CORE | Center for Outcomes Research and Education

OHA Transformation Center
Community Health Assessment and Community Health Improvement Plan Learning Collaborative:

Data Visualization with an Equity Lens

May 4, 2023
Facilitated by: Kristen Lacijan

Agenda

- Welcome & Introductions
- Session Overview
- Claire Devine & Kristen Lacijan, CORE
- Alicia Lee, Washington County
- Sadie Baratta & Kayla Watford, Lane County
- Discussion/Q & A
- Meeting Summary, Next Steps, & Evaluation

Zoom Logistics

- This session will be recorded
- Participants are on mute, please raise hand or private chat Kristen Lacijan or Claire Devine with questions
- Private chat or email Tom Cogswell (thomas.cogswell@oha.state.or.us) with any Zoom issues

Learning Collaborative Goals

- Support CCOs, local public health, hospitals, and their community partners in creating shared community health assessments & health improvement plans

- Provide a space for learning collaborative participants to discuss operational challenges, successes and best practices

- Today: Provide principles and examples of data visualization with an equity lens.

Learning Collaborative Workshop Series: Community Health Assessments & Community Health Improvement Plans

Resourcing

3/29/22

recording available on basecamp

Governance

5/17/22

recording available on basecamp

Timelines/Cycles

9/13/22

recording available on basecamp

Community Engagement

11/2/22

recording available on basecamp

Tribal Engagement I & II

3/29/23

recording available on basecamp

Data Viz with an Equity Lens

5/4/23, 11:00-12:30

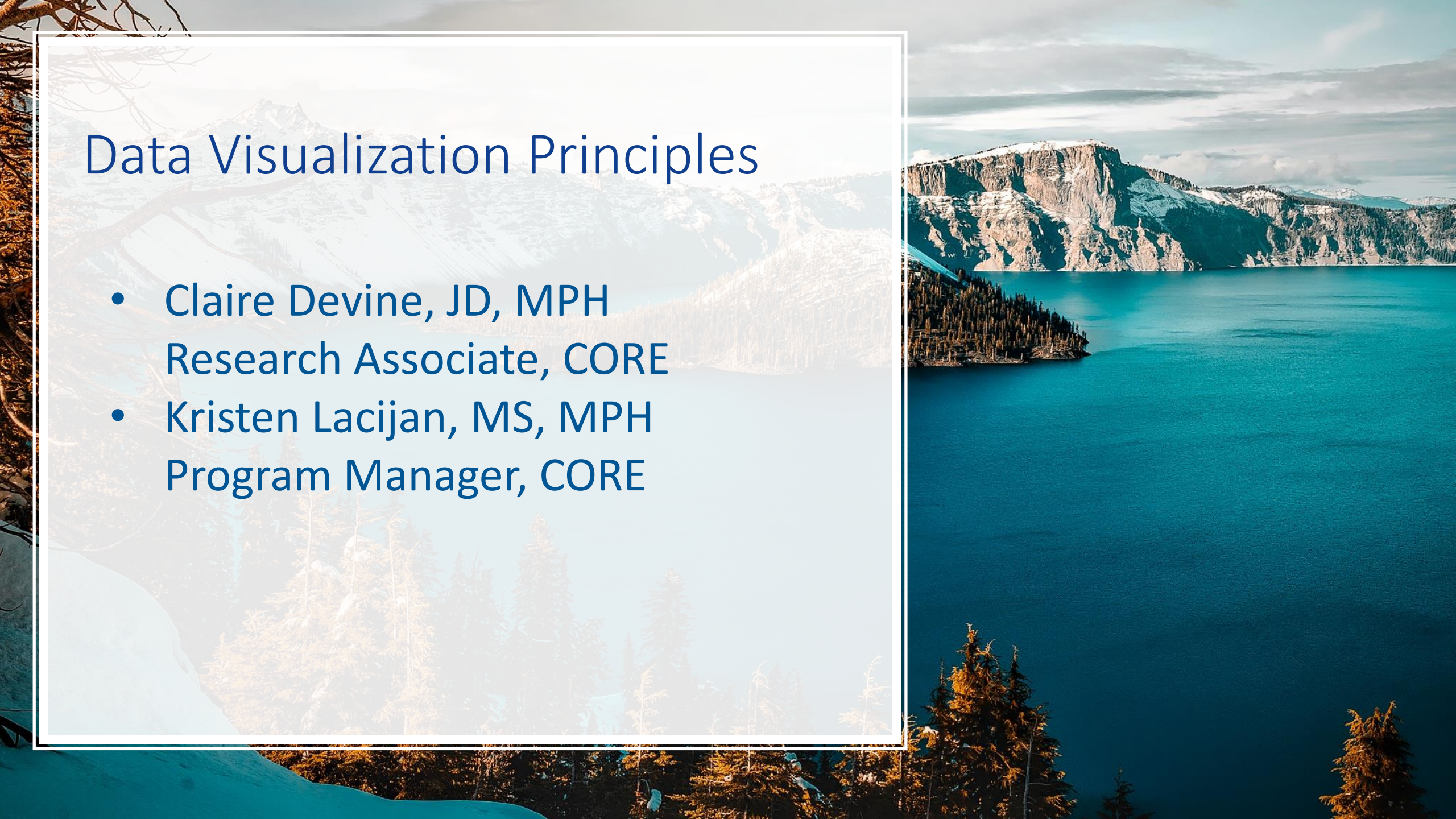
Sustainability & Dissemination

6/1/23

Participant Introductions

In the chat, please share:

- Name
- Pronouns
- Title
- Organization

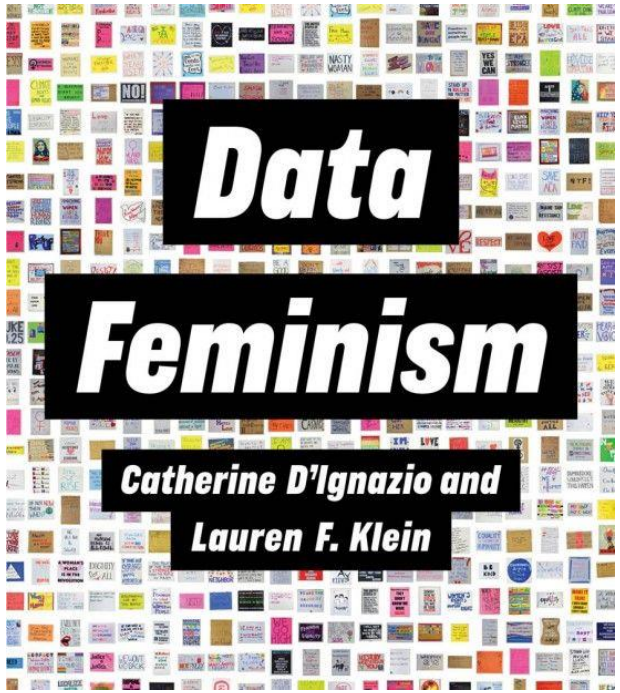


Data Visualization Principles

- Claire Devine, JD, MPH
  Research Associate, CORE
- Kristen Lacijan, MS, MPH
  Program Manager, CORE

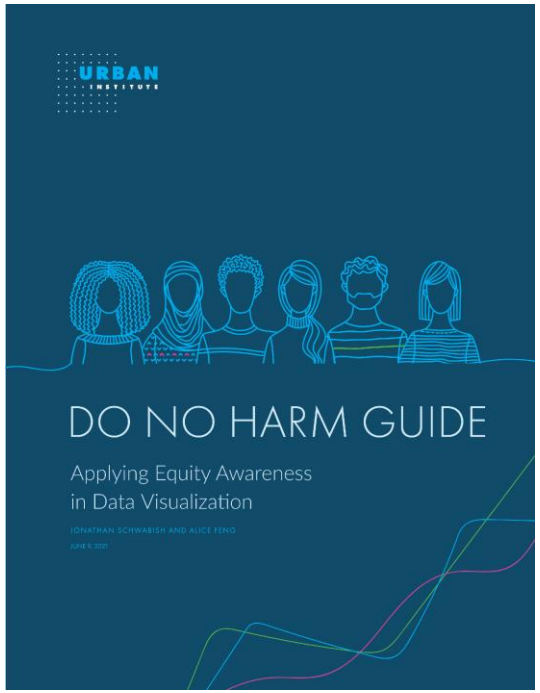
Introduction to Data Visualization Equity Principles

- These principles and examples draw heavily from two primary sources
- There are many resources that address equity in data visualization
- These principles are not meant to be prescriptive, but to raise ideas and questions
- Leading with race and ethnicity



Catherine D'Ignazio and Lauren F. Klein

The MIT Press, 2020



