved advocacy and policies ▪ Internet as a public utility ➢ Community/Institution ▪ Integrated data collection and sharing ▪ Workplace, etc. efficiencies ▪ Labor scarcity solutions ▪ Connectedness ▪ Equity outcomes ▪ Drones as first responders ▪ Automated transportation ▪ Telemedicine ➢ Intrapersonal/Interpersonal ▪ Dependence on smartphones ▪ Knowledge/trainings accessible

Public Discourse. Health and health systems are shaped by moral and political beliefs and public communication about these beliefs. Political divide at the national and state levels (Denning, 2019), as well as a misinformation stream at the national level (Kessler, Kelly, Rizzo, & Hee Lee, 2018), have led to public mistrust and fear (Montanaro, 2018), which in turn heighten oppositional conversations about moral and political beliefs (i.e., public discourse). Public discourse influences voter turnout. For instance, in the 2016 national election, only about 58% of eligible voters (138 million Americans) participated. In the 2018 midterm election, however, with public discourse heightened, an unprecedented number of people cast their ballet (47% compared to 37% in 2014; Domonoke, 2018). Public discourse, as well as voter turnout, influence health and health systems. For example, public discourse about immigration can influence people to vote for politicians who align with their own related beliefs, and subsequently, elected officials inform related policy development that inherently impacts the health of immigrants and the health systems that support immigrants.

Table 5. ***Public Discourse***

Sub-Forces	Threats Posed	Opportunities Created
➢ Political divide ➢ Voter turnout	➢ Public Policy ▪ Identity politics ▪ Big $ drives policy ➢ Community/Institution ▪ Resource competition ▪ Social media/Internet ▪ Lack of accountability (e.g., media, politics) ▪ Geographical differences (e.g., rural vs. urban) ➢ Intrapersonal/Interpersonal ▪ Government distrust ▪ Lack of critical and objective thinking ▪ Nationalism ▪ Personal interests override social good ▪ Racism ▪ Fear	➢ Public Policy ▪ Equity regulations ▪ Political term limits ▪ Supportive education ➢ Community/Institution ▪ Community leader engagement ▪ Effective leaders ▪ Community mobilizing ▪ Social media/Internet ▪ Increased youth involvement ▪ Voting ▪ Media accountability ➢ Intrapersonal/Interpersonal ▪ Knowledge of programs and politics

STRENGTHS AND LIMITATIONS

The qualitative nature of this assessment provides opportunity for exploration and discovery of forces expected to influence health and health systems in Lane County, Oregon over the next five years. Respondents were recruited from myriad different healthcare sectors in Lane County, and as a whole provided substantial contributions to assessing forces that may influence health over the next five years in Lane County (Polkinghorne, 2005). This report provides a snapshot of potential forces in the county. Nevertheless, the assessment results are based only on respondents' point-in-time perceptions, experience, and knowledge. Subsequently, although the methods for this assessment were the same as those used in 2015-2016, the results may be different due to different participants and different point-in-time responses. The current results, in turn, are meant to inform the 2020-2023 Community Health Improvement Plan, and should be considered in conjunction with the 2015-2016 FOCA results and other data collected during Lane County's 2018-2019 needs assessment MAPP process. Further, future assessments should replicate and extend this assessment to uncover details and nuances related to those factors that influence health and health systems in Lane County, Oregon.

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APPENDIX A.
Data Collected During the June 13 Assessment

1. Housing

Forces	Threats Posed	Opportunities Created
• Affordable housing (n = 3) • Lack of affordable housing (n = 2) • Housing First • Decreasing supply of housing • Increasing housing costs (31% increase in Oregon from 2010 – 2016) (n = 5) • Lack of missing middle housing and subsequent pipeline for more • Worsening housing shortage • Growing incidence of homelessness, especially those middle-aged or older (n = 4) • Increased children and families navigating homelessness • Housing crises: rents, availability, eviction/ prevention • Homelessness and burden on resources • Poverty Housing crisis growing • Housing crisis intensifies (due to wage stagnation) • Housing crisis: heavy demand versus low supply of affordable housing • Increase housing for single people (all income levels) • Housing bubble • Housing supply and types • Housing supply shortage/ cost burden. • Housing accessibility • Addressing housing insecurity in region (n = 2)	• Affordability gap • Lack of housing cost variety • Land locks • Accessible housing • Mismatch black and white HUD funding • Inward migration • Lack of documentation/background (V's?) • NIMBY & NIMFYE • Resources for homeownership • Real housing first • Land use zoning • Housing prices/inventory • Bubble • Increased construction and new developments (regional capital projects) • Local zoning/permitting • Increased construction $ • Eugene Construction Exercise Tax (CET) • Increasing homelessness overcomes local efforts • Discourages retention/recruitment of local talent (UO grads) • Failure to attract/retain healthcare providers due to no/low housing inventory (side effect: long patient waitlists due to decreased providers) • Smaller towns pricing out local residents • Increased crime rate • Inappropriate regulatory response (i.e. rent control) • Land supply restriction through land use regulations • Cost escalation via taxation and regulations (CTE, SDC's & Building codes)	• Missing middle • Tiny homes • Supportive housing • Co-housing opportunities • Increase state funding • Mixed use • Repurposed RV's • Zoning and codes • YIMBY • Housing laddering • IDA's • Educating local community on housing issue • Building community • Campaigns • More flexible land use • More local control • Accessible housing for seniors • Support for aging in place, structural modification for accommodation • Senior/millennial pairing in housing (multi-generational rebound) • Local zoning/permitting • Affordable housing subsidies • Service integration • Housing First • Healthcare and housing • Connection • Increase construction industry/jobs • Smaller towns also benefit from increased growth • Reduce homelessness • Mobile park renovation • Engage private money • Engage community and mobilize to create change • Land Trust Model

2. Federal and State Politics

Forces	Threats Posed	Opportunities Created
• Safety Net erosion • Broken budgets (State and Federal) • Federal health reform • Federal funding changes, reductions, and restrictions • Federal $ disinvestment in critical programs • U.S. Congress party "FLIP" • Decrease access to healthcare (e.g. attacks on ACA) • Changes in State and Federal programs and funding challenges (ACA, OHP, SAMHSA, VA, etc.) • Affordable Care Act repeal/reform • Modifications to SNAP and the ACA at the federal level • Essential repeal of ACA • Economic impact of healthcare legislation • Funding change or progress (how, who, how much?) • Changes in federal government support • Federal/regularity uncertainty	• Executive orders • Tax reform • Trump administration • ACA repeal • Immigration reform • Federal funding restriction • Social security cuts • Medicare cuts • SNAP cuts • Deficit – burden on upcoming generation • Healthcare reform pace → chaos/instability/discourages people entering field • Sustainability • Regulation requirements/admin burden • Increasing mergers and acquisitions • Lack of vision • Ethical challenges • 340B – Federal drug pricing (impact on rural healthcare) • Hyperinflation/market crash • Inequitable distribution of available funding, especially rural • Prioritization of defense industry investment • Medicare funded liability increase • Decrease in women's health services and supports • OWG's • EPA reform • Ignorance and distrust of science • Risky trade policy	• Elected officials can improve laws • E.O.(?) • Opioid funding • Creative budgets • Increased housing funding • Disaster prep • Wyden, Merkley, Walden, DeFazio • ACA improvements • Collaborative local funding • Dysfunctional federal/state government allows for proactive local engagement for change/collective impact (wake-up call) • V.A. reform • Collaboration reframed as a strength • Lack of funds = need to innovate • Local control • Vote • Public official outreach • Knowledge of rights • S.T.R.E.A.M. - Education

3. Immigration

Forces	Threats Posed	Opportunities Created
• Immigration reform • Anti-immigrant actions and policies • Hate crimes • Oregon driver licenses • Impact of immigration on Oregon ag sector (HB-1 visas) • IP22 - repealing Oregon Sanctuary Law • Growing fear and risk for non-citizens/immigration into the U.S. • Increased health disparities due to decreased access to services and supports • Immigrant workers access to healthcare during political pressure • Long-term impact of immigration policies (trauma) • Action by federal government, such as withholding funds, against sanctuary community • Psychological barriers to services continue to emerge for immigrant families	• Decrease in workforce (hospitality, food service, landscaping, farming) • Fear of accessing services • Potential for public health crisis • Public safety implications • Separation of families (locally too) • Exotic disease immigration • Impact/isolation of youth • Fear-based culture/attitudes (could spread sub-consciously due to public discourse) • Public officials using hate speech (overly or more subtle) • Children not receiving quality education while in detention • OR IP22, OFIR, Driver's License • Misinformation • Fear lads to mob mentality • Lack of political representation • Local government • Lack of public discourse • "Attacks" to all immigrants or "assumed" immigrants • Presents challenge to providing quality service • Lack of language and cultural support (translation/interpretation) in schools • Increased healthcare costs • Bias in treatment • Institutional racism (policies, local codes/laws, bias of services) • Law enforcement → ICE (supporting through tax $)	• Better advocacy and policies (legal path to citizenship) • Expand services locally in safe setting • Better communication of local policies on not using access to healthcare • Communicate with ICE • Workforce development that helps immigrants immigrate, adds skills to community • C.L.A.S. across more organizations • Cultural sensitivity training • Accurate demographic reporting and awareness • Encourage employment despite (jn spite of) current legal environment • Cultural enrichment • Language • Family connectedness • Cultural competence • Know your rights – U.S. Constitution • Sanctuary City • Media accountability on messaging and language use • Promote opportunities to integrate/become providers to better serve diverse communities

4. Technology

Forces	Threats Posed	Opportunities Created
• Increasing dependence on smart phones • Increasingly connected world • Increasing need for knowledge and data sharing • Greater availability of data and supportive technology • Telemedicine (or similar) becomes the standard of care • Artificial intelligence/automation – impact on low-skilled workers • Increased sharing and utilization of data and apps for population management and predictive outcomes • Technology evolves – new tools • Drones as first responders	• Social isolation • Increased cost/complexity • Tolls still not advanced to match vision • System isolation/fragmentation • Stress from 24/7 connectedness • AI – automation threats to some aspects of workforce • Pace of change/obsolescent • Knowledge gap between generations • Creates silos of care (systems do not talk to each other) • Privacy/PHI issues • Users cannot keep up with rapid change/iterations • Modernization of data that should be shared for greater good • People do not talk to each other anymore • Pedestrian fatalities • EMR connectivity • Access to technology ($ and socioeconomic) • Users ability to take advantage/access technology • Increased antisocial behavior • Anonymity	• Connectedness • Efficiencies • AI – integrate information and improve outcomes • Rural access/telemedicine • AI – Breakthroughs/cures for diseases • Opportunities to solve labor scarcity issues/new positions • Access to education/training/information • Internet as public utility • Self-management of health conditions and behaviors • Mobile technology and real-time response • Self-driving vehicle increase mobility for seniors • UO/Knight Science Center • Health Tech as an economic sector investment • Automated transportation to decrease isolation and lack of access • Collection of big data/sharing health risks and harm • Tele-community • Data sharing • Compatibility • Nano technology

5. Public Discourse

Forces	Threats Posed	Opportunities Created
• Engage community leaders • Community/neighborhood acceptance/awareness of social programs and facilities • Social/economic and cultural/geographic divide • Low voter turnout • Distrust/disillusionment with government leads to extreme political representation • Increased polarized agents • Political polarization • Increased political tribalism and social divisiveness • Declining ability for civil discourse	• Identity politics • Anonymity of internet → polarization • Competition for resources • Rural versus Urban "listening" • Fake news • "The Deep State" • Social media • Lack of critical/objective thinking in schools, society, etc. • Equity definition is not a positive word • Lack of accuracy, honesty, and accountability • Information echo chambers and confirmation bias • Personal interests trump social good • Willingness to believe inaccuracies • Increase in Nationalism • Widening chasm of opposing opinions • Distrust of government message filtering • Deep levels of racism • Politics of fear • Double think (holding opposites together) • Big corporations/$ are driving policy • Lack of objective reporting/objective news sources	• Teaching how to assume good intentions • Identify dialog leaders • "Bridge" projects • CTE in schools • Grants requiring inclusivity • Critical thinking education • Leverage community organizations (e.g. Rotary, civic, religious groups, etc.) • Social media • Increase youth involvement • Disrupt/dismantle algorithms in media • Term limits • Increase inter-agency cooperation/communication • Vote • Uniting messaging • Remove Us versus Them • Media accountability • Eliminate state initiative process • Opportunity for education of youth/community and highlighting the good happening in our communities

6. Access

Forces	Threats Posed	Opportunities Created
• Rx: increased cost & public demand for transparency • Access to care challenges • Increasing health care costs • Increasing insurance costs and decreasing access • Decreased access to healthcare due to lack of providers, change burnout, increased regulations, and overhead • Lack of availability and unequal distribution of resources for urban and rural communities in Lane County • Access to healthcare in rural areas • Access to healthcare for the vulnerable population (what defines vulnerable)	• Challenge(s) to coverage • OHP structure • Decreased MD's/Providers • Increased costs to all • Increased use of school funds to support healthcare/mental health (versus teachers in classrooms) • Similar in industry and small businesses • + taxes • Cultural/linguistic barriers • Loss of 340B • Lack of specialty services in rural areas • Erosion of women's reproductive health care rights at the federal and state level • Lack of nursing care (cost of living) in rural communities • Payer consolidation • Lack of dental care awareness and access • Fear of system • Immigrants/BH issues • Maintaining privacy • Rural areas = decreased life expectancy • Transportation, especially rural • Uninsured/low income different level of care • Stigma • Lack of cost • Transparency • Increased costs for recruitment/retention of healthcare professionals • Increased costs in insurance • Increased ER utilization/sicker people	• Increase use of "Extenders", PA's, NP's • New partners in prevention • Expand CHC's and FQHC's • Increase and embed healthcare in schools, food sites, etc. • Increase education on available programs • Increase use of Community Health Workers/Navigators • Community Health Workers • Increase inclusion of dental care • Access to full spectrum healthcare for women/children • Access to food (drones) • Deliver services where people are (mobile, rural) • One entry point; consolidate application process • Veggie prescription • Housing • Reading • Technology – telemedicine • Increased use of equity lens • Single payer • Seamless integration of Mental Health services into physical healthcare • Nonprofit health clinics • Healthcare education development/med school

7. Behavioral Health

Forces	Threats Posed	Opportunities Created
• Increase in-patient mental health services for youth • Growing need for increased mental health support • Behavioral health (mental health, addiction, access to care) (n = 2) • Increasing need for mental health services (suicide, social media, isolation) (n = 2) • Insufficient youth mental health resources • Opioids • Opioid epidemic continues to be misunderstood • Continued high drug use and addiction	• Suicide rate • Limited access, especially rural • Substance abuse • Schools overwhelmed • Financial decrease • Uncoordinated care • Availability and variety of service providers • Increased crime rate • Vicarious trauma of staff and families • Social isolation of youth and seniors • Underemployment/unemployment • Increased number of people experiencing behavioral health challenges • Inappropriate over-prescription of psychoactive drugs • Rx interactions • Lack of knowledge and training within senior services to address co-occurring physical and behavioral health • Pop “Science” • Social media (isolation, cyber bullying, “mean”) • Kids suffer from parents’ challenges • Stigma • Misdiagnosis • Billing and costs • Lack of prescribers • Overdose • Extended families taking on care of children	• Trauma-informed Care • Integration of all systems with physical health • Shared services and resources • Supported housing • Coordination of services between providers • Mobile crisis response in rural areas • Integration of public safety and behavioral health services • Youth prevention • Support in K-12 education • Housing and neighborhoods designed to promote socialization • Harm reduction versus abstinence (how to best treat individual addiction and awareness) • Early childhood/parenting interventions • Peer Support Specialists • Depression awareness for Seniors • Shared data across all health indicators • Study results incorporated into local public health education • Impact of activity on mental health • Supported employment • “In shape” exercise and nutrition • Mentoring peers • Person-centered care • Harm reduction • Focus on pain management • Provide services for youth (and others) in acute crises

8. Aging Population

Forces	Threats Posed	Opportunities Created
• Boomers • Diversifying, aging growing population • Increasing aging patient population • Increasing population of seniors without adequate retirement savings • Growing vulnerable elderly population • Exponential growth in seniors/older adults, (28% by 2020 of Lane County population; 30% by 2025)	• Isolation • High maintenance expected • Economic disparity 20 to 08 recession and decreased retirement plans • Higher incidence of chronic disease • Epidemic vulnerability • Bed availability • Lack of internal med and/or geriatric providers of all types • Increased number of elderly in the population • Burden on existing programs • Burden on younger, smaller generations • Increased suicide rates • Insufficient patient assistance programs • Increased institutional living that is unregulated • Lack of support for family/unpaid caregivers • Homelessness • Lack of retirement/savings/social security • Funding changes • Lack of variety of housing and service options • Changes to medicine programs • Rural access • Demand bubble (in 20 years, needs change) • Caring for elderly parents • Cultural differences between Boomers and other elderly • Services – in-home care • Increased cost of pharmaceuticals/biological agents (high impact to the community) • Caregiver depression, anxiety, and lack of support • Increased chronic conditions • Mobility and transportation	• Volunteerism • Telemedicine • Skills-based volunteerism • Health promotional, community-based programs – YMCA, Willamalane, Community Centers, Silver Sneakers, etc. • Immunization – flu, pertussis, (phell?), zoster • Mentorship • Exploit their advocacy • Generation – “focused” programs for Boomers versus GenX, etc. • Education/acceptance of palliative, terminal care options • Intergenerational connections • Foster Grandparents (seniors volunteer in schools) • Educational training opportunities • Volunteer/mentorship • Social interaction • Age-specific community building • Paid family leave • Smaller homes

APPENDIX B.
Forces of Change Brainstorming Worksheet

Forces of Change Brainstorming Worksheet

This two-page worksheet is designed to use in preparing for the Forces of Change Assessment.

What are Forces of Change?

Forces are a broad all-encompassing category that includes trends, events, and factors.

- **Trends are patterns over time**, such as migration in and out of a community or a growing disillusionment with government.
- **Factors are discrete elements**, such as a community's large ethnic population, an urban setting, or a jurisdiction's proximity to a major waterway.
- **Events are one-time occurrences**, such as a hospital closure, a natural disaster, or the passage of new legislation.

What Kind of Areas or Categories Are Included?

Be sure to consider any and all types of forces, including:

- social
- economic
- political
- technological
- environmental
- scientific
- legal
- ethical

How To Identify Forces of Change

Think about forces of change — outside of your control — that affect the local public health system or community.

1. What has occurred recently that may affect our local public health system or community?
2. What may occur in the future?
3. Are there any trends occurring that will have an impact? Describe the trends.
4. What forces are occurring locally? Regionally? Nationally? Globally?
5. What characteristics of our jurisdiction or state may pose an opportunity or threat?
6. What may occur or has occurred that may pose a barrier to achieving the shared vision?

Forces of Change Brainstorming Worksheet
(Page 2)

Using the information from the previous page, list all brainstormed forces, including factors, events, and trends. Continue onto another page if needed. Bring the completed worksheet to the brainstorming session

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

APPENDIX C.
Forces of Change Assessment – 2015 Highlights

The following forces were identified as influencing community health and/or impacting the work of the local public health system:

- Collaboration
- Access to primary care
- Funding for healthcare
- Affordable Care Act
- Care delivery system
- Technology in healthcare
- Dental
- Public Health workforce
- Political and leadership changes
- Economy
- Education funding
- Healthy schools
- Environment
- Community infrastructure
- Affordable housing
- Poverty
- Rural
- Changing demographics
- Behavioral/mental health
- Health behaviors
- Communicable disease

Common reoccurring threats emerged as:

- The impact of poverty and economic shifts overwhelming the systems of:
    - Education
    - Employment
    - Affordable housing
- Shortages of resources and funding shifts
- Increased costs
- New legislation

Common reoccurring opportunities emerged as:

- Access to healthcare
- Collaboration and innovation
- Emerging technology
- Focus on prevention

Forces of Change Assessment

June 13, 2018

Local Public Health Systems Assessment

August 14, 2018

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This document was developed by *Live Healthy Lane*, which is comprised of Lane County, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, and other organizations invested in the Lane County's 2018-19 Community Health Needs Assessment. Jocelyn Warren (Manager, Lane County Public Health) and Brian Johnson (Epidemiologist & Supervisor, Lane County Public Health) facilitated this assessment. Committees working to advance the health of Lane County were pivotal in completing this assessment and include:

100% Health Executive Committee
Live Healthy Lane Core Team

The participants who engaged in this assessment include:
Susan Blane, PeaceHealth Oregon Network
Jay Bozievich, Lane County Board of Commissioners
Morgan Cowling, Oregon Coalition of Local Health Officials
Danna Drumm, Oregon Health Authority
Noreen Dunnells, United Way of Lane County
Pat Farr, Lane County Board of Commissioners
Karen Gaffney, Lane County Health and Human Services
Richard Kincade, Community Health Centers of Lane County
Pat Luedtke, Lane County Health and Human Services
Elizabeth McCrary, Trillium Community Health Plan
Senna Towner, United Way of Lane County
Jocelyn Warren, Lane County Public Health

Please contact Senna L. Towner at United Way of Lane County (541-741-6000 X163, stowner@unitedwaylane.org) with questions about this document.

INTRODUCTION

Live Healthy Lane

Creating a healthy community is a shared responsibility. By working together, we have the potential to create a caring community where all people can live a healthier life. Live Healthy Lane brings together Lane County, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, local organizations, and community members to contribute to improving the lives of everyone in Lane County.

Live Healthy Lane uses the Mobilizing for Action through Planning and Partnerships (MAPP; NACCHO, 2018) model (see Figure 1) for collecting data that inform how we as a community can improve our health. Specifically, Lane County's Community Health Improvement Plan (CHIP) is shaped by data collected by the Community Health Needs Assessment (CHNA), which uses MAPP as its strategic planning process.

In 2015-2016, LHL conducted an in-depth MAPP assessment (see Appendix B). Although the current assessment uses MAPP principles, it is meant to "refresh," or update, 2015-2016 data, and thus the methods do not precisely reflect 2015-2016 methods (see limitations section, page 7). Consequently, this assessment cannot be directly compared to the 2015-2016 assessment.

Local Public Health Systems Assessment

A standard part of MAPP, the Local Public Health Systems Assessment (LPHSA) explores the performance of the local public health system as defined by the National Public Health Performance Standards (see Figure 2), which includes "all public, private, and voluntary entities that contribute to the delivery of the essential public health services within a jurisdiction." The public health system recognizes a broad range of entities' contributions to improving community health and quality of life including, for instance, non-profit organizations, schools, hospitals, employers, faith institutions, and tribal health. The

Figure 1

+ Care Integration Assessment

current assessment, however, focused primarily on the public health system in the most traditional sense (i.e., health education/promotion, community partnerships, policy development, and healthcare integration).

For a healthy community, the public health system should undertake **10 Essential Public Health Services** (ES; see Figure 3, page 3), which in turn sustain assessment, policy development, and assurance. Although the LPHSA does not focus on how individual entities perform on any one ES, it does ***measure organizational contributions to the ES, the interconnectedness of activities, and how the public health system can be strengthened.***

This report that summarizes the LPHSA is intended to assist the *Live Healthy Lane* planning teams (i.e., Core Team, 100% Health Executive Committee) in shaping the 2020-2023 CHIP strategy. The report includes the LPHSA's:

1) methods,
2) key findings,
3) strengths and limitations, and
4) an appendix with additional data.

METHODS

On August 14, 2018, Lane County Public Health held its Local Public Health Systems Assessment (LPHSA) "refresher" at Lane County Health and Human Services in Eugene, Oregon. To best consider the traditional local public health system, participants included 12 community members who are centrally involved with Lane County's public, private, and voluntary Local Public Health Systems (LPHS) efforts (e.g., government officials, non-profit directors, hospital administrators, health insurance administrators).

Jocelyn Warren (Manager, Lane County Public Health) and Brian Johnson (Epidemiologist and Supervisor, Lane County Public Health), facilitated the assessment. First, Jocelyn explained to participants that this 2018 LPHSA focuses on four of the 10 Essential Public Health Services (ES; see Figure 3) most germane to the 2016-2018 CHIP:

1) Inform, educate, and empower people about health issues;
2) Mobilize community partnerships to identify and solve health problems;
3) Develop policies and plans that support individual and community health efforts; and
4) Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable.

Figure 3

LPHSAs, including the current one, measure 2-5 model standards that correspond with each ES and define primary related activities. Participants of a LPHA score model standards by answering a series of related performance measure questions, which in turn scores each ES. Participants answer performance measure questions based on their point-in-time perception of how well the Local Public Health Systems (LPHS) meets the standard in the assessed jurisdiction (i.e., Lane County, Oregon). Results include the average response scores based on the following scale:

Optimal Activity (76-100%)	PHS* is doing everything possible for the activity; no room for improvement
Significant Activity (51-75%)	PHS participates in a lot of the activity; room for minor improvement
Moderate Activity (26-50%)	PHS participates in the activity only somewhat; room for improvement
Minimal Activity (1-25%)	PHS participates in the activity in a limited way; room for substantial improvement
No Activity (0%)	PHS does not participate in the activity; significant improvement needed

* PHS = Public Health System

Brian Johnson led the participants through each of the performance measure questions for each of the four ES being assessed using Poll Everywhere – an Internet-based program that allows responses to be submitted via text or directly in the computer browser system. In total, there were 36 performance questions asked for the four assessed ES.

Next, participants divided into two groups – A and B – and, using real-time data from the Performance Measure questions, asked to identify areas and related activities for focus over the next three years (i.e., for the 2020-2023 CHIP). Group A was asked to focus on ES 3 and 4, while Group B was asked to focus on ES 5 and 7. Both groups were asked to engage in discussion based on the following two questions:

1) Based on the performance measure scores, what would you like to discuss?
2) Based on the performance measure scores, which three items should we focus on in the next three years?
    A. What actions can we take in the next three years?
    B. Which from the question above (a) would be most impactful/help strengthen the system most?

The small group discussions were translated onto large sticky notes and, as one large group, participants discussed themes within and across the discussions. Finally, Jocelyn summarized the findings and shared next steps for the assessment process.

KEY FINDINGS

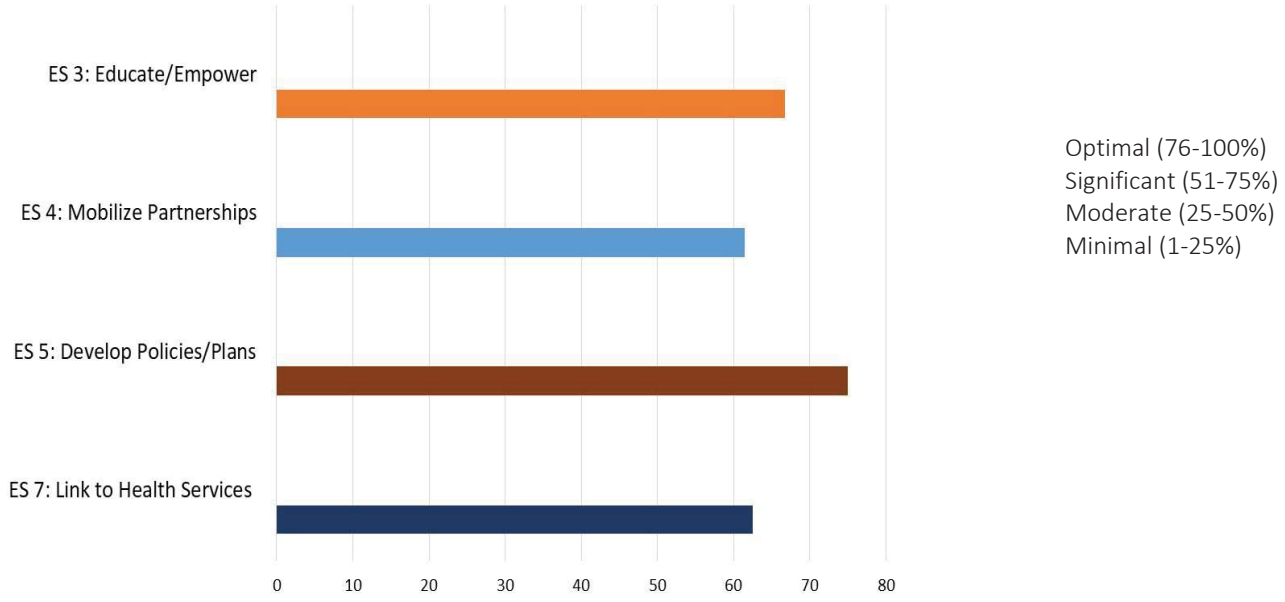
To follow is a quantitative summary of the participants' assessment of the following four Essential Services (ES): 1) *ES 3: Educate/Empower*, 2) *ES 4: Mobilize Partnerships*, 3) *ES 5: Develop Policies/Plans*, and 4) *ES 7: Link to Health Services*.

Quantitative Results: Performance Scores

Overall Scores for Essential Public Health Services

Figure 4 illustrates the average Performance Measure score for each of the Essential Services (ES) measured.

Figure 4: Summary Average for ES Performance Scores



Performance Scores per Model Standards

Table 1 illustrates the average performance score for each ES model standard. The Performance Score at the ES level is the calculated average of the respective Model Standard scores within that ES. This analysis enables the identification of specific activities that contribute to high or low performance within each ES.

Table 1. ***Overall Performance, Priority, and Contribution Scores by Essential Public Health Service and Corresponding Model Standard***

Model Standards by Essential Services	Performance Scores (%)
ES 3: Educate/Empower	**66.7**
3.1 Health Education/Promotion	75.0
3.2 Health Communication	58.3
3.3 Risk Communication	66.7
ES 4: Mobilize Partnerships	**61.5**
4.1 Constituency Development	56.3
4.2 Community Partnerships	66.7
ES 5: Develop Policies/Plans	**75.0**
5.1 Governmental Presence	66.7
5.2 Policy Development	75.0
5.3 CHIP/Strategic Planning	83.3
5.4 Emergency Plan	75.0
ES 7: Link to Health Services	**62.5**
7.1 Personal Health Service Needs	62.5
7.2 Assure Linkage	62.5
Average Overall Score	**66.4**

Note. Optimal (76-100%); Significant (51-75%); Moderate (26-50%); Minimal (1-25%)

Of particular note in Table 1 is the optimal performance score for *ES 5.3: CHIP/Strategic Planning* (83.3%). Moreover, significant activity (51-75%) was indicated for all other model standards measured.

Model standards by performance score ranked in order of priority with low scores being high priority (indicating the highest related activity gap) and high scores being low priority (indicating the lowest related activity gap) are listed in Table 2 (page 6). Although *ES 4 Mobilizing Partnerships* is marked as the highest priority when compared to the other three ES, there was little variation across the scores, and again, significant activity was noted for all ES.

Table 2. ***Essential Service and Model Standard Performance Scores***

Model Standards by Essential Services	Performance Scores (%)
ES 4: Mobilize Partnerships	**61.5**
4.1 Constituency Development	56.3
4.2 Community Partnerships	66.7
ES 7: Link to Health Services	**62.5**
7.1: Personal Health Service Needs & 7.2: Assure	62.5
ES 3: Educate/Empower	**66.7**
3.2 Health Communication	58.3
3.3 Policy Development	66.7
3.1 CHIP/Strategic Planning	75.0
ES 5: Develop Policies/Plans	**75.0**
5.1 Governmental Presence	66.7
5.2 Policy Development & 5.4 Emergency Plan	75.0
5.3 CHIP/Strategic Planning	83.3

Qualitative Results: Areas to Strengthen

Although participants noted significant public health activity related to education and empowerment, mobilizing partnerships, developing policies/plans, and linking to health services, there was also discussion about how the public health system can be strengthened over the next three years. Areas of focus did not necessarily align with low scores; for instance, participants highlighted the need to focus on health education/promotion, which they indicated had significant activity, by suggesting policymakers be provided with related ongoing analysis. In other words, even for those areas where there is significant public health attention, there are particular efforts that should continue to be given attention as to continue to improve the overall ES. Participants identified areas of focus, related activities, and why these areas and activities can improve ES in the next three years (see Table 3).

Table 3. ***Areas of focus and related activities for improving ES***

Area	Related Activity	Why
Data	• Effective, appropriate data sharing and communication	• Improve understanding, and subsequently alignment, of public health and response approaches
Communication and Engagement	• With business sector • With constituents (e.g., via community forums)	• Better integrate business and public health efforts by understanding current contributions and leveraging potential contributions (e.g., engage the Chambers of Commerce in ES efforts) • Better demonstrate the broad and integral nature of public health.
Partner Roles	• Understanding and defining as they support ES	• To hold partners accountable and develop scalable efforts
Housing	• Address housing affordability issues and homelessness (e.g., housing first efforts)	• Addressing housing requires addressing mental and behavioral health issues • Housing is a public health issue

STRENGTHS AND LIMITATIONS

Respondents were recruited because of their central involvement with the county's public, private, and voluntary LPHS efforts, and as a whole provided substantial contributions to assessing essential services in Lane County (Polkinghorne, 2005). Furthermore, the qualitative nature of the discussion portion of this assessment provides opportunity for exploration and discovery of how to strengthen Lane County's public health system. This report provides a snapshot of organizational contributions to the ES in 2018, the interconnectedness of activities, and how the public health system can be strengthened. Nevertheless, the current assessment results are limited, because they:

1) are based only on respondents' point-in-time perceptions, experience, and knowledge. When considering the results of the study, however, the variation in breadth and knowledge of participants, and differences in interpretation of the questions, should be considered; and
2) comparisons between the 2015 and 2018 LPHSA should be made with careful consideration, because the methods are different (i.e., in 2018, the focus was on the four domains most directly related to the CHIP, participants were from more traditional public health sectors, and there was real-time voting).

These results are meant to inform the 2020-2023 CHIP, and should be considered in conjunction with the results from other data collected during Lane County's 2018-2019 needs assessment MAPP process. Further, future assessments should replicate and extend this assessment to uncover details and nuances related to those factors that influence health and health systems in Lane County, Oregon.

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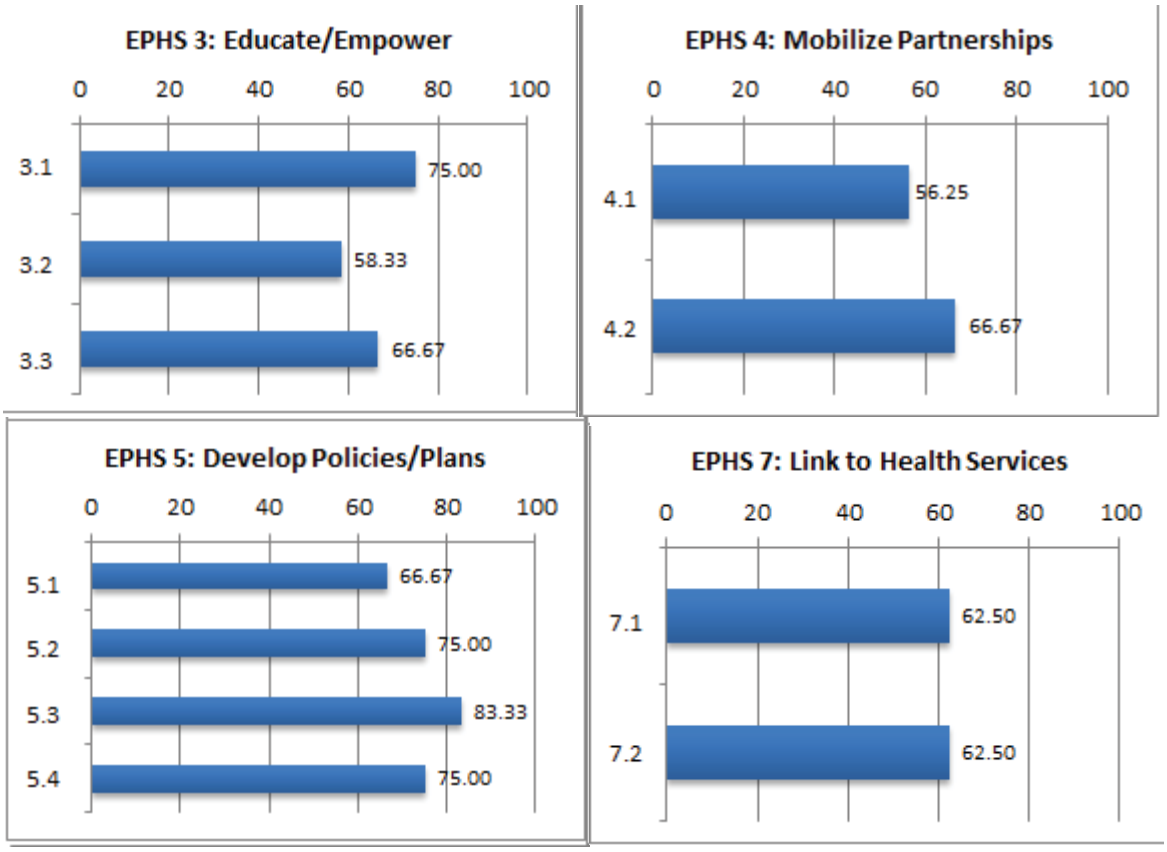
APPENDIX A.

Graphs of Performance Scores by Essential Public Health Service for Each Model Standard



Optimal Activity (76-100%)	PHS* is doing everything possible for the activity; no room for improvement
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APPENDIX B.
2015 Local Public Health Systems Assessment Summary

The Local Public Health System Assessment (LPHSA) evaluated the delivery of the 10 Essential Public Health Services by the local public health system, which includes all "public, private, and voluntary entities that contribute to the delivery of the essential health services within a jurisdiction." Through the process, the following questions were answered:

- *What are the components, activities, competencies, and capacities of our public health system?*
- *How well are the 10 Essential Public Health Services being provided in our system?*

To complete this assessment, participants (100% Health Steering Committee members and additional local public health system leaders) scored the system performance of each Essential Services and engaged in facilitated discussions to identify system strengths, weaknesses, and opportunities for improvement. Post-assessment, each Essential Service was prioritized for future action planning.

Results

Quadrant	Essential Service	Performance Score	Priority Rating
High Priority and Low Performance	ES 1: Monitor Health Status	48.6%	7.1
High Priority and Low Performance	ES 3: Educate/Empower	39.8%	6.4
High Priority and High Performance	ES 2: Diagnose and Investigate	60.4%	7.6
High Priority and High Performance	ES 4: Mobilize Partnerships	55.2%	6.0
High Priority and High Performance	ES 6: Enforce Laws	57.1%	6.0
High Priority and High Performance	ES 7: Link to Health Services	53.1%	7.1
Low Priority and High Performance	ES 5: Develop Policies/Plans	52.1%	5.3
Low Priority and High Performance	ES 8: Assure Workforce	57.8%	5.6
Low Priority and Low Performance	ES 9: Evaluate Services	47.9%	3.8
Low Priority and Low Performance	ES 10: Research/Innovations	31.9%	4.5

Strengths

- Successful organizational collaborations and community partnerships to mobilize and strategize.
- The involvement of community organizations in service delivery.
- Solid interest and support for strengthening the local public health system.
- A strong infrastructure exists for investigating and responding to public health threats and emergencies.

Weaknesses

- Local organizations are often unaware or unclear about their role in the public health system.
- The general public's lack of awareness and understanding regarding the local public health system.
- There is an insufficient degree of communication, which creates the perception of organizational silos.
- Limited capacity and infrastructure for research across the entire LPHS.

Opportunities for Improvement

- Bolster communication, coordination of efforts, and execution of action plans across the LPHS.
- Leverage the use of technology to better connect and communicate with our community.
- Strengthen the system for sharing data and conducting public health research to enhance decision making and implementing strategies that improve population health.

The findings from this assessment create a snapshot of activities being performed by the local public health system and will guide a system-wide infrastructure and data-driven performance improvement process.

Local Public Health Systems Assessment

August 14, 2018

100% Health
Community Coalition

LiveHealthy LANE

Community Themes and Strengths Assessment

2018-2019

PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

Trillium
Community Health Plan

United Way
United Way of Lane County

PeaceHealth

Acknowledgements

This document was This document was developed by Live Healthy Lane (LHL), which is comprised of Lane County, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, and other organizations invested in the Lane County's 2018-19 Community Health Needs Assessment. Senna Towner (Director of Health, United Way of Lane County) and Kayla Watford (Health Program Coordinator, United Way of Lane County) facilitated this assessment. Jennifer Webster (Epidemiologist, Lane County Public Health) was instrumental in assessment design and data analysis. Committees working to advance the health of Lane County were pivotal in completing this assessment and include:

100% Health Executive Committee
Live Healthy Lane (LHL) Operations Team

The Community Themes and Strengths Workgroup who led this assessment include:
Amanda Cobb, Trillium Community Health Plan
Bess Day, United Way of Lane County
Leah Edelman, Lane County Public Health
Debi Farr, Trillium Community Health Plan
Robert Phillips, Trillium Community Health Plan
Senna Towner, United Way of Lane County
Kayla Watford, United Way of Lane County
Jennifer Webster, Lane County Public Health

Lilian Morrill, United Way of Lane County's Community Health Intern, was pivotal in data collection and analysis.

Please contact Senna L. Towner at United Way of Lane County (541-741-6000 X163, stowner@unitedwaylane.org) with questions about this document.

TABLE OF CONTENTS

INTRODUCTION

Live Healthy Lane

Creating a healthy community is a shared responsibility. By working together, we have the potential to create a caring community where all people can live a healthier life. Live Healthy Lane (LHL) brings together Lane County, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, local organizations, and community members to contribute to improving the lives of everyone in Lane County.

Live Healthy Lane uses the Mobilizing for Action through Planning and Partnerships (MAPP; NACCHO, 2018) model (see Figure 1) as our strategic framework for prioritizing community health issues and developing strategies to improve health outcomes. There are six phases of MAPP: 1) Organize for Success & Partnership Development; 2) Visioning; 3) Four Assessments; 4) Identify Strategic Issues; 5) Formulate Goals & Strategies; and 6) Action Cycle. The final three steps together comprise the creating and implementation of a Community Health Improvement Plan (CHIP).

The four assessments in Phase 3 include the Community Themes and Strengths Assessment, Local Public Health System Assessment, Community Health Status Assessment, and Forces of Change Assessment. Live Healthy Lane has included a fifth assessment – Care Integration (see all reports here: Live Healthy Lane). In this report, we provide results and analysis from the 2019 Community Themes and Strengths Assessment.

Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment (CTSA) describes how community members perceive their health and quality of life, as well as their knowledge of community resources and assets.

In 2015, Live Healthy Lane conducted an extensive CTSA with 2,295 surveys, 50 focus groups, and 53 key informant interviews; see complete report here: 2015 CTSA). In fact, managing the participation of

Figure 1. MAPP Model

the high number of people interested in contributing was a particular challenge and took a greater proportion of the three-year assessment and CHIP time period than initially anticipated. As a consequence, we now have a robust foundation of collaboration and community involvement for deployment in the action cycle; however, we did not accomplish as much in the previous action cycle as we had planned.

For the 2019 CTSA, we focused on learning whether the community health issues identified in the 2015 CTSA continue to be priorities and whether those priorities resonate specifically with people from groups and populations that were not as well-represented in the 2015 CTSA.

To answer these questions and reach a broad cross-section of Lane County's population, Live Healthy Lane disseminated a Community Health Survey targeting priority populations, and engaged community members underrepresented by the survey in focus groups.

This report that summarizes the 2018-2019 CTSA is intended to assist the LHL planning teams (i.e., Operations Team, 100% Health Executive Committee) in shaping the 2020-24 CHIP. In sum, the report shares: **1)** progress made on the 2016-2019 CHIP; and **2)** community health priorities moving forward.

PROGRESS MADE ON THE 2016-2019 CHIP

Lane County, Oregon's Regional 2016-19 Community Health Improvement Plan (CHIP) is a three-year action-oriented plan informed by Lane County's 2015 Community Health Needs Assessment (CHNA), which considers population-level data and community input. The CHIP focuses efforts and mobilizes partnerships with the intention of improving the behavioral, physical and social health, and overall well-being of our community.

Table 1. 2016-2019 CHIP

Goals	Strategies
Increase social and economic opportunities that promote healthy behaviors	Support economic development through investing in workforce strategies that provide sustainable family wage jobs in our communities.
	Encourage a range of safe and affordable housing opportunities, including the development of integrated and supportive housing.
	Assure availability of affordable healthy food and beverages in every community.
Increase healthy behaviors that improve health and wellbeing	Encourage the implementation of programs to promote positive early childhood development and safe/nurturing environments.
	Support the implementation of evidence-based preventive screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers.

In 2018-2019, Lane County explored the community's perceptions of progress made on the 2016-19 CHIP goals in its Community Themes and Strengths Assessment (CTSA) and as part of the larger CHNA. Considering the strategies outlined by the 2016-19 CHIP, community members provided input through surveys (N=590; 17 Spanish, 573 English) and nine focus groups (2 Spanish, 7 English). Survey and focus group participants were asked how the health of our community could be improved and where to prioritize efforts. Below is a summary of the CTSA results, highlighting demographics, issues that rise to the top as most important including differences and similarities across priority populations and geographic areas, and a comparison to 2015 CTSA data.

Survey and Focus Group Demographics

Given the breadth and depth of the 2015 CHNA, the current CTSA focused on hearing from community members who were underrepresented in 2015 including: non-English speaking and those who speak English as second language, LGBTQ, rural community members, seniors, people living with a disability, and youth. Although there was success with reaching some of these populations, survey respondents were largely white, female, married, English-speaking, and with a higher income and education than the county population breakdown as a whole.

Table 2. Survey Demographics		
Demographic	**County**	**Survey**
Population who identify as female (%)	2018[1] 51.00	 81.13
Race (%)	2013-2017 estimate[2]	
2+ Races	4.96	-
Asian	2.57	2.36
Native American/Alaska Native	1.05	5.64
Black	1.14	1.45
Native Hawaiian/Pacific Islander	0.24	1.64
Ethnicity (%)	2013-2017 estimate[2]	
Hispanic/Latino	8.40	9.24
Population with a college degree (%)	2017[1] 17.70	 58.21

Sources: 1) American Community Survey; 2) ACS Community Survey 5-year estimates

Although there is always room for improvement, the current assessment demonstrates an increase in participation of some non-white populations, particularly Hispanic and Native American/Alaska Native populations. Focus groups were also conducted with priority populations:

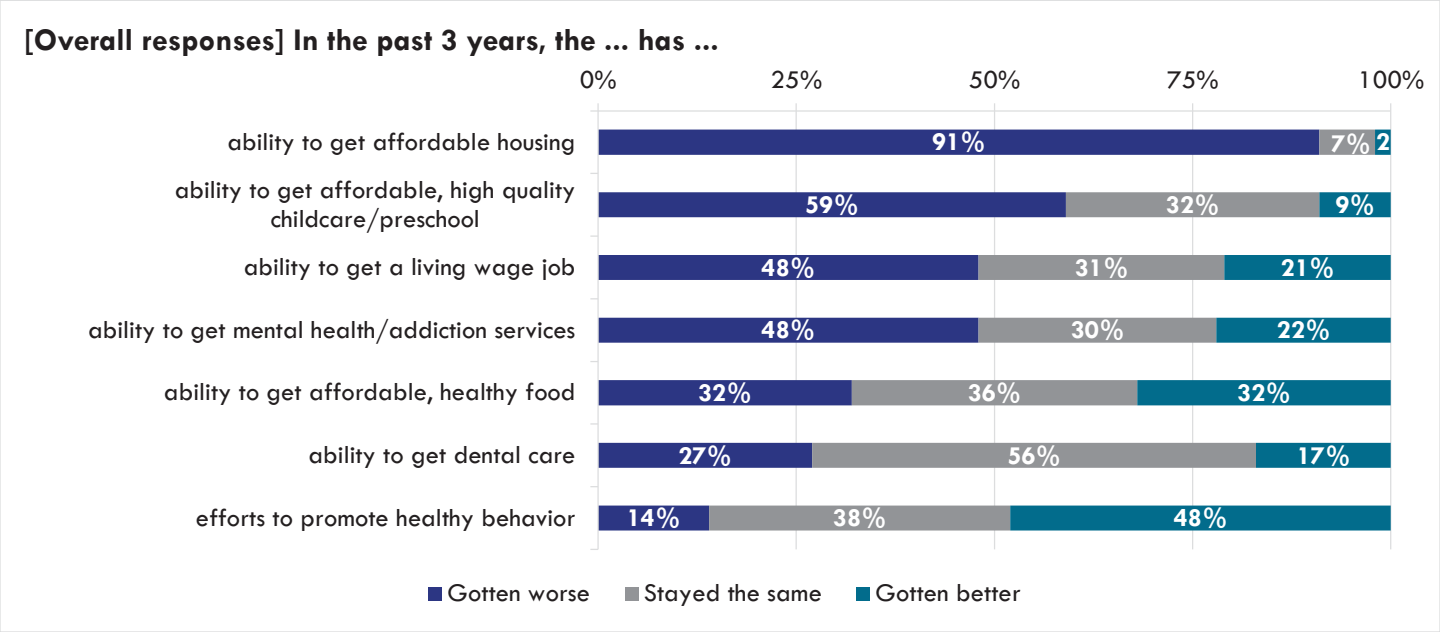
- **Rural communities** (4 focus groups): McKenzie Bridge/Blue River, Siuslaw Upriver, Oakridge/Westfir, Lowell
- **Seniors and people living with a disability** (1 focus group): Lane County Senior and Disability Services in Eugene
- **Spanish-speaking community** (1 focus group): Centro Latino Americano
- **Spanish- and Mam-speaking and rural** (1 focus group): Cottage Grove Community Center
- **Youth and rural** (1 focus group): Cottage Grove Youth Advisory Council
- **Youth** (1 focus group): Planned Parenthood of Southwest Oregon

Community Health Progress

Participants were asked to consider the seven strategic initiatives from the 2016-19 CHIP and indicate whether or not they had improved over the past three years. Approximately one-third (20-40%) of survey participants responded “I don’t know” to all the strategic initiatives except housing (9%), food (16%), and childcare/preschool (58%). Respondents were generally in agreement about the levels of improvement, even when analyzed by sexual orientation, income level, highest level of education, age group, Hispanic ethnicity and race (only White, Native

American/Alaska Native and people who identified multiple races had enough responses to be included in the analysis)[1].

Figure 2. Perceptions of CHIP Progress[2]



Gotten Better: Healthy Behaviors

According to almost half (48%) of survey respondents, in the past three years, **efforts to promote healthy behaviors have improved**; this is the only domain that has general agreement on improvement. Different from the other questions on the survey, however, this one asked about "efforts" to promote healthy behaviors rather than "ability" to promote healthy behaviors, thus focusing on the *work that has been done*, and not on community members' *access* to healthy behaviors, which, in turn, may have led to positivity bias.

That said, one focus group, the Cottage Grove Youth Advisory Council, did prioritize healthy behaviors with an emphasis on mental health and addiction services, demonstrating their broader understanding of the question. The youth understood the relationship between healthy behaviors and mental health:

- *If we focused on mental health in school, and starting at a young age, I think the affect would be tremendous and our community's mental health would go up. People need to be taught how to deal with problems healthier.* (Cottage Grove Youth Advisory Council Focus Group Participant)

In addition, survey respondents shined light on how the community might continue to improve upon supporting engagement in healthy behaviors (outlined in more detail in the next section on page 13), and these solutions

[1] The demographic breakdown for these questions tended to skew to higher income, higher levels of education and white, non-Hispanic race and ethnicity. The age breakdown was fairly evenly distributed between 25-74 year olds, with less representation for those under 25 and over 75. Data were not analyzed by gender because respondents were overwhelmingly female. Data were analyzed by language spoken at home but there were too few non-English speakers to be included in the analysis overall.
[2] Graph represents only respondents who expressed an opinion; "I don't know" responses are excluded.

indicate that some understand the root causes of unhealthy behaviors, and the intersection between basic needs (e.g., housing, food) and engaging in healthy behaviors:

- *I think we need to focus on root causes...get folks housed, get them treated, get them jobs. Unhealthy behaviors are often out of necessity or for coping*. (Survey Participant)
- *Many addictions stem from alienation and economic stresses. Addressing those will lead to healthier behaviors.* (Survey Participant)

Stayed the Same: Dental Care and Healthy Food

Of the survey respondents, **56% perceive that the ability to get dental care has stayed the same**, and **36% perceive that the ability to get affordable healthy food has stayed the same**. The ability to get affordable healthy food is split nearly evenly across perceptions of getting worse or staying the same, which holds true across demographic groups with a few exceptions. The ability to access dental care continues to be a concern. Accessibility was not good according to the 2015 assessment, and it continues to be a significant issue in 2019. The perceptions related to accessing affordable healthy food showed an interesting split. A slim majority saw access as staying the same, but 32% of respondents rated it as worsening, and another 32% perceived that access to affordable healthy food had improved.

Many in Lane County still consider Improving access to dental care and affordable healthy food a priority.

Four of the nine focus groups brought attention to the need to prioritize healthy foods. Also, both Spanish-speaking focus groups highlighted the need to prioritize healthy foods *and* dental care. Overall, the current CTSA indicate both dental care and food access a serious problem for rural and urban communities, and both are of particular concern for Spanish-speaking communities.

Both Spanish-speaking focus groups highlighted the need to prioritize healthy foods and dental care.

- *We have NO dental care in our rural community Oakridge.* (Survey Participant)
- *What I'm interested in is the dentist. It's so expensive! People just don't go to the dentist because of how expensive it is.* (Centro Latino Americano Focus Group Participant)

- *I worked at the high school, and students are starving.* (Lowell Focus Group Participant)
- *If rent was lower, we could afford healthy food.* (Survey participant)

Gotten Worse: Housing, Childcare/Preschool, Living Wage Jobs, and Mental Health/Addiction Services

Of the survey respondents, **91% consider the ability to get affordable housing as worse in the last three years, 59% consider the ability to get affordable, high quality childcare/preschool as worse,** and **48% perceive both the ability to get a living wage job and mental health/addiction services as worse.**

Seven of the nine focus groups voiced the need for the community to prioritize **affordable housing** and **living wage jobs** in the next three years. Further, these two issues are a priority in both rural and urban communities.

- *Local housing is simply not affordable, by the time you add in rent, utilities, first/last month's rent, security deposit, etc. If we solved the housing issue, we would build a strong foundation for all the other services.* (Senior and Disability Services Focus Group Participant)

Survey and focus group respondents emphasized the need to prioritize housing, childcare/preschool, living wage jobs, and mental health/addiction services in Lane County.

Although only three of the focus groups emphasized the need for **affordable childcare**, these are important to note, because they are priority populations: One of which was a rural focus group in McKenzie Bridge, and the other two were in the Spanish-speaking focus groups (one rural and one at Centro Latino Americano). McKenzie Bridge participants called attention the need to focus on bringing childcare to people living with addiction and/or mental health issues and families who are under- or unemployed, thus highlighting their understanding of the relationship between childcare, living wage jobs, and mental health services. The Spanish-speaking focus groups emphasized the need to prioritize childcare for undocumented families, families with young children, women, and immigrants and refugees.

- *I have a grandchild now, so I see more and more how important those early years are and driving into town [for work] is a big time commitment.* (McKenzie Bridge/Blue River Focus Group Participant)
- *Focus on [providing childcare] in rural areas…* (Survey Participant)
- *Childcare is so expensive and parents work completely different schedules to pay for it.* (Centro Latino Americano Focus Group Participant)

Five of the nine focus groups prioritized **mental health/addiction services**, especially for youth in rural areas. Increasing suicide rates, social isolation, lack of motivation and hope, and generational poverty were emphasized.

- *There are no counselors for young kids and [service providers] are pushed to the emotional max.* (Oakridge/Westfir Focus Group Participant)
- *[We need] shorter wait time. Options [Counseling Services] is 6-8 weeks out, but it is often 12 weeks out.* (Siuslaw Upriver Focus Group Participant)
- *A lack of hope among youth resulted in not enough football players for a varsity team, a first for Oakridge High School.* (Oakridge Focus Group Participant)
- *Every person in Eugene should walk the streets and see how serious homelessness, mental health, and addition [is, and much these issues have] increased – provide some kind of housing and tie mental health/addiction services to [those] living at subsidized housing.* (Survey Participant)

COMMUNITY HEALTH PRIORITIES MOVING FORWARD

In addition to providing feedback on progress made since 2016, the CTSA solicited information about how the community prioritizes the current strategic initiatives, as well as other barriers to health that may have emerged since 2016.

2016-19 CHIP Strategic Initiatives

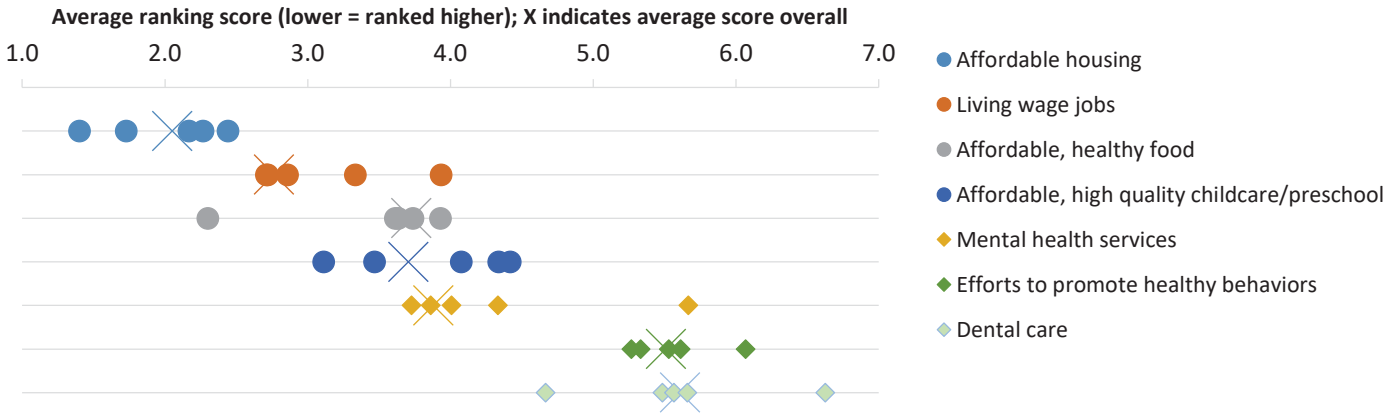
Survey and focus group participants were asked to rank what they consider "most important" to supporting Lane County's community health from the same seven health domains discussed in the previous section. These perceptions can help inform the development of CHIP priorities moving forward. Considering respondents' perceptions of whether they had gotten worse, stayed the same, or gotten better, the ranking results are unsurprising.

As demonstrated in Figure 3, the priorities of survey respondents in order of importance are essentially as follows (see 'X's on graph):

1) Housing
2) Living wage jobs
3) Affordable, healthy food; affordable, quality childcare, access to mental health services
4) Promoting healthy behaviors; access to dental care

Figure 3. Ranking of CHIP Priorities

Ranking of CHIP priorities was fairly consistent across populations. There were minor differences among some groups (represented as dots, see Appendix A), but overall housing, wages, and food ranked near the top for everyone (represented as an 'X').



Potential Issues of Equity

There were very few differences among the rankings between different socioeconomic and demographic groups, and the minor differences are among those who indicated they were:

- Living in a non-metro area (outside Eugene/Springfield zip code),
- Native American/Alaska Native,
- Hispanic,
- Spoke Spanish as their primary language at home, and
- A sexual orientation other than straight.

(see Appendix A for ranking by population details.)

Childcare/preschool seems to be a higher priority among non-white/racial ethnic groups, at least among Native American/Alaska Native and Hispanic identifying peoples. (Other groups had small response rates, making it difficult to be definitive.) This could indicate there are some equity issues related to accessing childcare/preschool that need to be addressed.

Further, Native American/Alaska Native ranked access to food as a high priority, which could also be related to an equity issue.

Although everyone ranked affordable housing as the highest priority, Native American/Alaska Natives gave it the lowest average score, and LGBTQ-identified respondents gave it the next lowest score, which could be indicative of inequities in this area as well.

Focus group results reaffirmed these priorities with minor differences in ranking among certain socioeconomic/demographic groups (see pages 7-8 for related discussion):

- Spanish-speaking focus group participants prioritized dental care and childcare/preschool,
- All rural focus groups prioritized mental health/addiction services, and
- One rural focus group (McKenzie Bridge) prioritized childcare/preschool.

Additional Community Health Priorities

Focus group and survey respondents were also asked if there were other issues important to their community's health that were not among the listed priorities. Three additional priorities (below) emerged with few differences between survey and focus groups with the exception of **transportation** being especially underscored by rural focus groups as a barrier to good health.

Transportation was underscored by rural communities as a barrier to good health.

- Clean environment that supports health
  - *Clean air and water; especially air quality and climate change*
- Social cohesion and connection
  - *More opportunities to connect, especially through recreation*
  - *More opportunities to connect for vulnerable populations*
- Discrimination and racism
  - *Address disparities*
  - *Create a more welcoming community for people of color and immigrants*

Improving Community Health

Survey and focus group participants were also asked to consider "how the community could improve upon these health domains." Responses can help inform CHIP strategy development. Below is a summary of these qualitative results including the themes, subthemes when they emerged, and some quotes from participants.

Affordable, High Quality Childcare/Preschool

- **Provide alternative hours and locations**
  - *In rural areas*
  - *Hours (e.g., evenings) and part-time hours*
  - *From employers/onsite employer care*
- **Subsidize childcare**
  - *Provide more Preschool Promise options*
- **Improve support and recognition of childcare providers**
  - *More training*
  - *Increase teacher/provider pay*

*Make [childcare] affordable, in places easy to access with working hours that **accommodate the schedules of students/working class people**.*

*Help employers offer **onsite daycare**.*

Affordable, Healthy Food

- **Need for local access to purchase food**
  - *Address transportation as a barrier/provide delivery options*
- **Support for local growers and improve access to locally grown fruits and vegetables**
  - *Reengage the Food Policy Council*
- **Provide subsidies to improve access to farmer's markets and Community Supported Agriculture (CSAs)**
  - *Sustain Double-Up Food Bucks*
- **Educate people on healthy eating**
- **Policies to support healthy eating**
  - *Tax unhealthy food*
  - *Restrict SNAP benefits to healthy options*

*Pair up with the local farmers' markets to **offer discounts to low-income people**.*

Affordable Housing

- **Change policies**
  - *Policies to encourage building more affordable homes*
  - *Policies to control housing costs*
- **Reduce barriers to renting**
- **Pay living wages**

*Get creative, **address infrastructure, zoning, and code issues** that prevent accessory dwelling, the ability to affordably build smaller homes and use of tiny homes. **Improve sustainability of housing**, especially around water and energy use so that homes remain viable and affordable in the future. Think about the longevity when it comes to building codes to **increase the life span of housing**.*

*Even **affordable housing is reaching prices that are not reachable** to many families or singles.*

Dental Care

- **Expand services in Lane County**
  - *In rural areas*
  - *Appointment availability*
- **Reduce cost of services**
- **Educate people on available services and dental hygiene**

> ***Better education*** *on the importance of dental care, and more programs offering* ***free or low cost dental care****.*

Living Wage Jobs

- **Raise minimum wage**
  - *Tie minimum wage to inflation*
  - *Tie minimum wage to CEO salaries*
  - *Better pay and benefits for entry-level jobs*
  - *Government contracts that require living wage jobs*
  - *CHIP partners ensure they are paying living wage jobs*
- **Attract new industry**
  - *Rural communities need more economic opportunity*
  - *Attract industries that will be sustainable*
- **Support local business**
  - *Vocational training that supports small/local businesses*
- **Control cost of living**
  - *Balance with burden of living expenses (e.g., education, housing, childcare, food, etc.)*
- **More/better training opportunities**
  - *Skills training for trades*
  - *Job training for young people*
- **Improve infrastructure**
  - *High-speed Internet and better transportation to improve commuting/telecommuting for people living in rural areas*

> *Wages have gone up some but rent and other* ***basic needs are going up so much faster than wages****.*

> *We need to* ***attract businesses****, other than just retail or service-type business, that pay more including such jobs that employ students...*

> *Do more* ***school-to-work with local high schools****. Be sure* ***local, existing businesses feel and are supported so their employees*** *feel more secure and they can add staff.*

Mental Health/Addiction Services

- **Address insurance and rural barriers**
- **Improve treatment**
  - *Evidence-based treatment*
  - *For youth*

> *Expand* ***tele-mental health*** *to increase access, but again,* ***broadband*** *access to must first be* ***expanded in rural areas.***

- **Educate the community**
  - *Destigmatize*
  - *Share available resources*
- **Address housing issues**

*Huge need for **residential treatment for youth**.*

Promotion of Healthy Behaviors

- **Continue to support related policies**
- **Increase access to healthy options**
  - *For all income levels*
  - *That are incentive-based*
  - *That are evidence-based*
  - *In rural areas*
- **Improve education and outreach**
- **Address root causes**

Support and promote evidence-based programs offered by community-based organizations.

*Many **addictions stem from alienation and economic stresses**. Addressing those will lead to healthier behaviors.*

CONCLUSION

In conclusion, CTSA participants confirm that the 2016-19 CHIP strategic initiatives should remain areas of focus if Lane County is to continue to reduce barriers to good health and ultimately improve community health. Survey and focus group data support continuing to work towards the goals laid out in the current CHIP: 1) increase social and economic opportunities that promote healthy behaviors, and 2) increase healthy behaviors that improve health and wellbeing. Although survey participants do not reflect the full diversity of Lane County, the current assessment has greater representation of priority populations compared to the 2015 assessment. As intended, focus groups greatly diversified participation, particularly among people living in rural areas, people for whom English is not their first language, and youth.

Appendix A

Ranking of CHIP Priorities by Population

CHIP Priorities	Overall		Non-metro zip code		Native American/ Alaska Native		Hispanic		Speaks Spanish at home		LGBTQ	
	R	***AS***	***R***	***AS***	***R***	***AS***	***R***	***AS***	***R***	***AS***	***R***	***AS***
Affordable Housing	1	*2.05*	1	*2.17*	1	*1.40*	1	*2.44*	1	*2.27*	1	*1.73*
Living Wage Jobs	2	*2.76*	2	*2.71*	4	*3.33*	2	*2.86*	3	*3.93*	2	*2.72*
Affordable, Healthy Food	3	*3.73*	3	*3.63*	2	*2.30*	4	*3.74*	3	*3.93*	3	*3.61*
Mental/Addiction Services	4	*3.88*	4	*4.01*	6	*5.67*	5	*3.86*	4	*4.33*	4	*3.73*
Childcare/Preschool	5	*4.34*	5	*4.07*	3	*3.11*	3	*3.71*	2	*3.47*	5	*4.42*
Healthy Behaviors	6	*5.51*	7	*5.61*	5	*5.33*	7	*5.53*	6	*5.27*	7	*6.07*
Dental Care	7	*5.61*	6	*5.56*	7	*6.63*	6	*5.49*	5	*4.67*	6	*5.66*

Key: ***R*** = Rank; ***AS*** = Average Score

Appendix B
Community Health Survey

1. In the past three years, the ability to get **affordable, high quality childcare/preschool** in Lane County has: (check one)			
☐ gotten better	☐ stayed the same	☐ gotten worse	☐ I don't know
2. How can we improve access to **affordable, high quality childcare/preschool** in your community? (briefly describe)			

3. In the past three years, the ability to get **affordable, healthy food** in Lane County has: (check one)			
☐ gotten better	☐ stayed the same	☐ gotten worse	☐ I don't know
4. How can we improve access to **affordable, healthy food** in your community? (briefly describe)			

5. In the past three years, the ability to get **affordable housing** in Lane County has: (check one)			
☐ gotten better	☐ stayed the same	☐ gotten worse	☐ I don't know
6. How can we improve access to **affordable housing** in your community? (briefly describe)			

7. In the past three years, the ability to get **dental care** in Lane County has: (check one)			
☐ gotten better	☐ stayed the same	☐ gotten worse	☐ I don't know
8. How can we improve access to **dental care** in your community? (briefly describe)			

9. In the past three years, the ability to get a **living wages job** in Lane County has: (check one)			
☐ gotten better	☐ stayed the same	☐ gotten worse	☐ I don't know
10. How can we improve access to **living wage jobs** in your community? (briefly describe)			

11. In the past three years, the ability to get **mental health and/or addiction services** in Lane County has: (check one)			
☐ gotten better	☐ stayed the same	☐ gotten worse	☐ I don't know
12. How can we improve access to **mental health and/or addiction services** in your community? (briefly describe)			

13. In the past three years, efforts to promote healthy behaviors, like quitting tobacco, in Lane County have: (check one)			
☐ gotten better	☐ stayed the same	☐ gotten worse	☐ I don't know

14. How can we improve efforts to promote healthy behaviors in your community? (briefly describe)

15. To-date, what do you think is most important to supporting Lane County's community health? (Rate the list of items 1-7, with 1 being most important and 7 being least important):			
____Affordable, healthy food	____ Affordable, high quality childcare/preschool	____Affordable housing	____Dental Care
____ Efforts to promote healthy behaviors	____Living wage jobs	____Mental health services	

16. Is there anything else that's important to your community's health that was not listed above? (briefly describe)

17. What other barriers to good health exist in your community that we have not yet mentioned?

18. What is your **age**?

- ☐ Under 18
- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75-84
- ☐ 85+

19. What is your **zip code**? _____

20. What is your **preferred language at home**? _____

21. What is your **gender identity**?

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Intersex
- ☐ An unlisted gender (please list) _____

22. What is your **sexual orientation**?

- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Queer
- ☐ Straight
- ☐ An unlisted sexual orientation (please list) _____

23. What is your **relationship status**?

- ☐ Married/partnered
- ☐ Widowed
- ☐ Divorced
- ☐ Single
- ☐ An unlisted relationship status (please list) _____

24. What is your **race**? (You may select more than one.)

- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ An unlisted race (please list) _____

25. What is your **ethnicity**?

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

26. What is your **estimated annual income**?

- ☐ Less than $20,000
- ☐ $20,000-29,999
- ☐ $30,000-49,999
- ☐ $50,000-69,999
- ☐ $70,000-99,999
- ☐ Over $100,000

27. What is the **highest level of education you have completed**?

- ☐ Less than high school diploma
- ☐ High school degree/GED
- ☐ Some college/no degree
- ☐ Associate/technical degree
- ☐ Bachelor's degree
- ☐ Advanced degree

28. Is there anything else you would like to share?

Optional. If you are interested in participating in a follow-up discussion that may result from this survey, please provide us with the following information:

29. Name:
30. Email:
31. Phone:

Appendix C

Focus Group Instrument

- **Community** includes all those who live, work, and play in Lane County.
- **Health** refers to the broad definition: a state of complete physical, mental, and social well-being and not just the lack of disease or illness.

1) To-date, what do you think is <u>most important</u> to supporting Lane County's community health? (Rate the list of items 1-7, with 1 being most important and 7 being least important).			
_____Affordable, healthy food	_____ Affordable, high quality childcare/preschool	_____Affordable housing	_____Dental Care
_____ Efforts to promote healthy behaviors	_____Living wage jobs	_____Mental health services	_____Something else List:
2) From the list above, what 3 do you want us to focus our attention on in the next few years? (These will likely match your above rankings)			
3) Which people or communities are most impacted by the top 3 focus areas?			
4) Thinking of your top 3 focus areas, how can we improve efforts to support your community's health? (briefly describe)			
5) Is there anything else that's important to your community's health that was not already discussed?			

Community Themes and Strengths Assessment

2018-2019

100% Health
Community Coalition

LiveHealthy LANE

Community Health Status Assessment

Summary

2018-2019

LANE COUNTY OREGON
PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

Trillium Community Health Plan

United Way
United Way of Lane County

PeaceHealth

Acknowledgements

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100% Health Executive Committee
Live Healthy Lane (LHL) Operations Team

The Community Health Status Assessment Workgroup who led this assessment included:
Senna Towner, United Way of Lane County
Kayla Watford, United Way of Lane County
Jennifer Webster, Lane County Public Health
Cynthia Brown, Trillium Community Health Plan
Johanna Loving-Belyea, Trillium Community Health Plan
Vishal Chaudhry, PeaceHealth
Eric Adams, Willamalane Recreation District

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Brian Johnson, Lane County Public Health

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Jessica Seifert, Epidemiologist
Roger Brubaker, Suicide Prevention and Mental Health Promotion Coordinator
Doug Gouge, Mental Health Promotion and Problem Gambling Prevention
Jacqueline Moreno, CCO Prevention Strategist
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Please contact Jennifer Webster at Lane County Public Health (541-682-4280, Jennifer.webster@lanecountyor.gov) with questions about this document.

Introduction

Live Healthy Lane

Creating a healthy community is a shared responsibility. By working together, we have the potential to create a caring community where all people can live a healthier life. Live Healthy Lane (LHL) brings together Lane County, PeaceHealth Oregon Network, Trillium Community Health Plan, United Way of Lane County, local organizations, and community members to contribute to improving the lives of everyone in Lane County.

Live Healthy Lane uses the Mobilizing for Action through Planning and Partnerships (MAPP; NACCHO, 2018) model (see Figure 1) for collecting data that inform how we as a community can improve our health. Specifically, Lane County's Community Health Improvement Plan (CHIP) is shaped by data collected by the Community Health Needs Assessment (CHNA), which uses MAPP as its strategic planning process.

In 2015-2016, LHL conducted an in-depth MAPP assessment (see here: Live Healthy Lane). Building on 2015 data, the current assessment collected data that explored quality of life and health issues in Lane County.

Community Health Status Assessment Summary

One of the four assessments in the MAPP process, the Community Health Status Assessment answers the question "how healthy is the community?" Indicators selected during the 2015 assessment process were updated with most recently available data, with a few indicators added to further inform Lane County's progress on 2016-2019 CHIP initiatives.

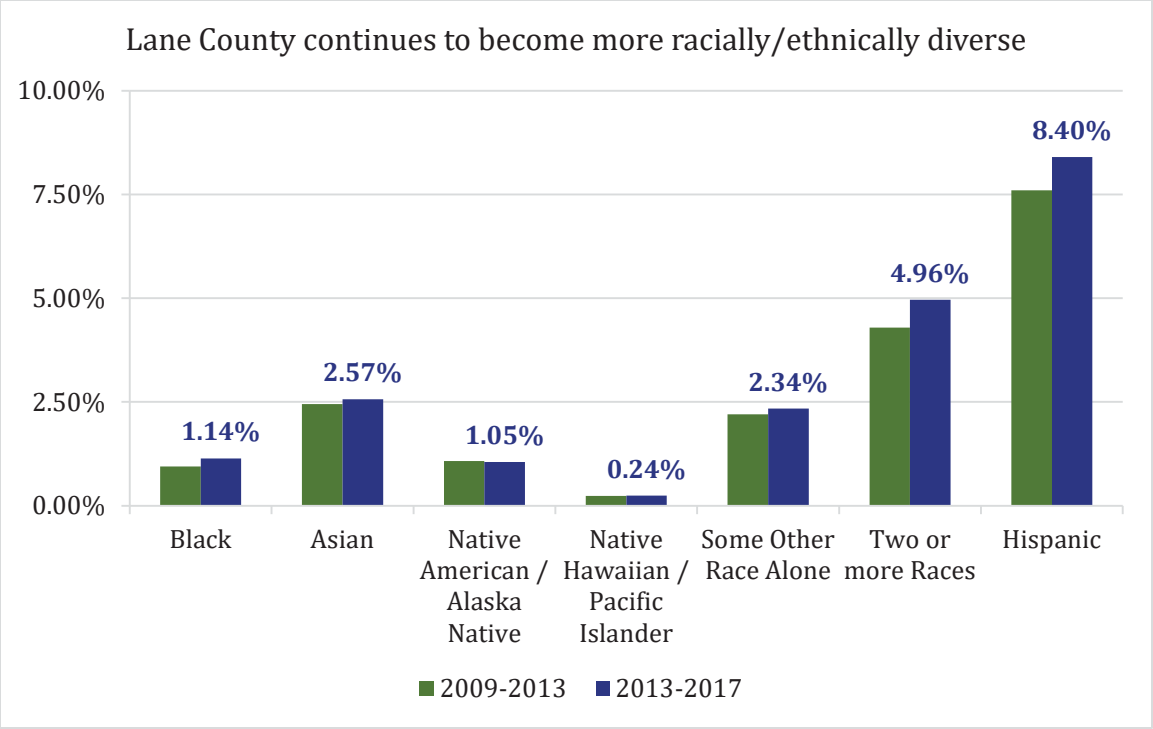
Unlike the other assessments, the Community Health Status Assessment is not a written report but a series of stories told by data visualizations. This document represents a brief summary of the highlights in the report. Full findings can be found at the Lane County Public Health website[1].

[1] https://www.lanecounty.org/cms/One.aspx?portalId=3585881&pageId=16236771

Overall, Lane County remains a moderately healthy community with well-educated and active residents. The 2019 County Health Rankings and Roadmap ranks Lane County 11th out of 35 counties (up from 16th in 2015) for overall health and quality of life[2]. Although good health outcomes and health behaviors are prominent in Lane County, many gaps remain to be addressed. As with the rest of the nation, health status in Lane County is tied to a number of social and environmental factors including income, poverty, race/ethnicity and geographic location.

Demographics

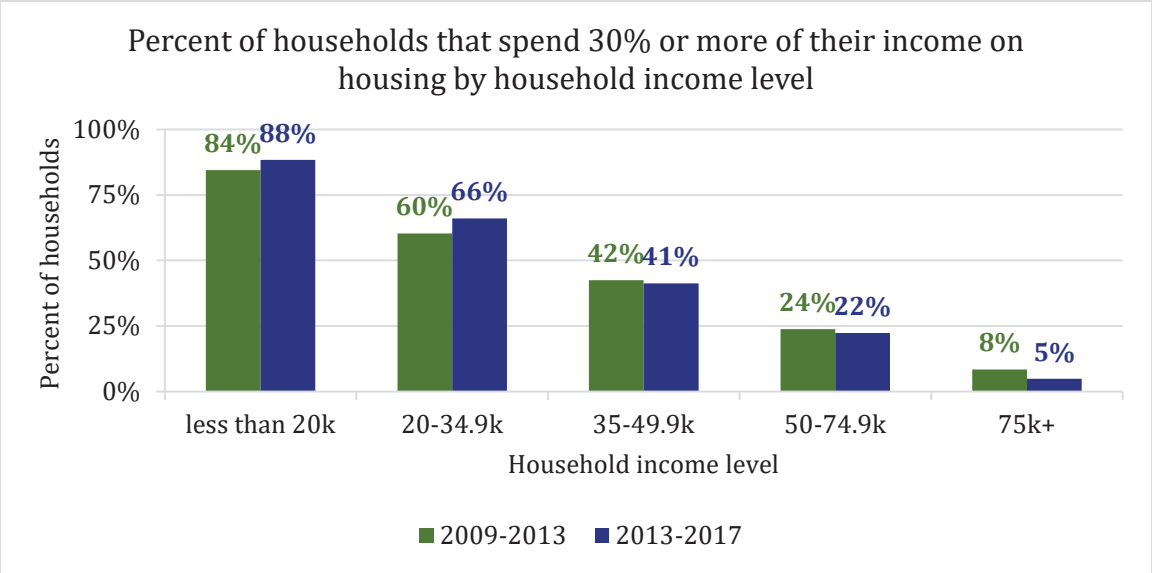
With a population of slightly over 360,000, Lane County's population continues to grow at a slightly slower rate than Oregon overall. Two-thirds of Lane County's population lives in the Eugene-Springfield metropolitan area. Lane County has a higher percent of residents in the 65+ category than the state overall. While Lane County's population is predominantly White (88%, 2013-2019), other racial and ethnic groups continue to grow.

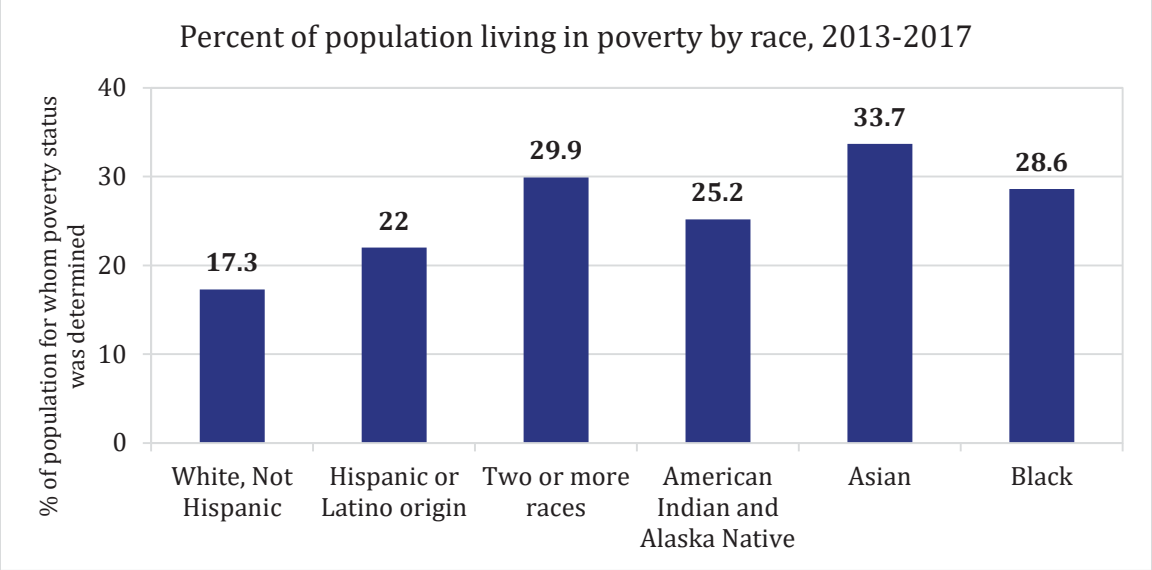


[2] https://www.countyhealthrankings.org/app/oregon/2019/rankings/lane/county/outcomes/overall/snapshot

Socioeconomics

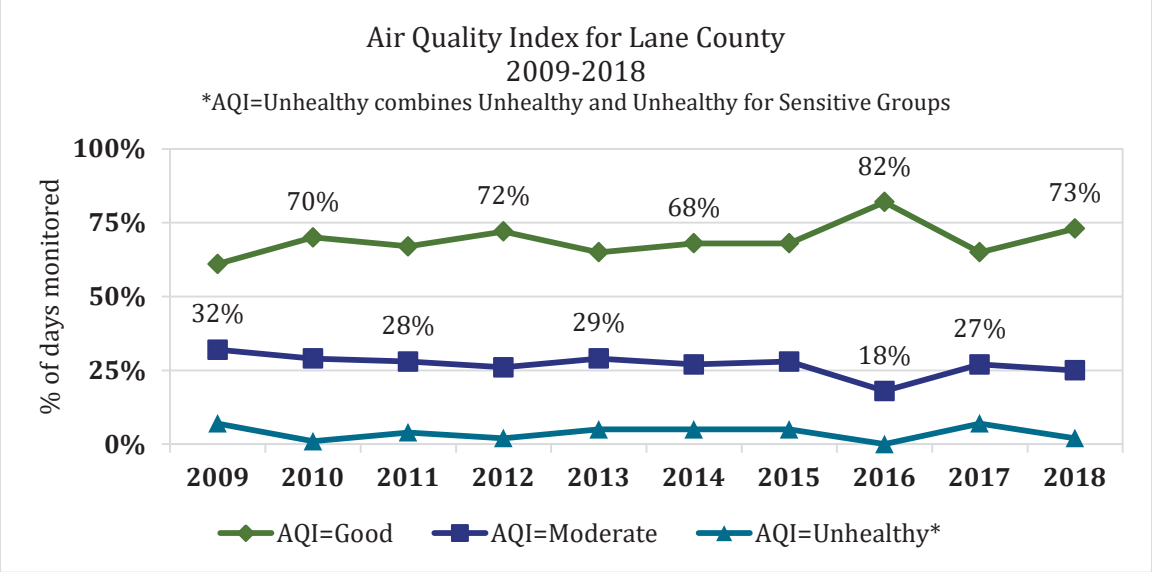
While unemployment rates and median household incomes for Lane County have improved in the last several years, poverty levels remain high. About 20% of Lane County's population still lives in poverty, 22% of households receive SNAP benefits and 52% of Lane County students participate in the Free/Reduced Lunch program. Rates of poverty also vary widely by geography and by race/ethnicity in Lane County. Another area of concern is high school graduation rates, As one of the strongest predictors of life-long health, educational atainment is an important indicator. Oregon has one of the lowest on-time graduation rates in the nation, and Lane County's rate, while improving, was even lower at 74% for academic year 2016-17. Finally, the percent of households that spend more than 30% of their income on housing has decreased slightly overall, it has not decreased for everyone – people who have an annual household income less than $35,000 have seen their housing cost burden increase.



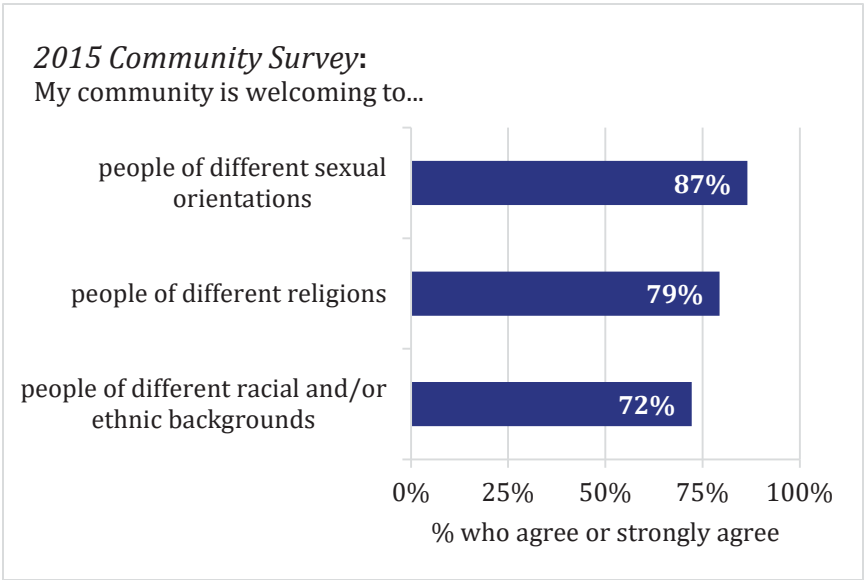


Environment

Extending from the Pacific Ocean to the crest of the Cascade mountains, Lane County boasts incredible scenic and natural areas. Lane County's water and soil are generally of good quality. After slight improvements in Lane County's air quality over the past decade, there has been a slight increase in the percent of days that measured 'moderate' on the Air Quality Index (AQI) in recent years, primarily due to wildfires.



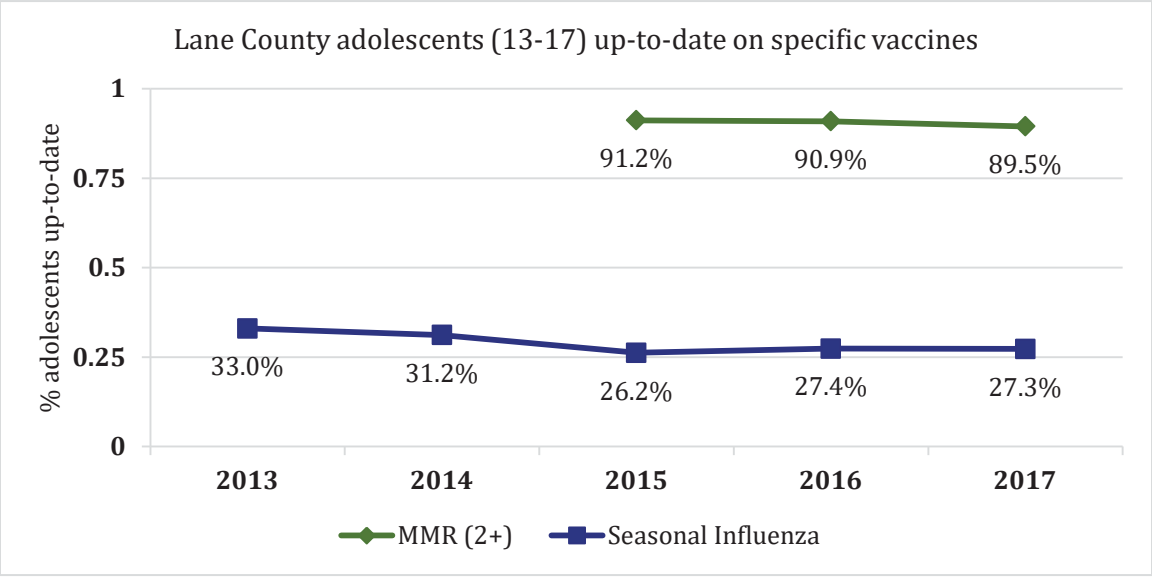
Community Vitality

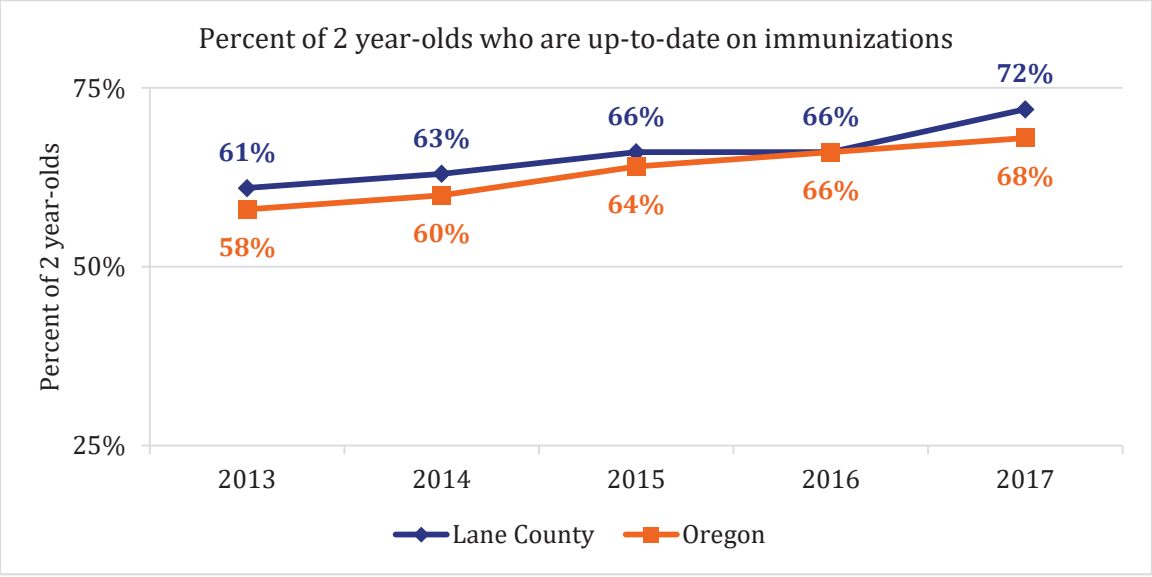


Lane County and Oregon have strong community participation in the forms of voter registration, voter turnout, volunteerism and feeling safe and connected. However, while 87% of participants in a 2015 survey in Lane County agreed that their community was a safe place to live, only 72% said that their community was welcoming to people of different racial/ethnic backgrounds. In addition, rates of child abuse continue to be higher in Lane County than in the state overall, and have risen slightly over the past several years.

Health System

Thanks in large part to the Affordable Care Act, Lane County's uninsured population has continued to decrease. Preventative health screenings in Lane County are comparable to the state overall, as are vaccination rates for 2 year olds and adolescents. Adult influenza vaccination rates for both Oregon (25%) and Lane County (27%) are below the national average (37%), and well below what is considered necessary to achieve community level protection[3].

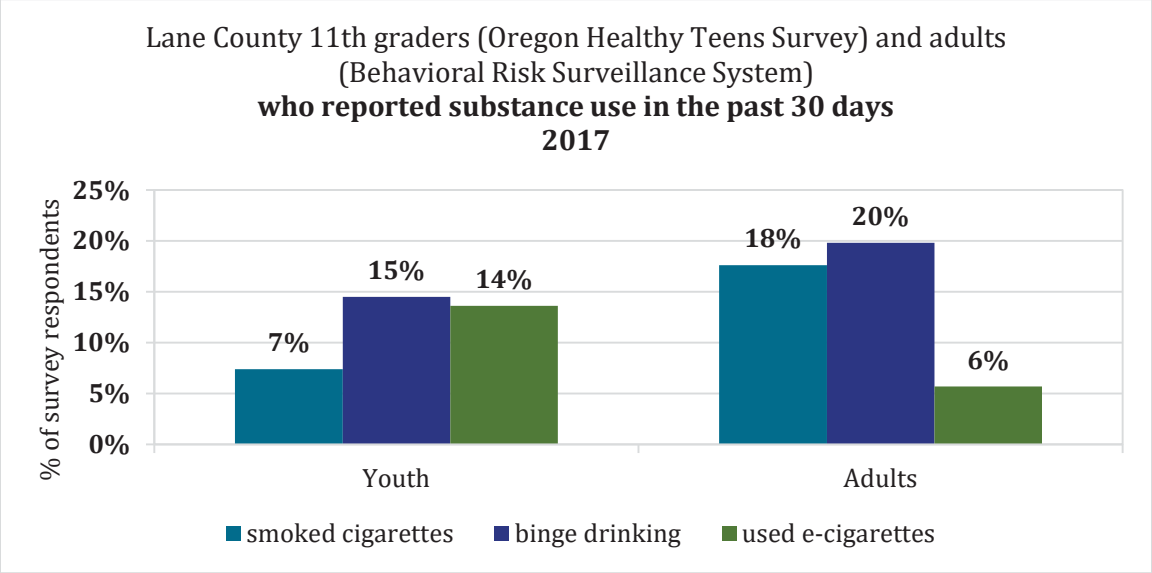


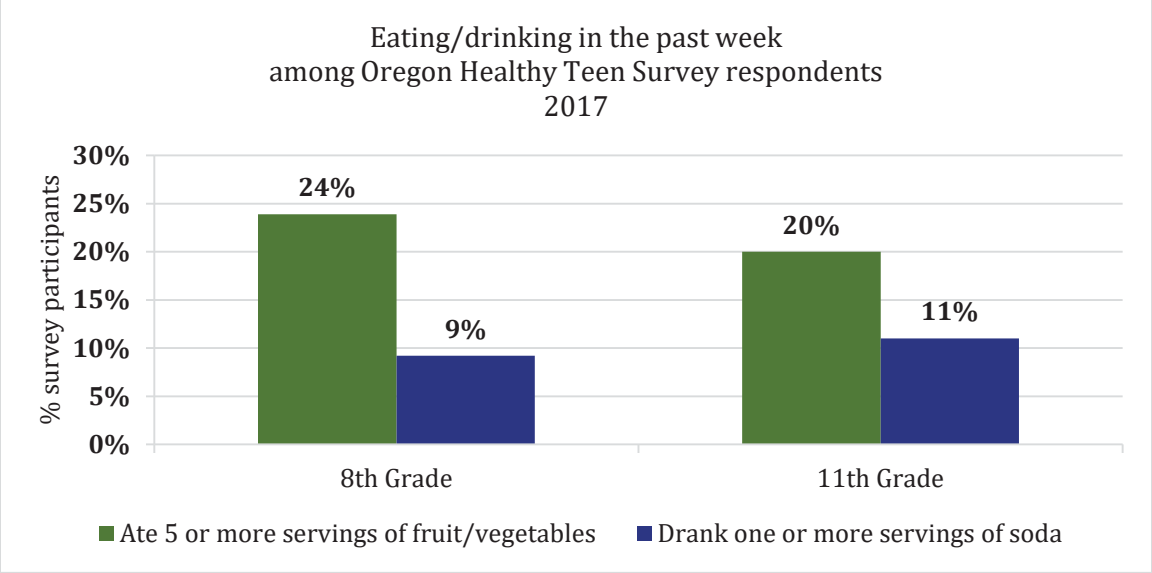


[3] In low-risk populations, 80% coverage is believed to be what is needed to protect a community from influenza: *Plans-Rubió P. The vaccination coverage required to establish herd immunity against influenza viruses. Prev Med. 2012 Jul;55(1):72-7. doi: 10.1016/j.ypmed.2012.02.015. Epub 2012 Mar 4.*

Health behaviors

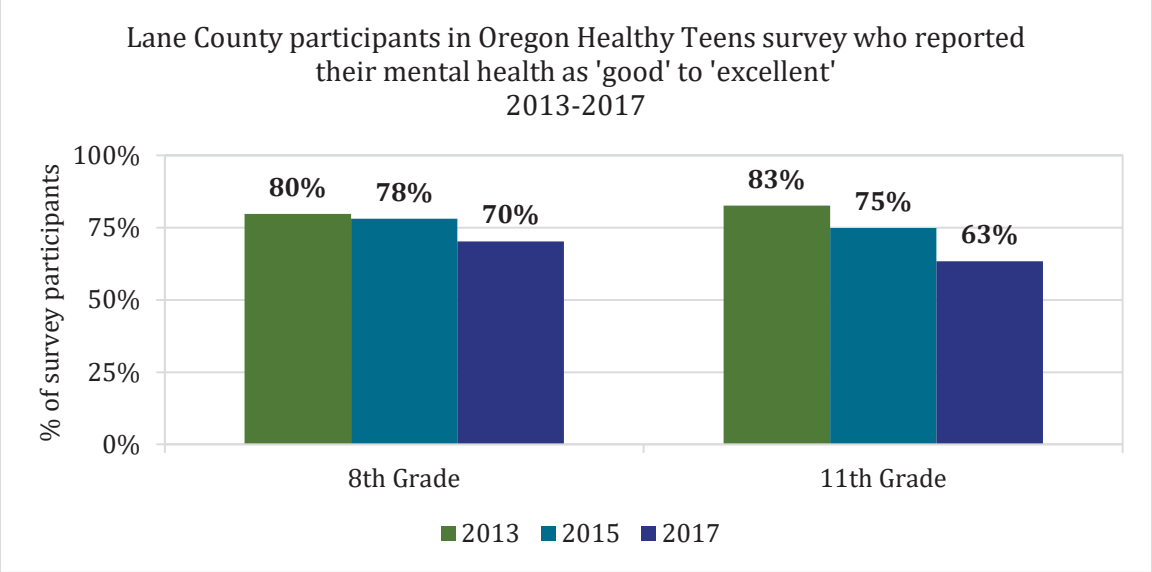
Rates of tobacco, marijuana and alcohol use in Lane County are generally comparable to the state overall, with slightly higher rates of adult tobacco and alcohol use. Fruit and vegetable consumption, physical activity and consumption of sugar-sweetened beverages in Lane County compare favorably to the state, but still fall far short of Healthy People 2020 goals.

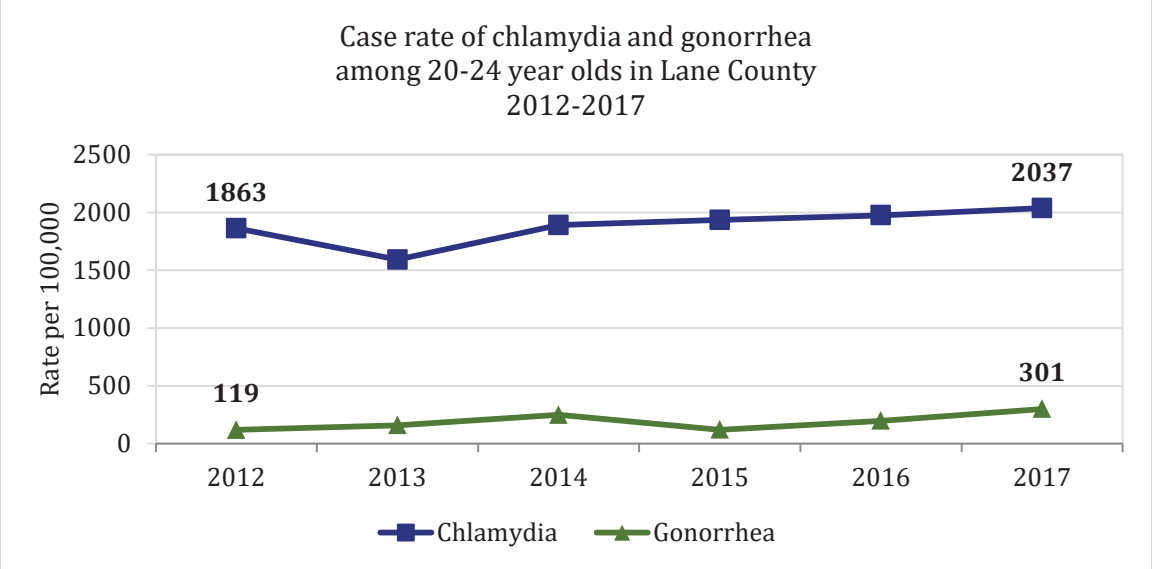




Health Outcomes

In Lane County, chronic disease rates are generally falling or stable, with the exception of childhood obesity rates. Sexually transmitted disease rates have continued a troubling trend of increased infections over the last several years. While percent of adults reporting 'good' mental health appears to be relatively stable, the percent of youth reporting that their mental health was "good" in the last thirty days has declined in the past few years. The percent of women reporting being diagnosed with depression also seems to be increasing, however, this could be due to increased access to treatment rather than an increase in the incidence.

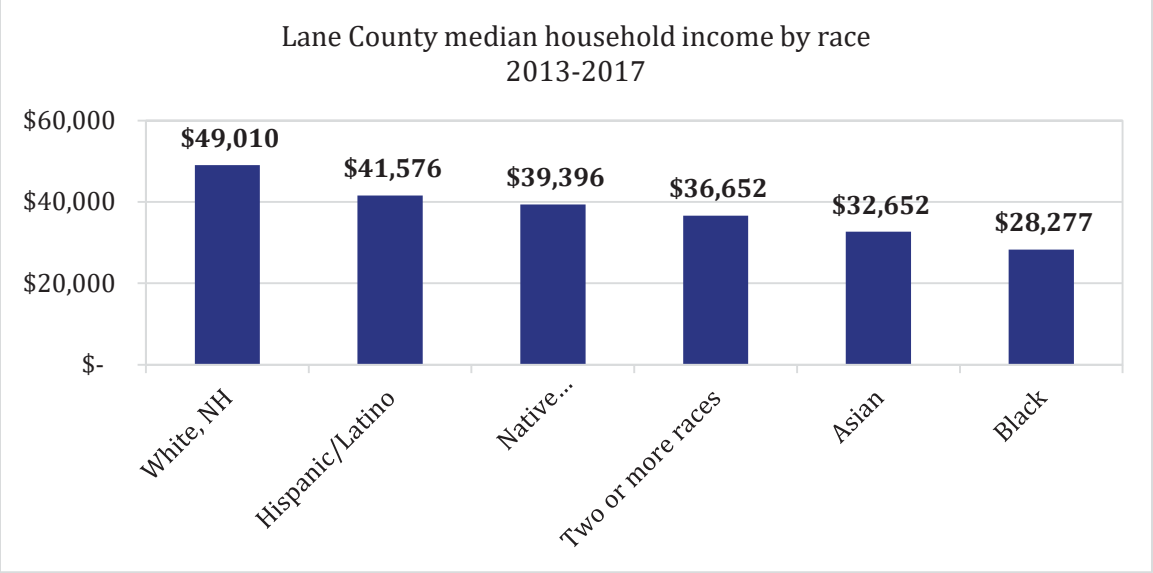




Health inequities

While Lane County's population is moderately healthy as a whole, there are a range of health conditions as well as social determinants of health that vary dramatically based on race/ethnicity and geography which create significant inequity in the community. Some of these health inequities include:

- Life expectancy for White, Non-Hispanic residents is generally longer than other racial and ethnic groups
- Infant mortality rates are higher for some non-white racial and ethnic groups
- Rates of STI infection are much higher for some non-white racial and ethnic groups
- Median household income varies by both race/ethnicity and by geography
- Poverty rates vary by race/ethnicity and by geography



Community Health Status Assessment 2018-2019

The Live Healthy Lane Community Health Status Assessment is best viewed on the website, which can be found via www.livehealthylane.org

About Lane County

Demographics

Environment

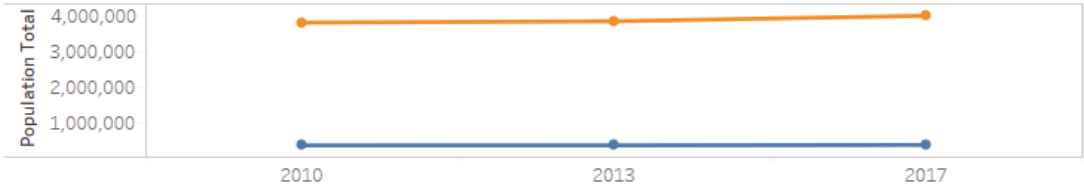
Demographics

Lane County Demographics

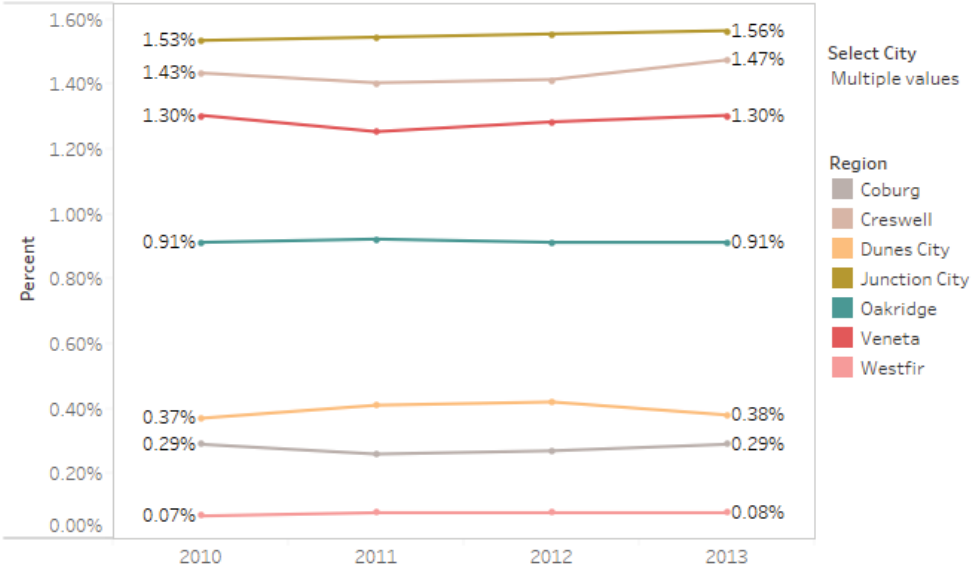
Population estimates | Population growth | Population by age group | Hispanic/Latina(o) population | Population by Race | La ng u..

Population Total

Total Population in Lane County and Oregon. Select city to view percentage of total Lane County by city.
Source: ACS 1-year estimates



Percent of Lane County Population by City

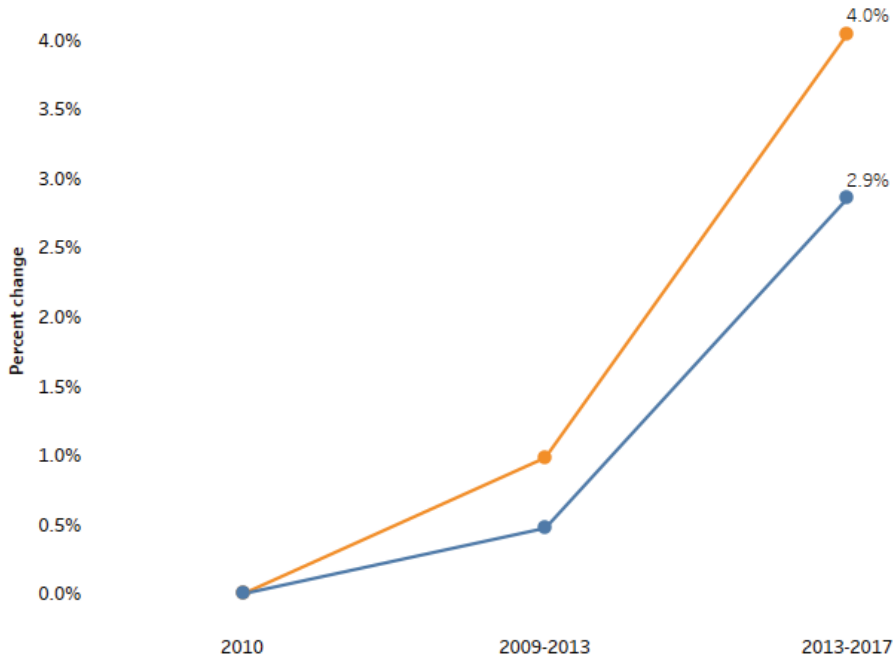


Lane County Demographics

Population estimates | **Population growth** | Population by age group | Hispanic/Latina(o) population | Population by Race | La ng u..

Population of Lane County and Oregon by Year

Percent change in population compared to previous period of measurement.



With a population of **363,471**, Lane County is the 4th most populous county in Oregon. Over 60% of the county's population lives in the Eugene-Springfield metro area. Most of Lane County is rural and unincorporated. Lane County's population continues to grow at a slightly lower rate than Oregon as a whole.

Source: ACS Community Survey, 5 year estimates.

Lane County Demographics

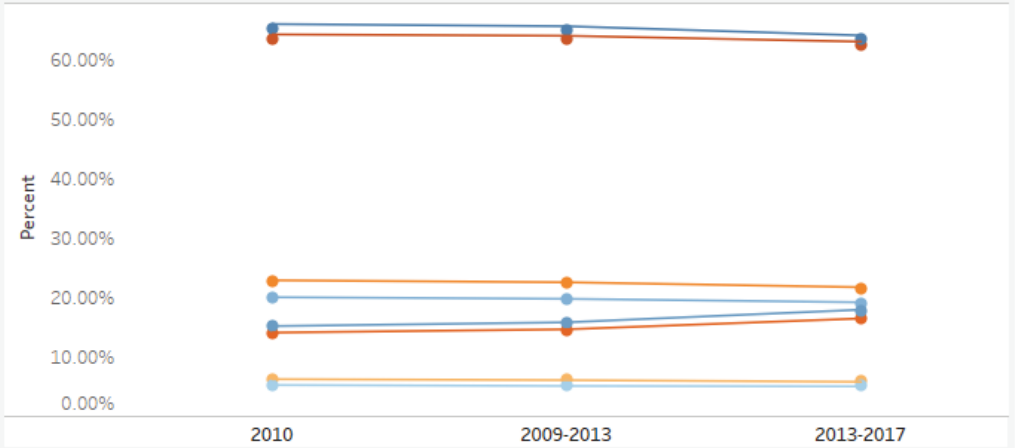
Population estimates | Population growth | **Population by age group** | Hispanic/Latina(o) population | Population by Race | La ng u..

Population by Age Group

Select a Region and Age Range to view Lane County and Oregon populations. Hover for more details.

Select a Region
All

Select an Age Range
Multiple values



Measure, Region

Age - 65+, Lane .. | Age - Under 18, .. | 18-64, Lane Cou..
Age - 65+, Oreg.. | Age - Under 5, L.. | 18-64, Oregon
Age - Under 18, .. | Age - Under 5, O..

Over two-thirds of Lane County's population is between the ages of 18-64. As with the country as a whole, the 65 and older population is growing.

Source: ACS Community Survey 5-year estimates

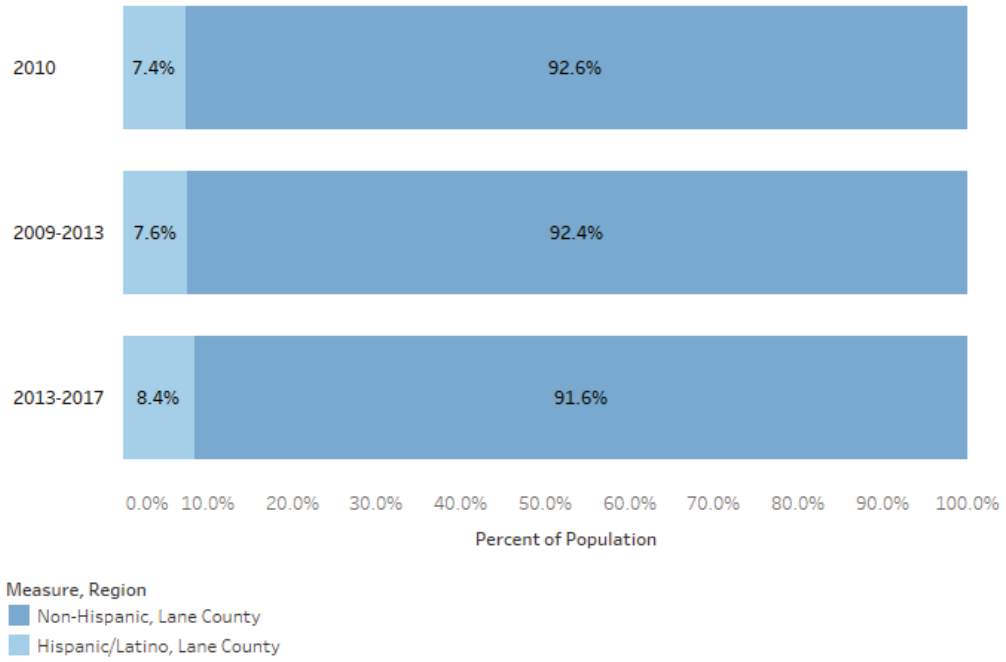
Lane County Demographics

Popul.. | Population growth | Population by age group | Hispanic/Latina(o) population | Population by Race | Language Spoken at Home

Hispanic/Latina(o) Population

Select a Region to view Lane County or Oregon population information. Hover for more details.

Select a Region
Lane County



The Hispanic/Latino community is the largest and fastest-growing ethnic group in Lane County. Lane County's Hispanic/Latino population, while proportionally smaller than the population of the state as a whole, is growing at a faster rate.

Source: ACS Community Survey 5-year estimates

Lane County Demographics

Popul.. | Population growth | Population by age group | Hispanic/Latina(o) population | **Population by Race** | Language Spoken at Home

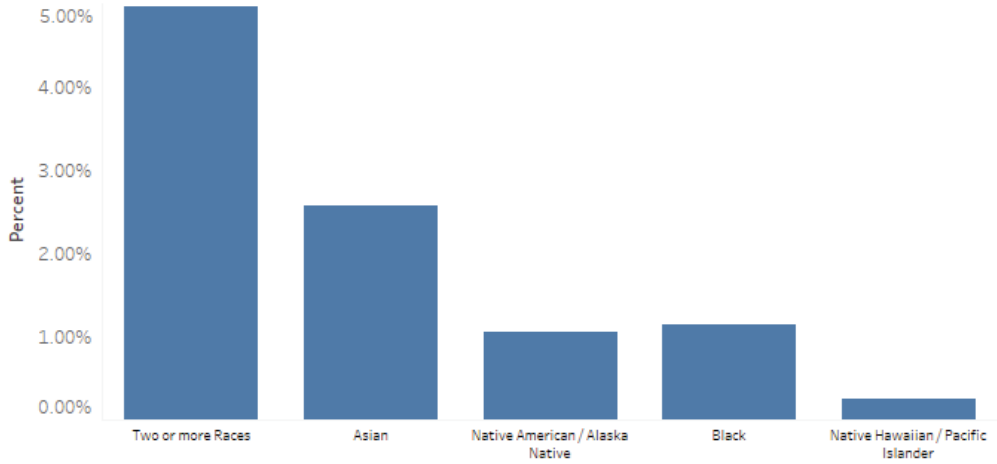
Population by Race

Select a Group to view population breakdown by race or ethnicity in Lane County. Hover for more details

Year
2013-2017

Region
Lane County

Lane County Minority Population by Race



While still predominantly white, Lane County is becoming increasingly diverse with increasing populations across all racial/ethnic groups.

Source: ACS Community Survey 5-year estimates

Lane County Demographics

Po pu l.. | Population growth | Population by age group | Hispanic/Latina(o) population | Population by Race | Language Spoken at Home

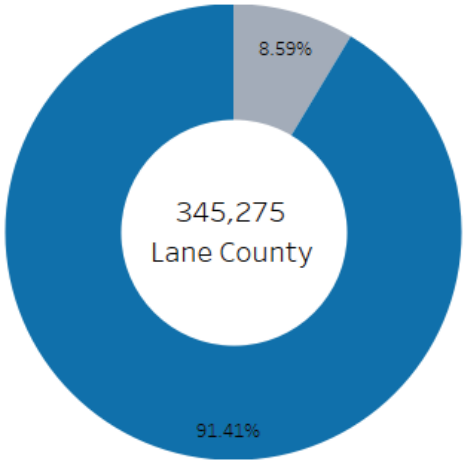
Languages Spoken at Home

Select a Region and Year to see the languages spoken in Lane County and Oregon. Hover for more details.

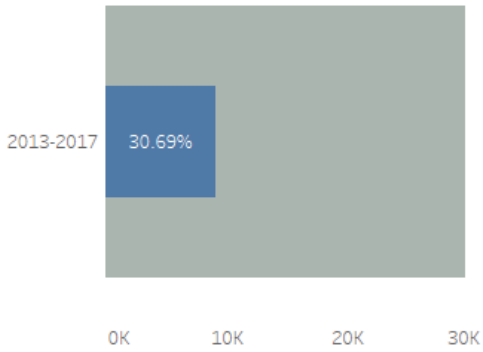
Region: Lane County

Year: 2013-2017

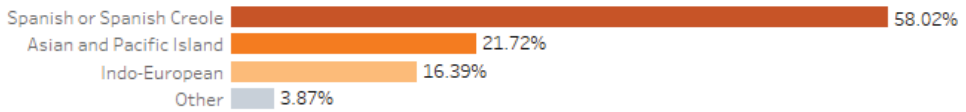
Population who Speak Only English at Home and who Speak a Language Other Than English at Home.



Of the Population who Speak a Language Other Than English, the percent who Speak English Less Than "Very Well"



Of the Population who Speak a Language Other Than English, the percent that speak each Language



The predominant language spoken at home in Lane County is English. In 2017, 8.6% of Lane County's population over the age of 5 spoke a language other than English at home. The most common language spoken at home after English is Spanish. About 30% of residents who speak a language other than English at home report that they speak English "less than very well."

Environment

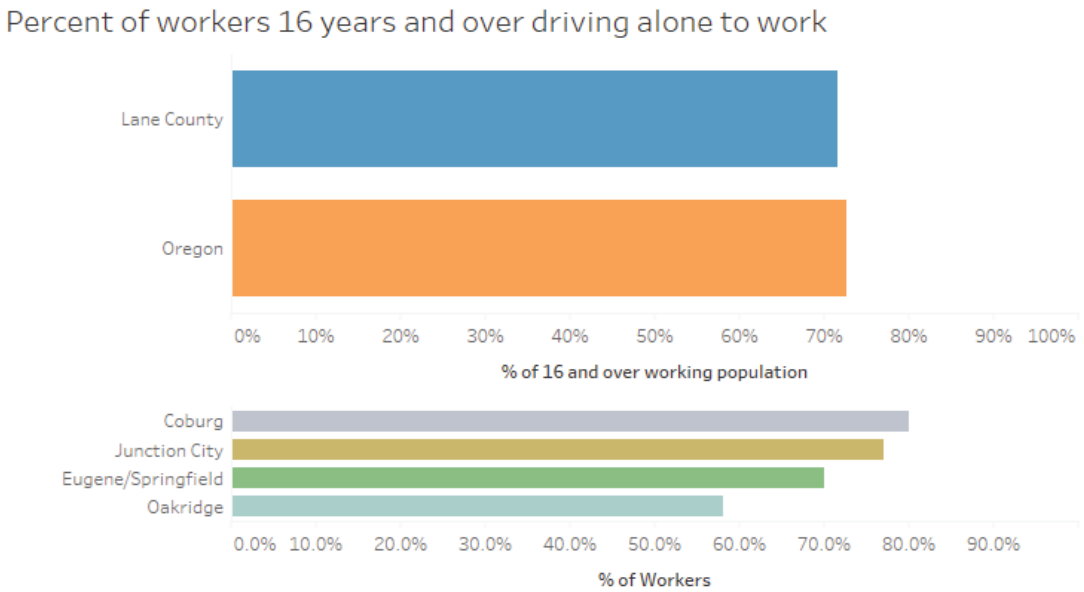
Lane County's Environment

Commute to Work Drive Alone	Commute to Work Public transit	Housing Quality	Median Age of Structures	Air Quality	W at e..

Work Commute - Drive alone

Select a city to view the percent of workers 16 years and over driving alone to work in 2017 in Lane County, Oregon and Cities within Lane County.

Cities
Multiple values



Driving alone to work consumes more fuel and resources than other modes of transportation, such as carpooling, public transportation, biking and walking. Driving alone also increases traffic congestion, especially in areas of greater population density.
Slightly fewer people drive to work alone in Lane County than in Oregon overall and there is variation by geographic area within Lane County.

Lane County's Environment

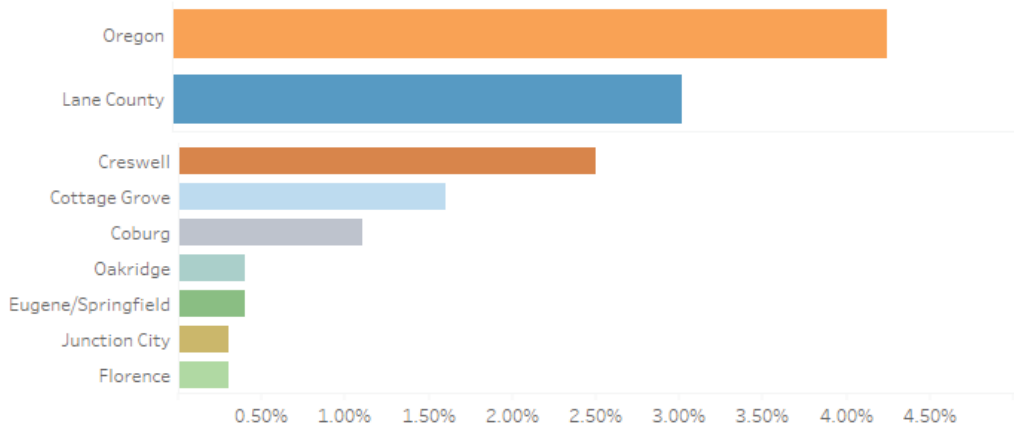
Commute to Work Drive Alone | **Commute to Work Public transit** | Housing Quality | Median Age of Structures | Air Quality | W at e..

Work Commute - Public Transportation

Select a city to view the percent of workers 16 years and over commuting to work by public transportation in 2017 in Lane County, Oregon and Cities within Lane County.

Select Cities
Multiple values

Percent of workers 16 years and over commuting to work by public transportation



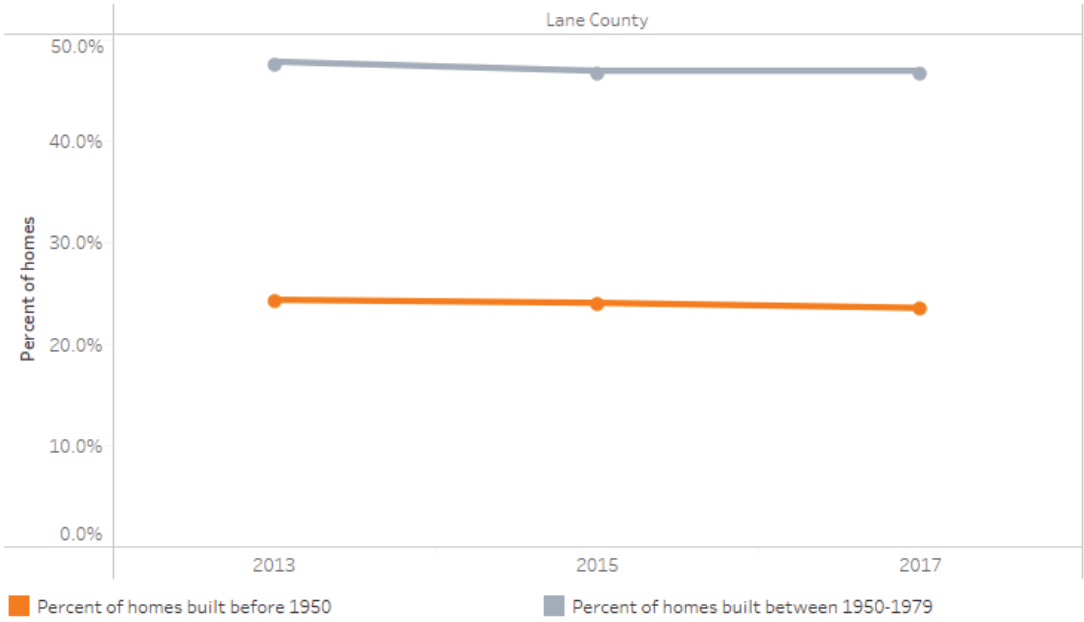
Public transportation offers mobility to U.S. residents, particularly people without cars. Transit can help bridge the spatial divide between people and jobs, services, and training opportunities. Public transportation is also beneficial because it reduces fuel consumption, minimizes air pollution, and relieves traffic congestion. Commuting by public transit is relatively low in Lane County, particularly in rural communities. On average, workers throughout the state of Oregon are slightly more likely to commute by Public Transit than in Lane County alone.

Source: American Community Survey, 5-year estimates for the period ending in the year indicated

Lane County's Environment

Commute to Work Drive Alone | Commute to Work Public transit | **Housing Quality** | Median Age of Structures | Air Quality | W at e..

Housing Quality



Quality housing is associated with positive physical and mental well-being. Aging homes can pose various health risks. For example, children living in homes built before 1950 are at elevated risk for lead-poisoning due to the use of lead paint in older homes. Less than one-quarter of homes in Lane County were built before 1950, with about half the homes in Lane County built between 1950-1979.

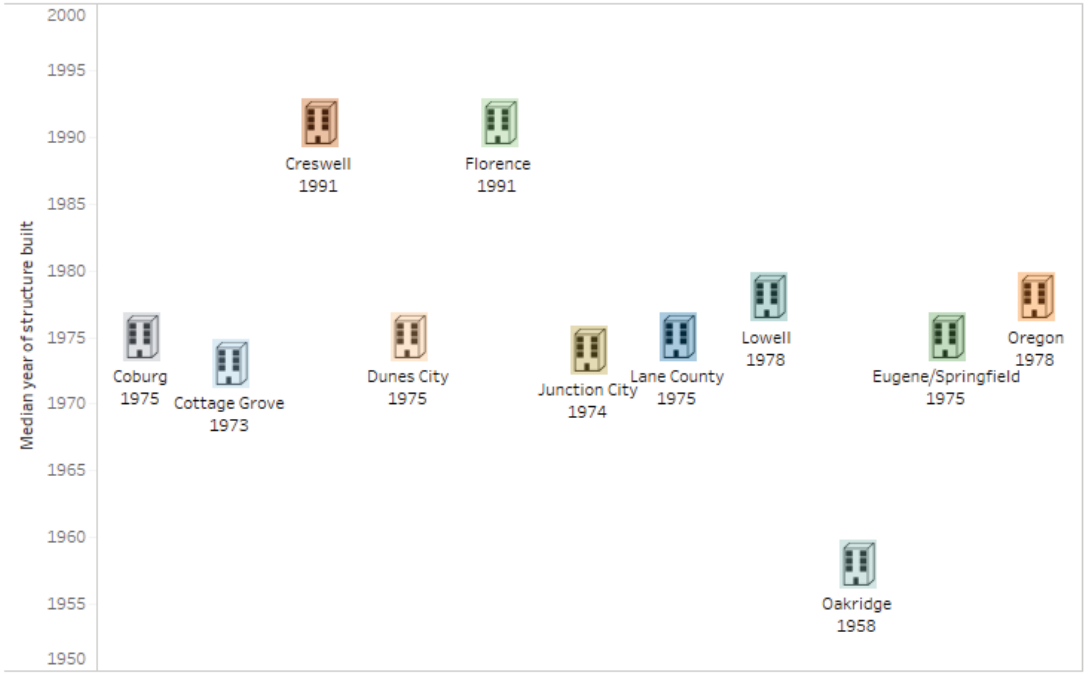
Source: American Community Survey, 5-year estimates ending in year indicated

Lane County's Environment

Co m. | Commute to Work Public transit | Housing Quality | Median Age of Structures | Air Quality | Water quality

Median Age of Structures

Median age of structures by Lane County, Oregon and Cities within Lane County.



Risks due to aging homes tend to be lower in Oregon than the rest of the nation. Most homes in Lane County were built after 1950. Less than 25% of homes in Lane County were built before 1950, and roughly half of the local housing stock was built between 1950 and 1979.

Source: American Community Survey, 5-year estimates for the period ending in the year indicated

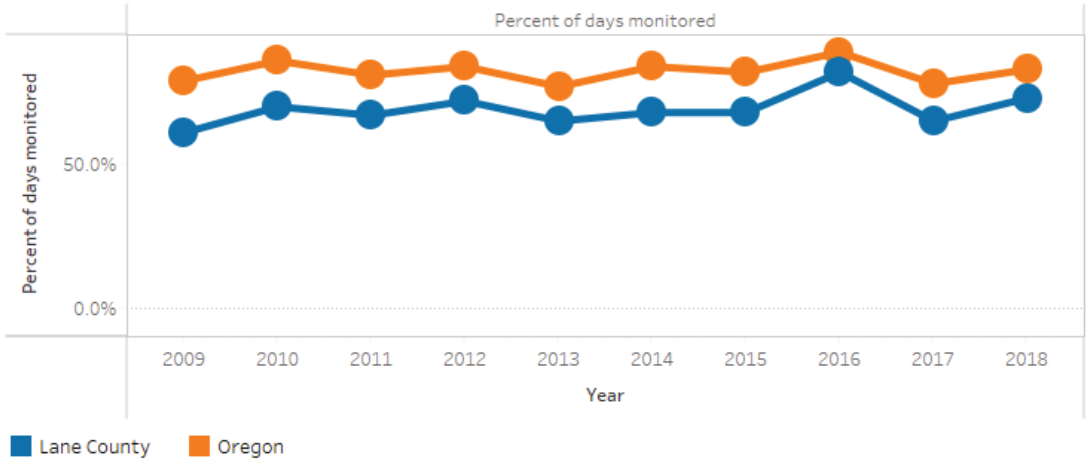
Lane County's Environment

Co m. | Commute to Work Public transit | Housing Quality | Median Age of Structures | **Air Quality** | Water quality

Air Quality Index Data

Air Quality Index (AQI) is an index that describes daily air quality. The EPA calculates AQI for five major air pollutants: ground-level ozone, particulate matter (PM2.5 & PM10), carbon monoxide, sulfur dioxide, and nitrogen dioxide. Percent of days monitored in Lane County and Oregon. Hover for more details.

Air Quality Index
AQI=Good



Poor air quality is linked to premature death, cancer, and long-term damage to respiratory and cardiovascular systems. Air pollution is a leading environmental threat to human health. Particles in the air like dust, dirt, soot, and smoke are one kind of air pollution called particulate matter. Fine particulate matter that is less than 2.5 micrometers in diameter, or PM2.5, is so small that it cannot be seen in the air is the leading cause of poor air quality in Lane County.

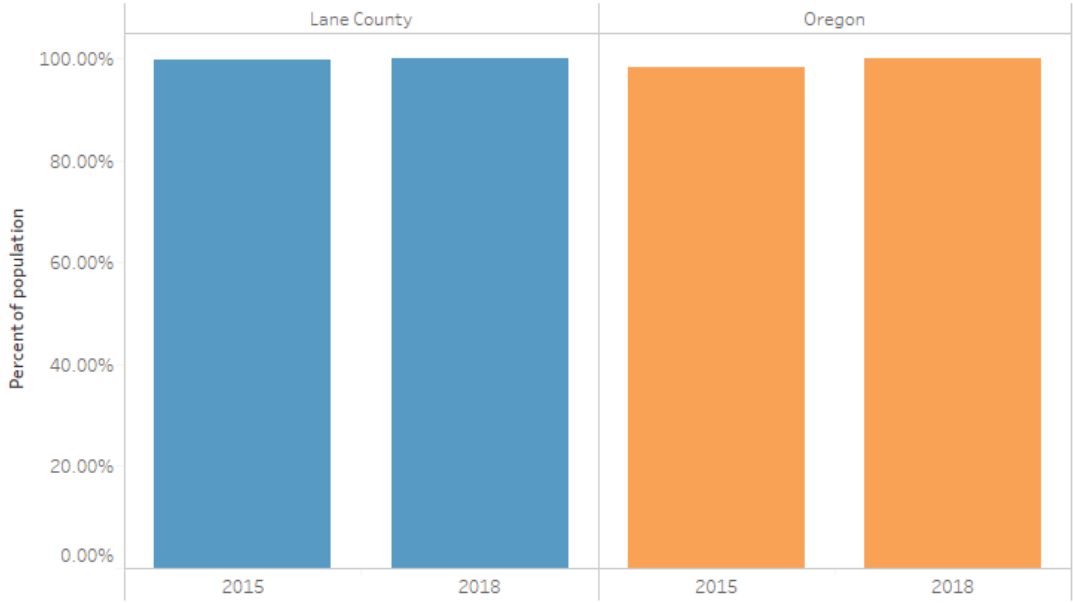
Source: Environmental Protection Agency: Air Quality System Monitoring Data

Lane County's Environment

Co m.	Commute to Work Public transit	Housing Quality	Median Age of Structures	Air Quality	Water quality

Population served by community water systems meeting health-based standards

Percentage of population served in Lane County and Oregon



Access to safe drinking water is essential to human health. Public drinking water systems are required to monitor approximately 90 contaminants and indicators regulated by the Environmental Protection Agency. Lane County's rivers are rated good to excellent by the Oregon Department of Environmental Quality: https://www.oregon.gov/deq/wq/Pages/WQI.aspx

Source: Oregon Public Health Drinking Water Data Online

Social Determinants of Health

Socioeconomic data

Community vitality

Health systems

Socioeconomics

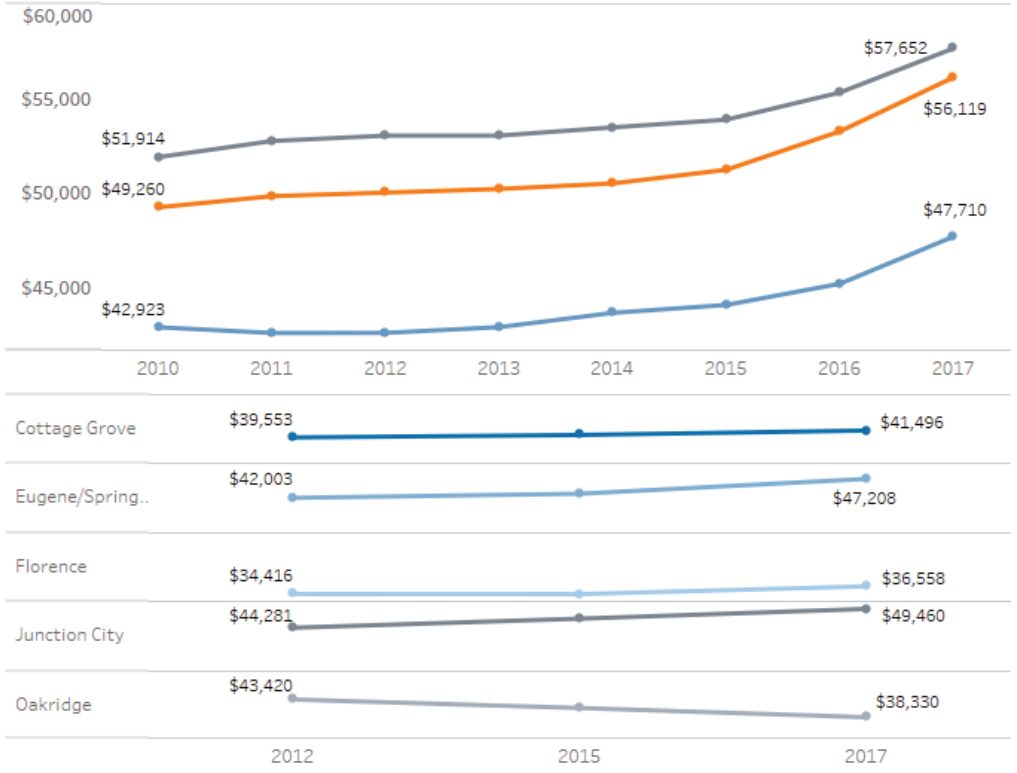
Lane County Socioeconomic Data

Median HH Income by City	Median HH Income by Race and Ethnicity	Unemployment	Vacancies Average Wage	Living in poverty	H ou s..

Median household income by year

*Select a city to view the Median Household Income by year in **Lane County**, Oregon, **United States** and Cities within Lane County. Hover for details.*

City
Multiple values



Median household income reflects the relative affluence and prosperity of an area and can indicate the ability of a household to access housing, health care, educational opportunities and food. While Lane

Lane County Socioeconomic Data

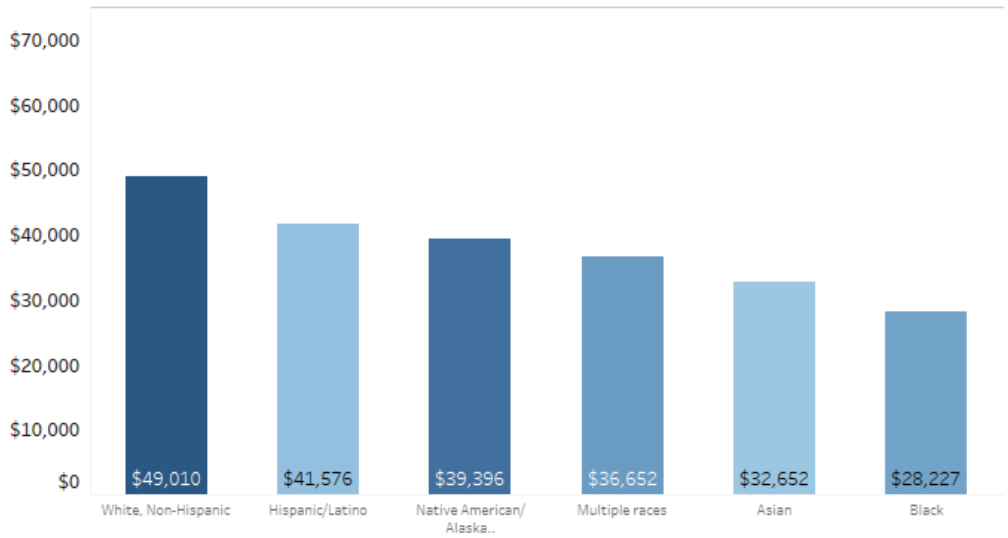
Median HH Income by City | **Median HH Income by Race and Ethnicity** | Unemployment | Vacancies Average Wage | Living in poverty | H ou s..

Median household income by race/ethnicity

*Select a **Year** and **Region** to view the Median Household Income by Race or Ethnicity in Lane County and Oregon.*

Year
2017

Region
Lane County



There are also some disparities between white, non-hispanic households and households of other races/ethnicities in Lane County and in the state overall. Due to small numbers, year-to-year trends for race/ethincity data should be interpreted with caution.

Source: American Community Survey, 5-year averages for period ending in year indicated.

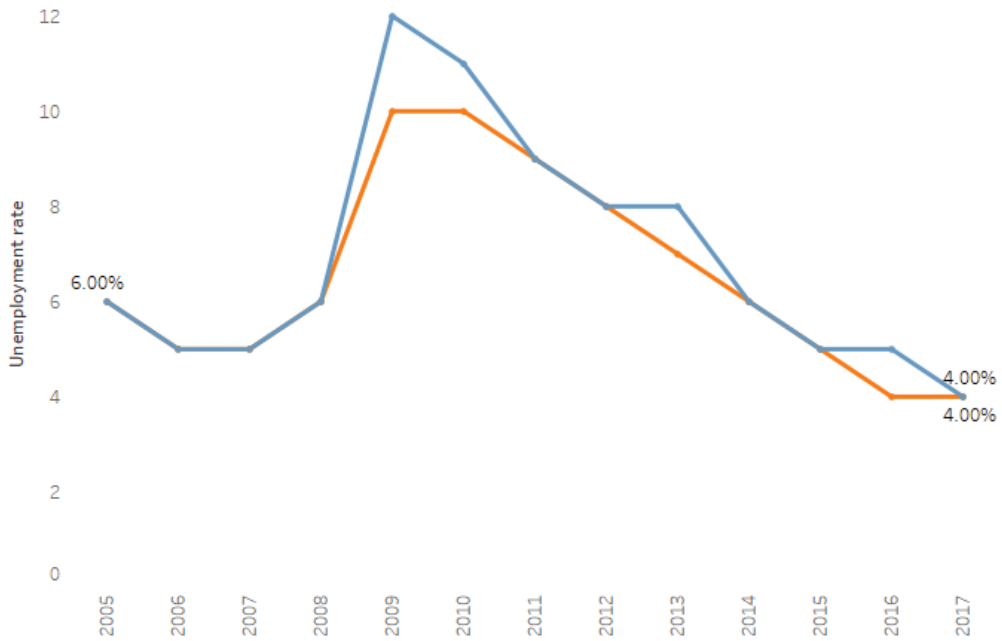
Lane County Socioeconomic Data

Median HH Income by City | Median HH Income by Race and Ethnicity | **Unemployment** | Vacancies Average Wage | Living in poverty | H ou s..

Unemployment rate

Select a region to view the unemployment rate by year for Lane County, Oregon, and US...

Region
All



The unemployment rate is a key indicator of the local economy and has implications for individuals' health. Lane County's unemployment rate has been steadily decreasing since the economic recession and is similar to Oregon's rate.

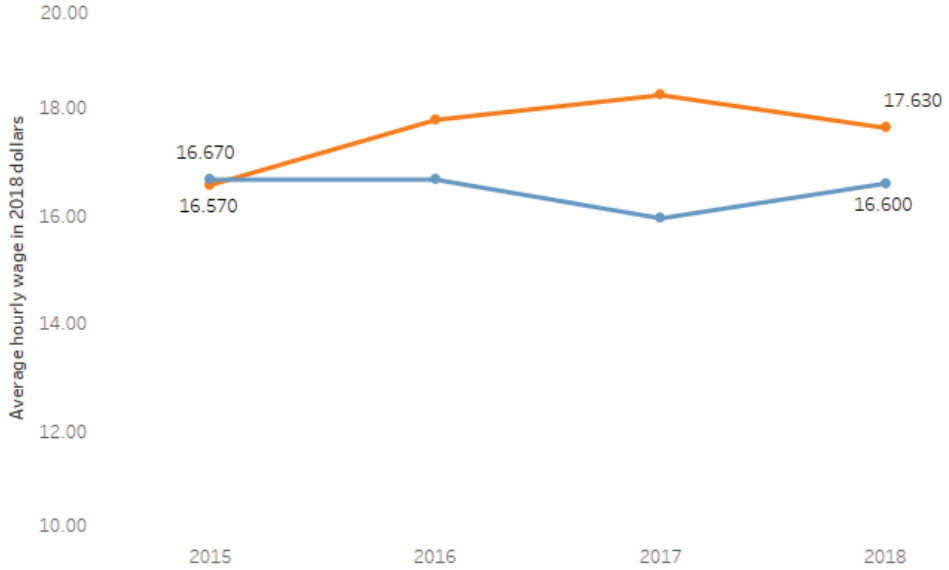
Source: Bureau of Labor statistics: *https://www.bls.gov/lau/ex14tables.htm*

Lane County Socioeconomic Data

Median HH Income by Race and Ethnicity | Unemployment | Vacancies Average Wage | Living in poverty | Households below ALICE | H o ..

Average wage of vacant, private-sector jobs

Average Wage of Vacant Positions in the private sector by year for Lane County and Oregon. Hover for more details.



Average wages for new private-sector jobs (shown in 2018 dollars) have remained relatively stable since 2015 in Lane County. Statewide, wages have increased slightly. According to the Living Wage Calculator for Lane County, OR, $16.95 is the wage needed by two working adults to support themselves and two children (see Living Wage Calculator, below).

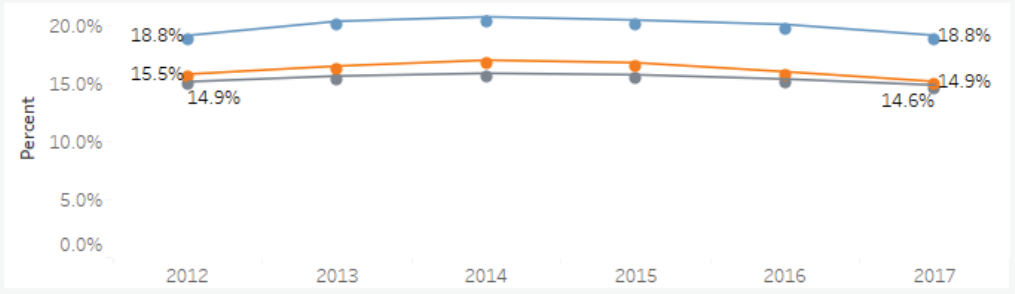
Sources: State of Oregon Employment Department: Job Vacancy Surveys 2015-2018; https://www.qualityinfo.org/lane Living Wage Calculator, Amy K. Glasmeier, PhD & Carey Anne Nadeau, Department of Urban Studies and Planning, Massachusetts Institute of Technology: http://livingwage.mit.edu/counties/41039

Lane County Socioeconomic Data

Unemployment | Vacancies Average Wage | **Living in poverty** | Households below ALICE | Households with housing cost burden | S N ..

Population living below federal poverty level

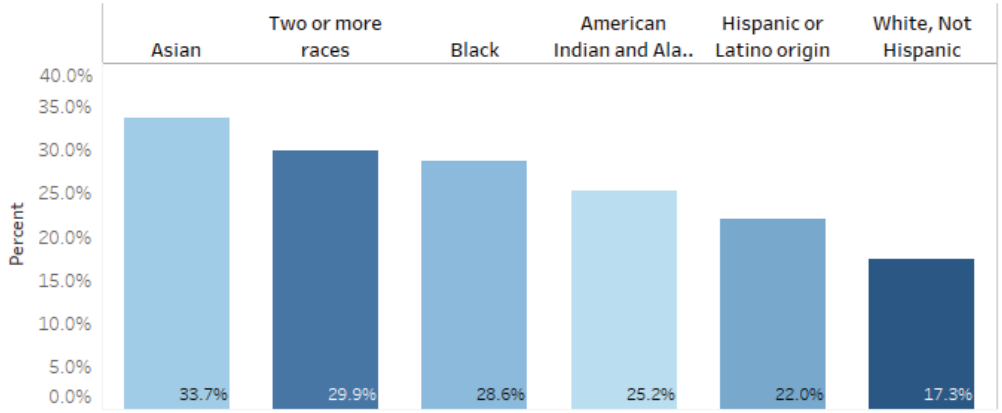
Percent of the population in Lane County and Oregon living at or below the Federal Poverty Level. Hover for details.



Poverty by Race/Ethnicity

Region: Lane County

Year: 2017



Poverty is associated with poor health. In Lane County, the poverty rate has remained stable since 2012

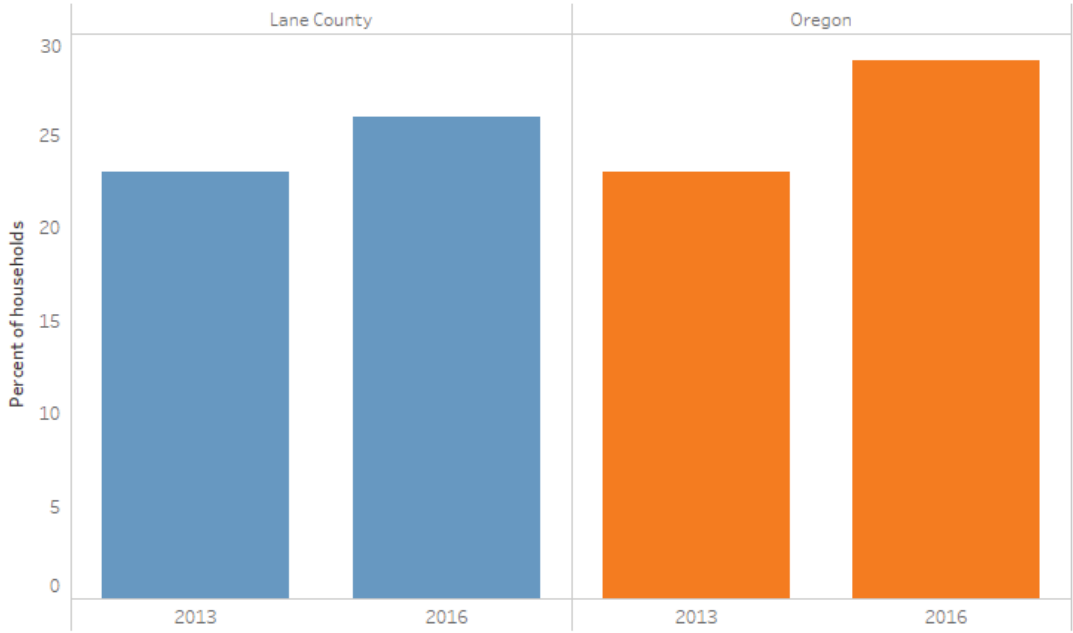
Lane County Socioeconomic Data

Vacancies Average Wage | Living in poverty | **Households below ALICE** | Households with housing cost burden | SNAP benefits | P a ..

Housholds living below ALICE threshold

Select a Region to view Lane County or Oregon. Hover for more details.

Region: All



Asset Limited, Income Constrained, Employed (ALICE) households are those that earn more than the federal poverty level, but less than the basic cost of living. In 2017, the income needed in Lane County to support two adults and one preschool-age child was $53,779.

Sources: United Way ALICE project - Oregon; Self-Sufficiency Standard for Oregon 2017

Lane County Socioeconomic Data

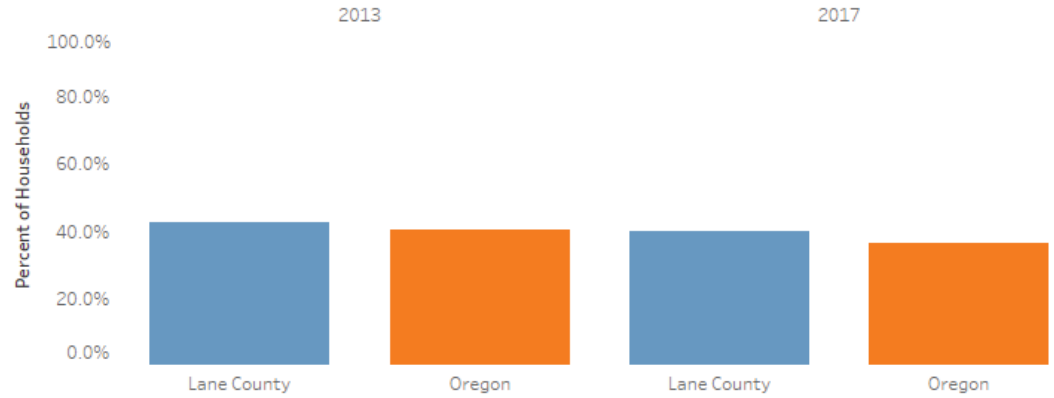
Living in poverty	Households below ALICE	Households with housing cost burden	SNAP benefits	Participation in Free/Reduced lunch program	H i. .

Households that pay more than 30% of income for housing by median income

in Lane County and Oregon. Hover for more details.

Median Household Income
Total

Housing cost burden



Families who spend more than 30% of their income on housing are considered "cost-burdened" by the US Department of Housing and Urban Development. This cost-burden can impact a family's ability to afford other expenses - such as transportation, food, or health care - and can create economic hardship. While overall, the percent of cost-burdened households has decreased slightly, there remain disparities between households at different income levels.

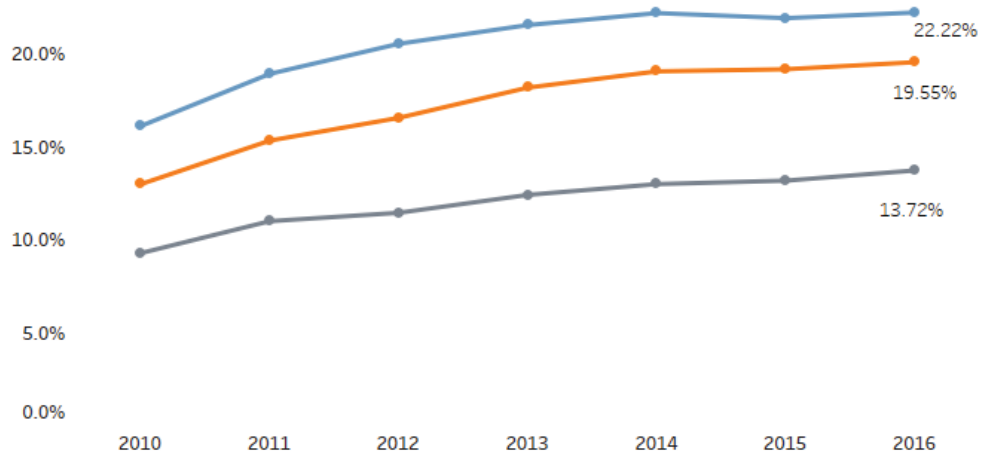
Source: American Community Survey, 5-year estimates for the period ending in the year indicated.

Lane County Socioeconomic Data

Households below ALICE	Households with housing cost burden	SNAP benefits	Participation in Free/Reduced lunch program	High School Graduation Rates	P o ..

Households receiving SNAP benefits

*Percent of Households receiving Foodstamps by year in **Lane County**, Oregon, and **United States**. Hover for details.*



Participation in the Supplemental Nutrition Assistance Program (SNAP, also called foodstamps), is an indicator of the rate of food insecurity, which is associated with numerous health problems. Rates of participation in Lane County have leveled off in recent years but remain higher than the state and nation overall.

Source: American Community Survey, 5-year estimates for the period ending in the year shown.

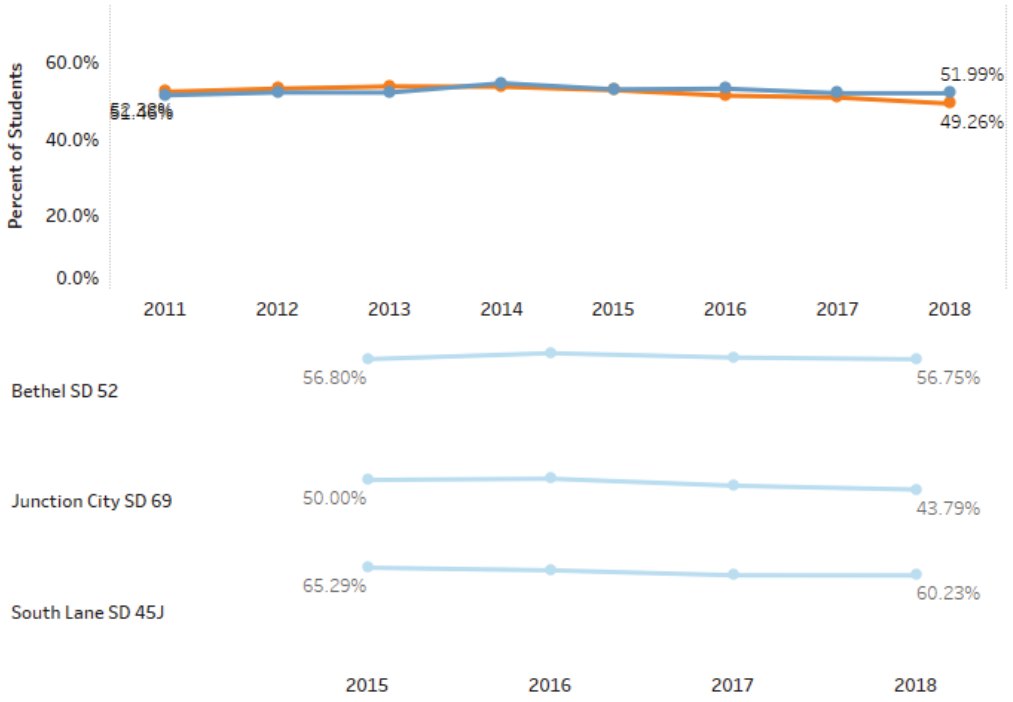
Lane County Socioeconomic Data

Households with housing cost burden | SNAP benefits | **Participation in Free/Reduced lunch program** | High School Graduation Rates | Population with college degree | K i. .

Students eligible for free/reduced lunch

Rates for Oregon and Lane County broken down by School District. Select a district to view district details from Academic Year (ending) 2015 and later. Hover for more details.

School District
Multiple values



Rates of participation in free/reduced lunch programs in schools is another indicator of food insecurity. Participation rates in Lane County have remained stable and similar to Oregon rates. Rates within Lane County school districts can vary considerably.

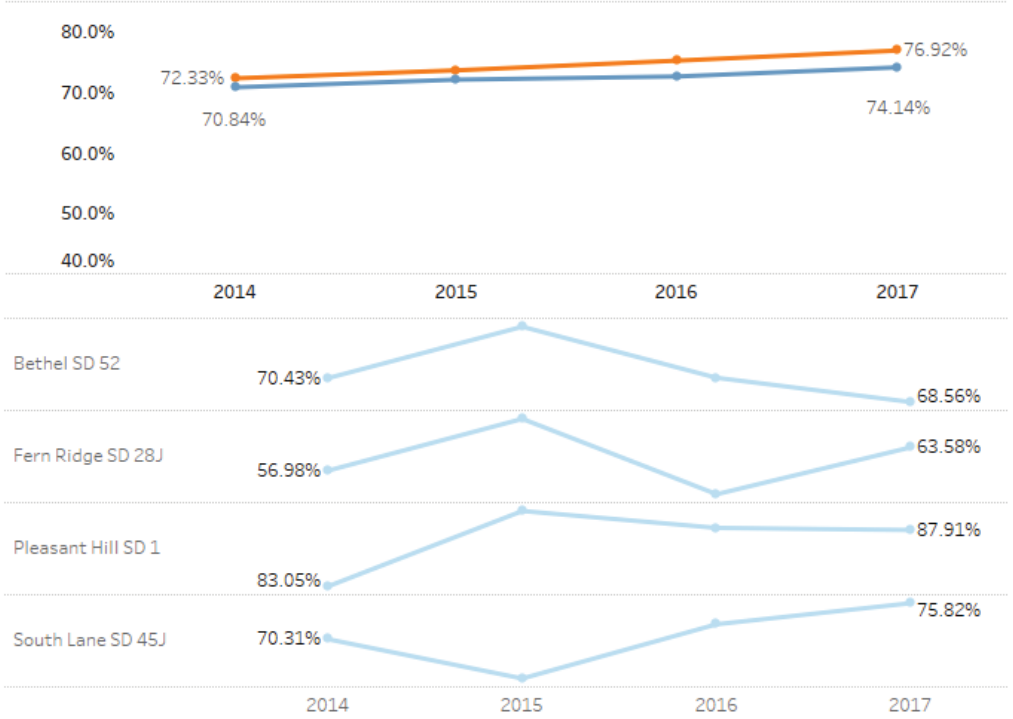
Lane County Socioeconomic Data

Ho us e..	SNAP benefits	Participation in Free/Reduced lunch program	High School Graduation Rates	Population with college degree	Kinder Assessment scores

4-year cohort high school graduation rates

In Lane County and Oregon. Select a School District to view district details.

School District
Multiple values



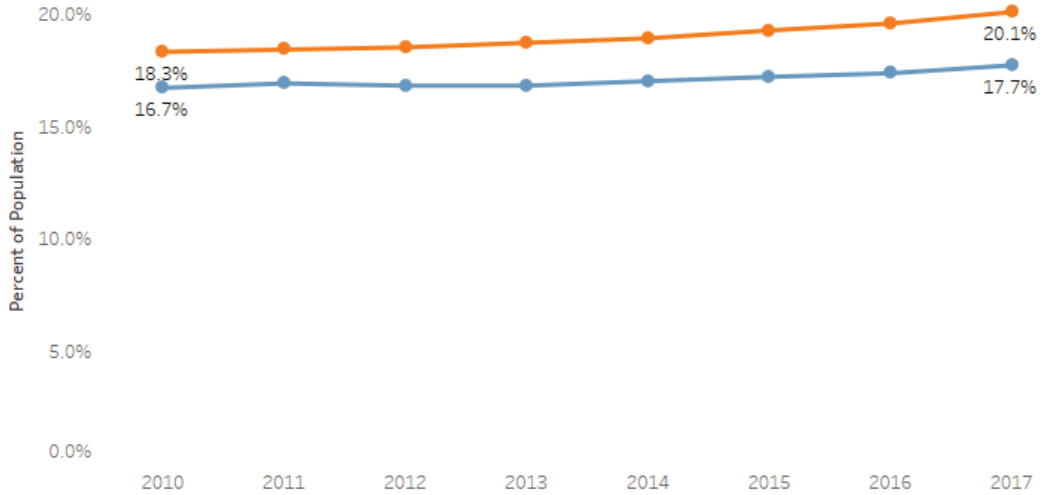
Educational attainment is one of the strongest predictors of life-long health. High school graduation rates by 4-year cohorts (or on-time graduation) is one indicator used to look at a community's health. Lane County's on-time HS graduation rate is simiar to Oregon's - both of which lag behind the nation overall. Graduation rates also vary by geography within Lane County and by race/ethnicity.

Lane County Socioeconomic Data

Ho us e..	SNAP benefits	Participation in Free/Reduced lunch program	High School Graduation Rates	Population with college degree	Kinder Assessment scores

Percent of population with a Bachelor's degree

in Lane County and Oregon Hover for additional details.



A college degree creates more opportunities for higher paying jobs and is associated with improved health outcomes across the lifespan. In Lane County, about 17% of the adult population over age 25 has a bachelor's degree.

Source: American Community Survey, 5-year estimates for the period ending in the year indicated

Lane County Socioeconomic Data

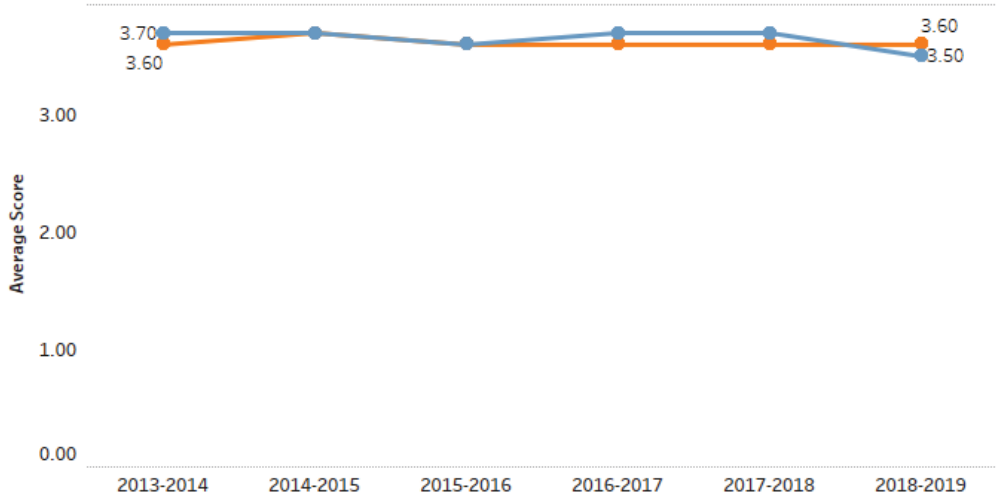
Ho us e..	SNAP benefits	Participation in Free/Reduced lunch program	High School Graduation Rates	Population with college degree	Kinder Assessment scores

Kindergarten assessment scores

Select a Kindergarten Assessment to view Lane County and Oregon resul..

Kindergarten Assessment
Approaches to Learning

Approaches to Learning



The Oregon Kindergarten Assessment was created in 2013 to provide a snapshot of the skills needed for educational success for children entering kindergarten in order to better inform early learning programs across the state.

Source: Oregon Department of Education

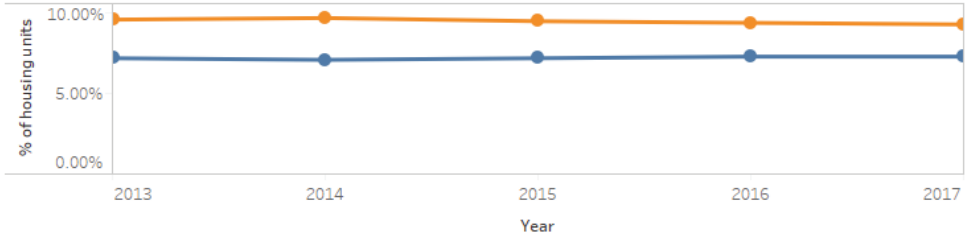
Community Vitality

Lane County's Community Vitality

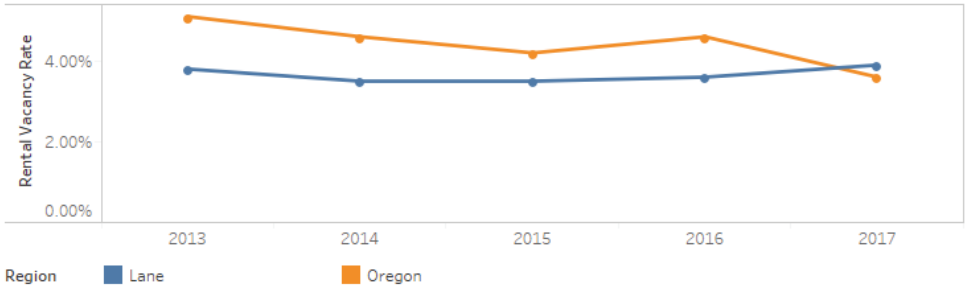
Vacant Housing Units

Percent of vacant housing units within Lane County and Oregon.

Total vacancies



Rental vacancies



Vacancy rates are an indicator of community and economic health. Lane County has historically had a slightly lower vacancy rate, both overall and for rental housing, than Oregon; the Lane County's rental vacancy rate rose slightly above Oregon's in the period 2013-2017.

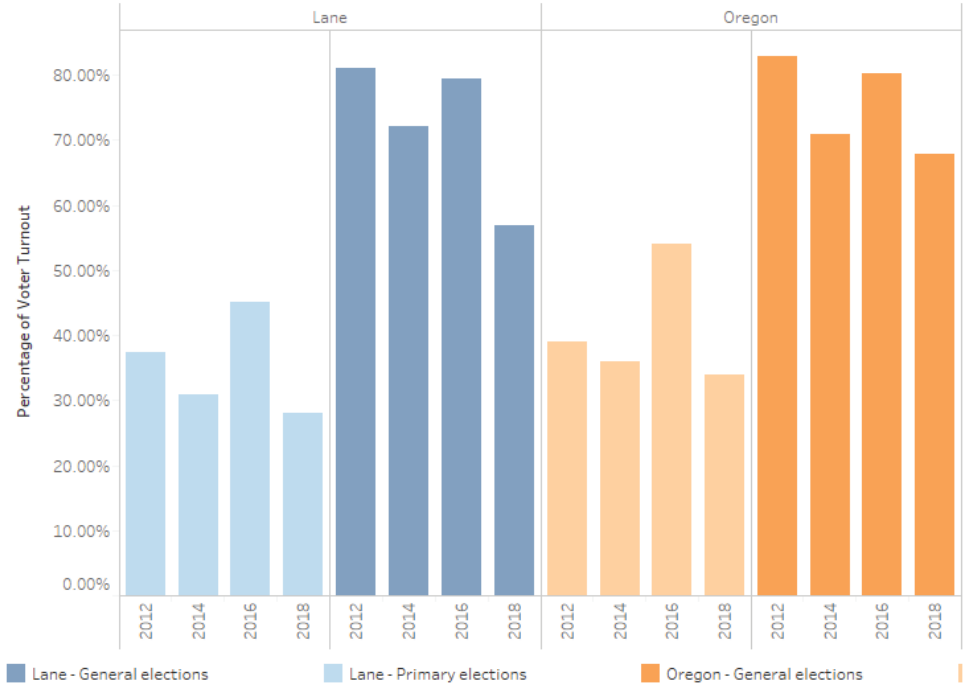
Source: American Community Survey, 5-year estimates for the period ending in the year indicated

Lane County's Community Vitality

Community stability: Housing vacancy | **Civic Engagement: Voter Turnout** | Community Strengths and Themes Survey 2015 | Child Abuse and Neglect | Domestic violence | Vi ol e..

Voter turnout

Rate of voter turnout in Lane County and Oregon.



Voter turnout is one indicator of how engaged a community is in the processes that shape community life. Lane County and Oregon have higher voter turnout rates than the nation overall.

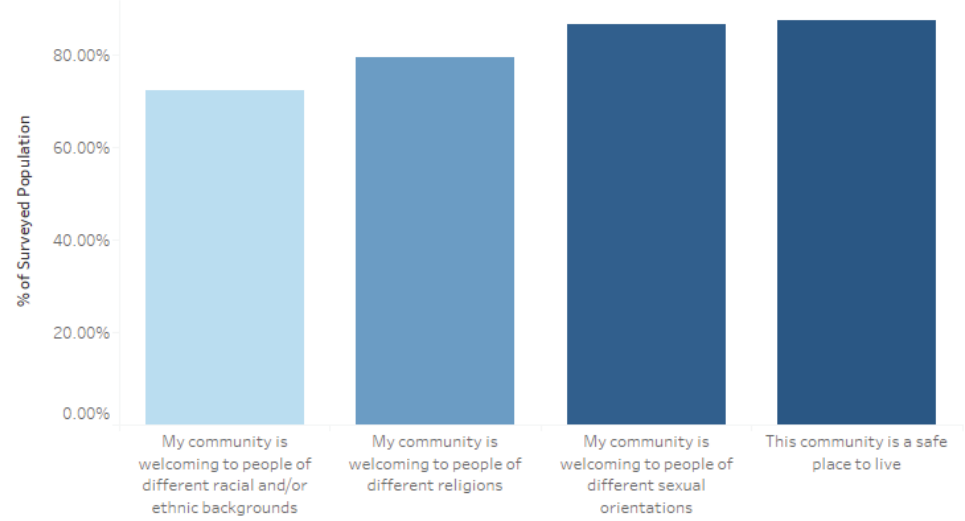
Source: Lane County Elections data

Lane County's Community Vitality

Community stability: Housing vacancy | Civic Engagement: Voter Turnout | **Community Strengths and Themes Survey 2015** | Child Abuse and Neglect | Domestic violence | Vi ol e..

Social Capital - Lane County as a safe and welcoming community 2015

As part of the 2015 Community Strengths and Themes Assessment, Live Healthy Lane surveyed more than 1,000 Lane County residents



Feeling safe and accepted for who we are is a basic need of all people and intimately tied to health.

Source: Live Healthy Lane Community Survey, 2015

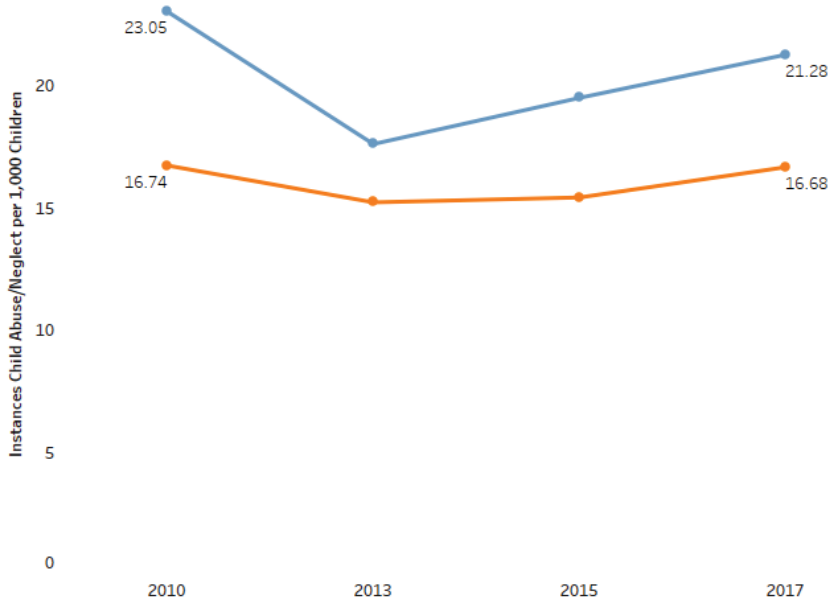
Lane County's Community Vitality

Co m. | Civic Engagement: Voter Turnout | Community Strengths and Themes Survey 2015 | **Child Abuse and Neglect** | Domestic violence | Violent Crime Rate

Incidents of Child Abuse and Neglect

In Lane County and Oregon. Hover over to view further details.

Incidents of child abuse/neglect per 1,000 people under 18

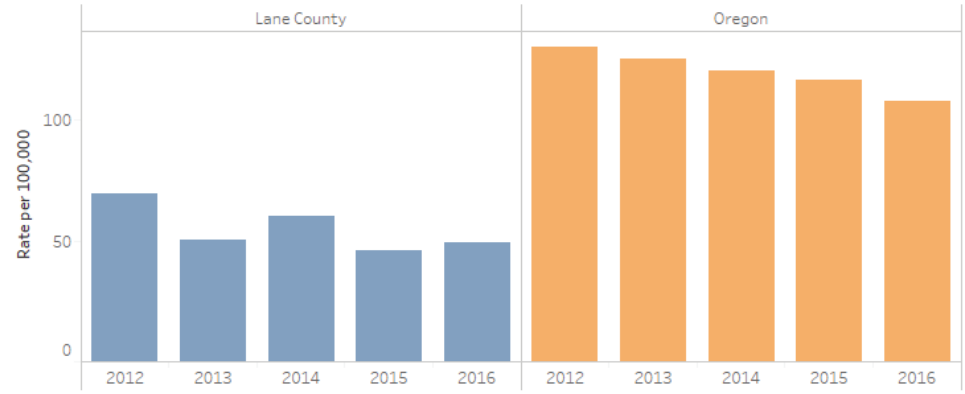


Child abuse and neglect, in addition to short-term impacts on health, can have effects on health outcomes across the life-span. Lane County has a higher incidence of child abuse and neglect than the state overall.

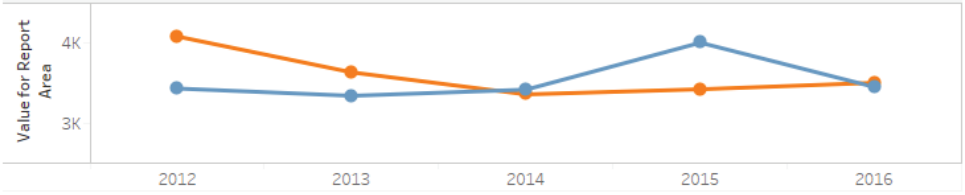
Source: Oregon Department of Human Services

Lane County's Community Vitality

People sheltered in domestic violence programs



Domestic calls to Oregon Sexual & Domestic Violence Program



Region Lane County Oregon

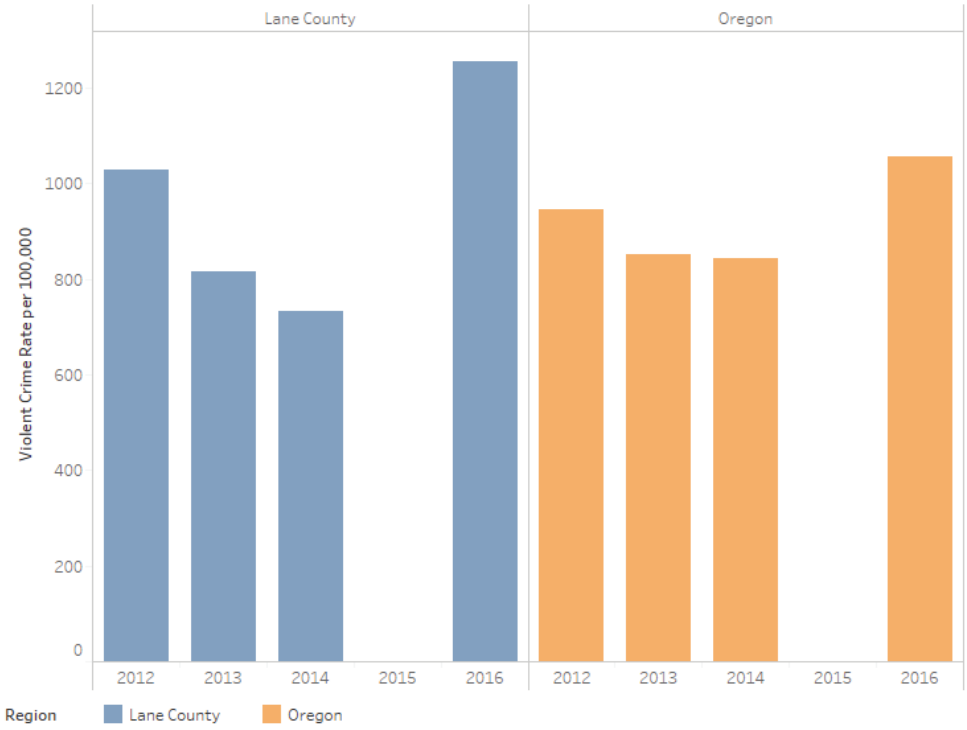
Intimate partner violence (IPV) can affect health in many ways. The longer the violence goes on, the more serious the effects. Many victims suffer physical injuries; some are minor, others are more serious and can cause death or disability. Not all injuries are physical. IPV can also cause emotional harm. IPV is linked to harmful health behaviors as well. IPV and sexual assault are underreported, so actual rates are difficult to determine.

Source: Oregon DHS Striving to meet the need report

Lane County's Community Vitality

Co m.	Civic Engagement: Voter Turnout	Community Strengths and Themes Survey 2015	Child Abuse and Neglect	Domestic violence	Violent Crime Rate

Violent Crime Rate



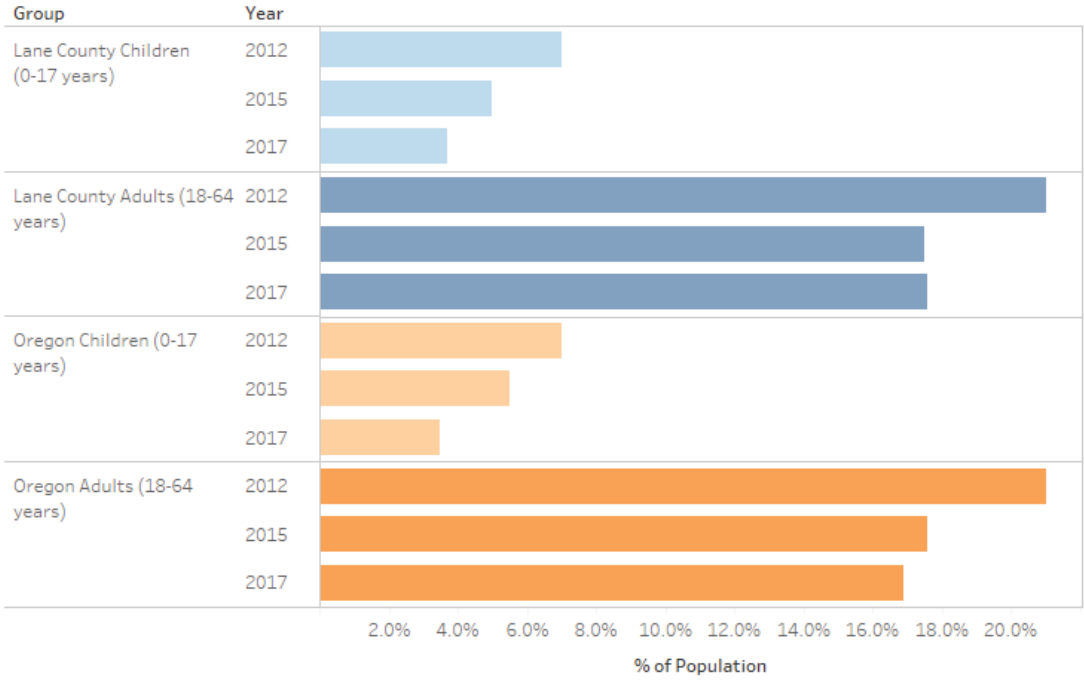
A violent crime is a crime in which the offender uses or threatens to use violent force upon the victim. Violent crimes can include homicide, rape, robbery, and assault.

Source: Oregon Uniform Crime Report Incidents: https://www.oregon.gov/cjc/data/Pages/OUCR.aspx

Health System

Lane County Health System

Percent of Population Uninsured



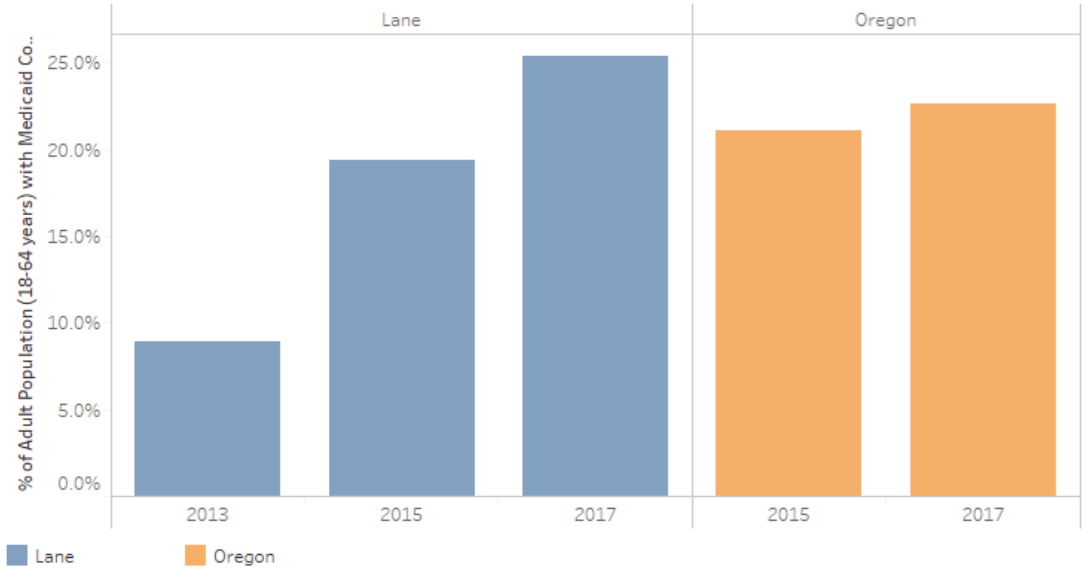
Lack of health insurance coverage is a significant barrier to accessing needed health care. People with health insurance and access to needed healthcare are more likely to have better health throughout their life. (*Note: 2017 data includes years before the Affordable Care Act expanded Medicaid, so may not accurately reflect current uninsured rates*).

Source: American Community Survey, 5-year estimates for the period ending in the year indicated

Lane County Health System

Health Insurance Status	Adult Population with Medicaid Coverage	Provider ratio: Trillium Community Health plan	CCO Performance Metrics: Trillium Community Health Pl..	CCO Members by Location	CC O ..

Adult Population with Medicaid Coverage



Medicaid is a social health care program for families and individuals with low income and limited resources. Free or low-cost health care coverage is available to people who meet requirements for income, residency, age, disability, and other factors. Oregonians may also qualify based on age and disability status.

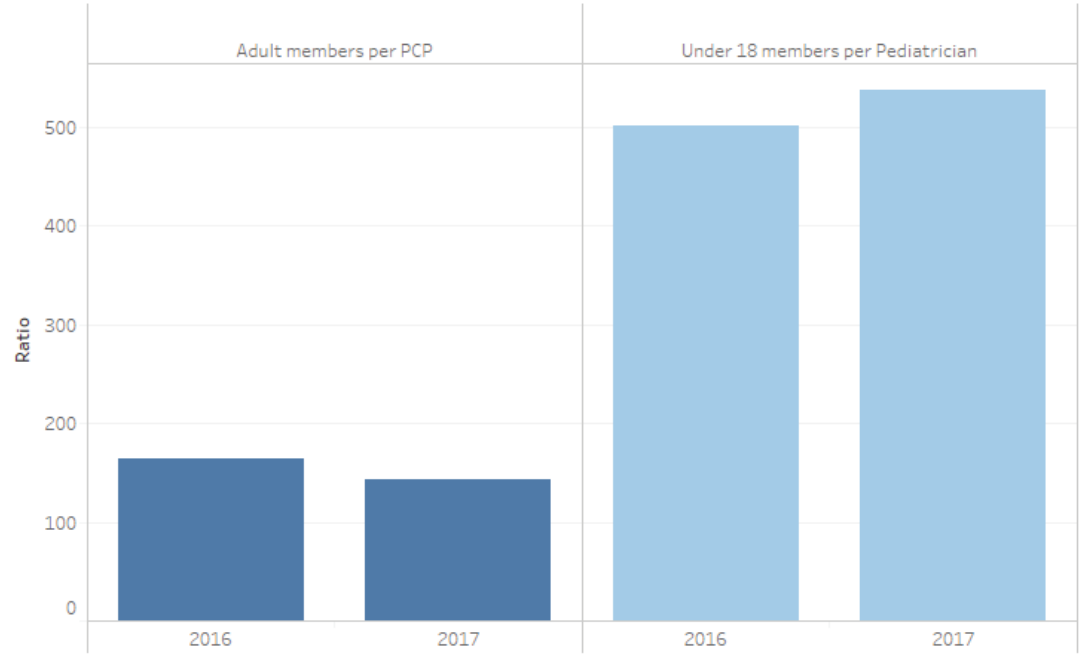
Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Lane County data is for the 4-year period ending in the year indicated

Lane County Health System

Health Insurance Status | Adult Population with Medicaid Coverage | **Provider ratio: Trillium Community Health plan** | CCO Performance Metrics: Trillium Community Health Pl.. | CCO Members by Location | CC O ..

Trillium Primary Care Provider Ratio

Number of Trillium members per care provider by year



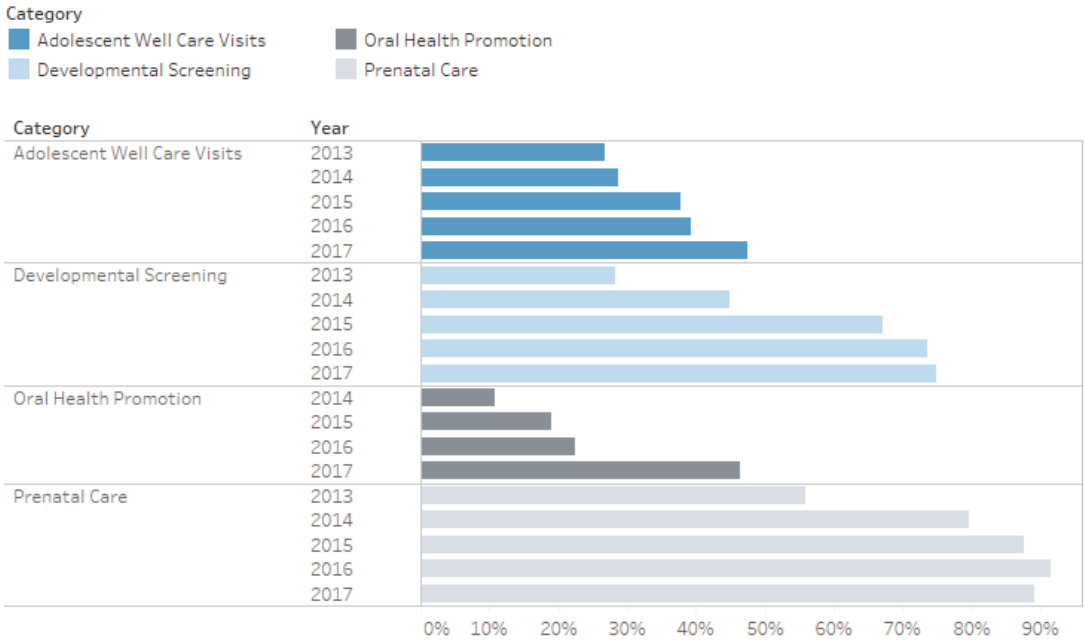
The ratio of patients to providers is an indicator of system capacity. Availability of primary care providers is necessary to ensure access to preventive care.

Source: Trillium Community Health Plan Analytics

Lane County Health System

Adult Population with Medicaid Coverage | Provider ratio: Trillium Community Health plan | **CCO Performance Metrics: Trillium Community Health Pl..** | CCO Members by Location | CCO members by Age Group | C C ..

CCO performance metrics: Trillium Community Health Plan



When Coordinated Care Organizations were created in 2012, the Oregon Health Authority created performance metrics that the CCOs needed to meet to ensure they were improving health outcomes for the populations they served. Many of those metrics included preventive health care services.

Source: Oregon Health Authority CCO Performance Report

Lane County Health System

Provider ratio: Trillium Community Health plan | CCO Performance Metrics: Trillium Community Health Pl.. | **CCO Members by Location** | CCO members by Age Group | CCO: Prenatal Care Visit within First Trimester | A d ..

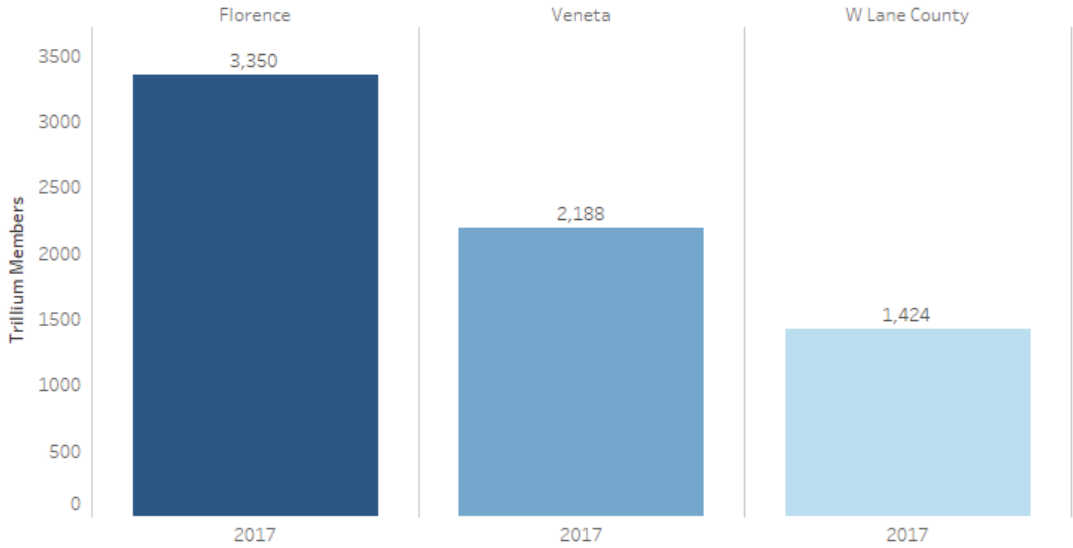
Lane County CCO Members by Location

Select a Year, Region of Lane County and Area within the Region to view the number of CCO Members

Area
All

Year
2017

Region
W Lane County



Where members of Trillium Community Health Plan live in Lane County.

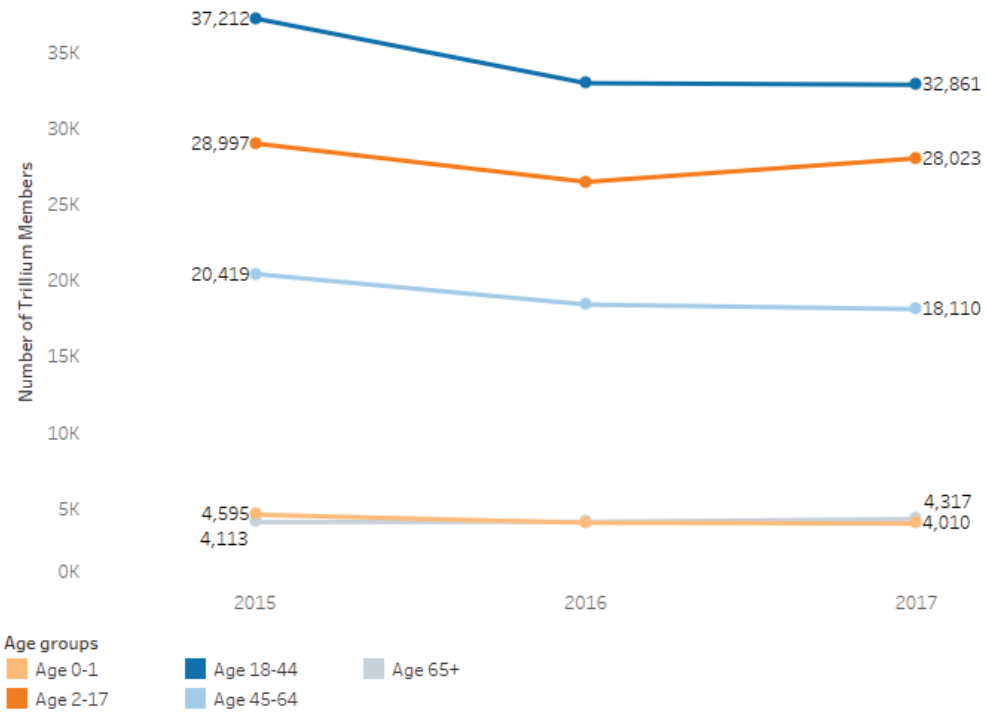
Source: Trillium Community Health Plan Analytics

Lane County Health System

CCO Performance Metrics: Trillium Community Health Pl.. | CCO Members by Location | **CCO members by Age Group** | CCO: Prenatal Care Visit within First Trimester | Adequate prenatal care | C o ..

Lane County CCO members by age group

Hover for more details

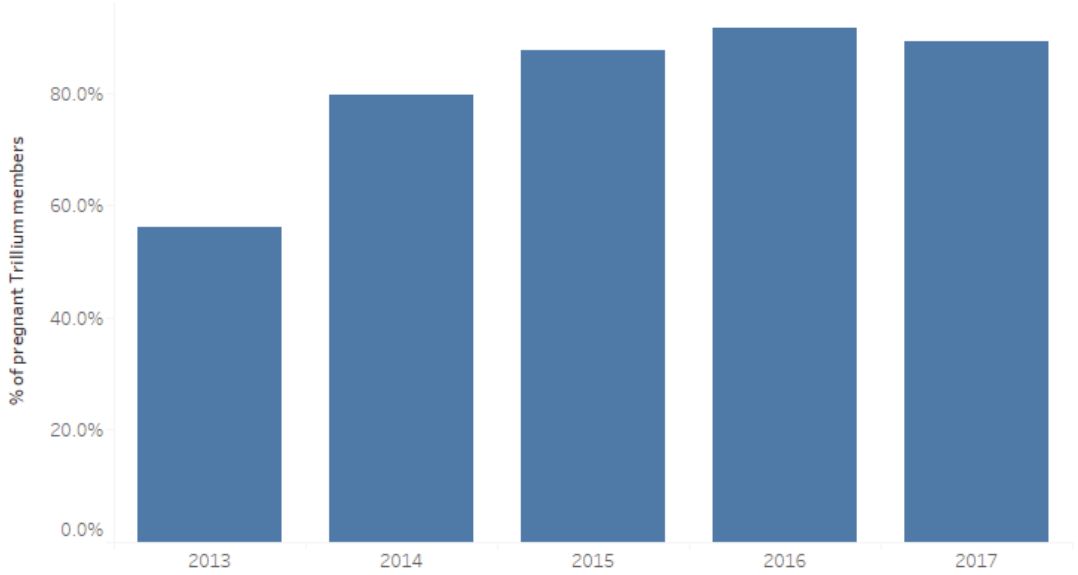


Lane County CCO members by age.

Lane County Health System

CCO Members by Location	CCO members by Age Group	CCO: Prenatal Care Visit within First Trimester	Adequate prenatal care	Colorectal Cancer Screening	C e ..

Pregnant CCO members who received prenatal care within first 42 days of enrollment



Prenatal visits are important for the health of both infant and mother. Health care providers can educate mothers on important health issues such as their diet and nutrition, exercise, immunizations, weight gain, and abstaining from drugs and alcohol. Health care professionals also have an opportunity to instruct expecting parents on nutrition for their newborn, the benefits of breastfeeding, and injury and illness prevention, as well as monitoring for health-compromising conditions, and helping them prepare for the new emotional challenges of caring for an infant.

Source: Oregon Health Authority CCO Performance Report for Trillium Community Health Plan

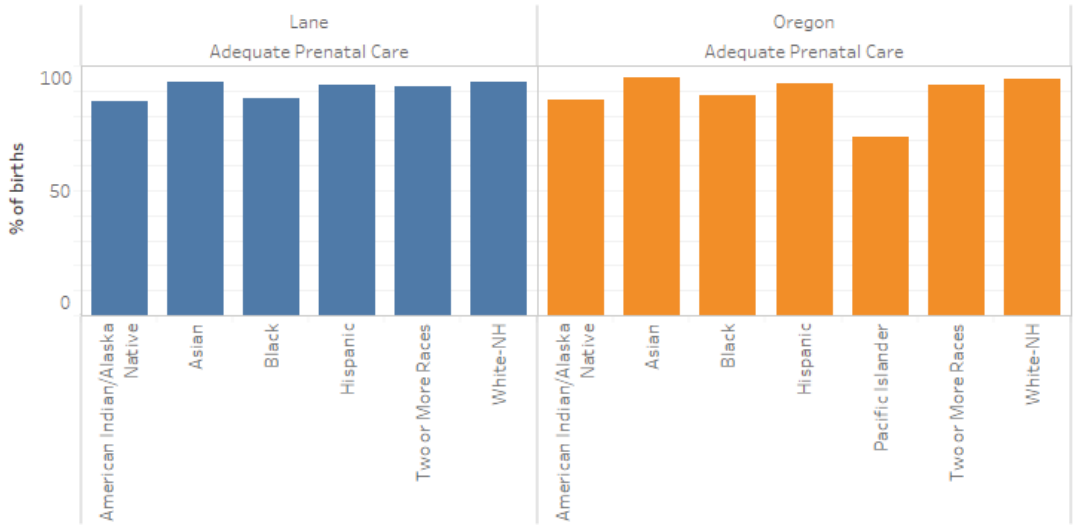
Lane County Health System

CCO members by Age Group | CCO: Prenatal Care Visit within First Trimester | **Adequate prenatal care** | Colorectal Cancer Screening | Cervical Cancer Screening | A d ..

Adequate Prenatal Care

Percent of births in Lane County & Oregon in which there were at least 5 prenatal visits and care began in the 1st or 2nd trimester.

5 years ending in
2018



Receiving prenatal care earlier in pregnancy can be beneficial to health outcomes for both mother and baby. There seems to be an increase in disparities since 2013 in both Lane County and Oregon.

Source: Oregon Birth Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority

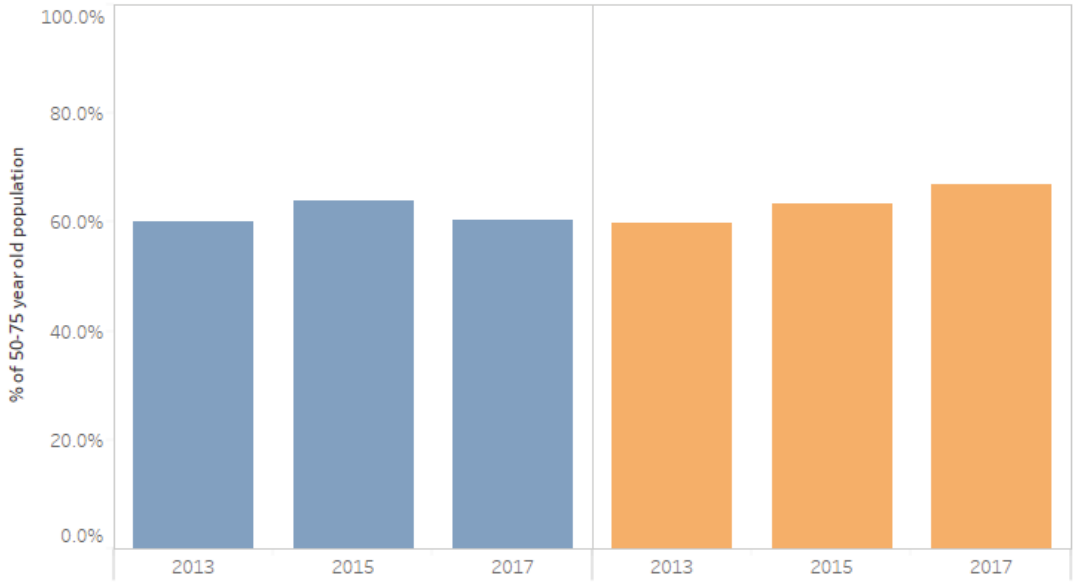
Lane County Health System

CCO: Prenatal Care Visit within First Trimester	Adequate prenatal care	Colorectal Cancer Screening	Cervical Cancer Screening	Adult Influenza Vaccination rate	U p ..

Colorectal Cancer Screening

Percentage of 50-75 year old population that have had a colorectal cancer screening in Lane County and Oregon.

Male



Colorectal cancer is one of the most commonly diagnosed cancers in the United States, and is the second leading cause of cancer-related death in the U.S.
Colorectal cancer screening helps prevent deaths from colorectal cancer.

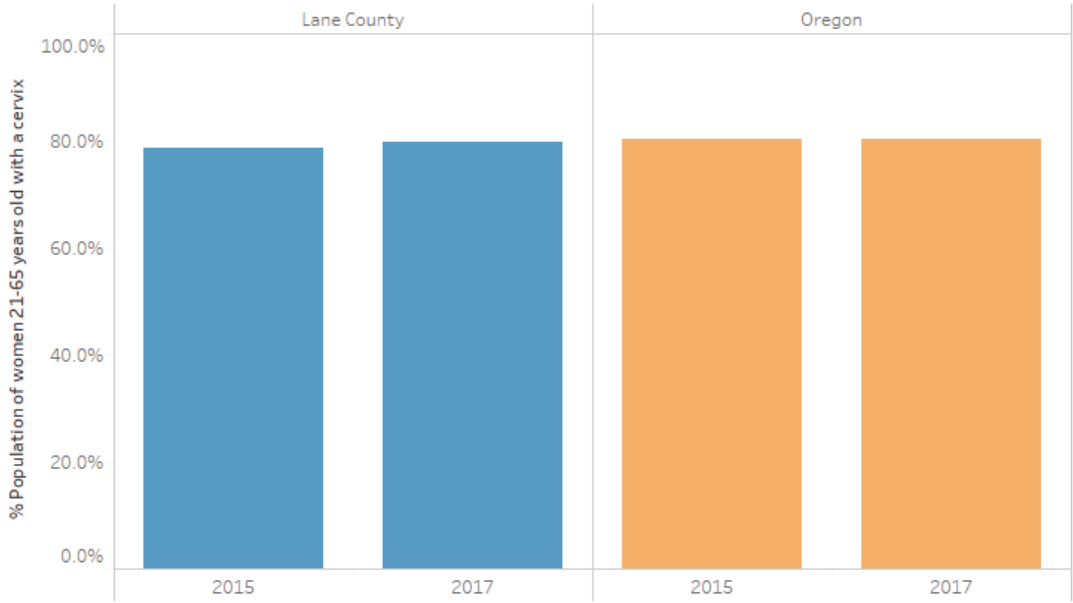
Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Lane County data is for the 4-year period ending in the year indicated

Lane County Health System

Adequate prenatal care	Colorectal Cancer Screening	Cervical Cancer Screening	Adult Influenza Vaccination rate	Up-to-date Immunization rate	A d ..

Cervical Cancer Screening

Percentage of women who had a pap smear within the past 3 years in Lane County and Oregon.



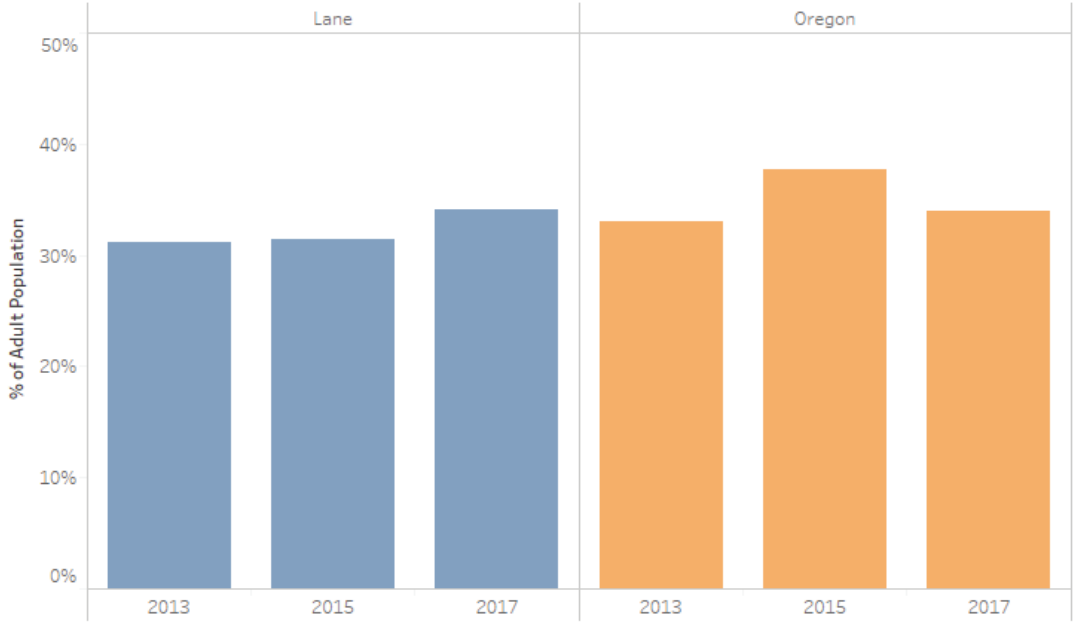
Cervical cancer is a common cancer that has a very high cure rate when detected and treated early. The Pap test, also known as a Pap smear, checks for changes in the cells of the cervix that can be early signs of cervical cancer.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Lane County data is for the 4-year period ending in the year indicated

Lane County Health System

Ad eq u..	Colorectal Cancer Screening	Cervical Cancer Screening	Adult Influenza Vaccination rate	Up-to-date Immunization rate	Adolescent Immunization rates

Adult Influenza Vaccination Rate



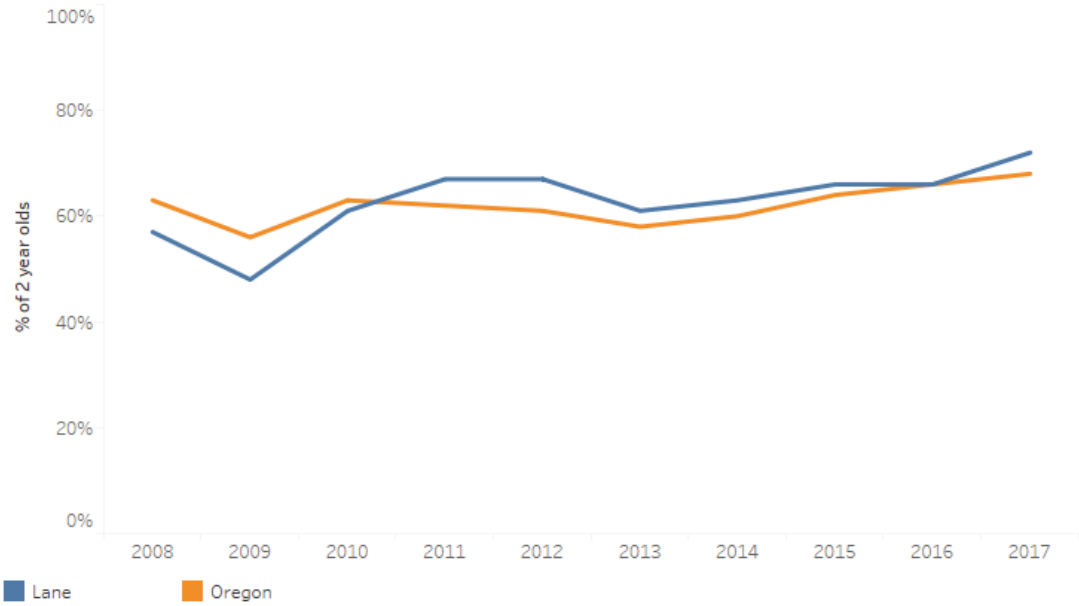
The seasonal flu vaccine protects against the influenza viruses that research indicates will be most common during the upcoming season.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Lane County data is for the 4-year period ending in the year indicated

Lane County Health System

Ad eq u..	Colorectal Cancer Screening	Cervical Cancer Screening	Adult Influenza Vaccination rate	Up-to-date Immunization rate	Adolescent Immunization rates

Up-to-date Immunizations Rate (2 year olds)



Being up-to-date on childhood vaccinations means that more children are protected against diseases that can cause health problems, both in childhood and over the lifespan, such as measles, polio, tetanus, ruebella, etc.

Source: Population based immunization rates for Lane County and Oregon

Lane County Health System

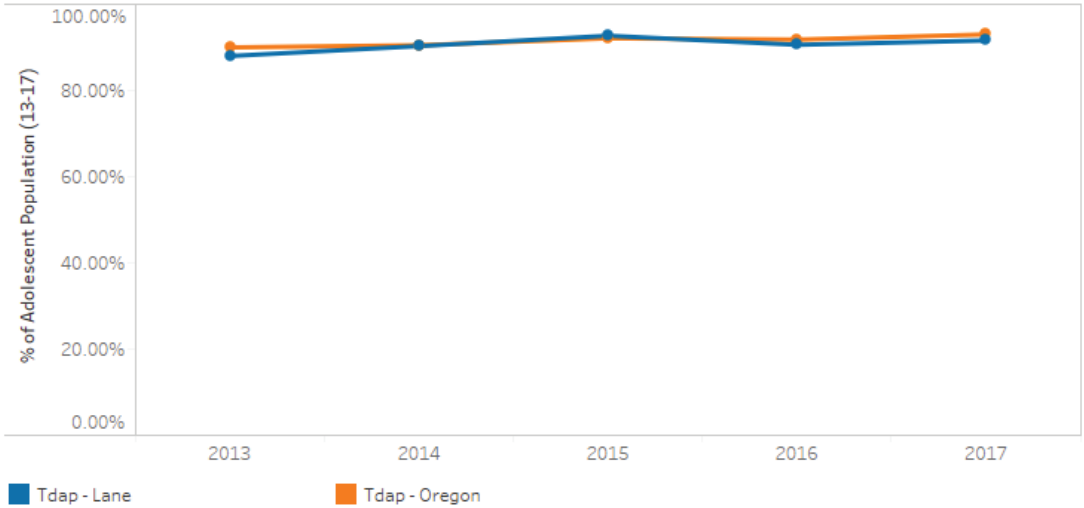
Ad eq u.. | Colorectal Cancer Screening | Cervical Cancer Screening | Adult Influenza Vaccination rate | Up-to-date Immunization rate | **Adolescent Immunization rates**

Adolescent Immunization Rate by Vaccination

Select vaccine(s) to see the immunization rate for adolescents (13-17) in Lane County and Oregon.

Select Region(s)
All

Select Vaccine(s)
Tdap



There are record or near record low levels of vaccine-preventable childhood diseases in the United States, but that does not mean they have disappeared completely. Vaccines help prevent epidemics of these diseases. A number of vaccines and/or boosters are recommended for adolescents.

Source: Oregon Health Authority, Adolescent Immunization Rates by County

Health Behaviors & Health Outcomes

Health behaviors

Births

Behavioral health

Infectious disease

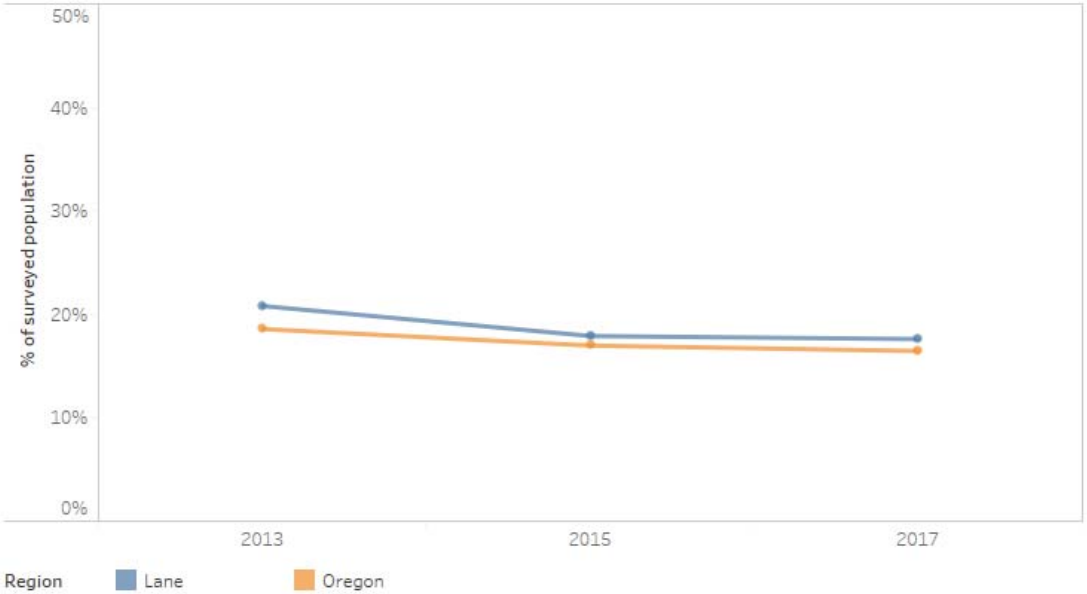
Chronic disease

Deaths

Health Behaviors

Adults who currently smoke cigarettes | Youth who currently smoke cigarettes | Adult e-cigarette use | Youth e-cigarette use | Tobacco use in pregnancy | A du l...

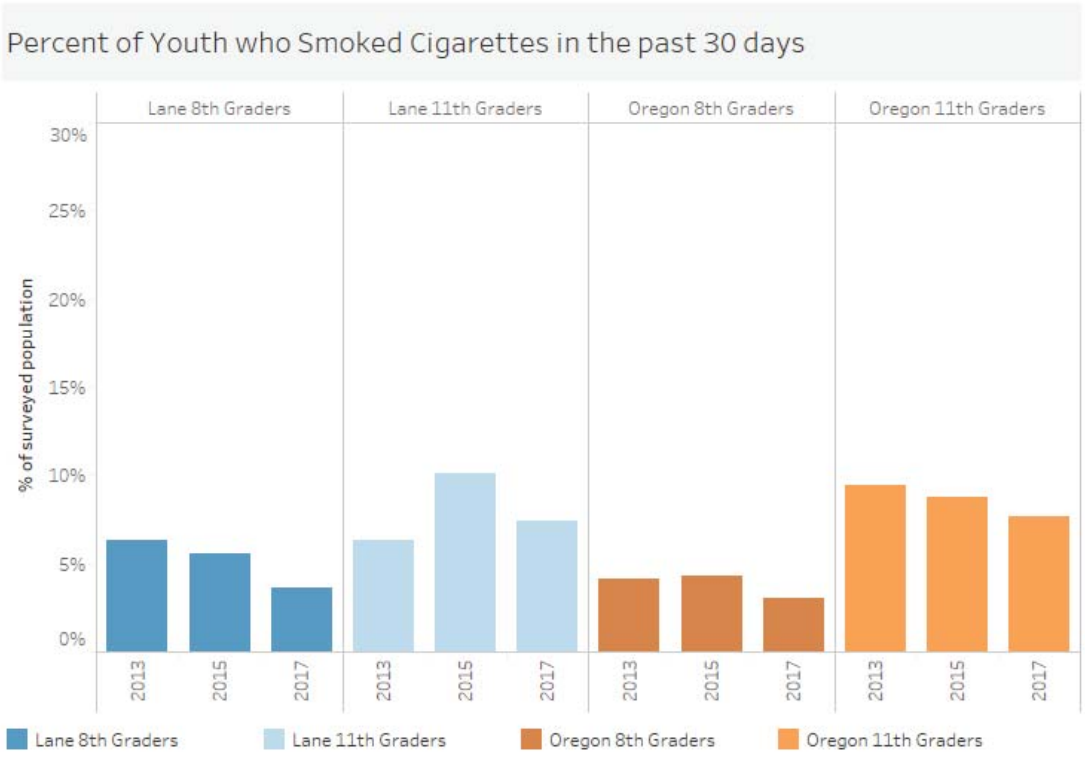
Percent of Adults who Currently Smoke



Tobacco use is a major health concern for Lane County. Tobacco use is the single most preventable cause of death and disease in the United States and Oregon. It kills more than 7,000 Oregonians annually, and costs the state $2.5 billion in health care costs and lost productivity due to premature death.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; 4 year average for the period ending in the year indicated; ***change in data collection methods in 2011 means that previous years are not comparable to current years.***

Adults who currently smoke cigarettes | **Youth who currently smoke cigarettes** | Adult e-cigarette use | Youth e-cigarette use | Tobacco use in pregnancy | A du l...



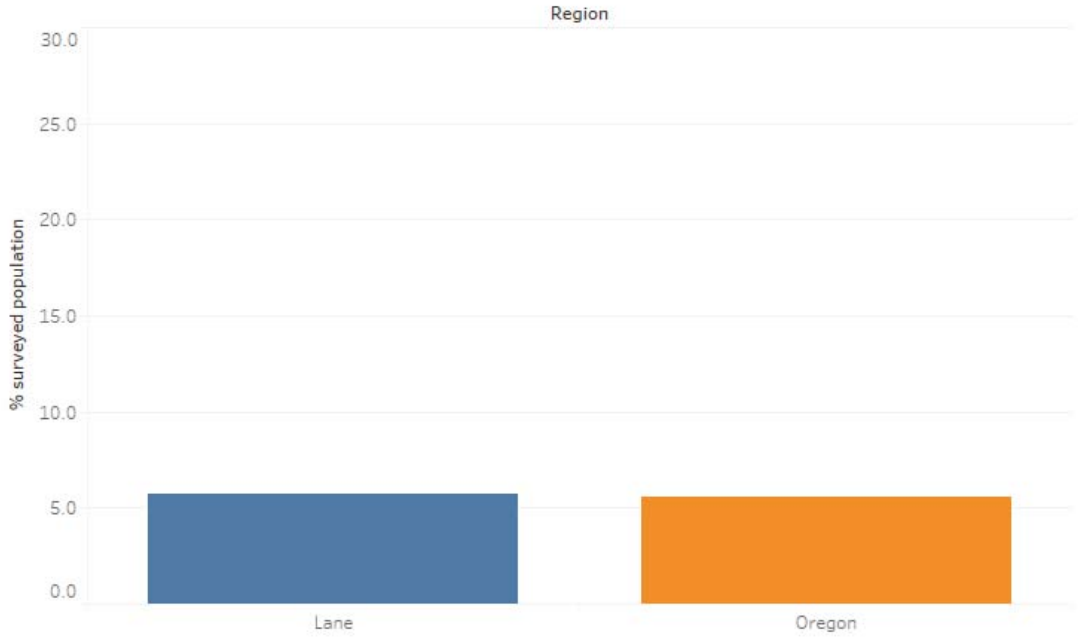
Youth cigarette usage rates are much lower than adult usage rates both state and county wide. While 8th grade usage in Lane County seems to be continuing on a downward trend, the trend amongst 11th graders in Lane County is less clear.

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Adults who currently smoke cigarettes | Youth who currently smoke cigarettes | **Adult e-cigarette use** | Youth e-cigarette use | Tobacco use in pregnancy | A du l...

Percent of Adults who reported e-cigarette use in the past 30 days

2014-2017 in Lane County and Oregon.

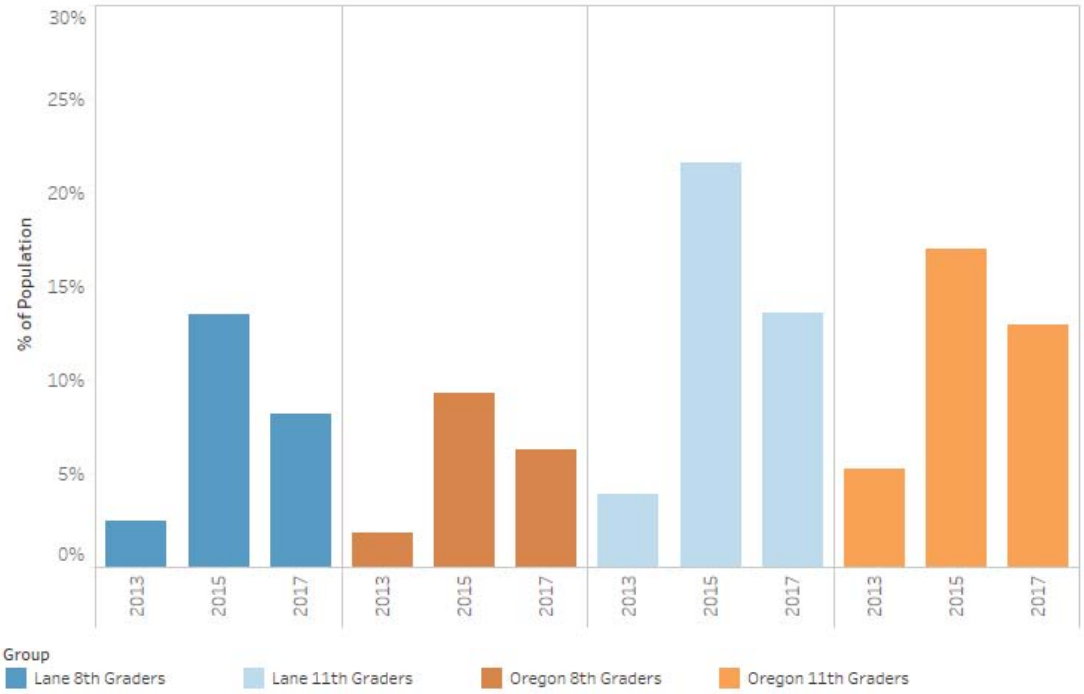


While use of electronic cigarettes has grown dramatically over the past few years, use of e-cigrettes among adults remains lower than cigarette use.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; 2014-2017

Youth who currently smoke cigarettes | Adult e-cigarette use | **Youth e-cigarette use** | Tobacco use in pregnancy | Adult binge drinking | Y o ..

Percent of youth who reported using E-cigarettes in the past 30 days

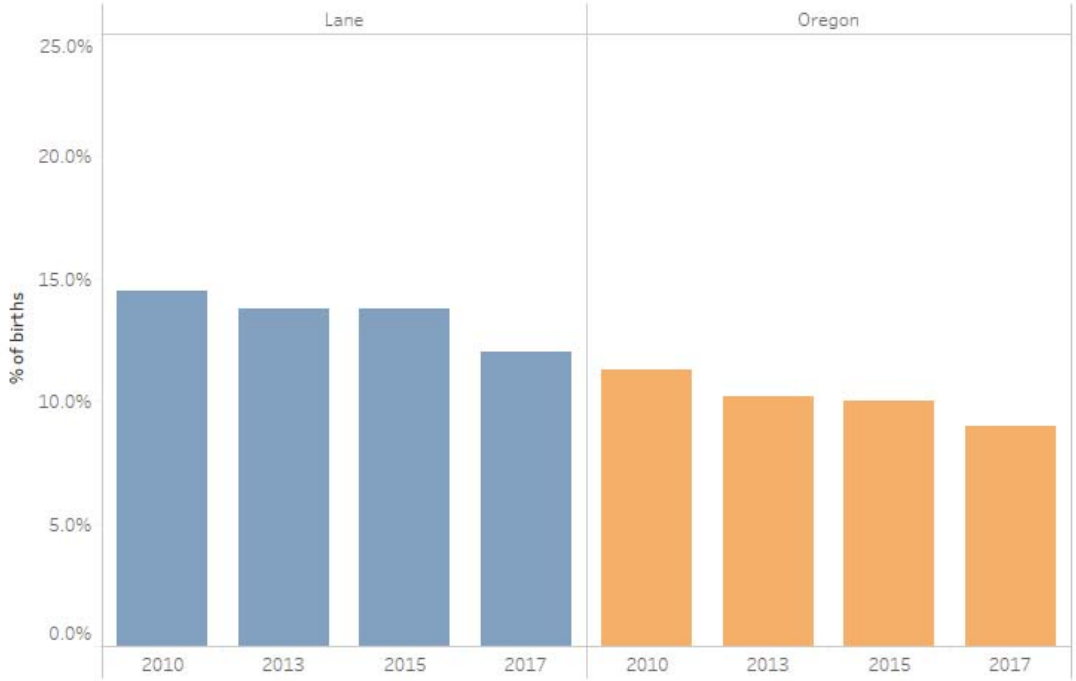


Electronic cigarettes (also called e-cigarettes or electronic nicotine delivery systems) are battery-operated devices designed to deliver nicotine, with flavorings and other chemicals, to users in vapor instead of smoke. E-Cigarettes are increasingly popular among adolescents nationwide.

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Adult e-cigarette use | Youth e-cigarette use | **Tobacco use in pregnancy** | Adult binge drinking | Youth Alcohol use | Y o ..

Tobacco Use in Pregnancy

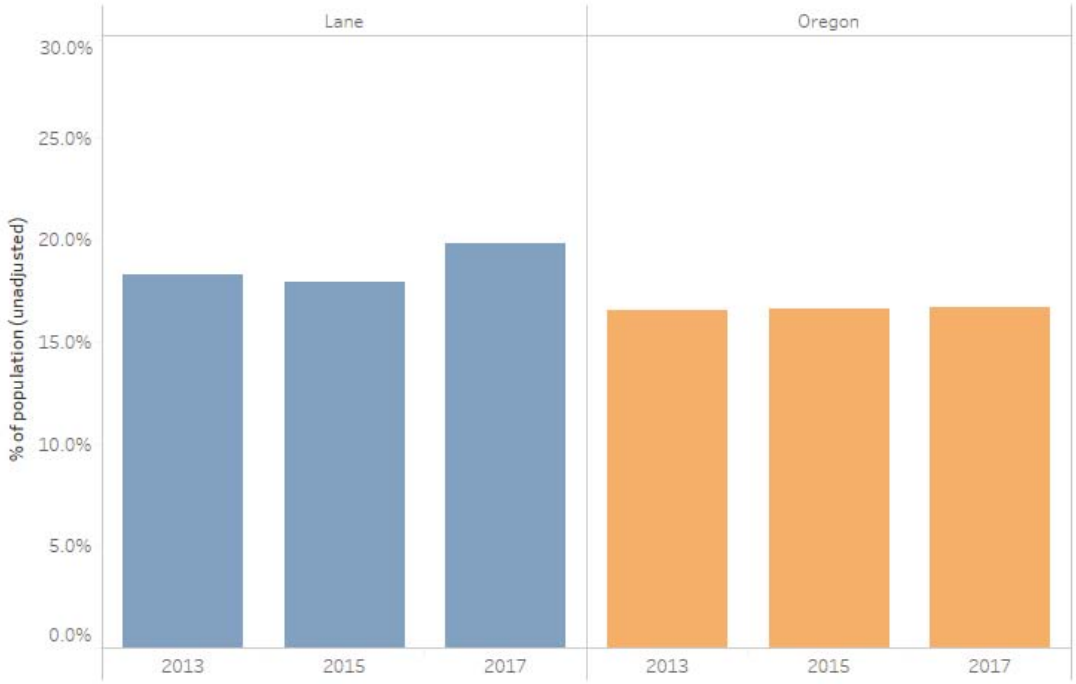


Women who smoke during pregnancy increase their risk of complications, including low infant birth weight. Infants and children exposed to secondhand smoke are at increased risk of sudden infant death syndrome, acute lower respiratory infections, ear infections, and asthma attacks. Overall, the rate of tobacco use during pregnancy continues to decline, however, the rate for Lane County remains higher than the state.

Source: Oregon Center for Health Statistics

Youth e-cigarette use | Tobacco use in pregnancy | **Adult binge drinking** | Youth Alcohol use | Youth marijuana use | A d ..

Percent of adults who participated in binge drinking within the past month

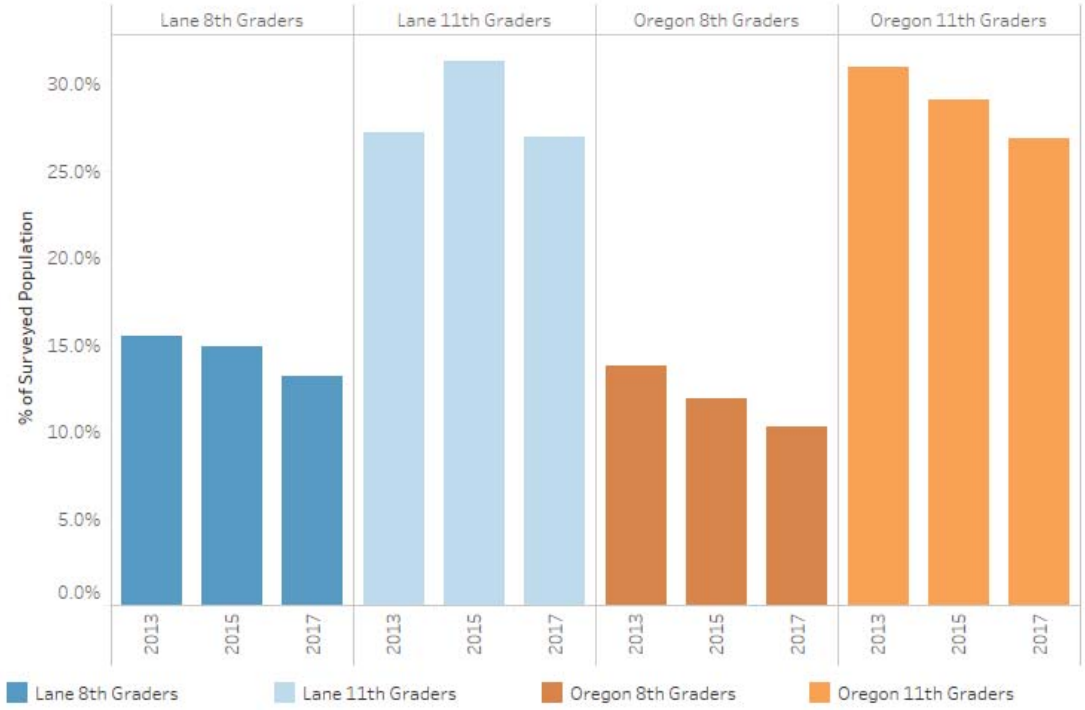


Binge drinking alcohol is a significant risk factor for injury, violence, substance abuse and alcoholism. Binge drinking is defined as five or more drinks for men and four or more drinks for women, on one occasion.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Lane County data is for the 4 year period ending with the year indicated.

Tobacco use in pregnancy | Adult binge drinking | **Youth Alcohol use** | Youth marijuana use | Adult fruit and vegetable consumption | Y o ..

Youth who Used Alcohol in the past 30 days



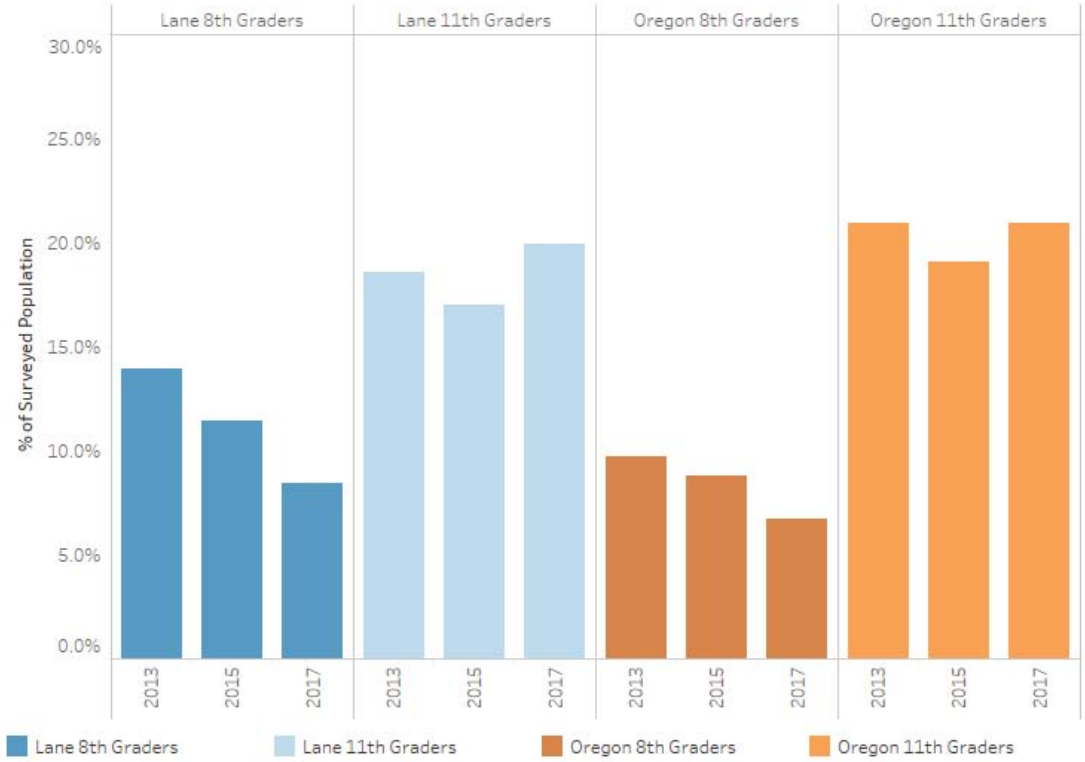
Teens who have their first drink before age 15 are four times more likely to become alcohol dependent at some point in their lives than those that wait until they are 21 to drink (the rate of alcohol dependence drops the closer they get to 21).

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

..

Adult binge drinking | Youth Alcohol use | **Youth marijuana use** | Adult fruit and vegetable consumption | Youth fruit & vegetable consumption | A d ..

Percent of youth who used marijuana in the past 30 days



Historically, youth marijuana use among Lane County 11th graders has been higher than statewide use among 11th graders. While marijuana use among 8th graders has continued to decline in recent years, use among 11th graders has remained stable or slightly increased since retail marijuana was legalized in 2015.

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Youth Alcohol use | Youth marijuana use | **Adult fruit and vegetable consumption** | Youth fruit & vegetable consumption | Adult soda consumption | Y o ..

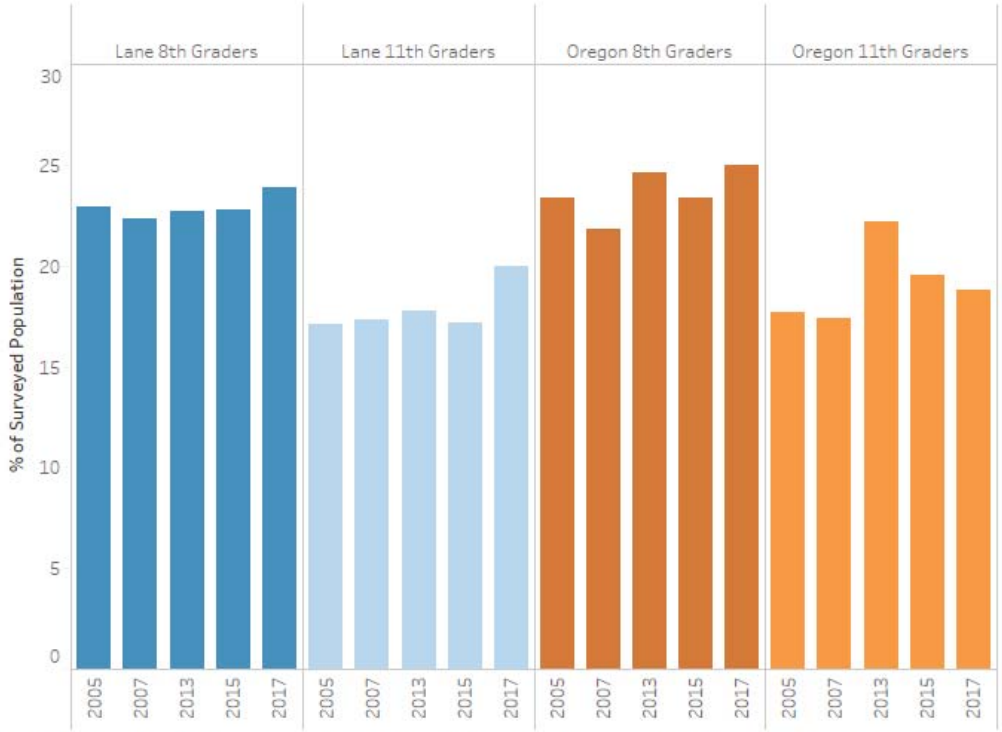
Adult Consumption of 5 or more Fruits or Vegetables per day

A balanced diet consisting of sufficient fruits and vegetables is necessary to maintain health and prevent chronic disease. Despite the many benefits, most adults do not eat recommended amounts of fruits and vegetables.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority

Youth marijuana use | Adult fruit and vegetable consumption | **Youth fruit & vegetable consumption** | Adult soda consumption | Youth soda consumption | A d ..

Youth Consumption of 5 or more servings of fruits or vegetables

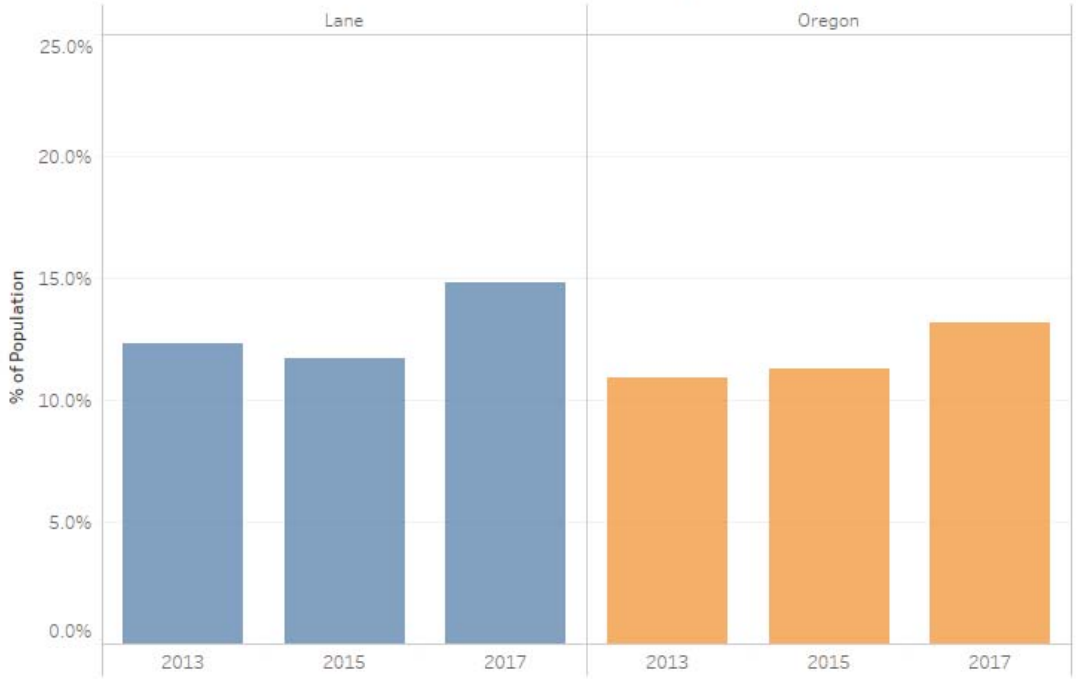


Healthy eating habits start early. Despite the many benefits of adequate fruit and vegetable consumption, most adolescents do not meet the recommended 5 or more servings per day.

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Adult fruit and vegetable consumption | Youth fruit & vegetable consumption | **Adult soda consumption** | Youth soda consumption | Adult physical activity | Y o ..

Percent of Adults who drank one or more sugary drinks per day

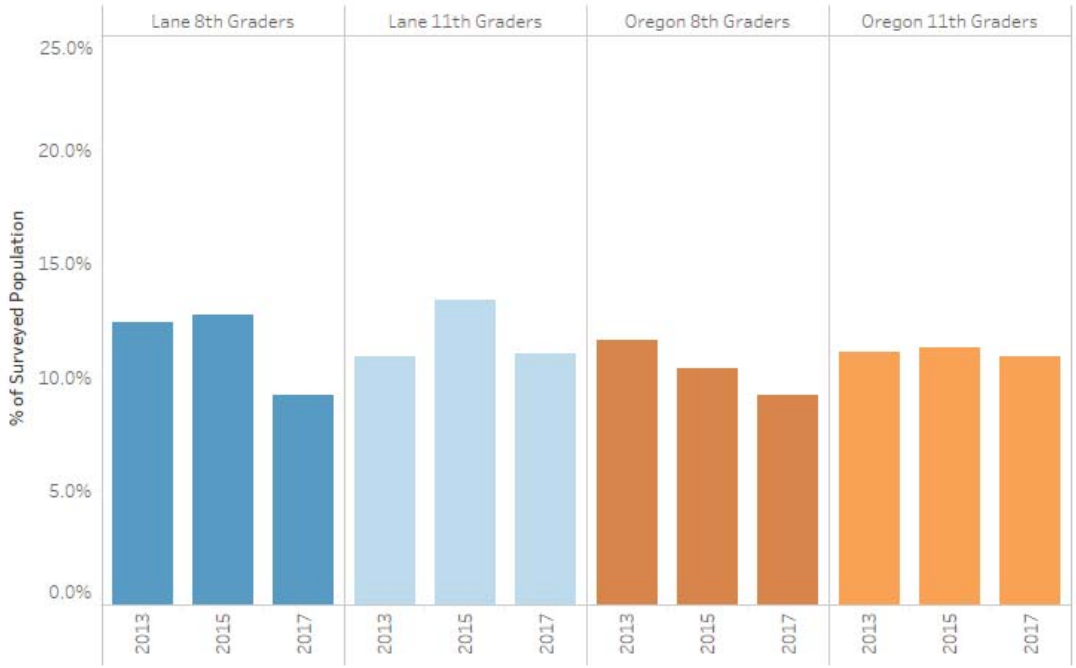


Sugar-sweetened beverages are the largest source of added sugar in the American diet. Sugar-sweetened beverage consumption is associated with overweight and obesity in both adults and children.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Lane County data is for the 4-year period ending in the year indicated

Youth fruit & vegetable consumption | Adult soda consumption | **Youth soda consumption** | Adult physical activity | Youth physical activity | A d ..

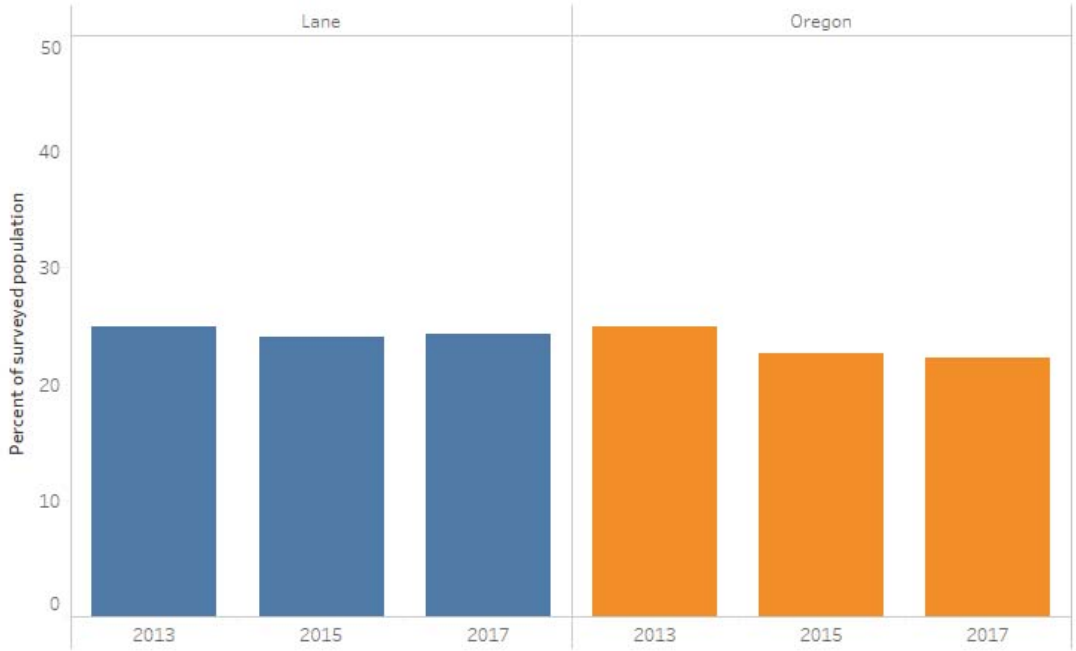
Youth who drank one or more sodas per day



There is increasing evidence of a link between childhood obesity and sugar-sweetened beverage consumption. While there seems to be a trend of decreasing consumption among 8th graders, 11th grade consumption remains steady.

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Percent of adults who meet the CDC guidelines for physical activity

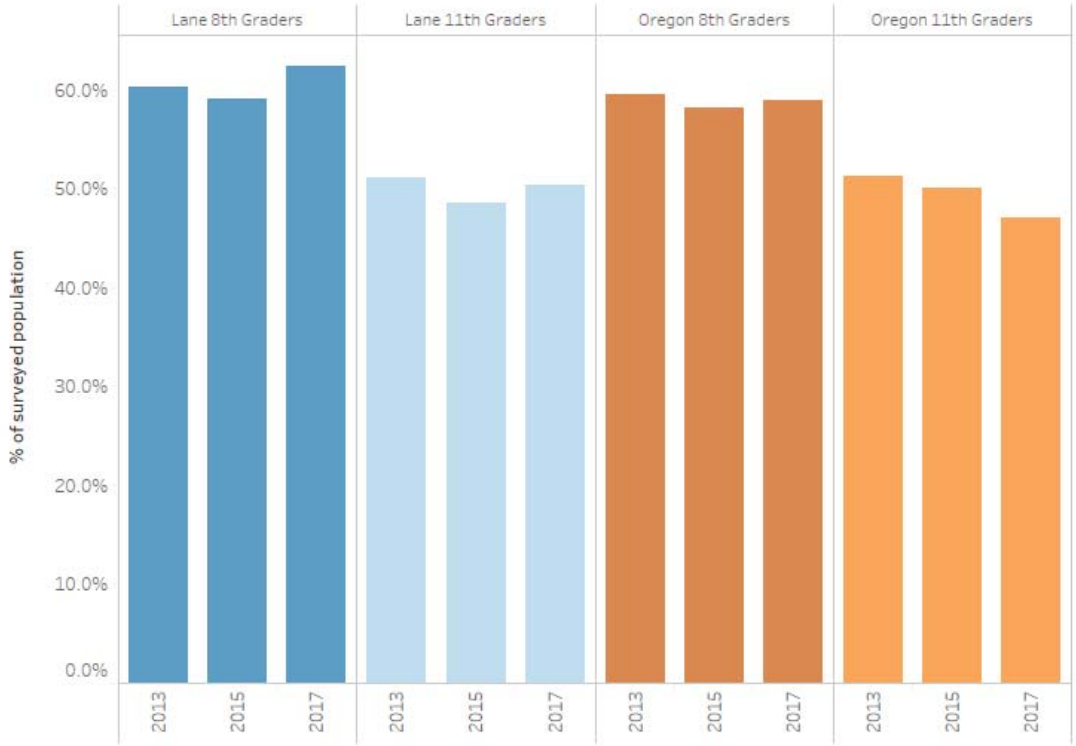


Regular physical activity can improve health and quality of life in people of all ages. Active adults reduce their risk of many serious health conditions including obesity, heart disease, diabetes, colon cancer, and high blood pressure. In addition, physical activity reduces the symptoms of anxiety and depression, improves mood and feelings of well-being, and promotes healthy sleep patterns. Despite the many benefits, less than 1/4 of Lane County residents report getting adequate physical activity.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Lane County data is 4-year average for the period ending in the year indicated

Youth soda consumption | Adult physical activity | **Youth physical activity** | Adult effective contraceptive use | Youth who ever had sexual intercourse | Y o ..

Percent of youth who met Physical Activity Recommendations

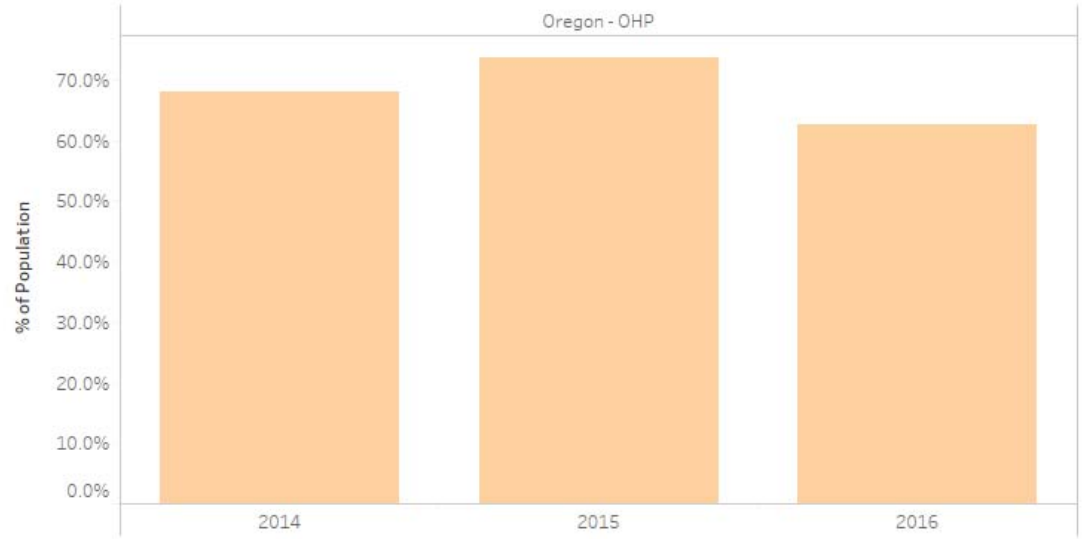


In addition to reducing the risk of multiple chronic diseases, physical activity helps maintain healthy bones, muscles, joints, and helps to control weight, develop lean muscle, and reduce body fat. Inactivity during childhood and adolescence increases the likelihood of being inactive as an adult. Participation in all types of physical activity declines drastically with both age and grade in school.

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Yo ut h..	Adult physical activity	Youth physical activity	Adult effective contraceptive use	Youth who ever had sexual intercourse	Youth who used condom during last sexual intercourse

Percent of women reporting effective contraceptive use

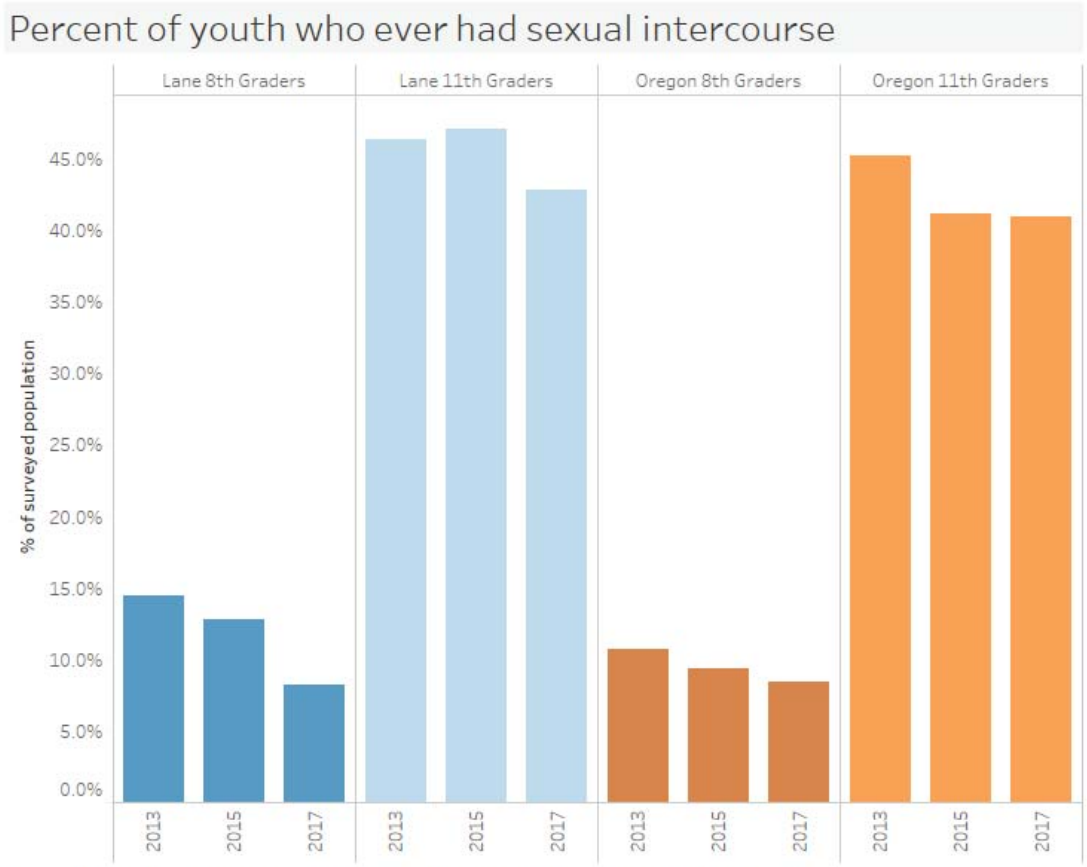


Group
Oregon - OHP

Unintended pregnancy poses health risks to both mother and baby. Effective contraceptive methods that prevent unintended pregnancy include: male and female sterilization, intrauterine devices (IUD) and contraceptive implants, hormonal pills, patches, rings, and shots, as well as non-hormonal diaphragms. Data on contraceptive use is not available for Lane County; Oregon data is presented for population enrolled in the Oregon Health Plan (OHP), and the population not enrolled in OHP along with data on the members of Trillium Community Health Plan.

Sources: Oregon data: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Trillium data: Oregon Health Authority CCO Performance Metric Reports; due to different data collection methods, Oregon and Trillium data are not directly comparable.

Yo ut h..	Adult physical activity	Youth physical activity	Adult effective contraceptive use	Youth who ever had sexual intercourse	Youth who used condom during last sexual intercourse

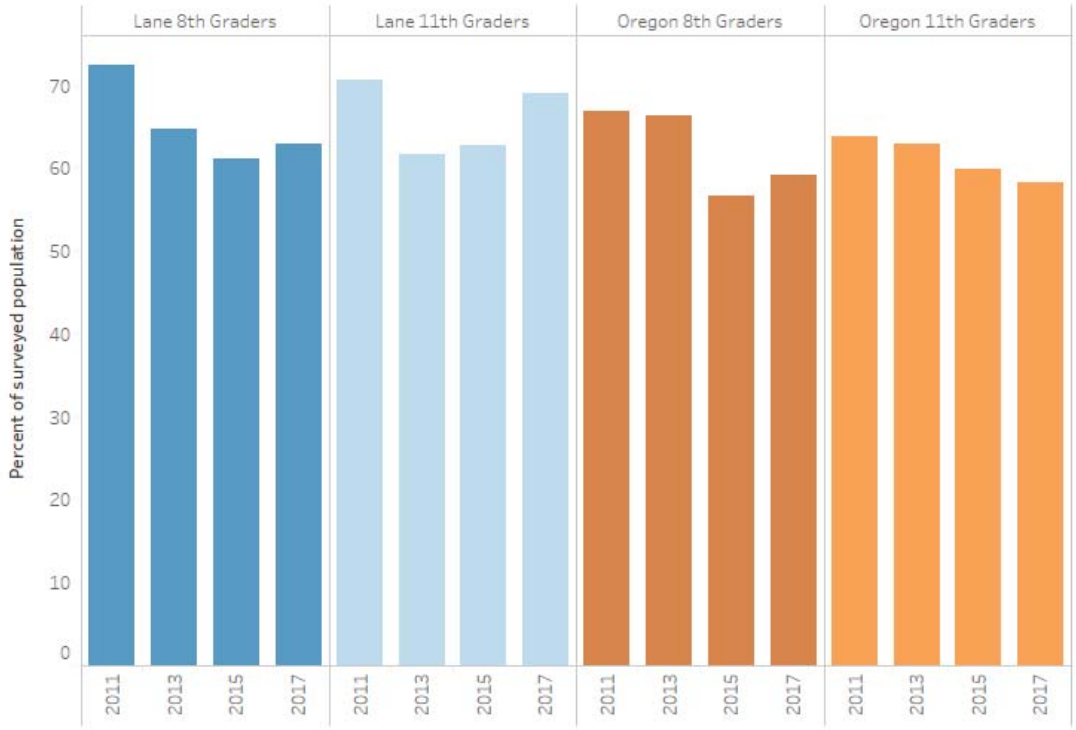


Almost half of Lane County 11th graders and less than 10% of Lane County 8th graders report ever engaging in sexual intercourse, similar to rates statewide.

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Yo ut h..	Adult physical activity	Youth physical activity	Adult effective contraceptive use	Youth who ever had sexual intercourse	Youth who used condom during last sexual intercourse

Percent of youth who used a condom during last sexual intercourse



While the only 100% effective way to prevent unintended pregnancies and sexually transmitted infections is to abstain from sex completely, use of condoms can reduce unintended pregnancy and reduce the spread of infections. Rates of condom use in Lane County are similar to the state as a whole.

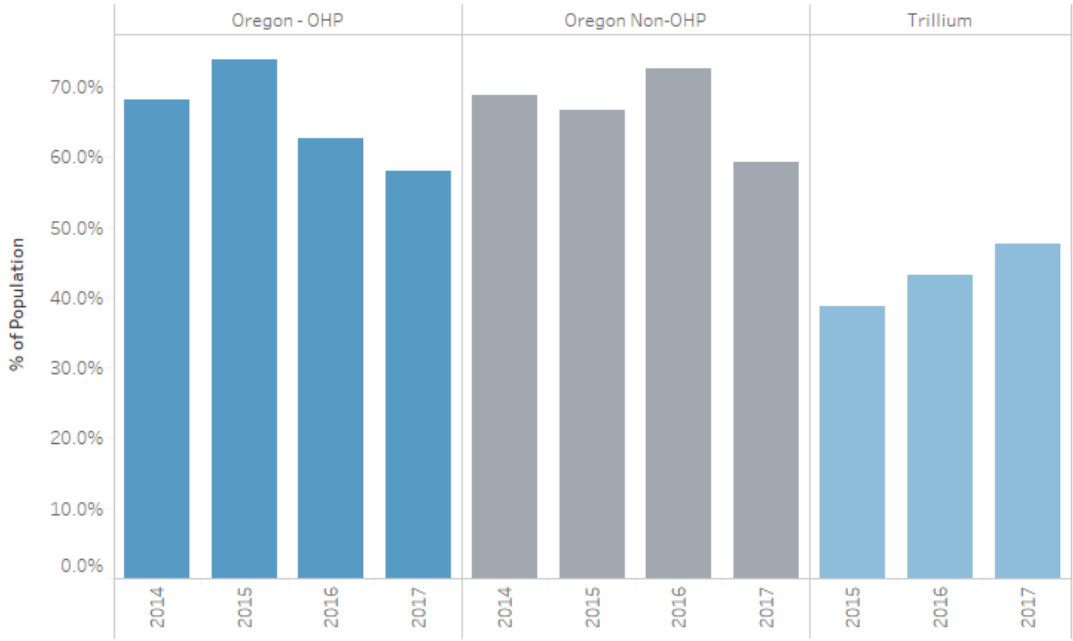
Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Births

Births

Effective contraceptive use	Low Birth Weight	Low Birth Weight by group	Preterm births

Percent of women reporting effective contraceptive use



Effective use of contraception helps to prevent unintended pregnancies. Unintended pregnany can pose health risks for both mother and baby.

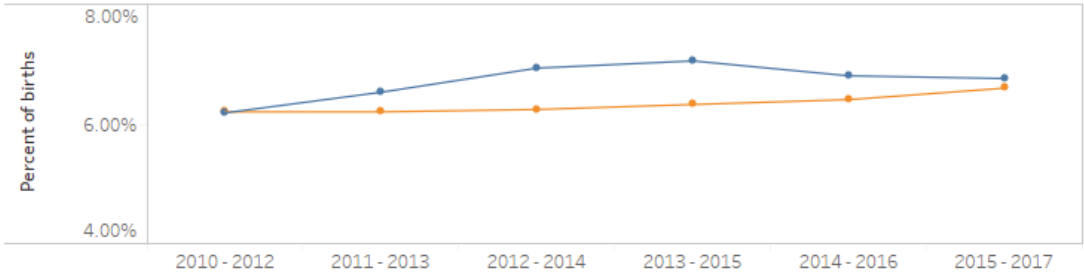
Sources: Oregon data: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Trillium data: Oregon Health Authority CCO Performance Metric Reports; due to different data collection methods, Oregon and Trillium data are not directly comparable.

Births

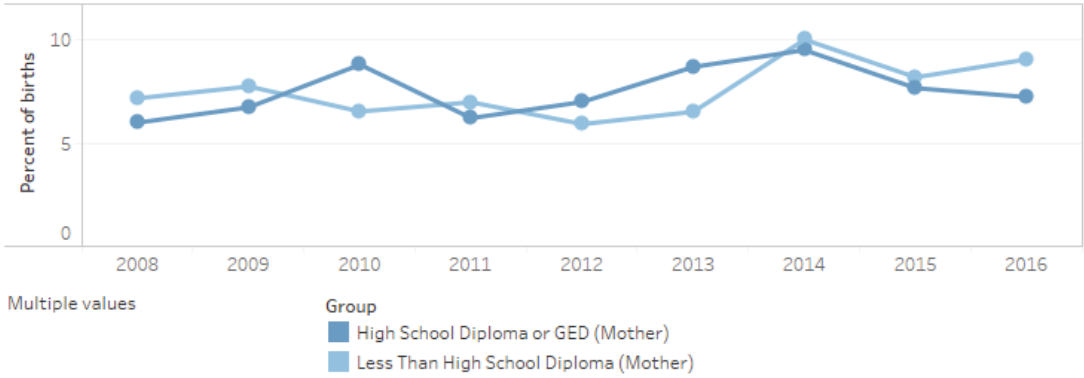
Effective contraceptive use	Low Birth Weight	Low Birth Weight by group	Preterm births

Low Birth Weight

Percentage of low birth weight by population in groups within Lane County and Oregon.



Lane County: Low birth weight by mother's education



Babies born with a low birth weight are more likely than babies of normal weight to require specialized medical care, and often must stay in the intensive care unit. Low birth weight is often associated with premature birth. Incidence of low birth weight vary by socioeconomic status both in Oregon and Lane County.

Source: Oregon Center for Health Statistics

Births

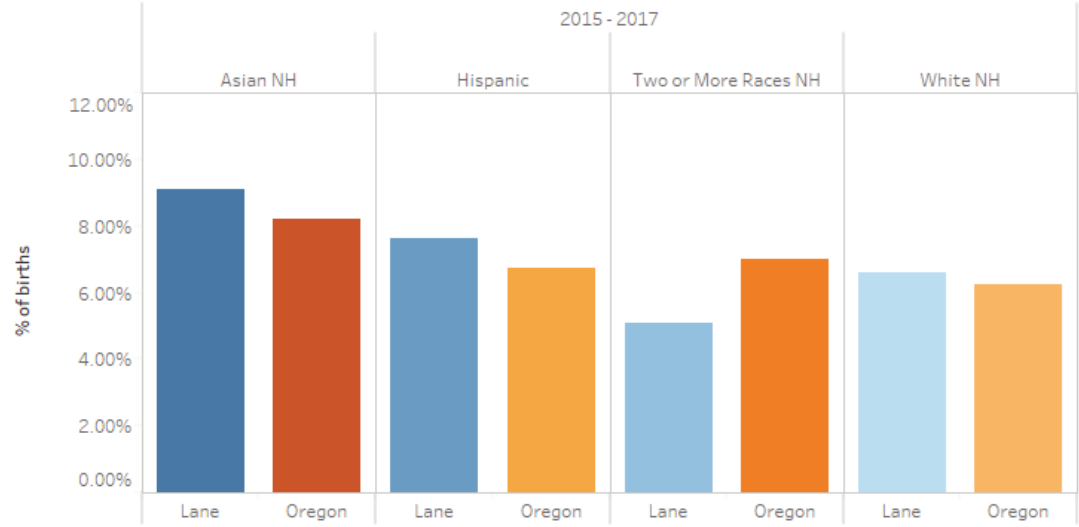
Effective contraceptive use	Low Birth Weight	Low Birth Weight by group	Preterm births

Low Birth Weight by Group

Percentage of low birth weight within group population.

Region
All

Year
2015 - 2017



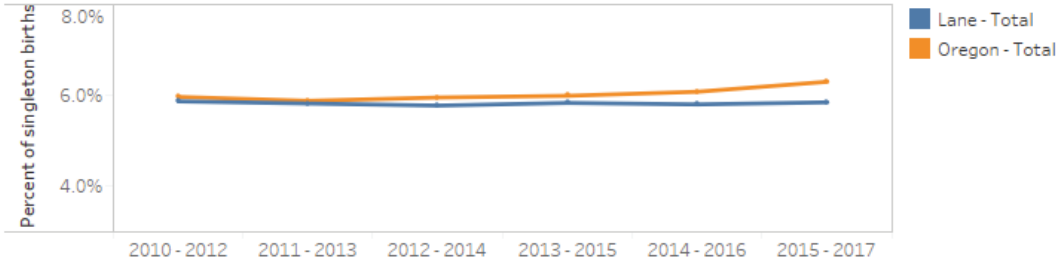
In Lane County and in Oregon, low birth weight rates vary by race and ethnicity.

Source: Oregon Center for Health Statistics; Note: data on Pacific Islander/Native Hawaiian populations should be interpreted with caution due to low numbers; Lane County data on some populations is omitted due to small numbers

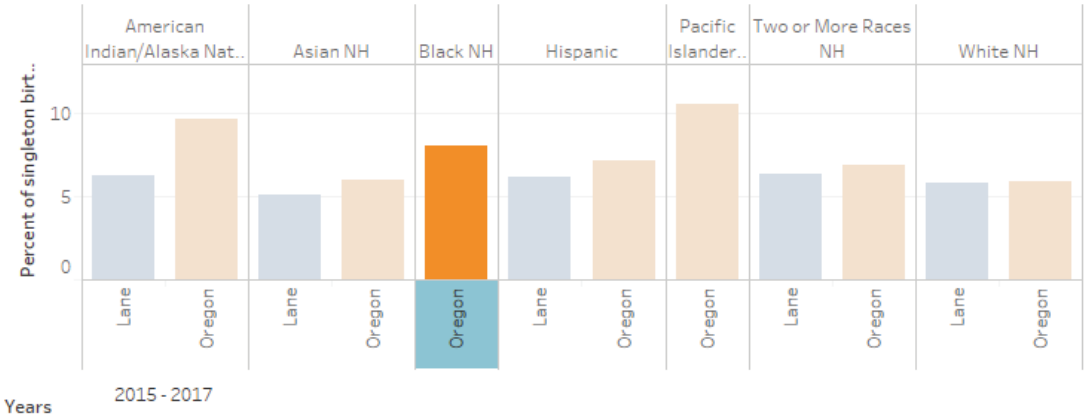
Births

Effective contraceptive use	Low Birth Weight	Low Birth Weight by group	Preterm births

Preterm Births *Percentage of singleton births <37 weeks by group(s) within Lane County and Oregon.*



Percent of preterm births by race/ethnicity for Lane County and Oregon



Preterm birth is the birth of an infant before 37 weeks of pregnancy. Infants born preterm are at increased risk for a number of health problems and are likely to require specialized medical care, and oftentimes must stay in intensive care nurseries. Preterm birth rates vary by race/ethnicity in both Oregon and Lane County.

Source: Oregon Center for Health Statistics; [Note: data on Pacific Islander/Native Hawaiian populations should be interpreted with

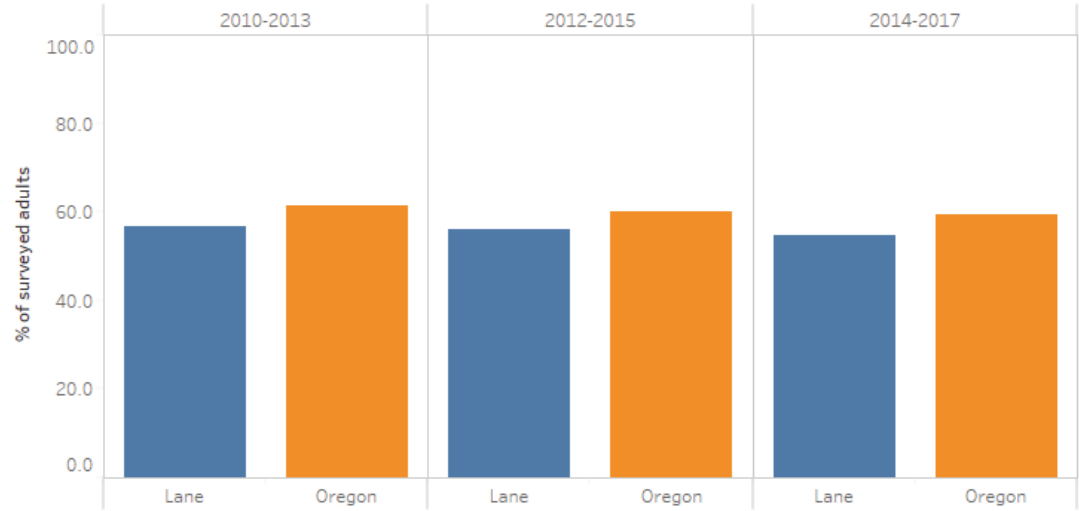
Behavioral Health

Behavioral Health

Adult mental health	Youth mental health	Substance Abuse	Prevalence of severe, persistent mental illness (SPMI)	Prevalence of any mental health condition	Pr ev a..

Percent of adults who reported having 'good mental health' in the past 30 days

Age Group
Total



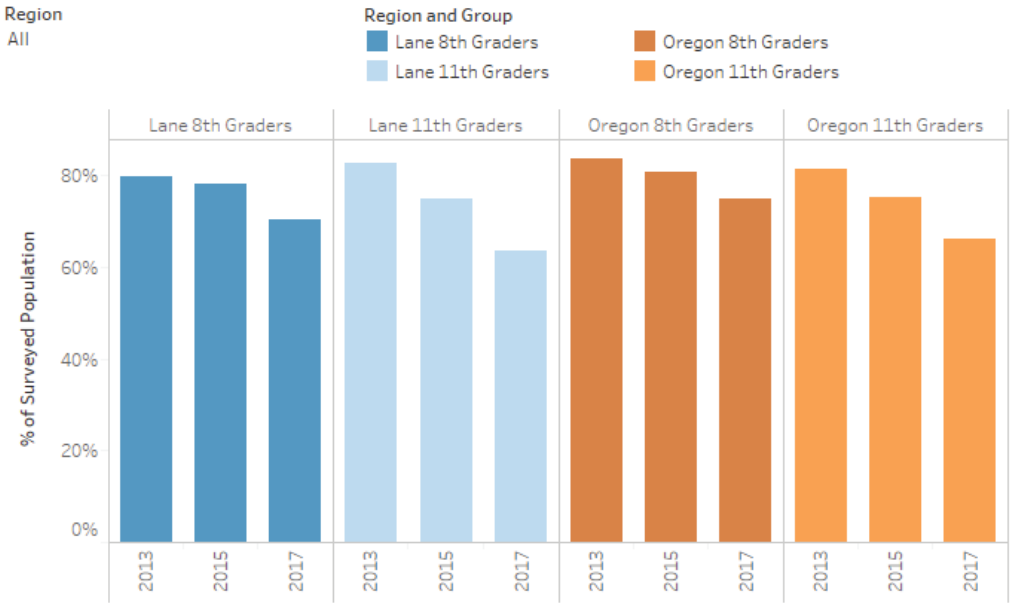
Overall health depends on both physical and mental well-being. Having good mental health is one facet of understanding health-related quality of life.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority

Behavioral Health

Adult mental health	Youth mental health	Substance Abuse	Prevalence of severe, persistent mental illness (SPMI)	Prevalence of any mental health condition	Pr ev a..

Percent of youth who say their emotional and mental health is "good" to "excellent"



Good mental health is important to achieving overall health; Lane County youth report similar rates of good mental health as the state overall, however there is a troubling trend, both at the state and county level, of declining mental health among youth.

Source: Oregon Healthy Teens Survey; [Note: due to low participation in the survey in Lane County, results can only be interpreted as representative of survey respondents and not of the County as a whole]

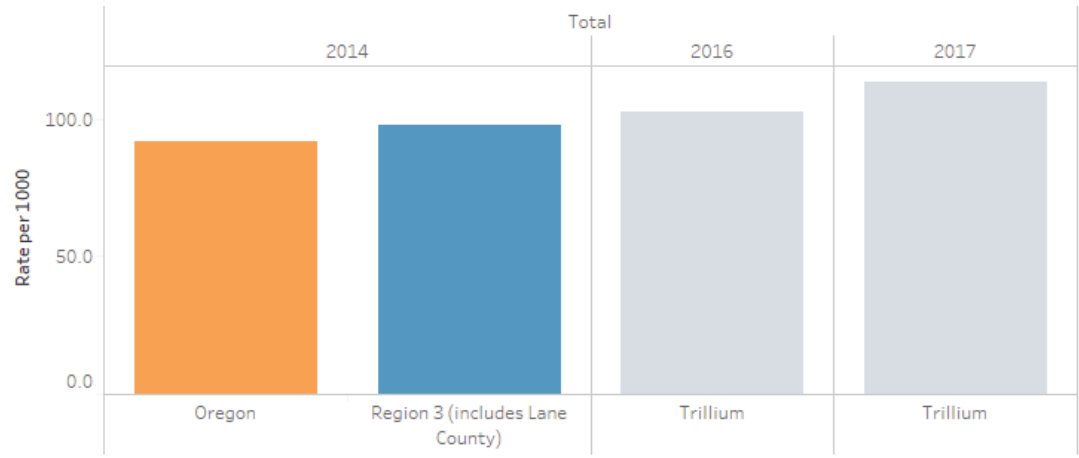
Behavioral Health

Adult mental health	Youth mental health	Substance Abuse	Prevalence of severe, persistent mental illness (SPMI)	Prevalence of any mental health condition	Pr ev a..

Adult rates of substance abuse

Rate per 1000

Subgroup Total



Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. Rate increases in the CCO population could be the result of more people seeking treatment and not necessarily reflect an increase in the actual prevalence.

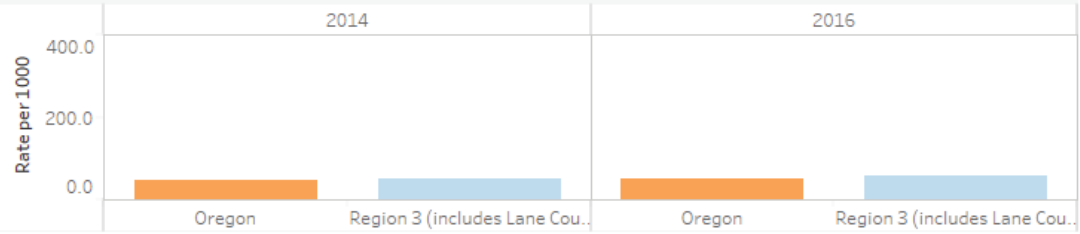
Sources: Trillium Community Health Plan Analytics and the National Survey on Drug Use and Health provides periodic data for Oregon and sub-regions within Oregon; Lane County is part of Region 3, which includes Benton, Clatsop, Columbia, Lane, Lincoln, Marion, Polk, Tillamook, and Yamhill counties. Rates for Oregon and Region 3 are from survey data and rates for CCO members come from claims data, as such they are not directly comparable.

Behavioral Health

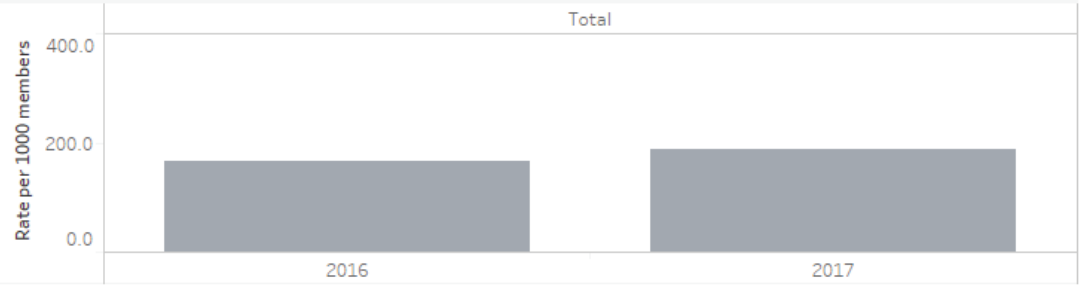
Ad ul t .. | Youth mental health | Substance Abuse | **Prevalence of severe, persistent mental illness (SPMI)** | Prevalence of any mental health condition | Prevalence of depression

Prevalence of SPMI diagnosis

Oregon and Region 3 (which includes Lane County)



Among CCO members



Select Group
Total

Severe, Persistent Mental Illness (SPMI) creates many challenges for an individual's overall health. Rate increases could be the result of more people seeking treatment and not necessarily reflect an increase in the actual prevalence.

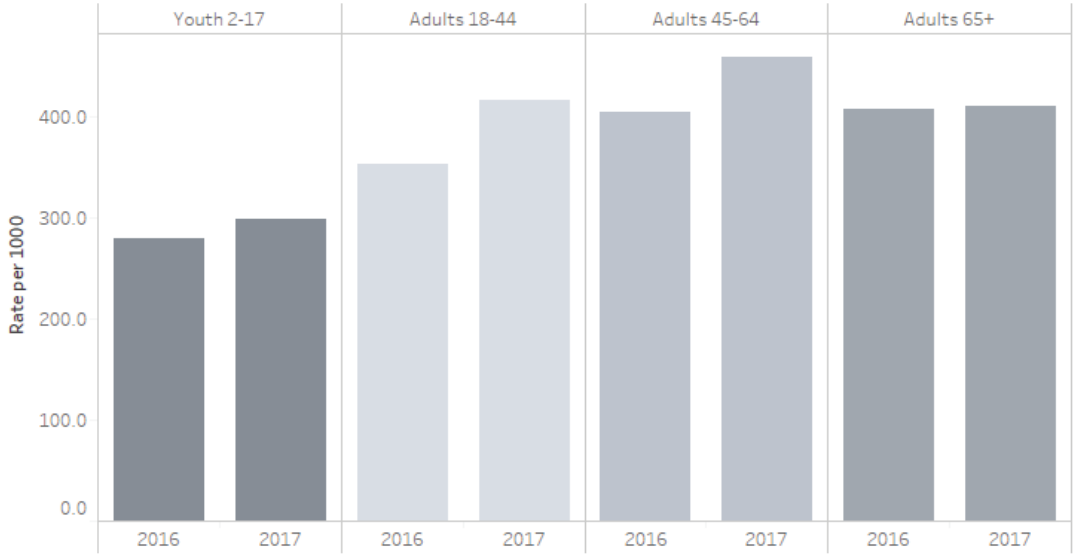
Sources: Trillium Community Health Plan Analytics and the National Survey on Drug Use and Health provides periodic data for Oregon and sub-regions within Oregon; Lane County is part of Region 3, which includes Benton, Clatsop, Columbia, Lane, Lincoln, Marion, Polk, Tillamook, and Yamhill counties. Rates for Oregon and Region 3 are from survey data and rates for CCO members come from claims data, as such they are not directly comparable.

Behavioral Health

Ad ul t .. | Youth mental health | Substance Abuse | Prevalence of severe, persistent mental illness (SPMI) | **Prevalence of any mental health condition** | Prevalence of depression

CCO members: Prevalence of any mental health condition

Members with diagnosis of any mental health condition



An increase in mental health diagnosises may indicate that more people are seeking treatment and does not necessarily indicate an increase in the actual prevalence of mental health conditions.

Source: Trillium Community Health Plan Analytics

Behavioral Health

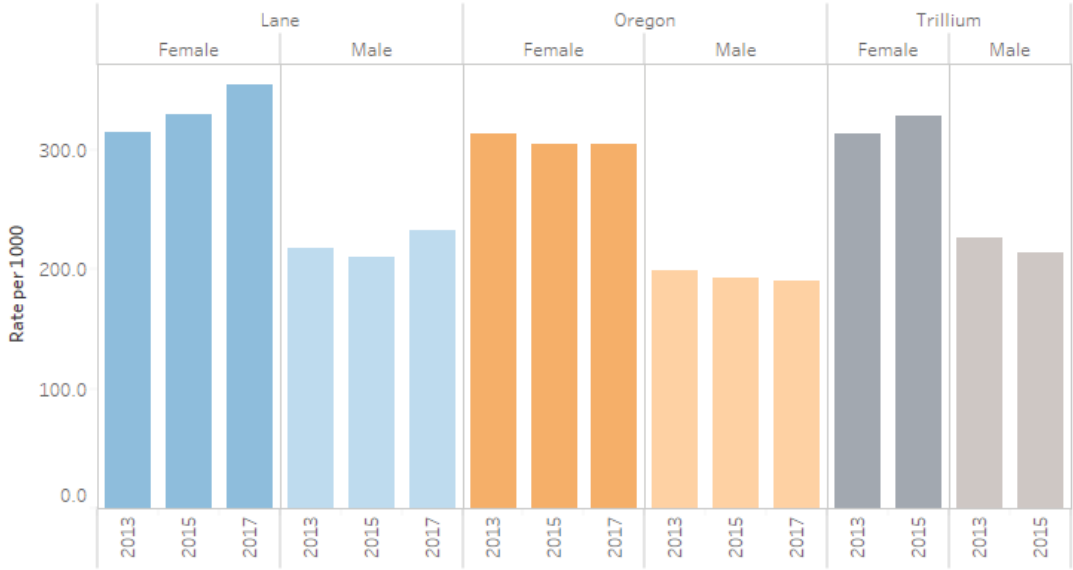
Ad ul t ..	Youth mental health	Substance Abuse	Prevalence of severe, persistent mental illness (SPMI)	Prevalence of any mental health condition	Prevalence of depression

Adults reporting ever being diagnosed with depression

Select a region and group to view the rate per 1000 within Lane County, Oregon and Trillium.

Region
All

Group
Multiple values



Women are diagnosed with depression at higher rates than men; both in Lane County and in Oregon. Lane County has higher rates of depression diagnosis than the state as a whole for both men and women.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Lane County and Trillium data is for the 4-year period ending in the year indicated

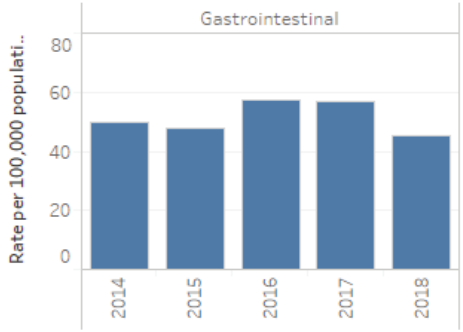
Infectious Disease

Infectious Disease

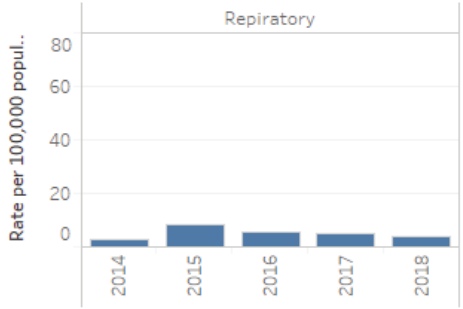
Gastrointestinal, Respiratory & Vaccine preventable	HIV / AIDS Case Rate	Chlamydia: all adults	Chlamydia: 15-24 yo	Gonorrhea: all adults	G on o..

Lane County communicable diseases 2014-2018

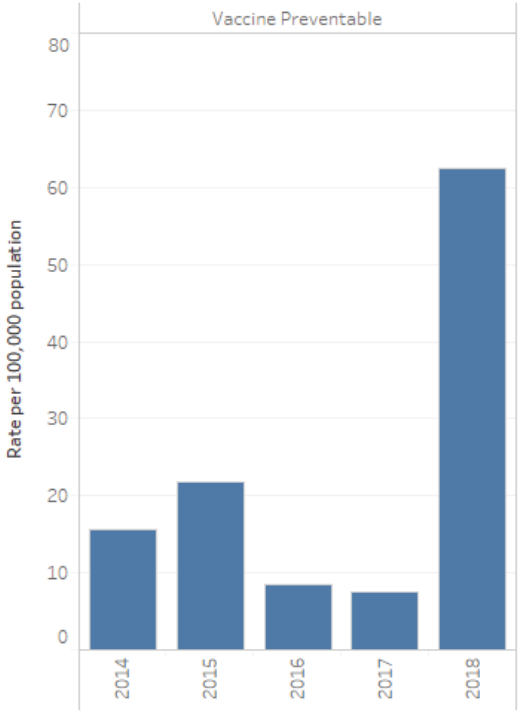
Gastrointenstial diseases



Repiratory diseases



Vaccine preventable diseases



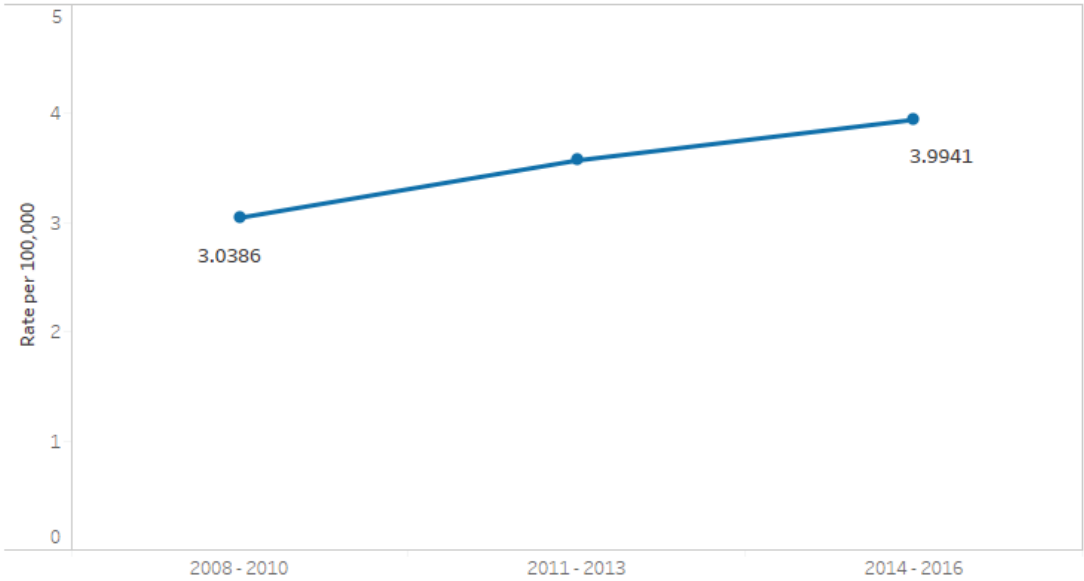
While rates of gastrointestinal and respiratory disease are relatively stable, rates of vaccine preventable diseases spiked in 2018, primarily due to a pertussis outbreak.

Source: Lane County Communicable disease Epi Reports

Infectious Disease

Gastrointestinal, Respiratory & Vaccine preventable | **HIV / AIDS Case Rate** | Chlamydia: all adults | Chlamydia: 15-24 yo | Gonorrhea: all adults | G on o..

Lane County HIV/AIDS case rate



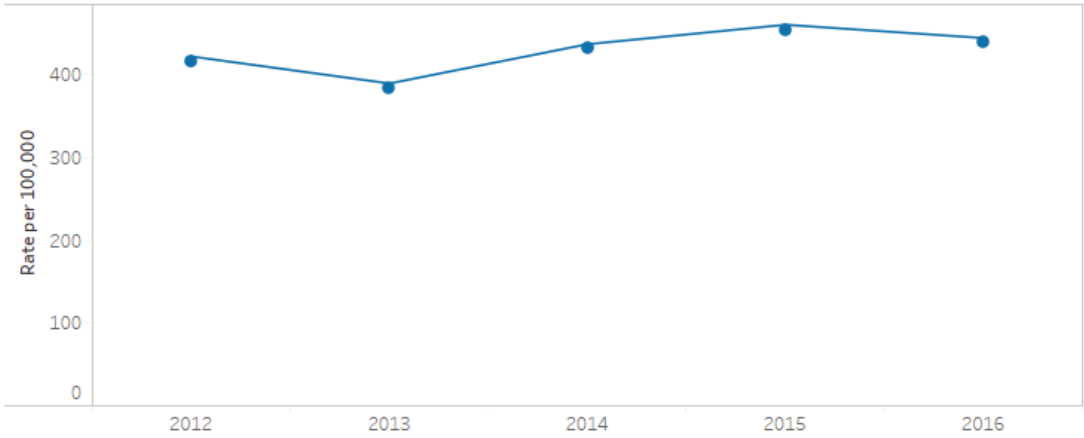
HIV is a virus spread through body fluids that attacks the body's immune system, specifically the CD4 cells which are often called T cells. These special cells help the immune system fight off infections. Over time, HIV can destroy so many of these cells that the body can't fight off infections and disease. Untreated, HIV reduces the number of CD4 cells (T cells) in the body. This damage to the immune system makes it harder and harder for the body to fight off infections and other diseases. Opportunistic infections or cancers take advantage of a very weak immune system and signal that the person has AIDS.

Source: Lane County Public Health Communicable Disease Section

Infectious Disease

Gastrointestinal, Respiratory & Vaccine preventable | HIV / AIDS Case Rate | **Chlamydia: all adults** | Chlamydia: 15-24 yo | Gonorrhea: all adults | G on o..

Lane County Chlamydia case rate



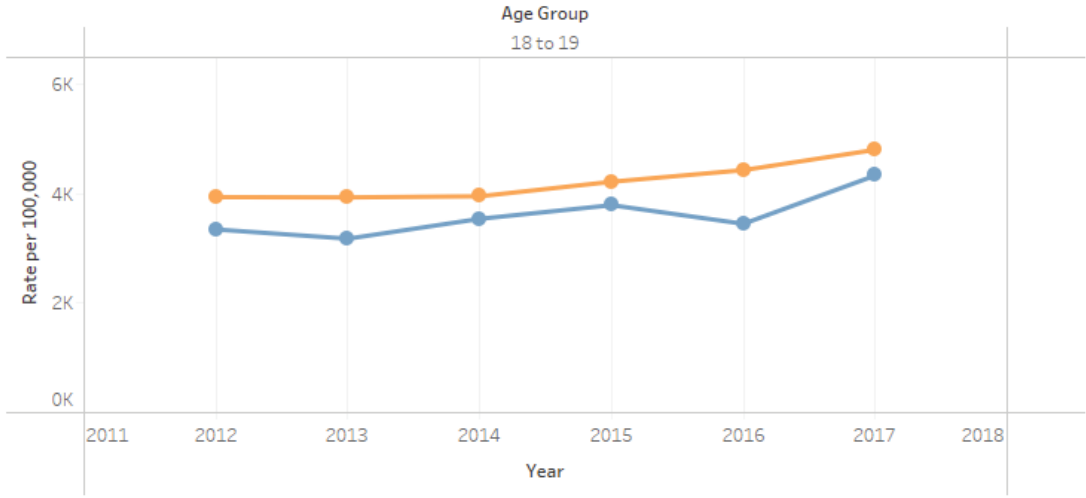
Chlamydia, the most frequently reported bacterial sexually transmitted disease in the United States, is caused by the bacterium, Chlamydia trachomatis. Although symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia also can cause discharge from the penis of an infected man. Under-reporting of chlamydia is substantial because most people with chlamydia are not aware of their infections and do not seek testing.

Source: Lane County Public Health Communicable Disease Section

Infectious Disease

HIV / AIDS Case Rate | Chlamydia: all adults | **Chlamydia: 15-24 yo** | Gonorrhea: all adults | Gonorrhea: 15-24 yo | S y ..

Chlamydia Rates in 15-24 year olds



Place, Sex, Age Group
Lane, Female, 18 to 19
Oregon, Female, 18 to 19

Sex	Female
Place	All
Age Group	18 to 19

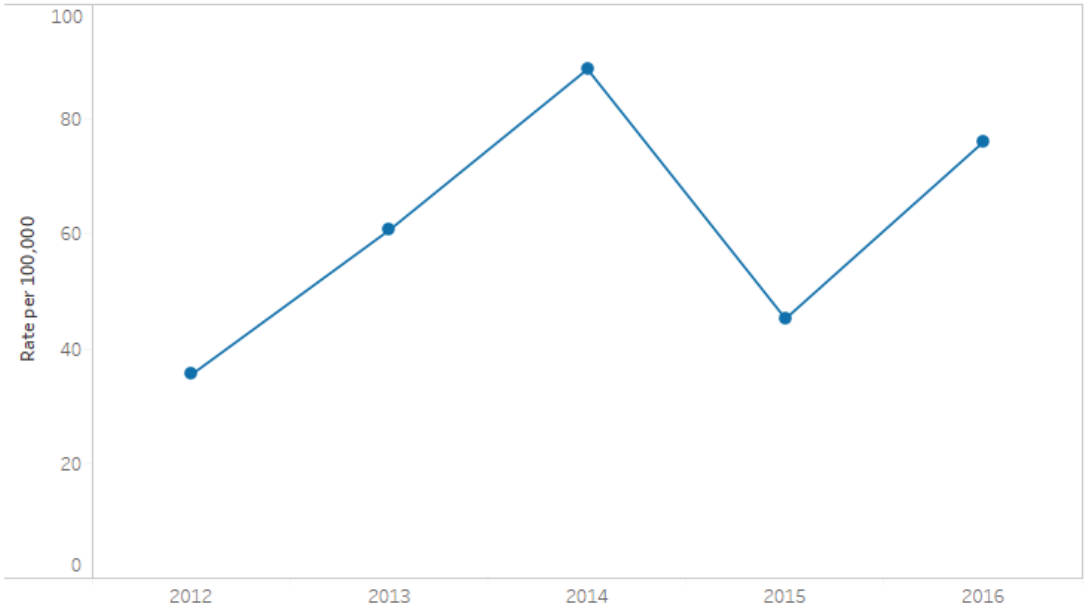
Nationally, STI rates are highest in the 15-24 year old population. This is true for both Lane County and Oregon as a whole. Women also tend to have higher rates than men, though this may be due to greater rates of testing rather than actual prevalence rates.

Source: Communicable Disease case reports: Acute & Communicable Disease Prevention Program, Center for Public Health Practice, Public Health Division, Oregon Health Authority

Infectious Disease

Chlamydia: all adults | Chlamydia: 15-24 yo | **Gonorrhea: all adults** | Gonorrhea: 15-24 yo | Syphilis | H e ..

Lane County Gonorrhea case rate



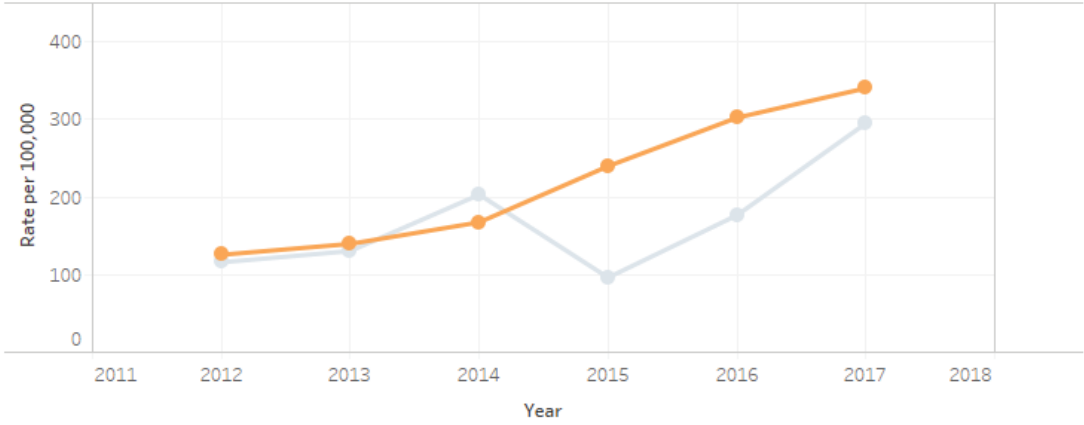
Gonorrhea is a sexually transmitted infection that can infect both men and women. It can cause infections in the genitals, rectum, and throat. It is a very common infection, especially among young people ages 15-24 years. In both the state of Oregon as a whole and Lane County the rates for gonorrhea in males and females have increased dramatically since 2012.

Source: Lane County Public Health Communicable Disease Section

Infectious Disease

Chlamydia: 15-24 yo | Gonorrhea: all adults | **Gonorrhea: 15-24 yo** | Syphilis | Hepatitis C | C h ..

Gonorrhea rates for 15-24 year olds



Place, Sex, Age Group
Lane, Female, 20 to 24
Oregon, Female, 20 to 24

Sex	Female
Place	All
Age Group	20 to 24

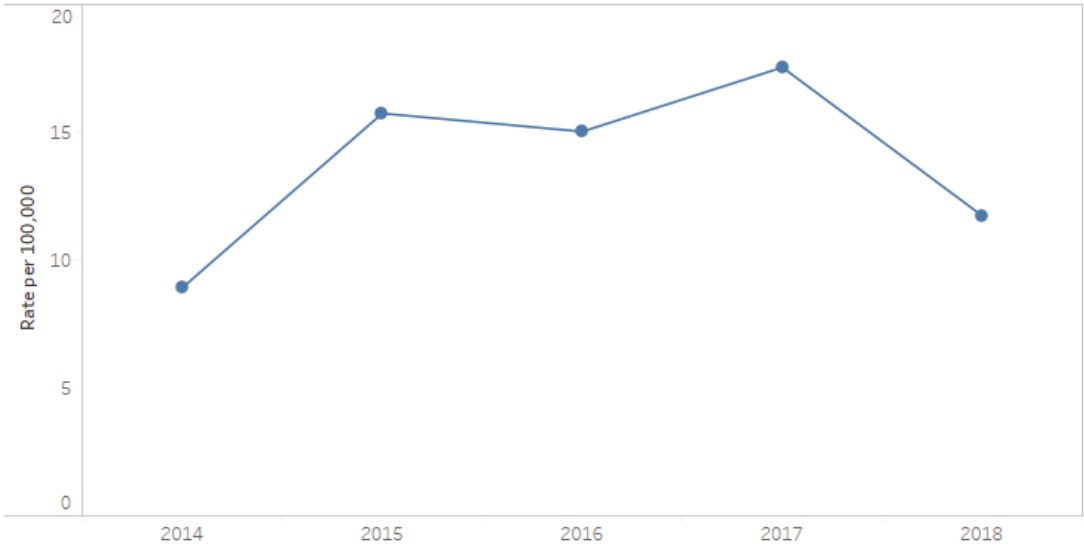
As with all sexually transmitted infections, gonorrhea is transmitted most commonly in the 15-24 year old population. Rates of infection tend to be higher in men and, in both Lane County and Oregon, have been increasing over time.

Source: Communicable Disease case reports: Acute & Communicable Disease Prevention Program, Center for Public Health Practice, Public Health Division, Oregon Health Authority. Note: some data points are suppressed due to low numbers

Infectious Disease

Ch la.	Gonorrhea: all adults	Gonorrhea: 15-24 yo	Syphilis	Hepatitis C	Chronic Hepatitis B

Syphilis Case Rate



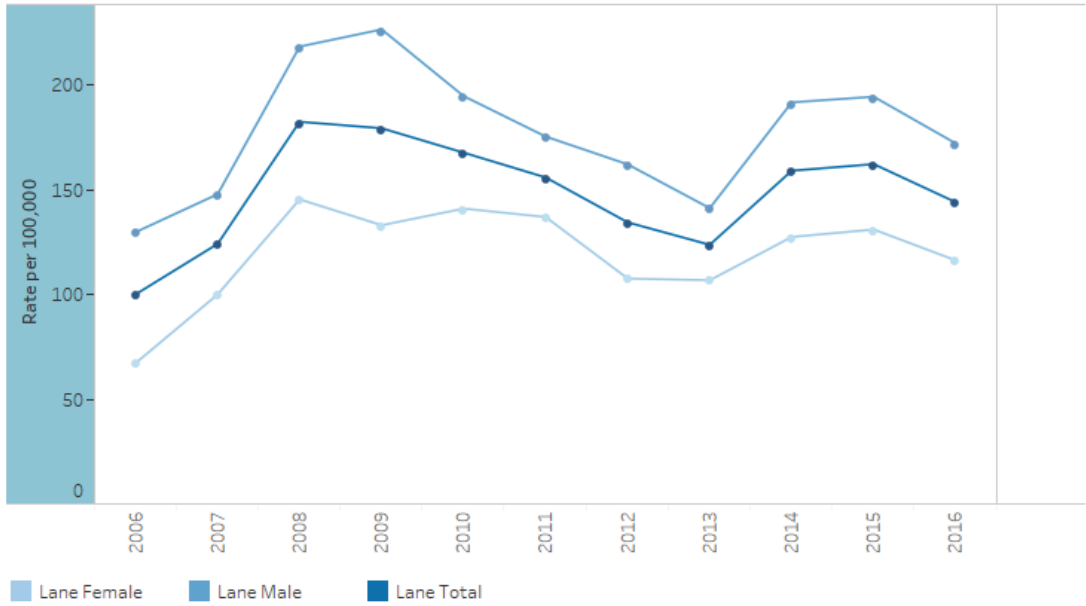
Syphilis is an STI that can cause long-term complications if not treated correctly. You can get syphilis by direct contact with a syphilis sore during vaginal, anal, or oral sex. Syphilis can also be spread from an infected mother to her unborn baby.

Source: Lane County Public Health Communicable Disease Section

Infectious Disease

Ch la. | Gonorrhea: all adults | Gonorrhea: 15-24 yo | Syphilis | **Hepatitis C** | Chronic Hepatitis B

Chronic Hepatitis C case rate by Sex



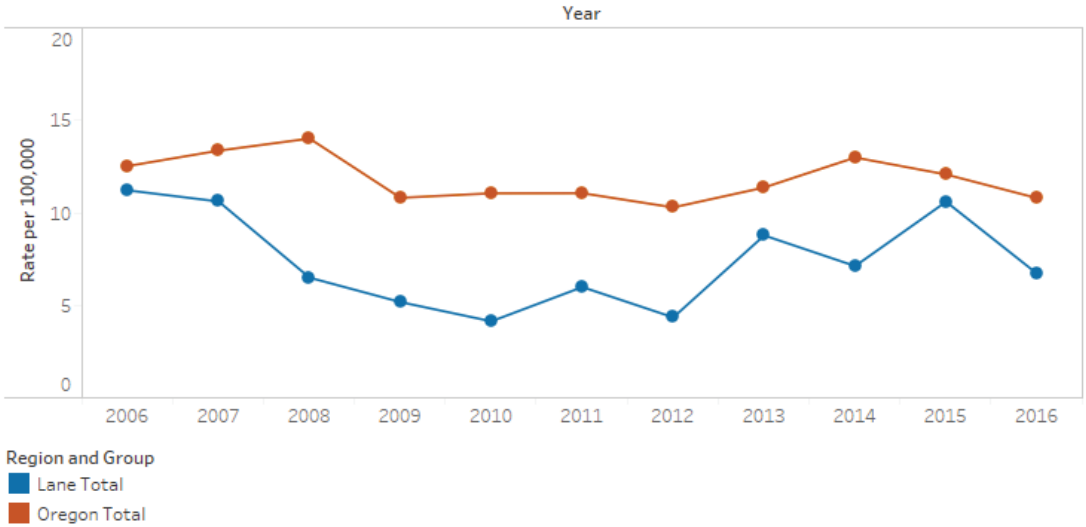
Hepatitis C is a contagious liver disease that ranges in severity from a mild illness lasting a few weeks to a serious, lifelong illness that attacks the liver. It results from infection with the Hepatitis C virus (HCV), which is spread through contact with the blood of an infected person, usually by sharing needles for illegal drug injection. Hepatitis C can be either "acute" or "chronic." Acute hepatitis C virus infection is a short-term illness that occurs within the first 6 months after someone is exposed to the Hepatitis C virus.

Source: Lane County Public Health Communicable Disease Section

Infectious Disease

Ch la.	Gonorrhea: all adults	Gonorrhea: 15-24 yo	Syphilis	Hepatitis C	Chronic Hepatitis B

Hepatitis B Chronic Crude Rate



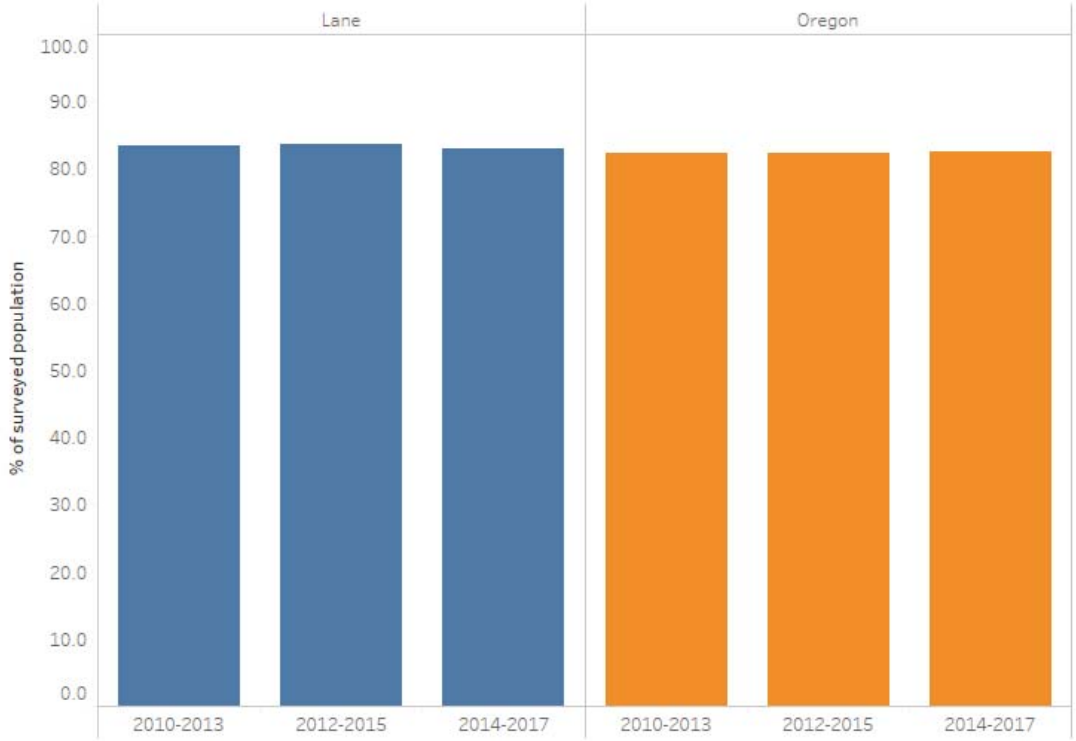
Hepatitis B is a contagious liver disease that ranges in severity from a mild illness lasting a few weeks to a serious, lifelong illness. It results from infection with the Hepatitis B virus, spread through sexual contact. Hepatitis B can be either "acute" or "chronic." Acute hepatitis B virus infection is a short-term illness that occurs within the first 6 months after someone is exposed to the hepatitis B virus. Acute infection can — but does not always — lead to chronic infection. This can also be prevented with a vaccine, usually combined with hepatitis A. Chronic Hepatitis B virus infection is a long-term illness that occurs when the hepatitis B virus remains in a person's body; it can lead to liver cancer or cirrhosis that may require liver transplant.

Source: Lane County Public Health Communicable Disease Section

Chronic Disease

Adults in good health | Youth in good health | Adult Asthma | Percent of Youth with Asthma | Adult Obesity | Yo ut h..

Adult reporting good physical health



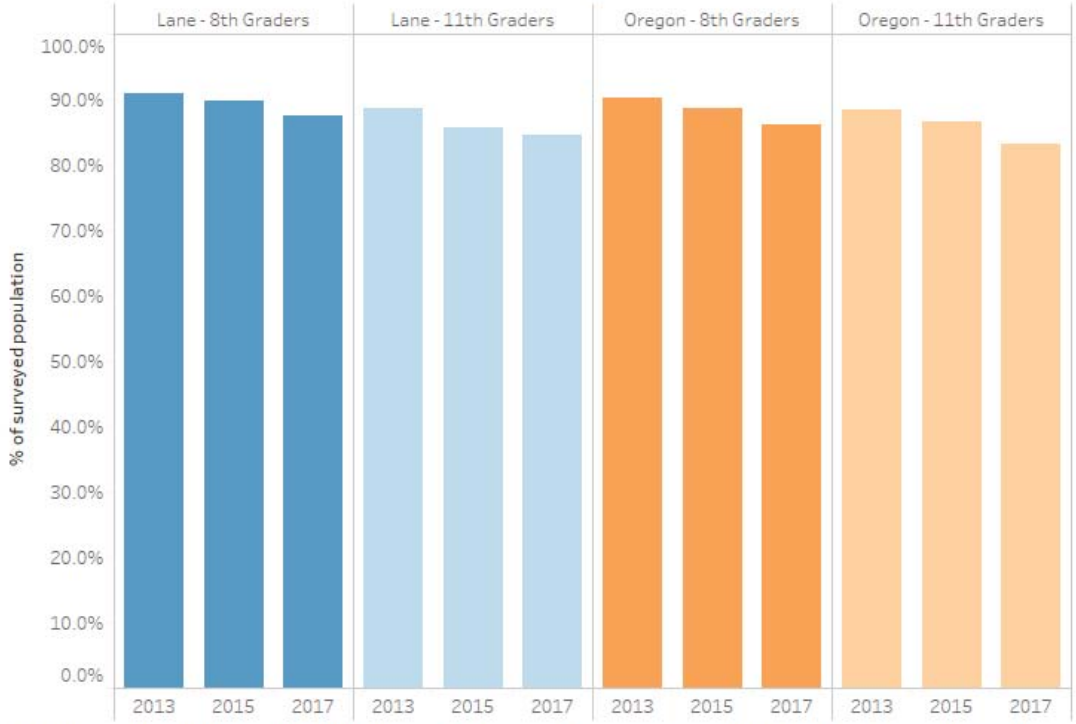
The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absense of disease"; self-reported health status for the past 30 days is one indicator of the general well-being of Lane County and Oregon.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority

Adults in good health | **Youth in good health** | Adult Asthma | Percent of Youth with Asthma | Adult Obesity | Yo ut h..

Youth reporting Good Physical Health

Percent of surveyed youth population within Lane County and Oregon.



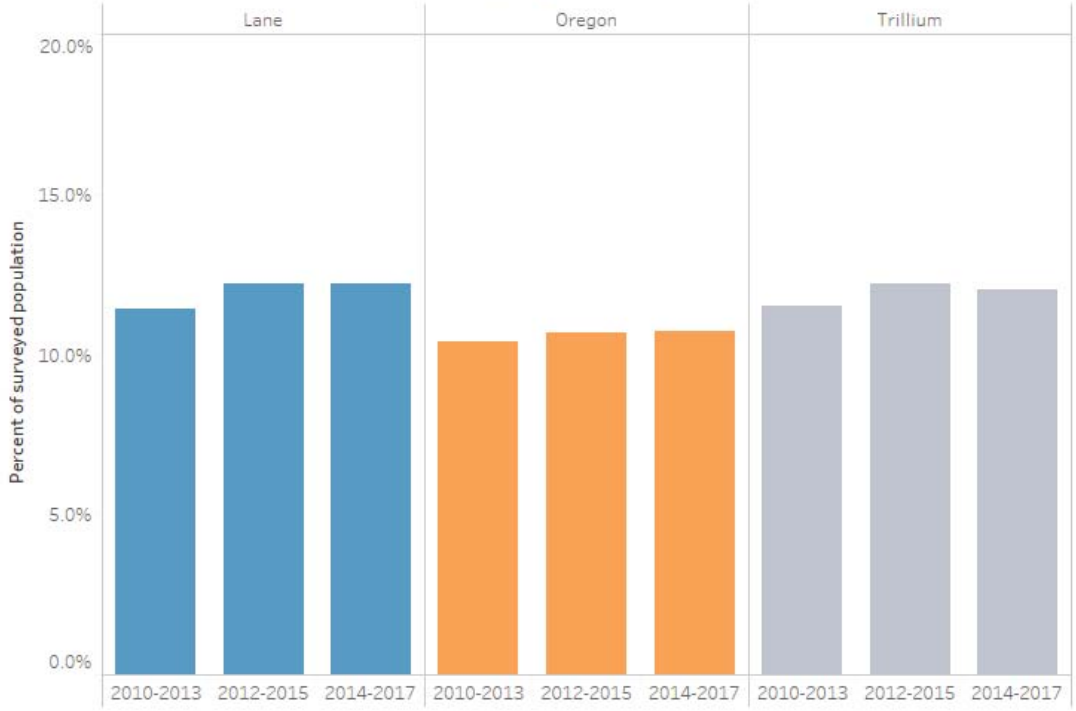
Good physical health is associated with improved academic performance and higher academic achievement is one of the best predictors of lifelong health.

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Adults in good health | Youth in good health | **Adult Asthma** | Percent of Youth with Asthma | Adult Obesity | Yo ut h..

Adult Asthma

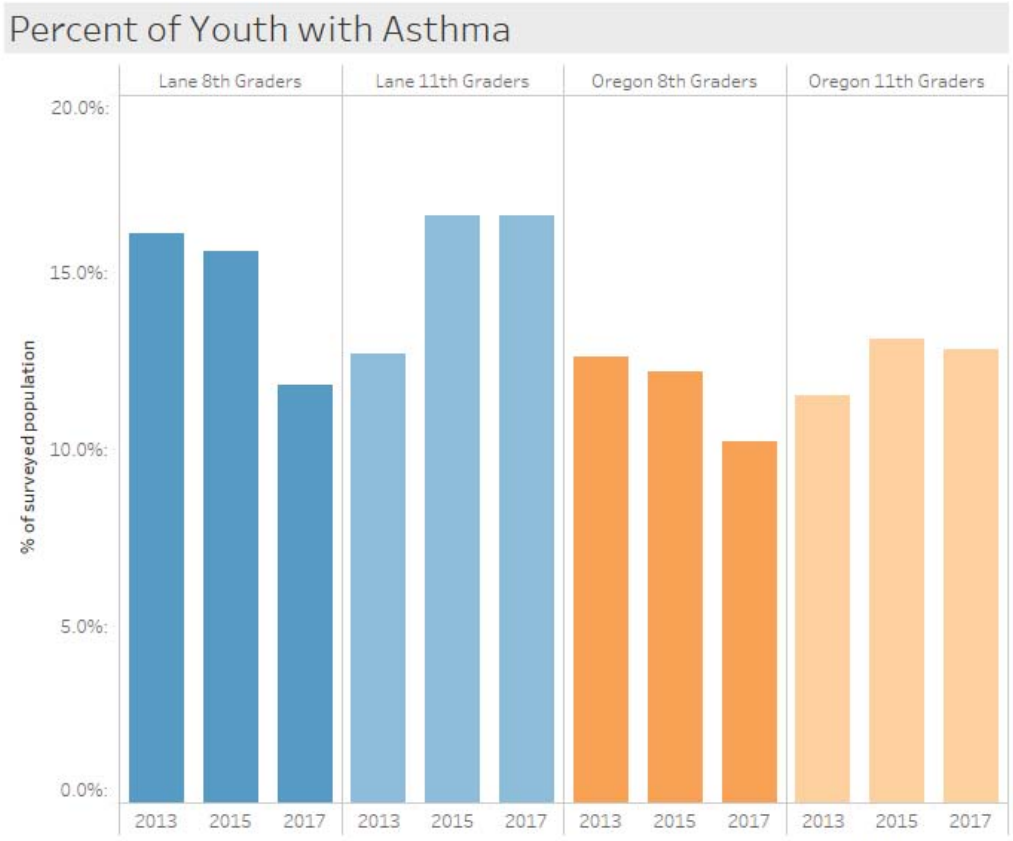
Percent of adults diagnosed with asthma in Lane County, Oregon and Trillium.



Asthma is a chronic inflammatory disorder of the airways, characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority

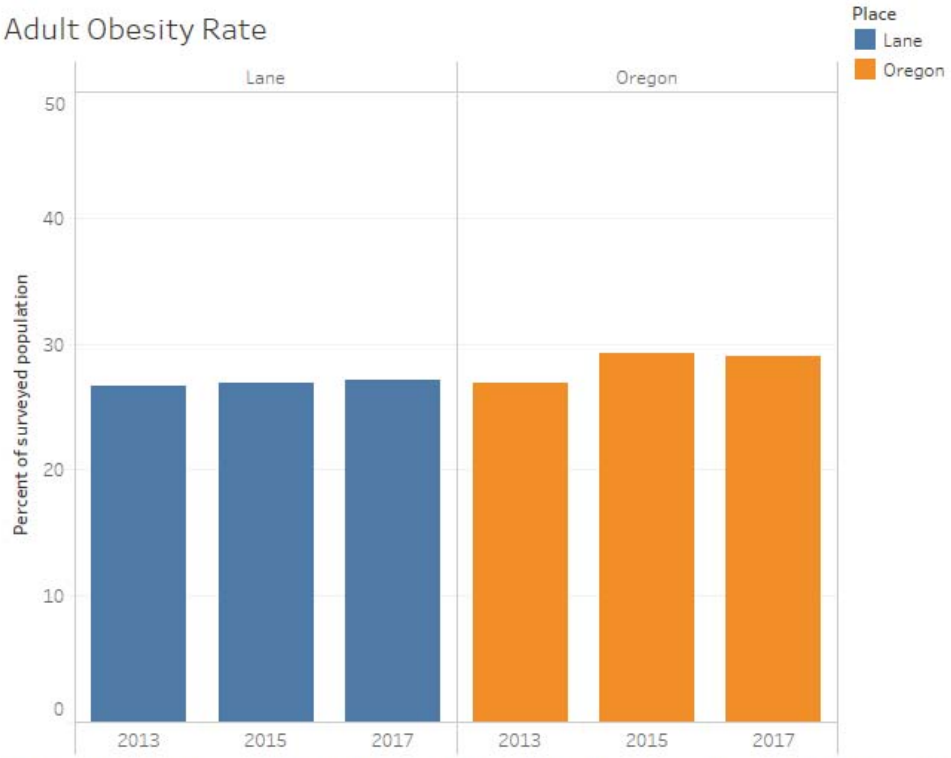
Youth in good health | Adult Asthma | Percent of Youth with Asthma | Adult Obesity | Youth Obesity | A d ..



Asthma is a chronic inflammatory disorder of the airways, youth asthma is more prevalent in Lane County than the state overall.

Source: Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Adult Asthma	Percent of Youth with Asthma	Adult Obesity	Youth Obesity	Adult Diabetes	P r.



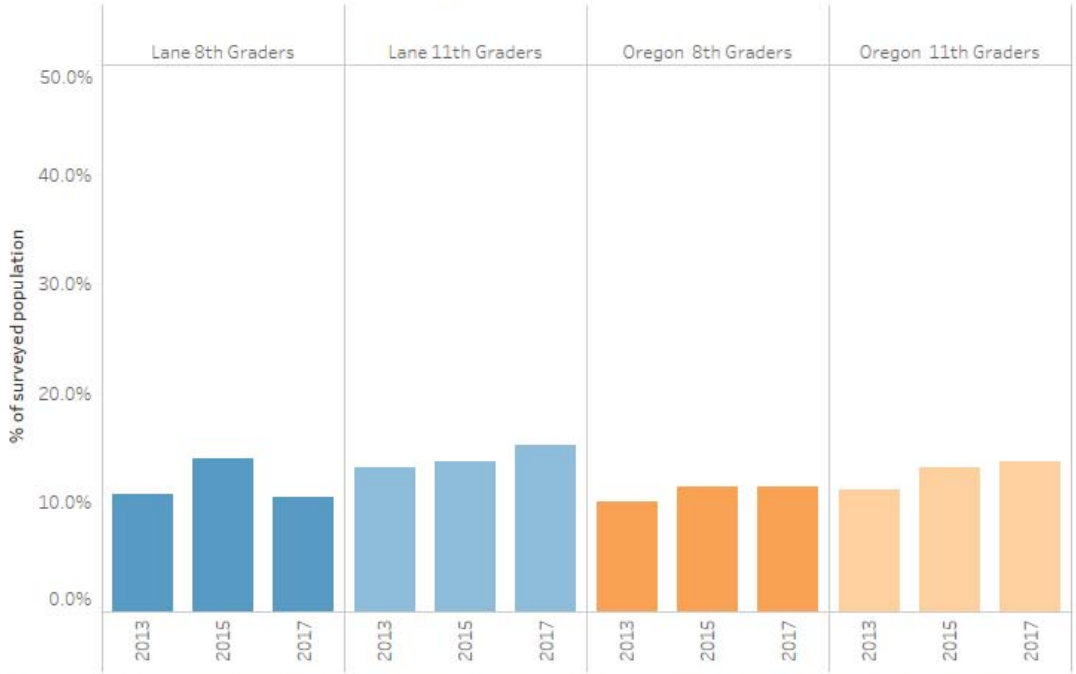
While obesity is not a good indicator of overall health, obesity is a risk factor for developing many diseases - such as heart disease, diabetes, stroke and some forms of cancer - and is therefore an important indicator for looking at the overall risk of a population.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Lane County data is for the 4-year period ending in the year indicated

Percent of Youth with Asthma | Adult Obesity | **Youth Obesity** | Adult Diabetes | Prevalence of Stroke | H i.

Prevalence of Obesity in Youth

Percent of population within Lane County and Oregon.



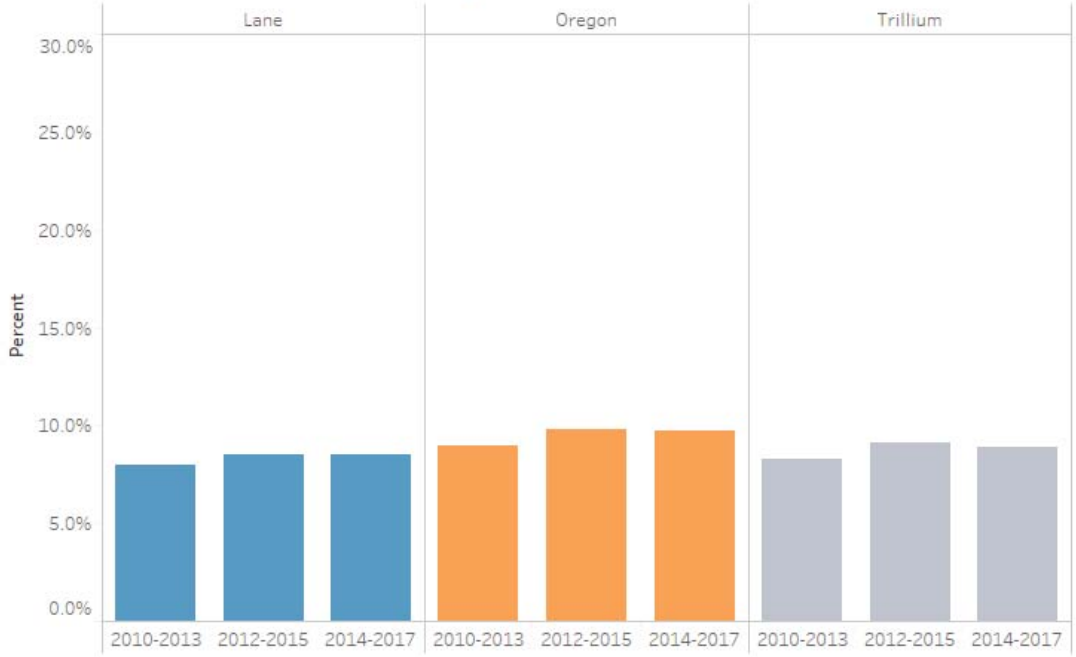
Obesity in childhood is associated with increased risk of obesity as an adult. While obesity is not necessarily an indicator of poor health, it does increase risk of many diseases.

Source: Oregon Healthy Teens Survey; [Note: Lane County data only represents the students who participated in the survey and cannot be interpreted as representative of the County as a whole due to low-participation rates]

Adult Obesity	Youth Obesity	Adult Diabetes	Prevalence of Stroke	High Blood Pressure	C a ..

Prevalence of Adult Diabetes

Percentage of adult population of Lane County, Oregon and CCO members with diabetes diagnosis.



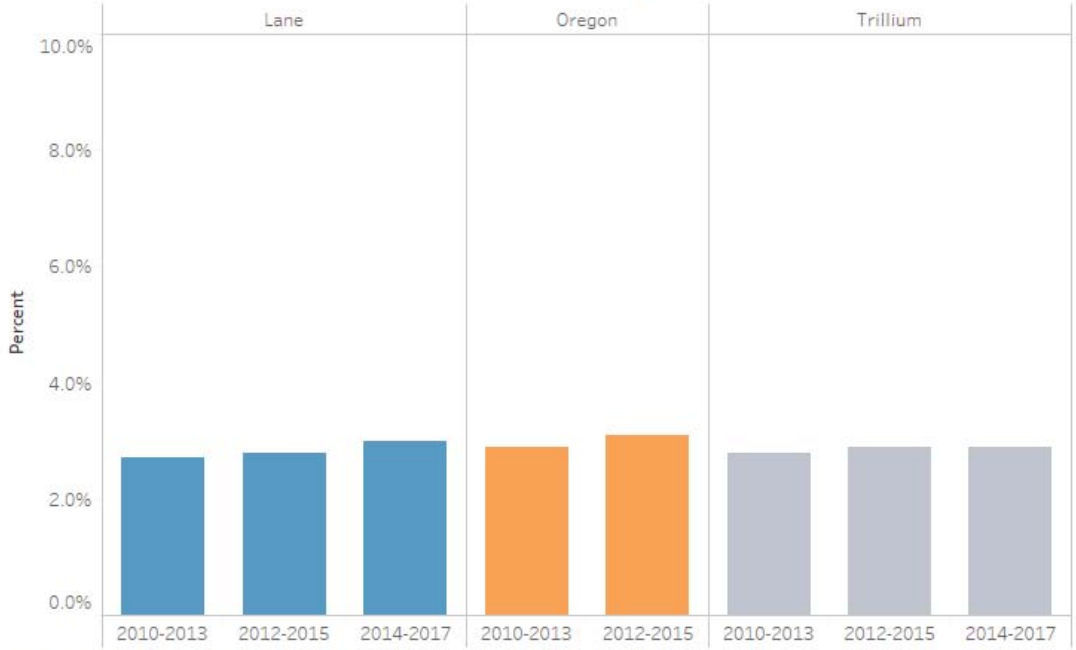
Diabetes mellitus is a group of diseases marked by high levels of blood glucose, also called blood sugar, resulting from defects in insulin production, insulin action, or both. Diabetes lowers life expectancy, increases the risk of heart disease, and is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority

Ad ul t.. | Youth Obesity | Adult Diabetes | Prevalence of Stroke | High Blood Pressure | Cancer Incidence Rates

Prevalence of Stroke

Percent of Adult populations who ever had a stroke in Lane County, Oregon and among CCO members.

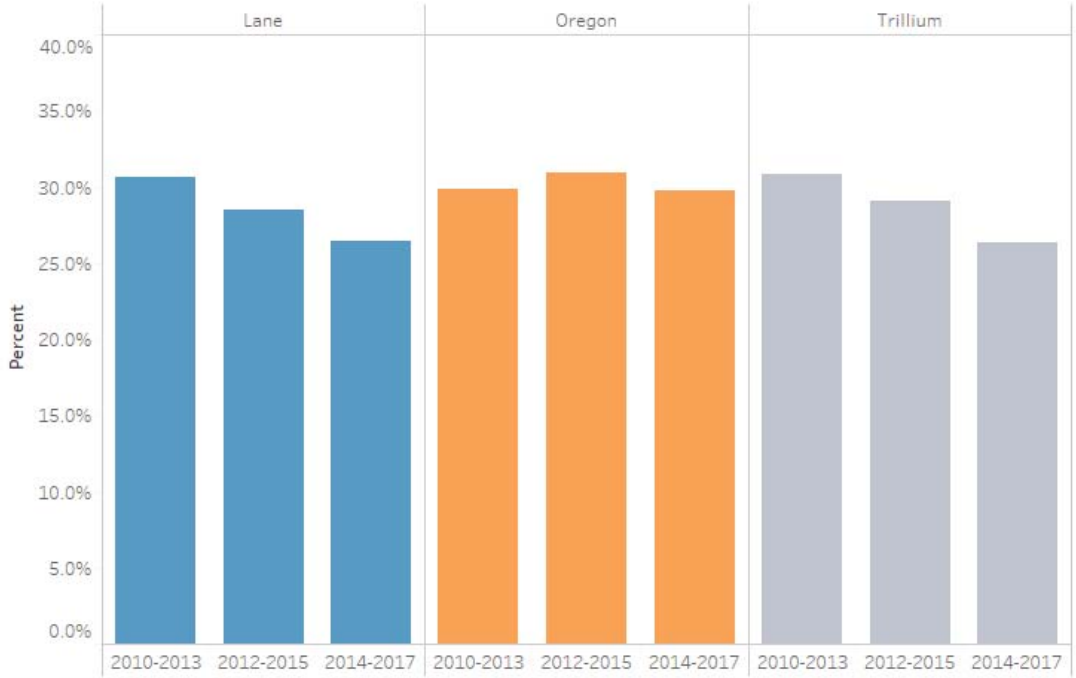


Stroke is a leading cause of death and long-term disability in Lane County.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Trillium data comes from Trillium Community Health Plan Analytics

Prevalence of High Blood Pressure

Percent of adults diagnosed with hypertension in Lane County, Oregon and among CCO members



Hypertension, also known as high blood pressure, is a significant increase in the blood pressure in the arteries. Hypertension is the leading cause of stroke and a major cause of heart attacks.

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS), Program Design & Evaluation Services, Public Health Division, Oregon Health Authority; Oregon data is missing 2016

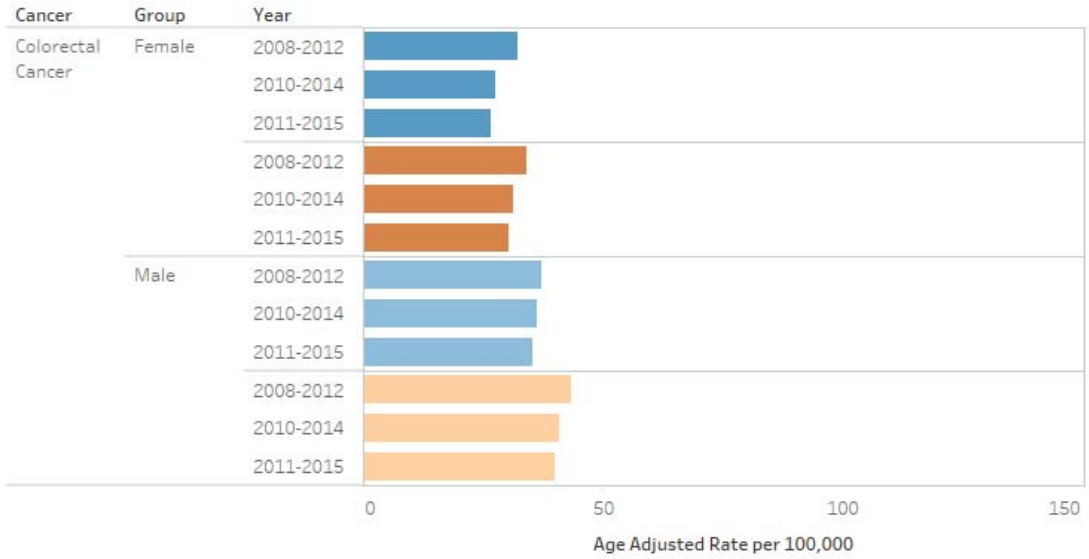
Cancer Incidence by Type and Region

Select region and Cancer Type to view incidence rate details in Lane County and Oregon.

Region: All

Cancer: Colorectal Cancer

Group(s): Multiple values



Cancer is a leading cause of death in the United States, the state of Oregon, and Lane County. According to the National Cancer Institute, lung, colon and rectal, breast, pancreatic, and prostate cancers lead to the greatest number of annual deaths.

Source: National Cancer Institute State and Local Profiles

Deaths

Deaths

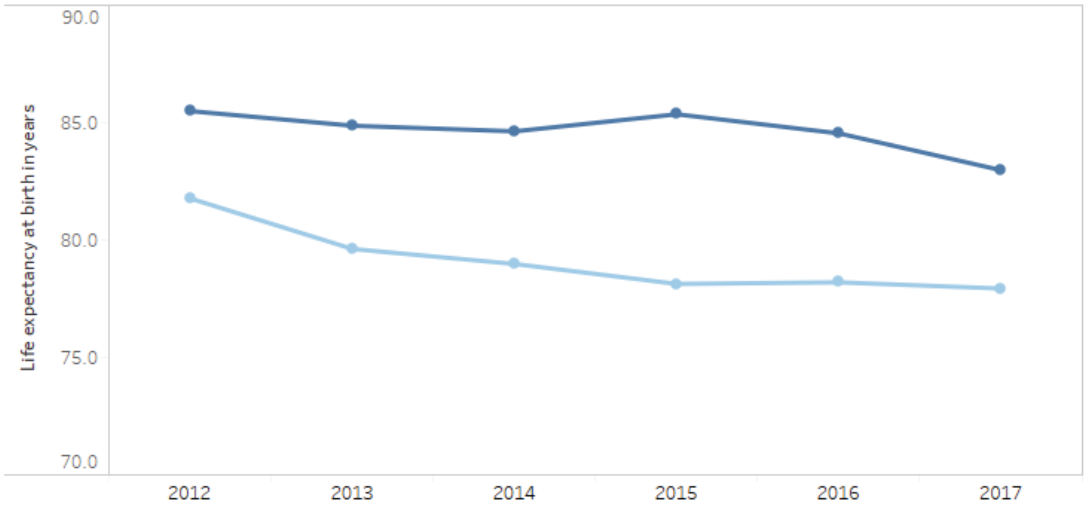
Life Expectancy | Life Expectancy by Race/Ethnicity | Premature Death | Leading Causes of Death by Age | Leading Causes of Death by Sex | Su ici d..

Average life expectancy at birth

Lane County and Oregon. Hover for more details

Select a Region
Lane

Select a Group
Multiple values



Lane County tends to have lower average life expectancy compared to the state overall; women continue to experience longer life expectancy than men.

Source: Oregon Center for Health Statistics

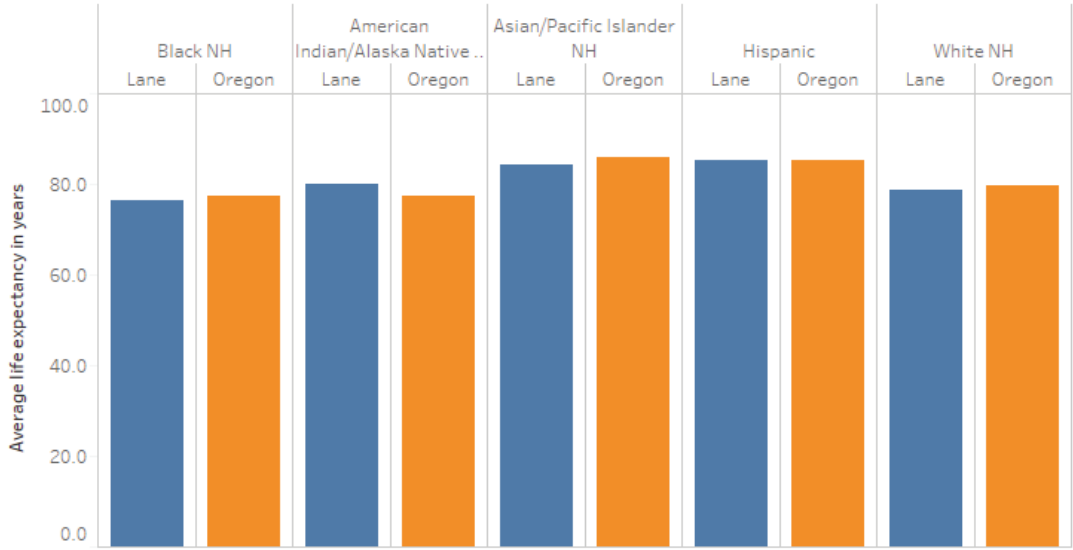
Deaths

Life Expectancy | **Life Expectancy by Race/Ethnicity** | Premature Death | Leading Causes of Death by Age | Leading Causes of Death by Sex | Su ici d..

Life Expectancy at birth by race/ethnicity

for Lane County and Oregon

Year
2017



Life expectancy at birth is considered a good indicator of population's longevity and general health. Although the overal average life expectancy at birth has been steadily increasing in the US, there remain great variations between different racial/ethnic groups, socioeconomic groups and even in geographic regions. (NH=Non-Hispanic)

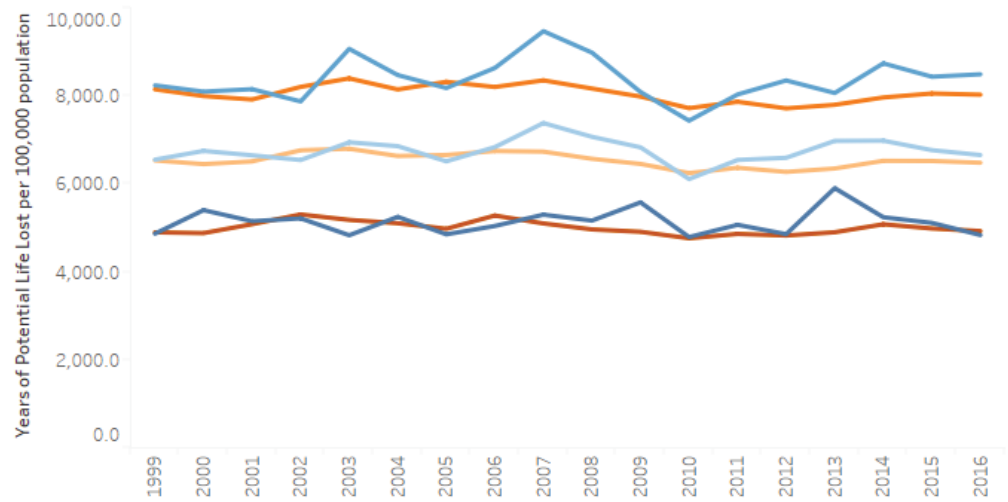
Source: Oregon Center for Health Statistics; note some race/ethnicity categories are omitted due to small numbers/reliability of the data

Deaths

Life Expectancy | Life Expectancy by Race/Ethnicity | **Premature Death** | Leading Causes of Death by Age | Leading Causes of Death by Sex | Su ici d..

Years of Potential Life Lost, Relative to age 75 by Sex

Region
All



Premature death is measured by the number of years of potential life lost before age 75. Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a regions's years of potential life lost (YPLL).

Source: Oregon Center for Health Statistics

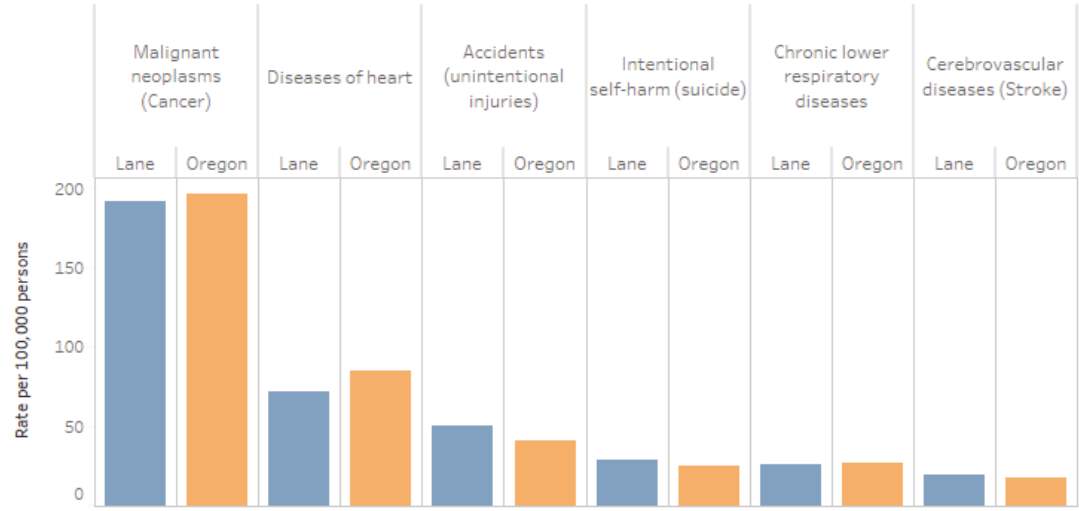
Deaths

Life Expectancy by Race/Ethnicity | Premature Death | **Leading Causes of Death by Age** | Leading Causes of Death by Sex | Suicide Rate | I n ..

Leading Causes of Death by Age

Rate by age groups within Lane County and Oregon.

Select Group
45 to 64



Year
2008 - 2012

Comparable to the state as a whole, Lane County's leading causes of death are: cancer, heart disease (diseases of the heart), respiratory disease, accidents, Alzheimer's disease, and stroke. Leading causes of death also vary by age group.

Source: Oregon Center for Health Statistics; data for some causes in some age groups are omitted due to low numbers/unreliability of the data.

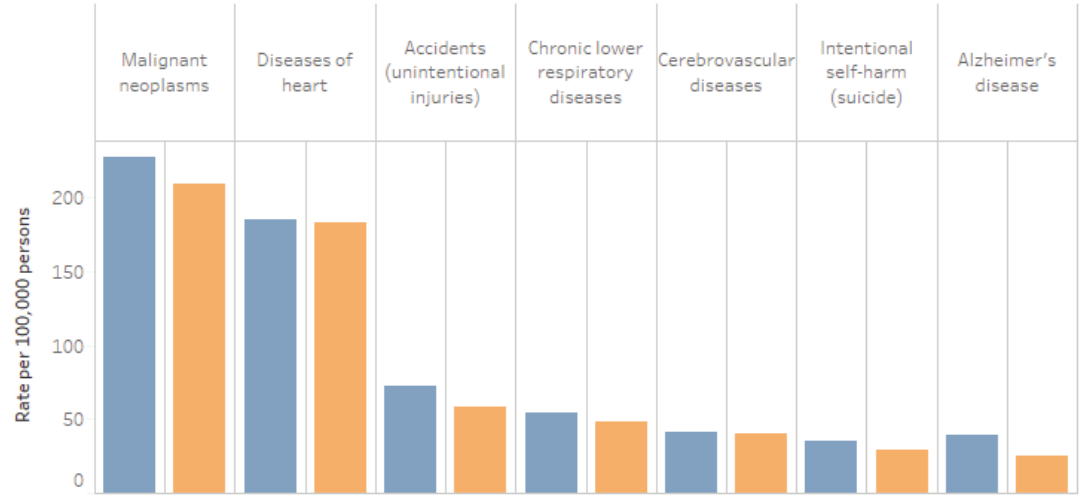
Deaths

Life E.. | Premature Death | Leading Causes of Death by Age | **Leading Causes of Death by Sex** | Suicide Rate | Infant Mortality

Leading Causes of Death by Sex

Rate per 100,000 persons by sex in Lane County and Oregon.

Group
Male



Year
2013 - 2017

Lane County has compareable rates of the leading causes of death by sex to the state as a whole. While the rates of death vary slightly by sex, the top five causes are the same.

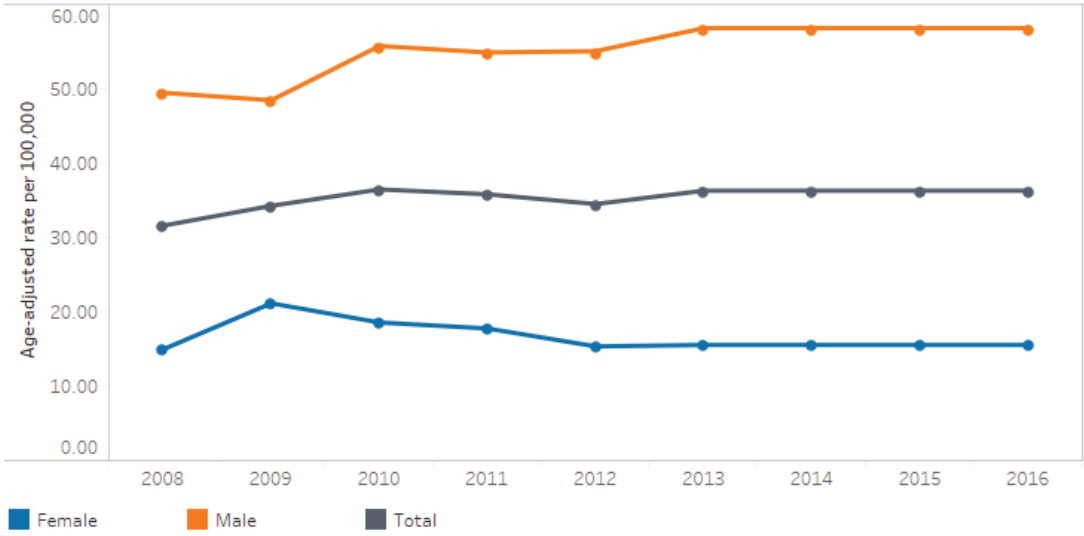
Source: Oregon Center for Health Statistics

Deaths

Life E.. | Premature Death | Leading Causes of Death by Age | Leading Causes of Death by Sex | **Suicide Rate** | Infant Mortality

Suicide Rate

Rate per 100,000 persons by sex in Lane County



Suicide, a death resulting from the intentional use of force against oneself, is one of Lane County's most persistent yet largely preventable public health problems. Suicide rates in Lane County have been consistently higher than the U.S. for the past 30 years. Suicide affects survivors and entire communities, and the effects are devastating and long lasting. It is one of the most persistent public health concerns for our state and county.

Source: Oregon Center for Health Statistics; for a more in-depth report on suicide in Lane County:
https://www.lanecounty.org/cms/One.aspx?portalId=3585881&pageId=12971841

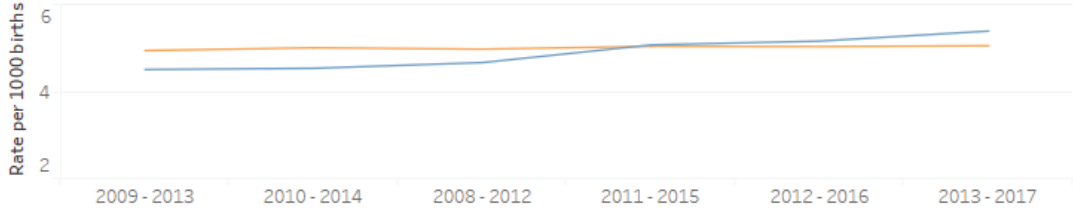
Deaths

Life E.. | Premature Death | Leading Causes of Death by Age | Leading Causes of Death by Sex | Suicide Rate | **Infant Mortality**

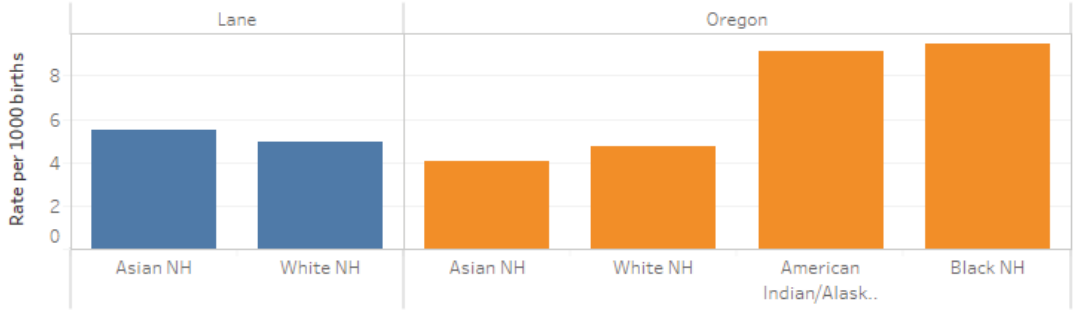
Infant Mortality

Region: Lane, Oregon Race/Ethni.. Multiple values

Infant Mortality: 5-year rolling average



Total Infant Mortality by Race/Ethnicity: 2008-2017



Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy.

Source: Oregon Center for Health Statistics; NOTE: rates for some groups are suppressed due to low numbers/unreliability of the data

Lane County Health Equity Report 2020

This report is best viewed on the website, which can be accessed via www.livehealthylane.org

Lane County Health Equity Report 2020

Next

Health disparities are the differences in health outcomes or other health-related behaviors between population groups. Health inequities are differences that are avoidable and unjust. Health inequities are rooted in unjust social conditions that make some populations more vulnerable to poor health outcomes. Like the rest of the country, Lane County has a history of systematically disadvantaging certain populations based on race that has led to inequities in health outcomes, health behaviors, and the social determinants of health.

This report presents data disaggregated by race, ethnicity, immigration, and disability status from various sources in order to better understand how different communities in Lane County are experiencing health and the social determinants of health. This report is intended as an update to the 2017 report on health disparities (https://bit.ly/2Rl6R2d) while informing the development of Lane County's 2020 Community Health Improvement Plan (CHP), a collaborative effort by Live Healthy Lane (see http://www.livehealthylane.org for more information). In addition, indicators in this report may be useful for monitoring progress on reducing inequities in Lane County.

Although every effort has been made to collect accurate information, the data in this report have several limitations. The most significant limitation is that numbers cannot tell the whole story. The numbers in this report indicate that many people in our county face enormous barriers to optimal health, but these numbers cannot tell the story of the strength and resilience of many communities in the face of such challenges. The numbers cannot tell the story of why or how barriers came to be. They do not tell us about the institutions built by a nation, state, and county with a racist past. There are communities and populations that are not represented in the data here, specifically gender identity and sexual orientation. Therefore these data cannot tell us about the intersections of multiple identities of the people in Lane County. Finally, due to limitations on how these data are collected and from whom the data are collected, it may not accurately represent the experiences of the populations indicated.

Despite these limitations, these data are presented here as the best information currently available on health risk factors, health conditions, and the social determinants of health for certain populations in Lane County.

About the data

PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

Lane County Health Equity Report 2020: **Key findings**

The health inequities that exist in Lane County are deep, pervasive, and a direct result of a racist history and the systems built on racist principles. The systematic oppression of Black, Indigenous, People of Color (BIPOC) communities has perpetuated generational poverty, higher rates of trauma, and chronic stress that lead to the poor health outcomes we see today.

The data in this report show higher rates of **poverty**, lower **median income**, and fewer **educational opportunities** for people of races/ethnicities that have born the brunt of racist policies and practices. The impacts of racist policies on the social determinants of health lead to more **risk behaviors** (such as tobacco and binge drinking) and reduced access/utilization of **health care services**. This, in turn, results in higher rates of **disease** and increased **mortality**.

The data in this report are not complete. Due to limitations, the data reported here cannot tell the story of intersectionality. Gender identity, sexual orientation, disability, race, and ethnicity are all various aspects of every person in Lane County, and the available data have gaps in how these various identities interact and intersect.

The data in this report cannot tell the story of people's resilience in the face of structural and cultural barriers, nor can the data tell the story of community building and the resulting cultural and spiritual assets that help people overcome the many obstacles to good health.

The story told by these data has long been known to the communities experiencing inequities; this is not a new story. To change this story we need to make fundamental changes to the structures and institutions that create these inequities. This report is neither the beginning nor the end of oppressive systems that advantage some people over others. To create better health in Lane County for everyone, this report needs to become one of many tools used to deepen engagement with communities experiencing inequities, better learn their stories, and work collaboratively to dismantle the structures and systems that created these inequities.

LiveHealthy LANE

Introduction

Health outcomes

Health behaviors

Social determinants

About the data

How to navigate this report:
Each tab above links to a section that corresponds to sections of the Community Health Status Assessment. Each section contains a set of indicators. Navigate to the section to see an overview of the **indicator dashboards.** To move from one dashboard to another, you can click on Next, Previous or come back to the main page for that section.

PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

Lane County Health Equity Report - 2020: **Health outcomes**

Leading causes of death | Chronic diseases | Infectious diseases | Health status

When most people think about health data, health outcome data are what comes to mind. These are the end results of living in certain kinds of environments and engaging in some behaviors. In Lane County, there are significant disparities in health outcomes depending on your race, ethnicity, and disability status. There are also likely disparities based on gender identity and sexual orientation, however, we do not have sufficient data to say that for sure.

The data in this report suggest the following inequities in health outcomes:

Among the **leading causes of death** in Lane County, cancer deaths impact the Black and Pacific Islander populations at higher rates than any other race/ethnicity, and heart disease causes more deaths in the Native American, Black, and Pacific Islander communities.

Among **chronic conditions**, asthma and diabetes occur at higher rates in the Native American and Black populations. Obesity rates are highest among Native American and Latinx peoples.

When it comes to **infectious diseases**, the Asian community has the highest rates of vaccine-preventable infections, while the Black community experiences the highest rates of sexually transmitted infections.

Asian and white communities report the highest rates of overall good **physical and mental health**.

When compared to those who do not report having a disability, **people with disabilities** report higher rates of poor mental health days, depression, obesity, and asthma.

Use the **green** tabs above to view the data.

Introduction

Key findings

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Leading causes of death

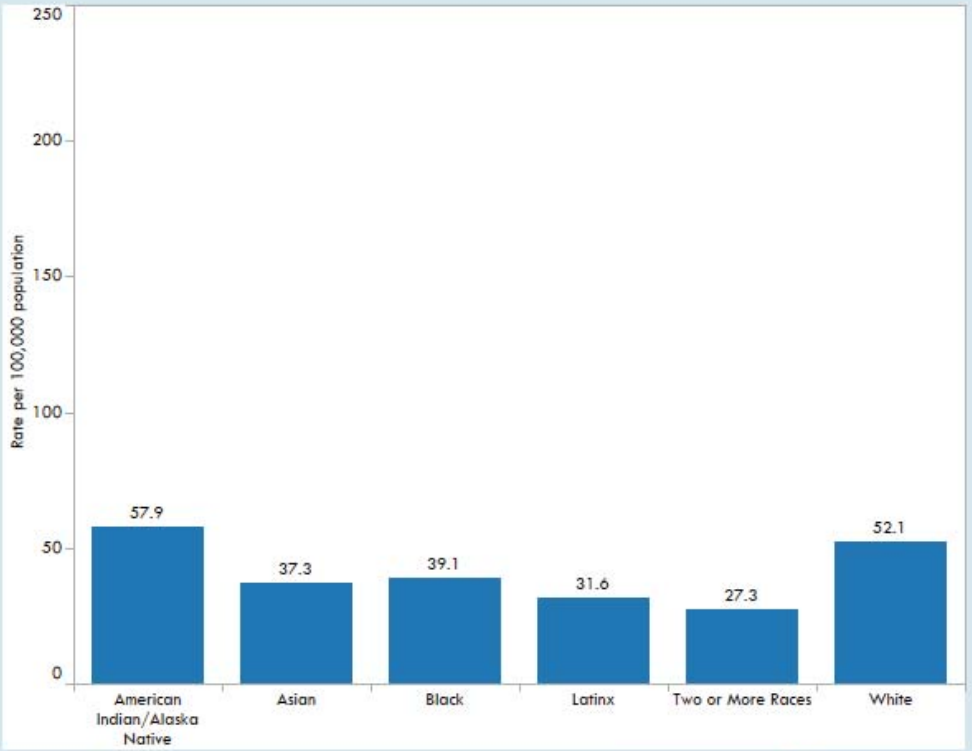
Select cause of death
Accidents (unintentional injuries)

Use the drop-down menu above the graph to select a cause of death and see the rate for each population.

The top 5 leading causes of death in Lane County between 2009-2018 are:
1. Cancer
2. Heart disease
3. Accidents (unintentional injuries)
4. Chronic lower respiratory diseases
5. Alzheimer's disease

Tobacco-related deaths are of particular concern because the tobacco industry is known to target certain populations, including Black communities and people who identify as LGBTQ.

Source: ORCHS 2009-2018; note that some racial/ethnic groups may be excluded due to small numbers



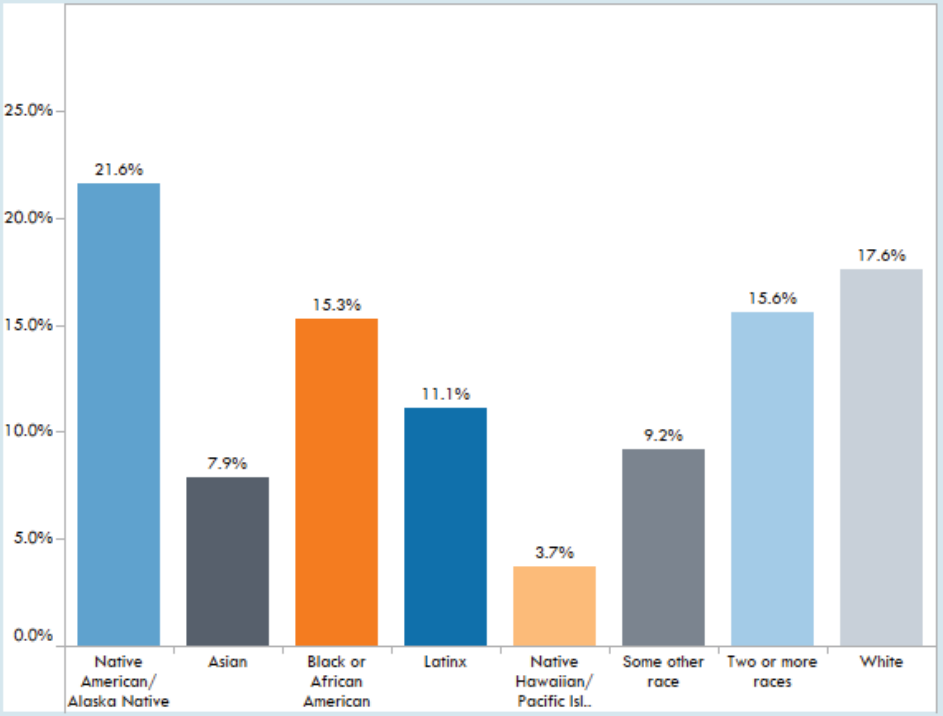
Health Outcomes | Key findings | Previous | Next

Percent of adult population reporting a disability by race/ethnicity

The racial/ethnic breakdown of Lane County's population living with a disability is provided as a reference as several social determinants of health indicators are presented by whether or not respondents indicated they had a disability.

Unfortunately, it is not possible to examine the intersection of race and disability in the data currently available. It is clear that there is disproportionate representation of several races among Lane County's population living with disabilities.

Source: ACS 2013-2017



Health outcomes | Key findings | Navigation | Previous | Next

Chronic conditions

Survey participants are asked if they have ever been told by a health professional that they have one of the following conditions.
Overweight and obesisty rates are calculated based on self-reported height and weight.

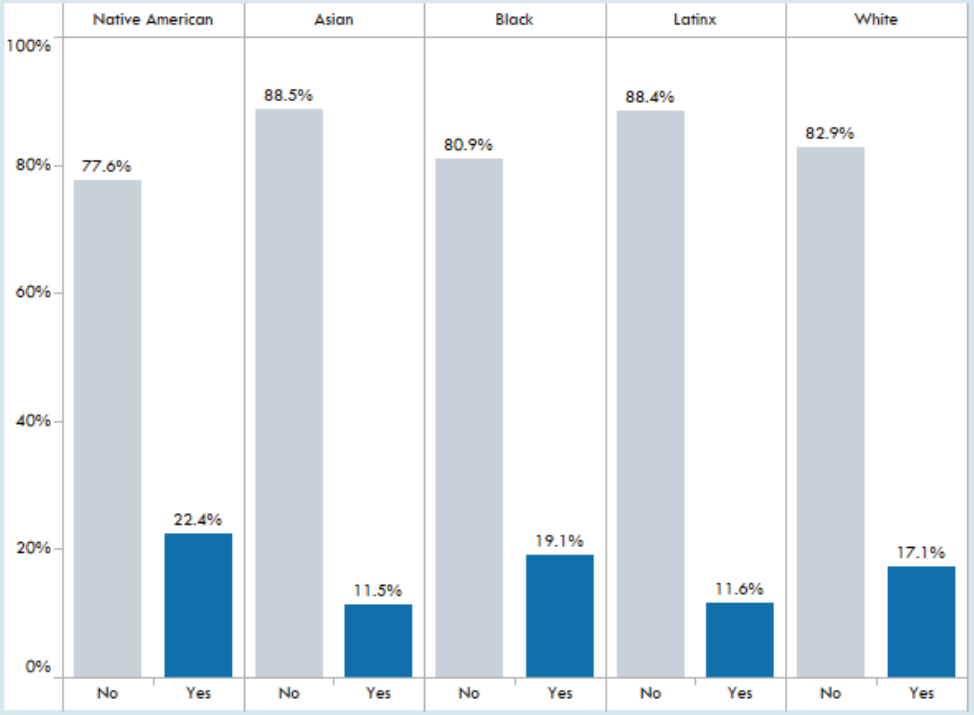
Chronic health conditions can lead to disability and/or death if not well-managed. They are often the result of a combination of environmental factors, risky behaviors and some genetic factors.

Obesity is a risk factor in several chronic illnesses (e.g., diabetes) as well as classified as a chronic condition on its own. Using BMI to determine obesity is imperfect and should not be used to diagnose obesity in the absence of other risk factors. At the population level, it can give us a glimpse into populations that are at risk.

Use the drop-down menu above the graph to select different chronic conditions.

Source: Oregon's Behavioral Risk Factor Surveillance System (BRFSS) 2017 survey from Lane and Benton Counties

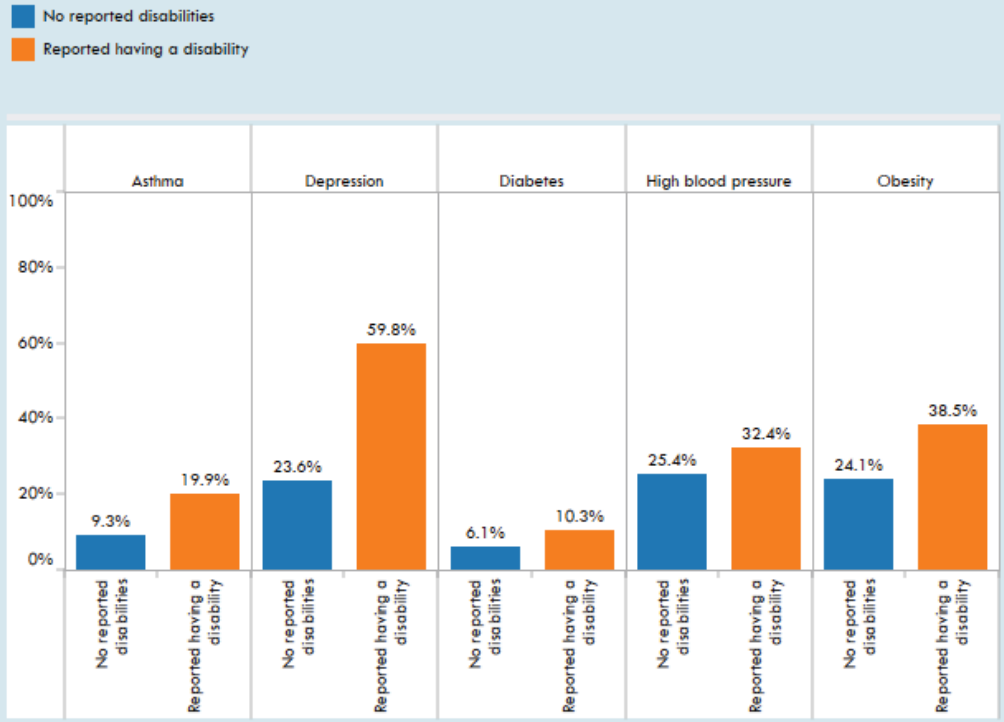
Select a condition
Asthma



Health outcomes | Key findings | Previous | Next

Chronic conditions by disability

Survey participants are asked if they have ever been told by a health professional that they have one of the following conditions. Overweight and obesisty rates are calculated based on self-reported height and weight.



In Lane County, people who report having a disability tend to also report having a chronic condition more often than those who do not have a disability.

Source: ORBRFSS 2013-2017

Health outcomes | Key findings | Previous | Next

Infectious diseases: Vaccine preventable

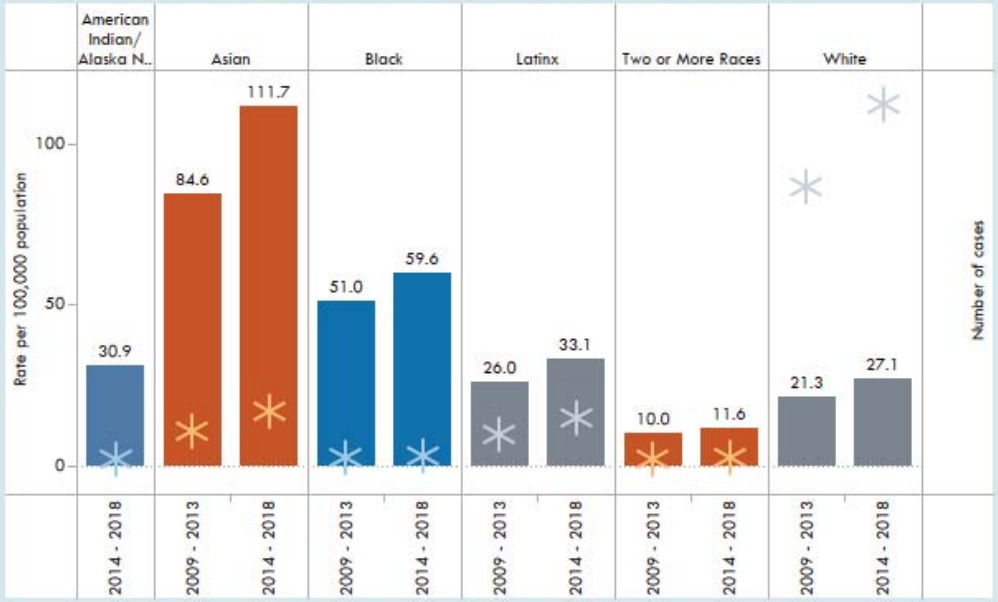
Rate per 100,000 population (**bars**) with total number of cases (*)
Races/ethnicities with fewer than 5 cases are not shown

Even though there are more cases of vaccine preventable diseases overall (*) in the white population, people who identify as Asian or Black experience higher rates of these diseases in their communities.

Use the <> arrow buttons (top) to navigate to data on sexually transmitted diseases

Source: ORCHS 2009-2018

Vaccine preventable diseases include: Haemophilus influenzae (Flu), Hepatitis A , Hepatitis B (acute) , Hepatitis B (chronic), Meningococcal disease, Mumps, and Pertussis (whooping cough)



Health Outcomes | Key findings | Previous | Next

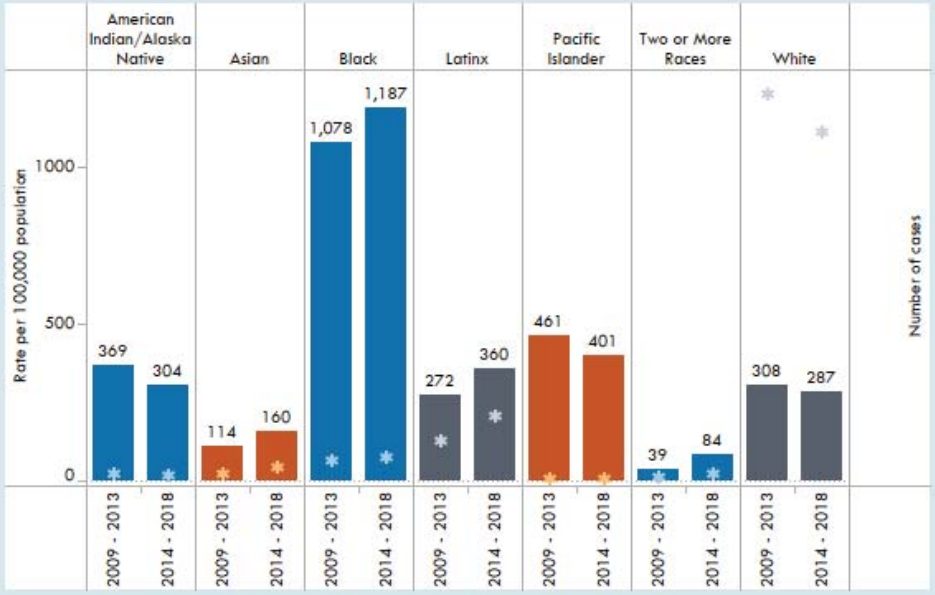
Infectious disease: Sexually transmitted infections

Rate per 100,000 population (**bars**) with total number of cases (*)
Races/ethnicities with fewer than 5 cases are not shown

Choose type: Chlamydia

Despite the majority of sexually transmitted infection occuring in the white population of Lane County, the overall impact tends to be greater in BIPOC communities, particularly among those who identify as Black or Pacific Islander.

Use drop-down menu to choose infection type



Use the <> arrow buttons (top) to navigate to data on vaccine-preventable diseases

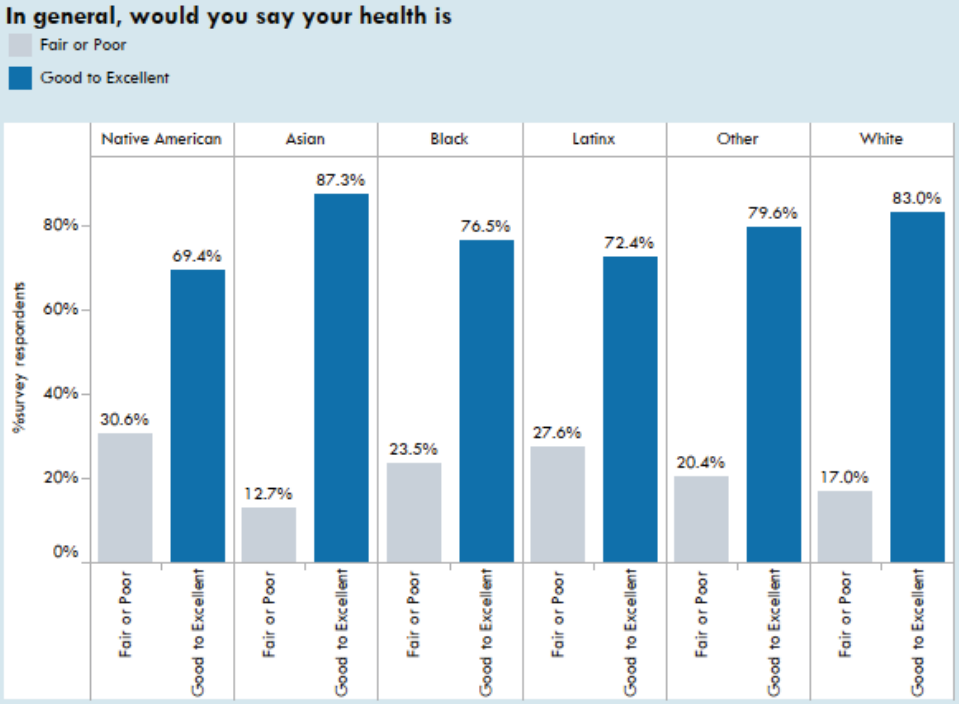
BIPOC = Black, Indigenous, People of Color

Source: ORCHS 2009-2018

Health status: general health

People who identify as white or Asian are the most likely to report their general health as good or excellent, while people who identify as Native American or Latinx are more likely to report their general health as fair or poor.

Source: ORBRFSS 2017 for Lane and Benton counties



Health Outcomes | Key findings | Previous | Next

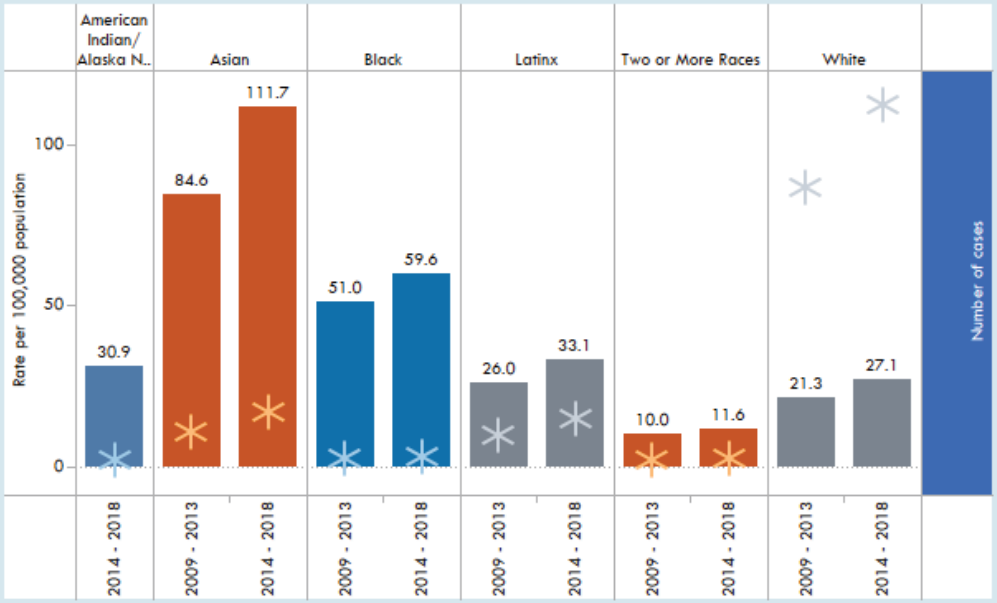
Infectious diseases: Vaccine preventable

Rate per 100,000 population (**bars**) with total number of cases (*)

Races/ethnicities with fewer than 5 cases are not shown

text

Vaccine preventable diseases include: Haemophilus influenzae (Flu), Hepatitis A , Hepatitis B (acute) , Hepatitis B (chronic), Meningococcal disease, Mumps, and Pertussis (whooping cough)



Health Outcomes | Key findings | Previous | Next

Infectious disease: Sexually transmitted infections

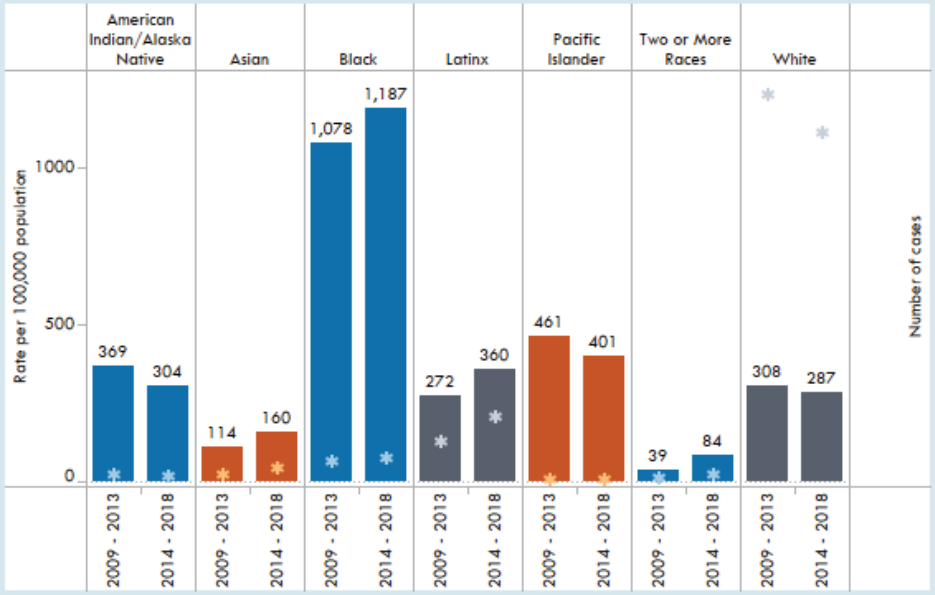
Rate per 100,000 population (**bars**) with total number of cases (*)

Races/ethnicities with fewer than 5 cases are not shown

Choose type: Chlamydia

Adding a text box for descriptions...

Use drop-down menu to choose infection type



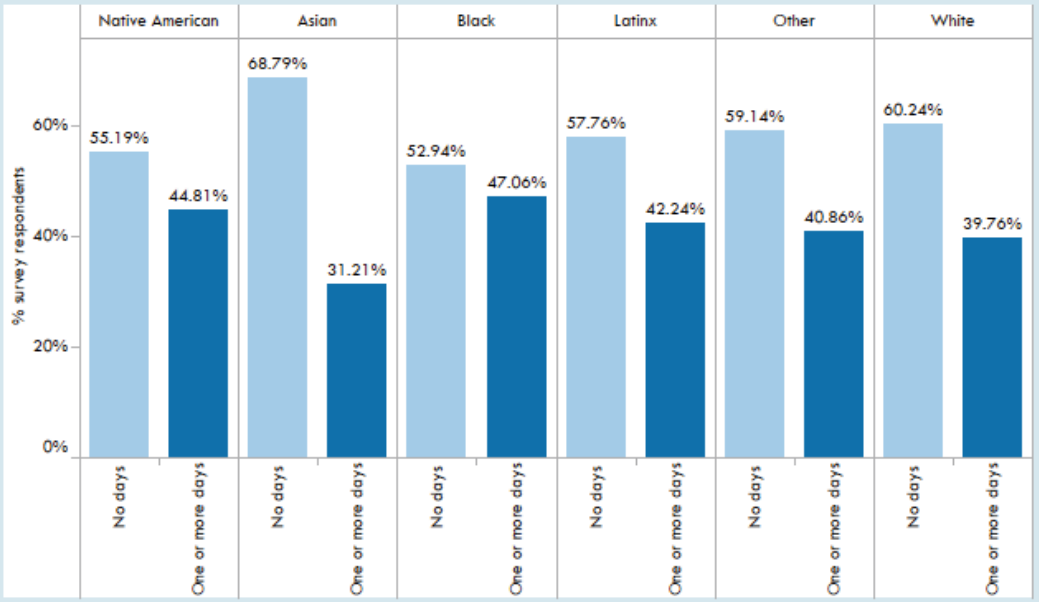
Health Outcomes | Key findings | Previous | Next

Health status: mental health

People who identify as Asian are more likely to report no days of poor mental health than people of any other race/ethnicity.

Source: ORBRFSS 2017 for Lane and Benton counties

How many days in the past 30 was your mental health 'not good'?



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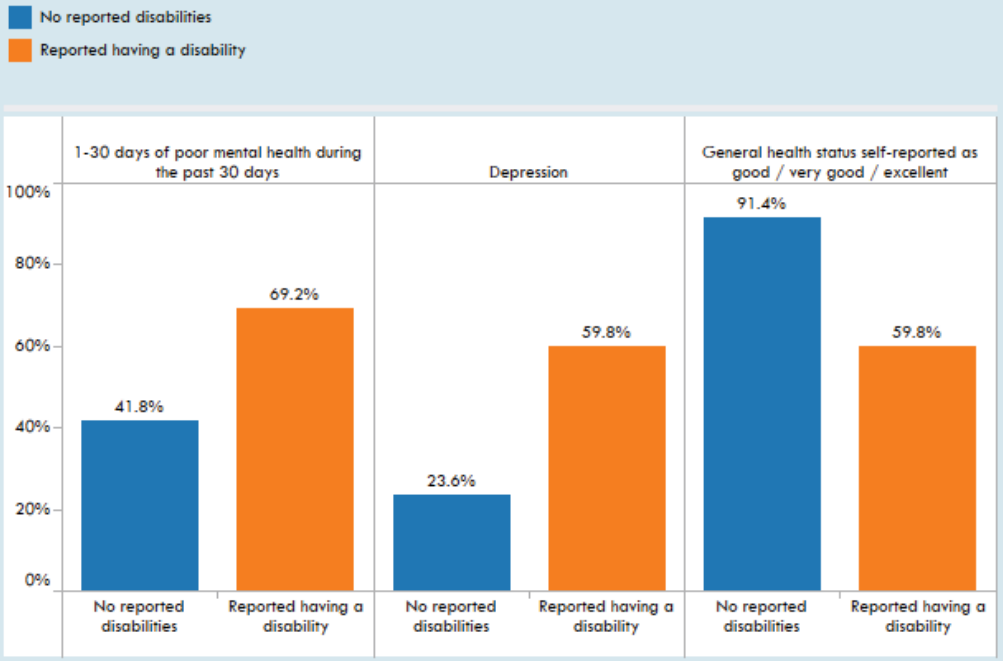
Health status by disability



In Lane County, people who reported having a disability were more likely to report poor general health and more days of poor mental health than those without a disability.

People with a disability are more than twice as likely to have have ever been diagnosed with depression compared to those without a disability.

Source: ORBRFSS 2013-2017

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Lane County Health Equity Report 2020: **Health behaviors**

Accessing care | Risk behaviors

Introduction | Key findings | Health outcomes | Social determinants | About the data

Health behaviors are a big part of what determines health outcomes. For this report, behaviors are divided into two categories: accessing health care and behaviors that are risky to our health.

Accessing health care, such as **routine check-ups** (i.e., seeing a primary care provider) and **dental check-ups**, is important to maintaining good health. Catching potential health problems early can be beneficial to ensuring better outcomes. In Lane County, people who identify as Asian or Latinx are less likely to have had a routine check-up in the past year. People of all races/ethnicities saw a dentist at similar rates, but people who reported having a disability were slightly less likely to have seen a dentist in the past year.

Adequate prenatal care is essential to improving outcomes for both mother and baby. People who identify as Native American or Black were slightly less likely to have gotten adequate prenatal care in Lane County.

One action people in Lane County can take to protect their health is to get an annual **flu shot**. People who reported having a disability and people who identify as Black were least likely to have had a flu shot in the last year.

Certain behaviors can create risks for poor health outcomes. **Using tobacco** and **binge drinking** are two behaviors that pose known risks to lifelong health. People who identify as white were most likely to have reported drinking alcohol in the last 30 days, but people who identify as Native American were more likely to have engaged in binge drinking compared to other races/ethnicities. People who identify as Native American or Black report the highest rates of daily smoking compared to other races.

In Lane County, people who reported having a disability used tobacco and marijuana at higher rates than those who do not report having a disbility, but reported binge drinking at a lower rate.

Tobacco use during pregnancy creates risks for both mother and baby. In Lane County, people who identify as Black or Two or more races reported the highest rates of tobacco use in pregnancy.

Use the green tabs above to navigate to the data.

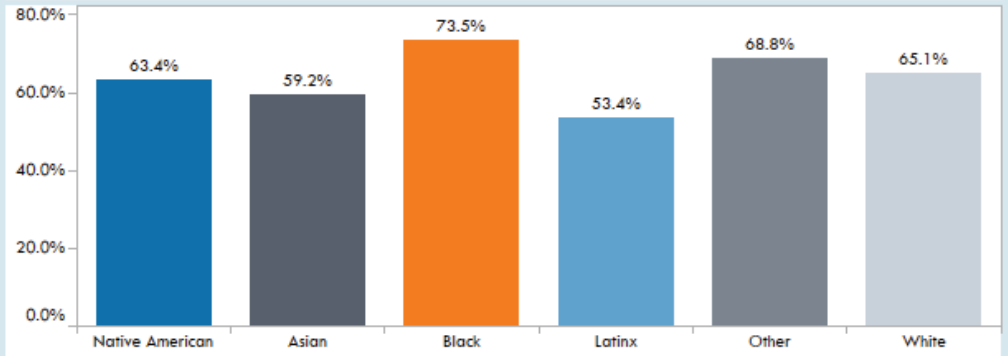
How to navigate this report:
Each tab above links to a section that corresponds to sections of the Community Health Assessment. Each section contains a set of indicators. Navigate to the section to see an overview of the **indicator dashboards**. To move from one dashboard to another, you can click on **Next**, **Previous** or come back to the **main page** for that section.

Routine care is important for maintaining good health.

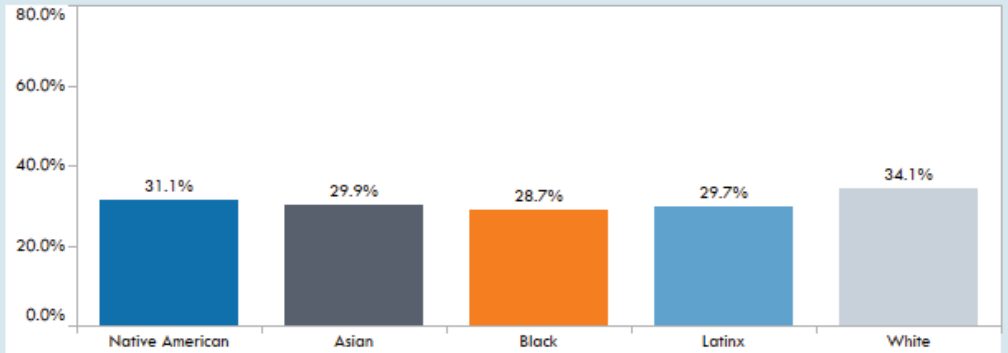
There are slight differences by race for who sees a primary care provider and a dentist regularly, with those who identify as Latinx being the least likely to have sought routine primary care and those who identify as Black being less likely to have sought routine dental care.

Source: ORBRFSS 2017 for Lane and Benton Counties

Had a routine check-up within the past year



Saw a dentist in the past two years



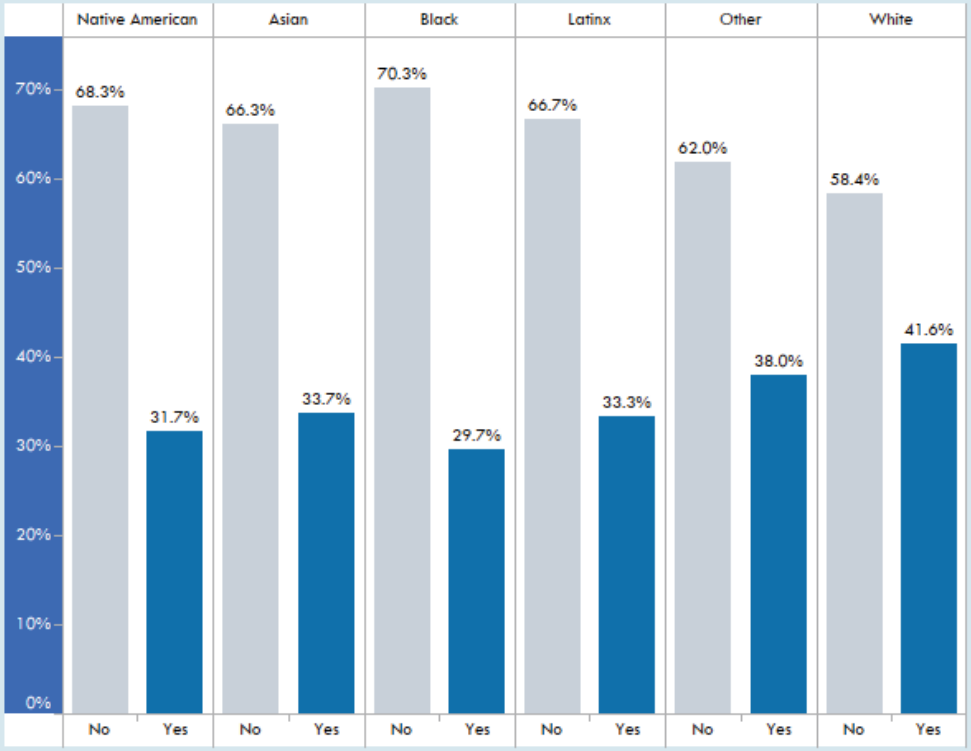
Health behaviors | Key findings | Previous | Next

Adults who got a flu shot in the past year

An annual flu shot is one of the best ways to protect yourself and your family from severe illness during flu season.

People who identify as Black or Native American were less likely to have gotten a flu shot in the past year than people of other races.

Source: ORBRFSS 2017 for Lane and Benton Counties

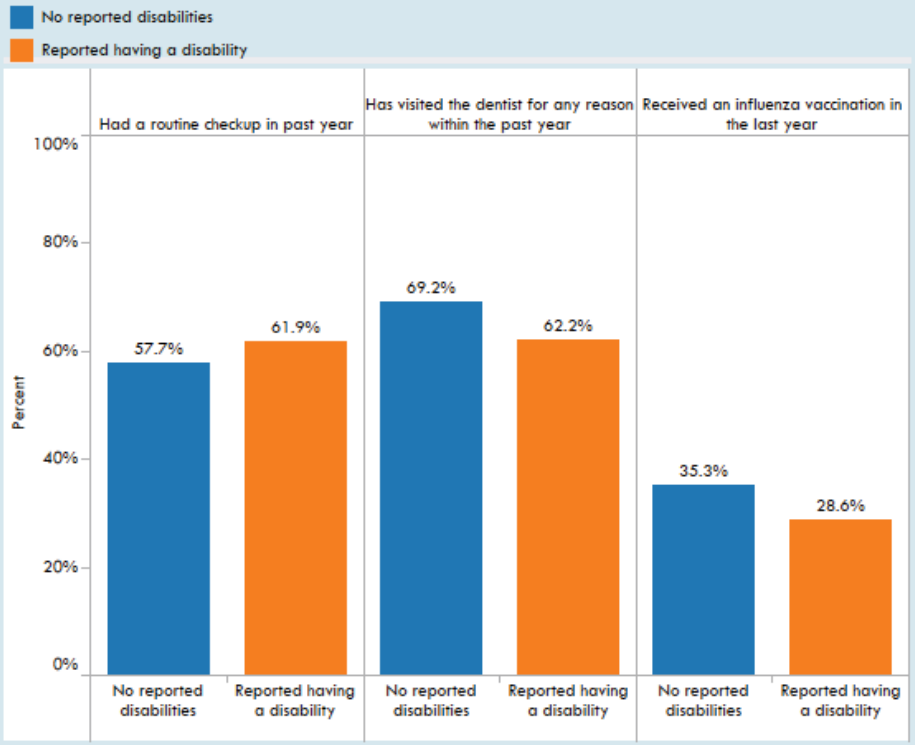


Health behaviors | Key findings | Previous | Next

Accessing care by disability status

Those with a disability were slightly more likely to report having had a routine check-up, but less likely to report having seen a dentist or gotten a flu shot than those who do not have a disability.

Source: ORBRFSS 2014-2017 for Lane County



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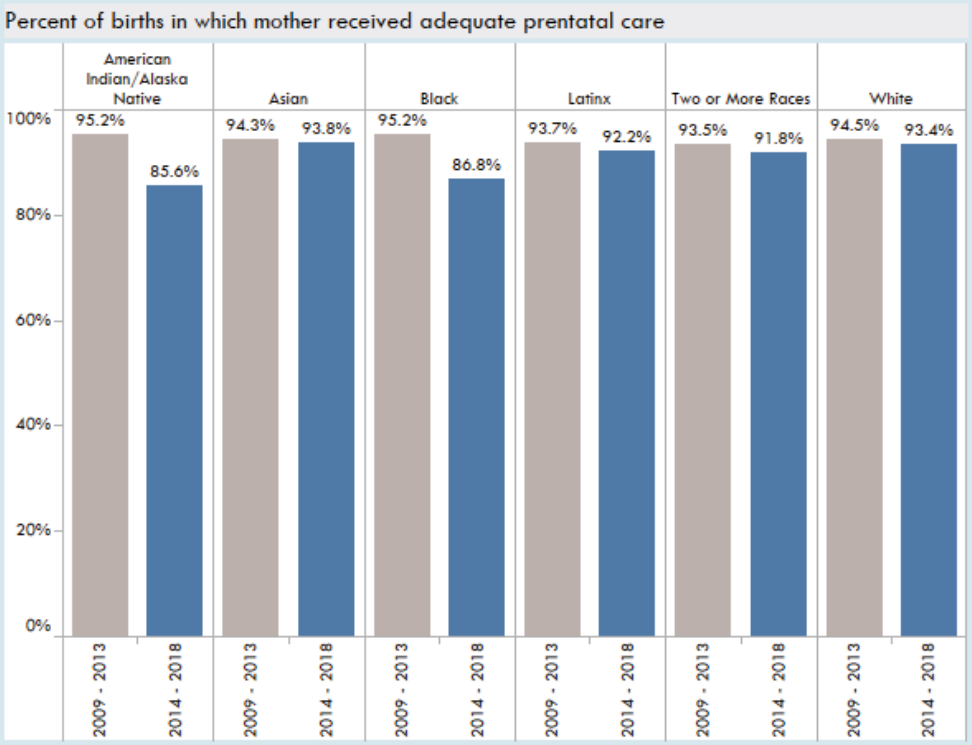
Adequate prenatal care by race/ethnicity

Adequate prenatal care is defined as five or more prenatal care visits starting in 1st or 2nd trimester

Receiving adeqate care during pregnancy is important to birth outcomes. People of all races/ethnicities seem to obtain this care at similar rates in Lane County. However, there appears to be a concerning drop in receiving adequate prenatal care in Native American and Black communities in the most recent five year period (2014-2018).

Source: ORCHS 2009-2018



Health behaviors | Key findings | Previous | Next

Alcohol consumption

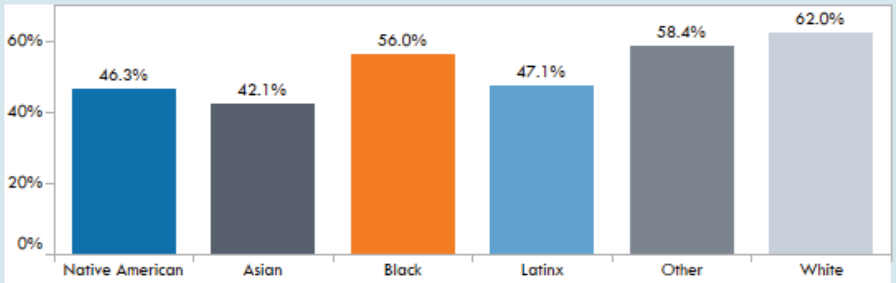
Alcohol consumption has been linked to cancer, liver disease, and other conditions that cause chronic illness or even death. Higher rates of consumption increase the risk.

In Lane County, those who identify as white, Black, or some other race are more likely to have consumed alcohol in the past 30 days. Among those who consume alcohol, those who identify as Native American, other races, and Latinx are more likely to engage in binge drinking.

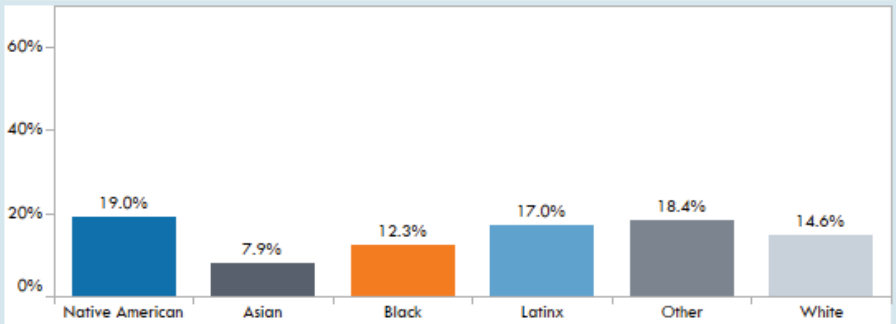
(binge drinking is defined as >5 drinks for a man, >4 drinks for a woman)

Source: ORBRFSS for Lane and Benton counties, 2017

Had an alcoholic drink in the past 30 days



Engaged in binge drinking in the past 30 days



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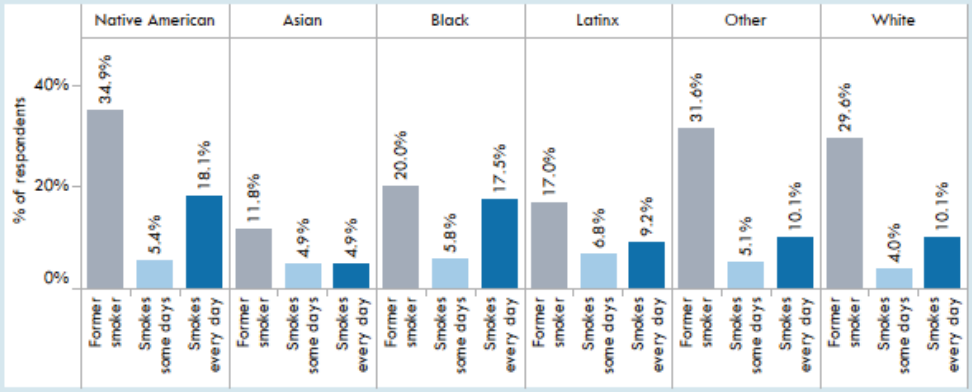
Tobacco use

Tobacco use is the leading cause of preventable death in the United States. Use varies widely by race, with people who identify as Latinx being the least likely to report having used tobacco and those who identify as Native American the most likely.

Sources: adult smoking, ORBRFSS 2017 Lane and Benton counties; tobacco use in pregnancy, ORCHS 2009-2018

Adult Smoking status 2017

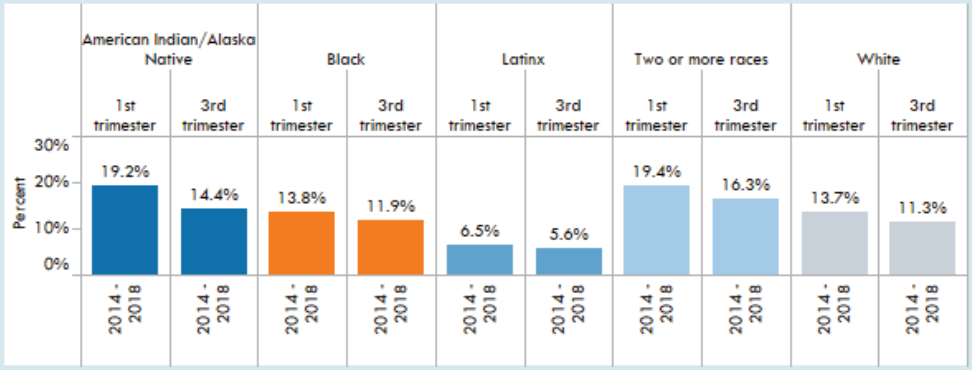


Tobacco use by trimester
Multiple values

Year
2014 - 2018

Use the dropdown menus to see tobacco use during pregnancy by year and to see use in diferent trimesters.

Tobacco use in pregnancy



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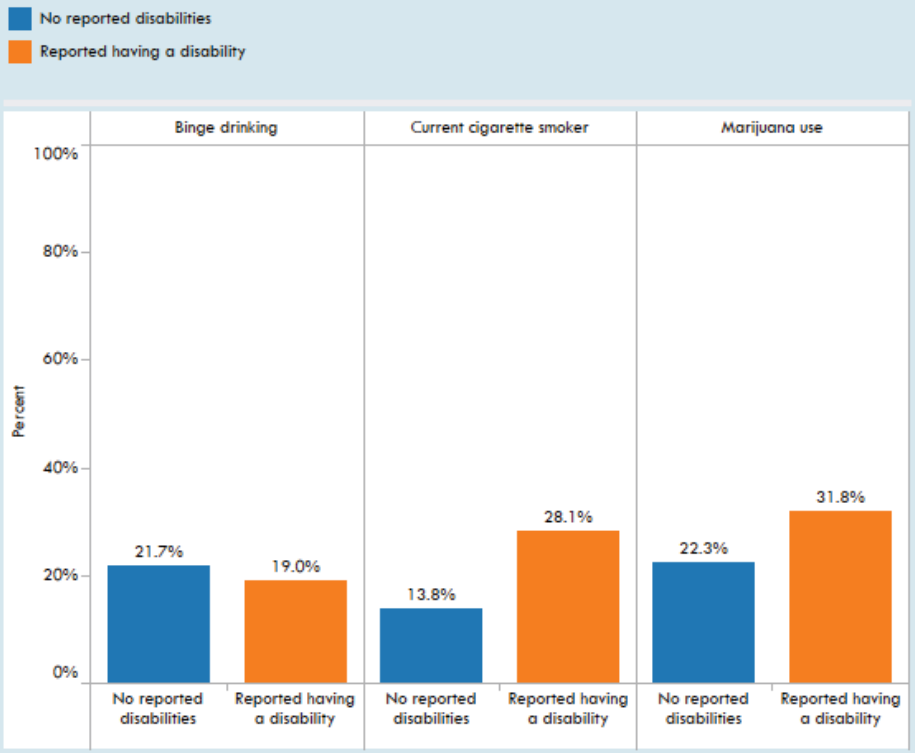
Health risk behaviors by disability

Those who reported having a disability are more likely to be current smokers and/or to have used marijuana in the past 30 days compared to those without a disability. Those without disabilities are slightly more likely to engaged in binge drinking.

(binge drinking is defined as >5 drinks for a man, >4 drinks for a woman)

Source: ORBRFSS 2014-2017 for Lane County



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Lane County Health Equity Report 2020: **Social determinants of health**

LiveHealthy LANE

Education | Economics | Food access

Introduction | Key findings | Health outcomes | Health behaviors | About the data

The social determinants of health are the underlying community conditions that influence health behaviors and health outcomes. Inequities in access to housing, educational opportunities, and jobs contribute to the inequities in health behaviors and health outcomes. The social determinants of health are influenced by the same systems and structures that create and maintain racial inequities in our communities.

On-time high school graduation is both an indicator and a predictor of academic success. Oregon has one of the lowest on-time high school graduation rates in the country, and Lane County's is similar. Asian/Pacific Islander students have the highest on-time graduation rate in Lane County, followed by white students. People who identify as Asian or Black currently have the highest rates of **holding a bachelor's degree or higher** in Lane County.

Median household income tells part of the story of whether or not families can meet basic needs and is often associated with health outcomes. People who identify as Black or Asian currently have the lowest median incomes in Lane County. Not surprisingly, people who identify as Asian or Black also have the highest **rates of poverty**. Immigrants and people who report having a disability also have higher rates of poverty in Lane County.

Owning a home is a common way to accumulate wealth that can be shared with future generations. People who identify as white own their homes at higher rates than any other race/ethnicity and at twice the rate of people who identify as Black in Lane County.

Programs that provide **access to healthy food** for vulnerable populations are important for promoting good health outcomes. While people who identify as Asian experience poverty at higher rates that other racial/ethnic groups in Lane County, they access programs like SNAP and WIC at much lower rates.

Use the green tabs above to navigate to the data.

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LANE COUNTY OREGON PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

On-time high school graduation

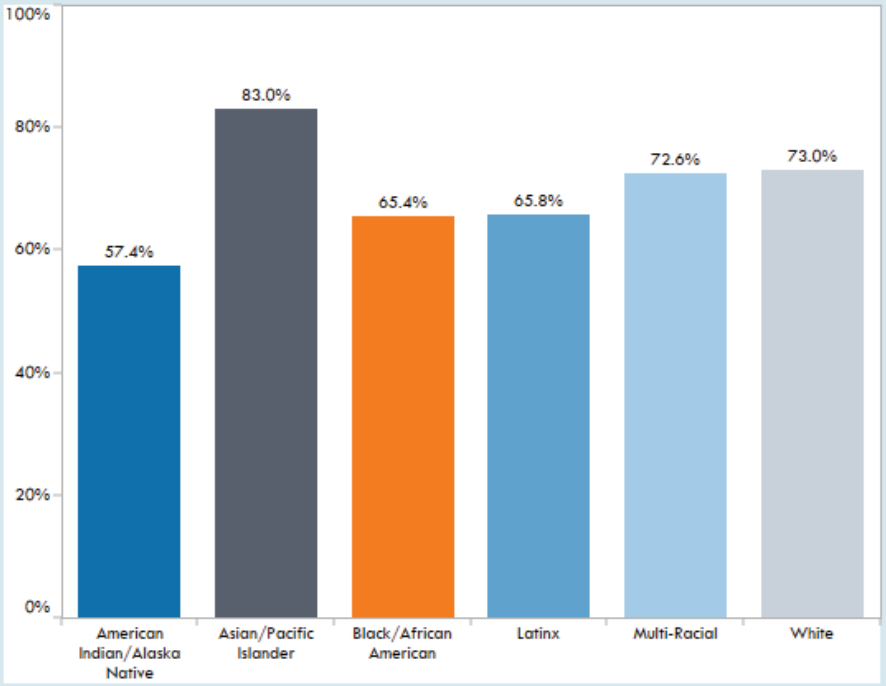
(on-time graduation rate is defined by the percent of students who graduate with their cohort within 4 years of starting high school)

Educational attainment is one of the strongest predictors of lifelong health. Graduating from high school on-time (with a 4-year cohort), is one indicator that demonstrates young people are set up for success.

Native American, Black, and Latinx students have lower rates of on-time graduation compared to other racial/ethnic groups in Lane County.

Source: OR Department of Education; note that race categories may include both individuals who identity as Latinx and those who do not

5-year average, 2013-2018



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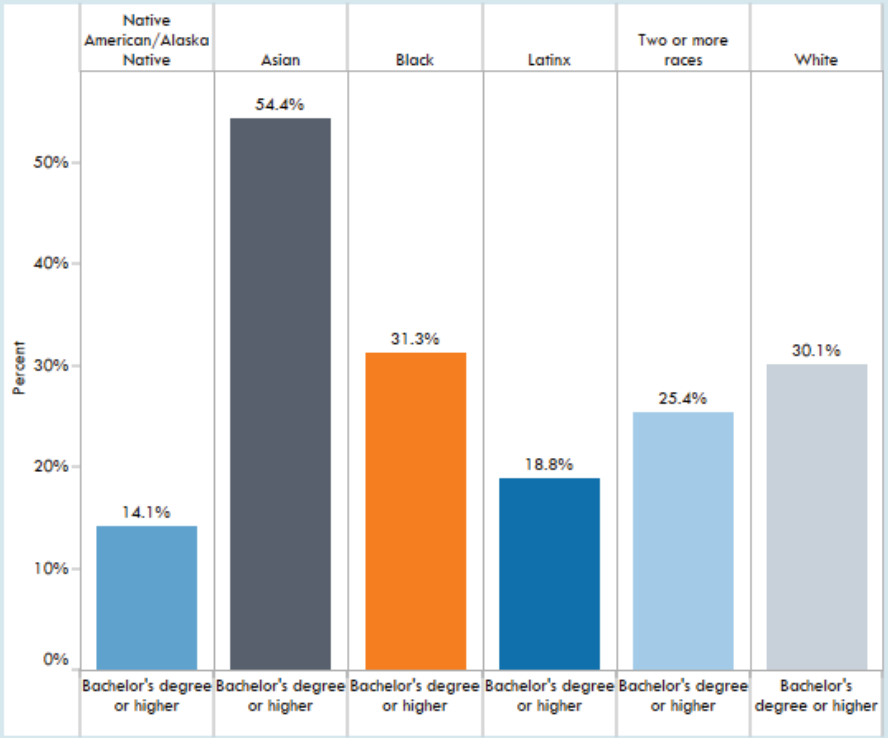
Population with a bachelor's degree or higher

Year
2018

Having a college degree is associated with numerous benefical health outcomes - higher life expectancy, lower rates of risky behaviors, and lower risk of certain diseases.

The percentage of people in Lane County with a bachelor's degree or higher is greater than the national average. However, not all races/ethnicities have similar rates. In Lane County, people who identify as Native Americans or Latinx are less likely to have a college degree when compared to other races/ethnicities. People who identify as Asian are more likely to have a bachelor's degree than any other race/ethnicity.

NOTE: Choose a year from the drop-down menu above to see different 5-year rates
Source: *ACS 2013-2017, ACS 2014-2018*



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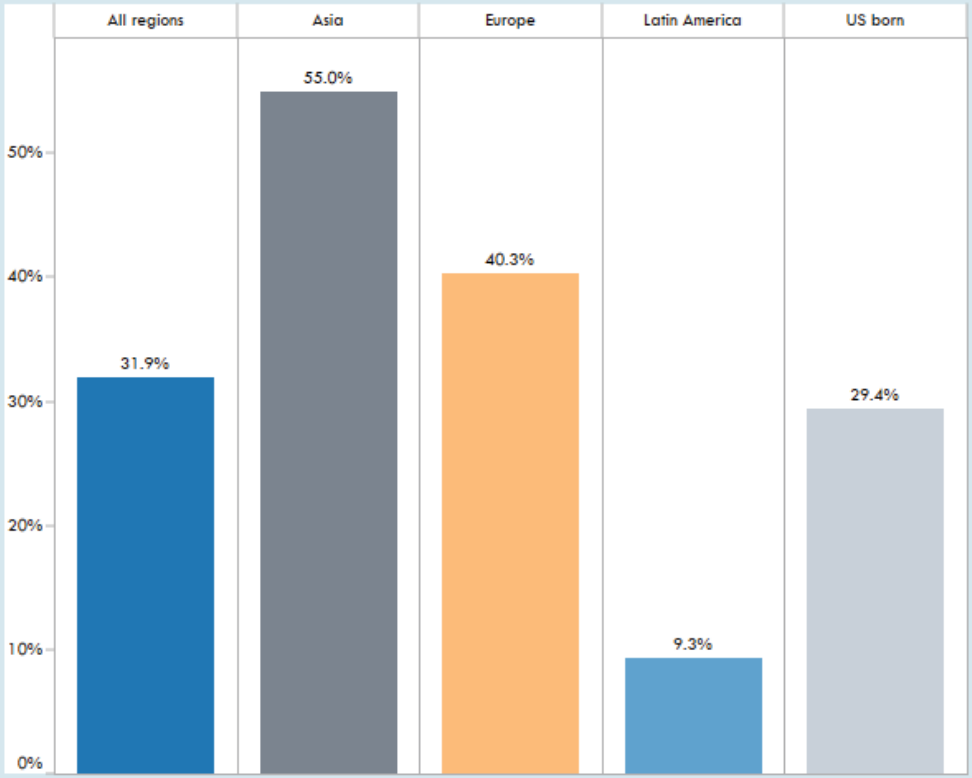
Overall, immigrant populations in Lane County have similar rates of earning a bachelor's degree or higher compared to the county's US born population. However, rates vary quite a bit within the immigrant population depending on region of origin.

Source: ACS 2014-2018

Percent of immigrant population with a college degree or higher by region of origin.



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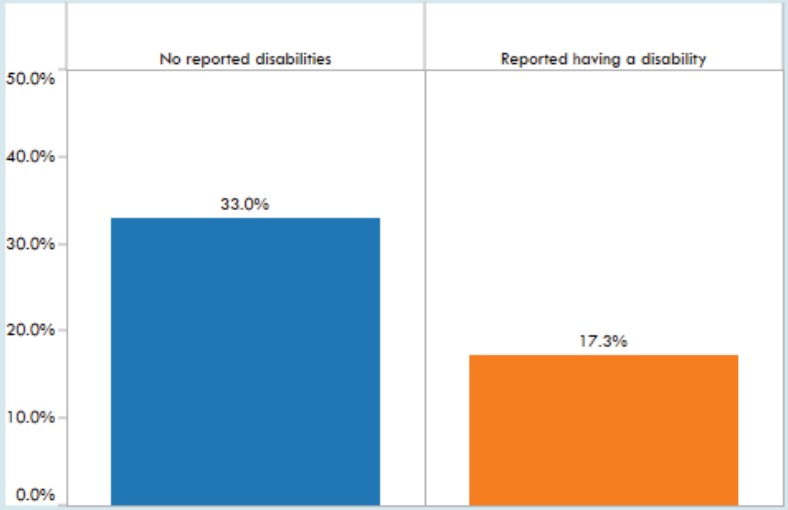
Population with a bachelor's degree by disability status

People who reported not having a disability are almost twice as alikely to earn a bachelor's degree compared to those who reported having a disability.

Source: *ORBRFSS 2014-2017*



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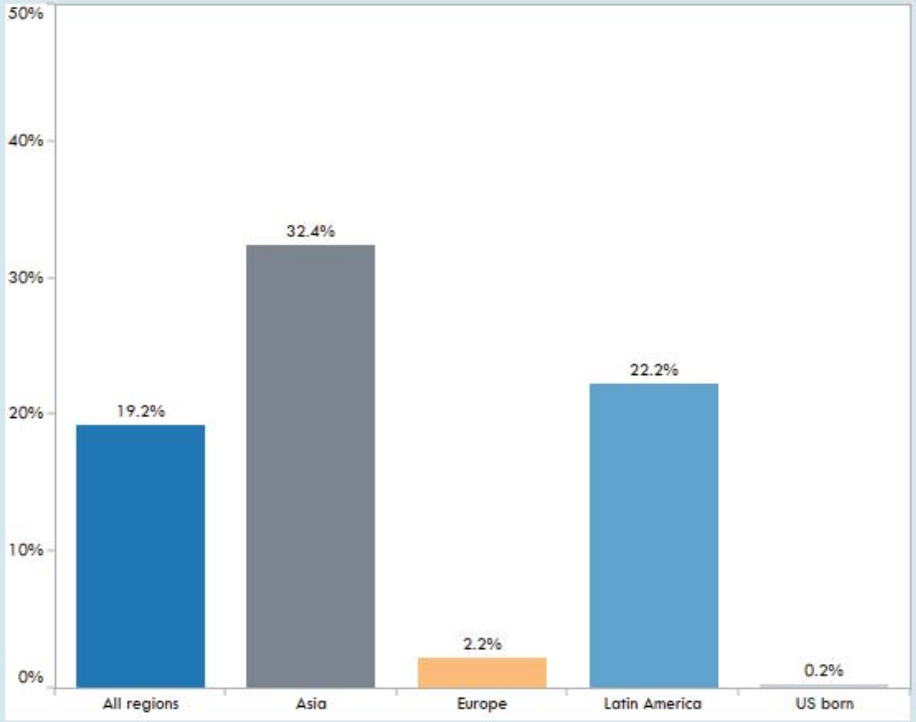
Understanding the extent of English proficiency among Lane County's immigrant population is important to providing services and programs that meet the community's needs. Immigrants from Asia and Latin America are the most likely to need translation services and materials in other languages.

Note that each of these regions hosts many cultures and many different languages, so it is important to assess what languages are most needed by better understanding the clients and participants engaging in a specific programs/servies.

Source: ACS 2014-2018

Percent of immigrant households with limited English skills by region of origin



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Median income

Note: median income is calculated for all households, regardless of size/composition

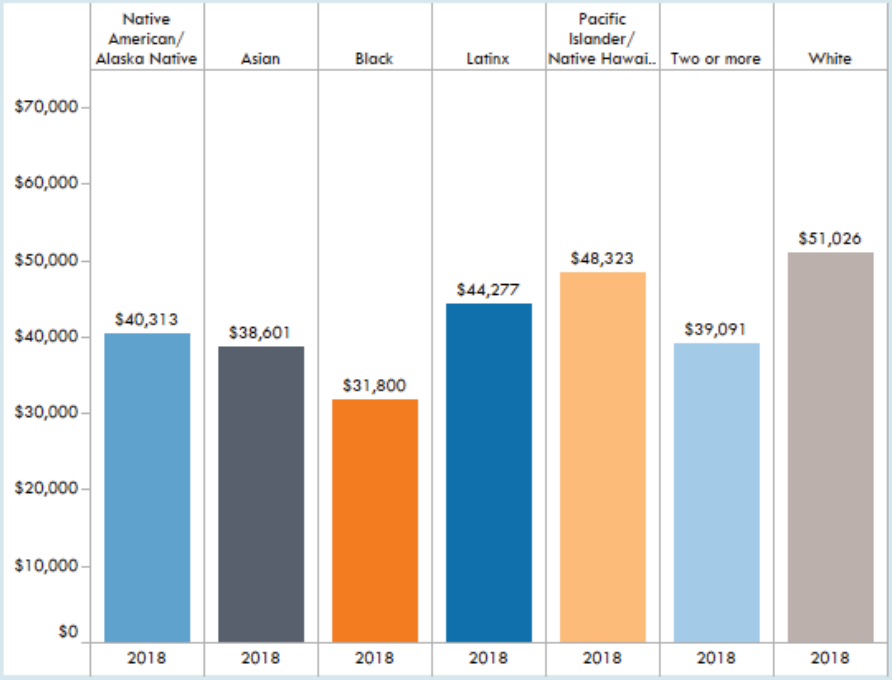
Use the drop-down menu above to select the five-year period ending in the year indicated
2018

Income is often used as an indicator of household financial well-being. When paired with local cost of living, it can be an indicator of which populations are best able to meet basic living costs.

In Lane County, two working adults with two children need an annual income of about $74,000 to meet basic living costs (see https://living-wage.mit.edu/counties/41039).

There are significant disparities in median income between different races/ethnicities in Lane County, with people who identify as Black or Asian currently experiencing the lowest median incomes. Previously, people who idenified as Latinx or Two or more races had the lowest median incomes.

Source: ACS 2006-2010, ACS 2009-2013, ACS 2014-2018



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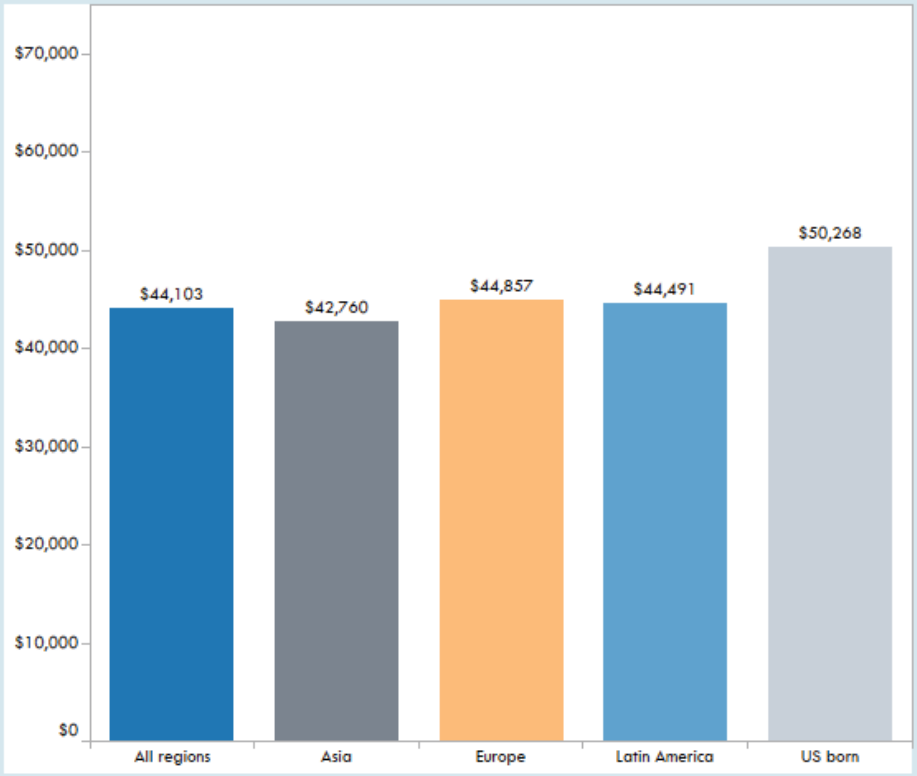
Overall, US born residents in Lane County have a higher median income than immigrant residents. There is not a significant difference in immigrant residents' income based on region of origin.

Source: ACS 2014-2018

Median household income of immigrant households in Lane County by region of origin



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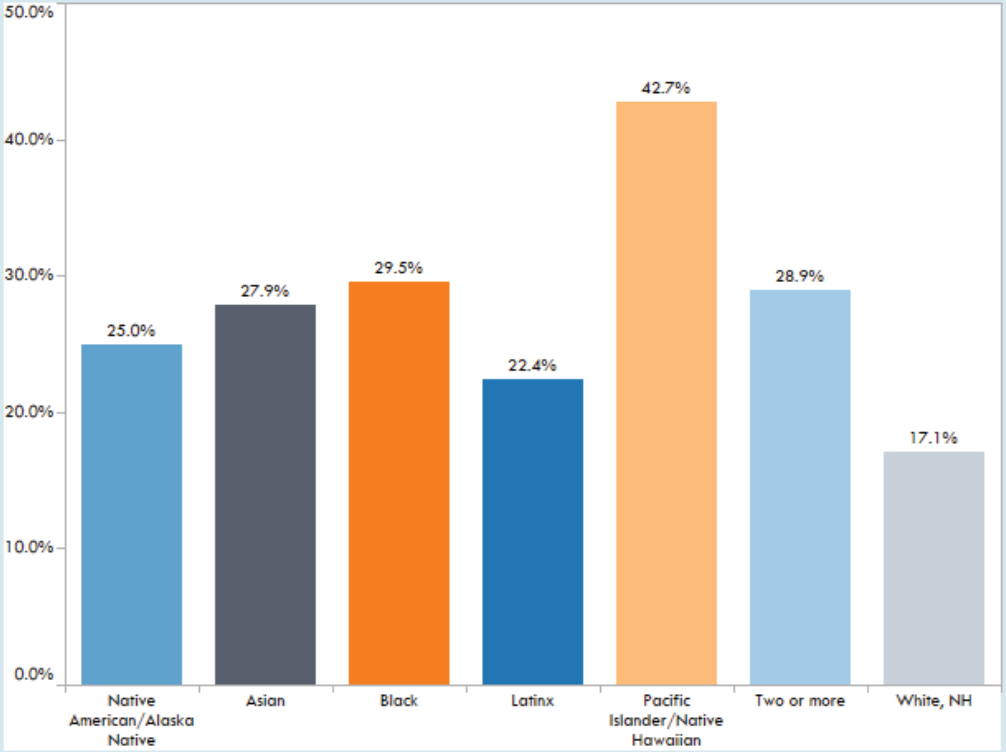
Households experiencing poverty in the last 12 months

Poverty is associated with many poor health outcomes and can be a source of inter-generational trauma that can have health impacts across multiple generations. Overall, Lane County has a higher poverty rate than both the state and the nation as a whole.

In Lane County, households that identify as white experience poverty at a lower rate than any other race or ethnicity. Households that identify as Asian, Black or Pacific Islander consistently have the highest rates of poverty in Lane County.

Source: ACS Community Survey, 5-year estimates 2008-2018

Use the drop-down menu above to select the five-year period ending in the year indicated
2018



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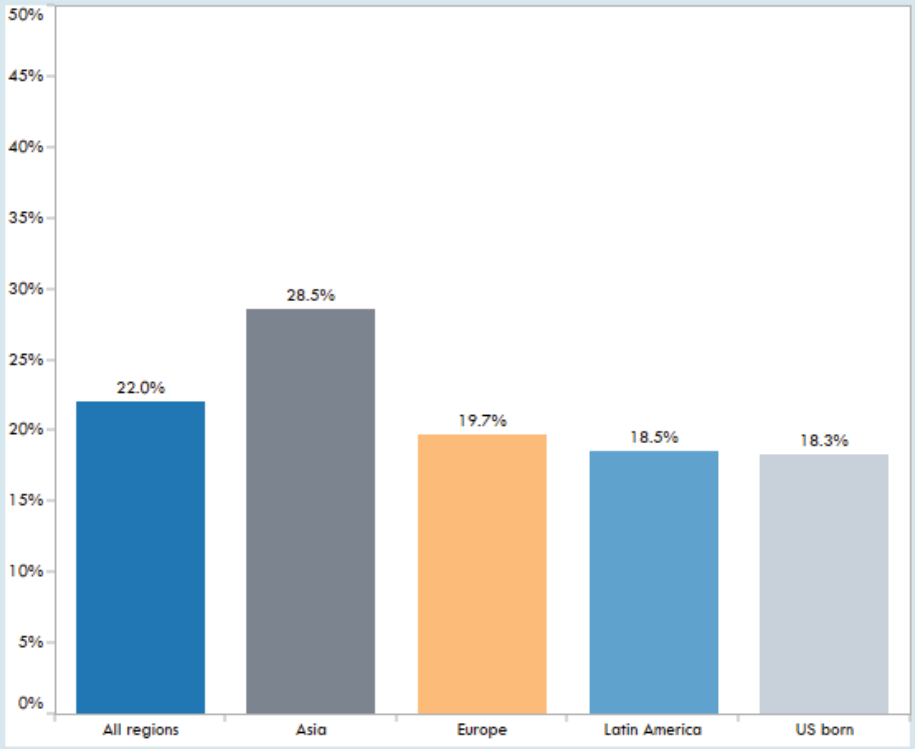
Households that identify as US born experience similar rates of poverty to immigrant households from Europe and Latin America, while immigrant households from Asia experience the highest rate of poverty.

Source: *ACS 2014-2018*

Percent of immigrant households experiencing poverty in last 12 months by region of origin



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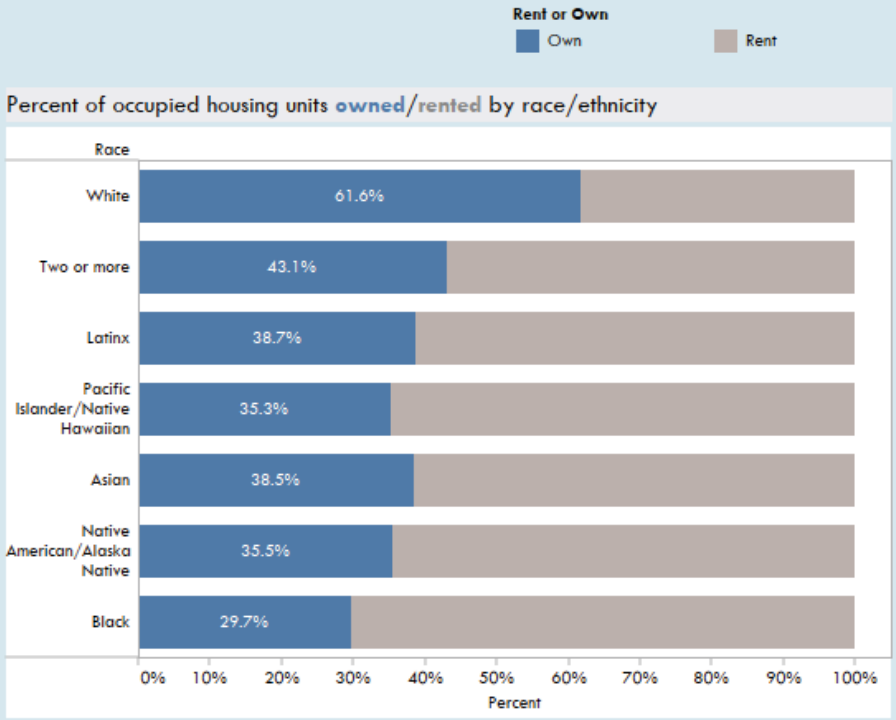
Home ownership is one of the most common sources of intergenerational wealth for families in the US.

The rates of home ownership in Lane County by race are a direct result of racist policies that began with Oregon's founding and continue through today.

Source: ACS 2014-2018



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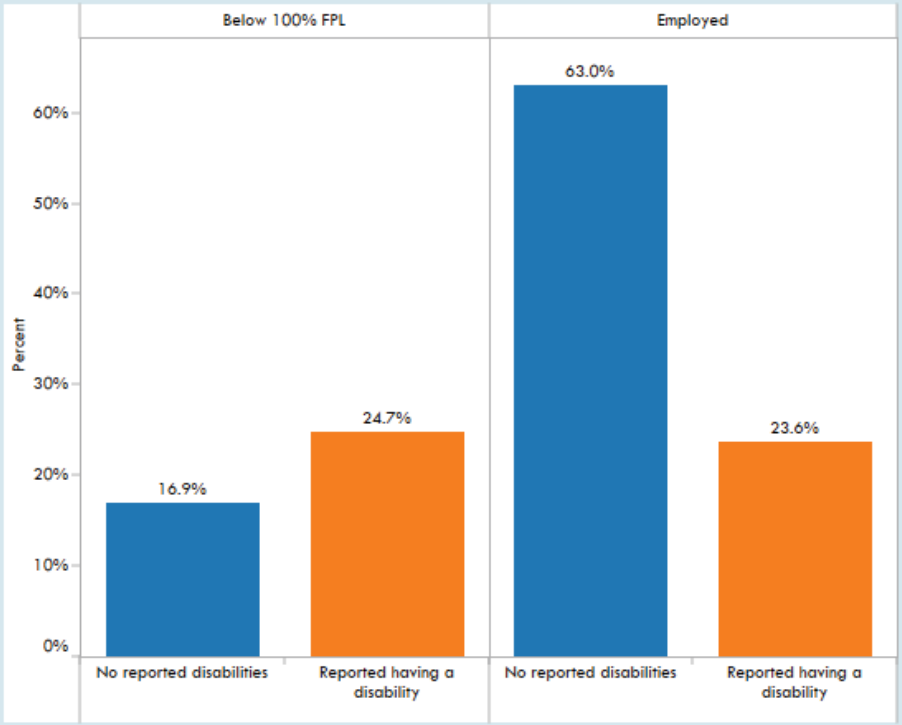
Poverty & employment by disability status

(percent of households at or below 100% of the Federal Poverty Level (FPL) and percent of adult population over age 25 who are employed)

People who reported having a disability have higher rates of poverty and much lower rates of unemployment than people who did not report having a disability.

Source: ORBRFSS 2014-2017



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Access to food for vulnerable populations

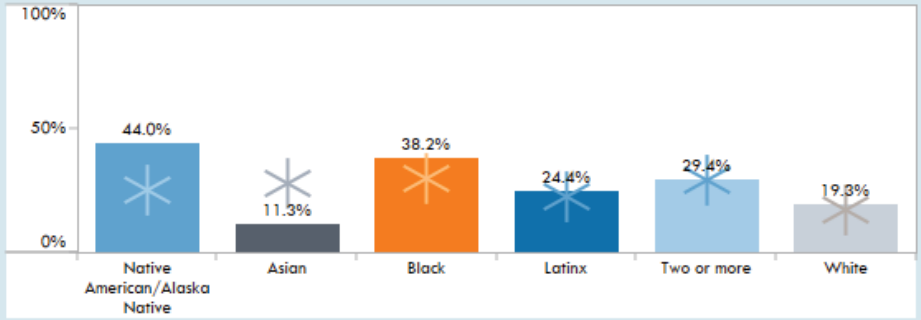
Having access to healthy food is essential to good lifelong health. Programs like SNAP and WIC help ensure that people with limited financial resources can still access the food their families need.

Given the disparities in poverty rates, it is not surprising that people who identify as white access these programs at lower rates.

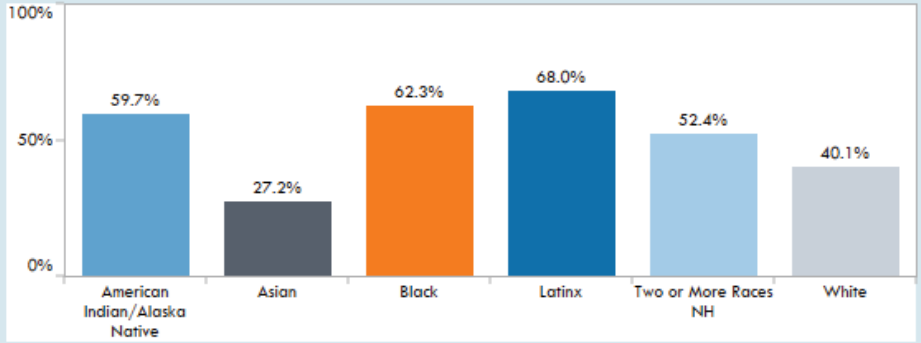
People who identify as Asian in Lane County have one of the highest rates of poverty, yet participate in food assistance programs at lower rates compared to people of other races/ethnicities. This may be an indicator of cultural differences or barriers to access for those communities.

Source: ACS 2014-2018, ORCHS, 2010-2018

Percent of households receiving SNAP benefits (bars) with percent of households at or below 100% FPL (*) 2014-2018



Percent of births in which mother was enrolled in WIC during pregnancy 2010-2018



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Lane County Health Equity Report 2020: **About the data**

The data in this report tell a part of the story of inequities experienced by people of differnt races, different abilities, and different immigration statuses. However, these numbers cannot and do not tell the whole story.

Race/ethnicity categories used in data collection are inherently problematic as they do not capture the true intersectionality of people's identity and are not consistent across various data sources. In this report, categories are used according to the data source and, unless otherwise noted, single race categories include only those who reported themselves of that race and not of Latinx (or Hispanic) ethinicity.

The data sources used in this report are updated periodically according to their own schedule and the data presented here represent what was current at the time of the report. Updates will be made as time and resources allow.

Data on health behaviors and self-reported health status by race/ethnicity are from **Oregon's Behavioral Risk Factor Surveillance System (ORBRFSS) 2017 survey from Lane and Benton Counties**. Due to low numbers, some races/ethnicities are excluded from this report. Addionally, these data should be interpreted with caution, as participation in the survey may not be representative of the community as a whole. While Oregon BRFSS makes every effort to collect a representative sample from each county, when those data are disaggregated, it can become less representative. Data on health behaviors/health status by disability are from **ORBRFSS 2014-2017** for Lane County via Oregon's Public Health Assessment Tool (OPHAT).

Data on mortality, pregnancy (including tobacco use and WIC participation), and infections diseases come from the **Oregon Center for Health Statistics (ORCHS)** and are population-level data. Some racial/ethnic groups may be omitted due to small numbers.

Demographic and socio-economic data by race, disability, and immigrant status are from the 5-year estimates of the **American Community Survey (ACS)**, and when disaggregated may or may not reflect actual conditions in the community due to small numbers and/or survey participation rates.

Data on high school graduation rates come from the **Oregon Department of Education**. Note that racial groups in this data set may include students who also identify as Latinx.

This report makes clear that much work needs to be done to correct the historical and current injustices that lead to different outcomes for many members of our community and that we must do better in collecting data that can tell a more complete story.

Introduction

Key findings

Health outcomes

Health behaviors

Social determinants

If you would like to provide feedback on this report:

We are committed to making health data useful and meaningful to our community. If you would like to provide feedback, please take a moment to complete our survey: https://www.surveymonkey.com/r/CHAdatasurvey

For more data about health in Lane County, see the Community Health Status Assessment: https://bit.ly/3bl67DN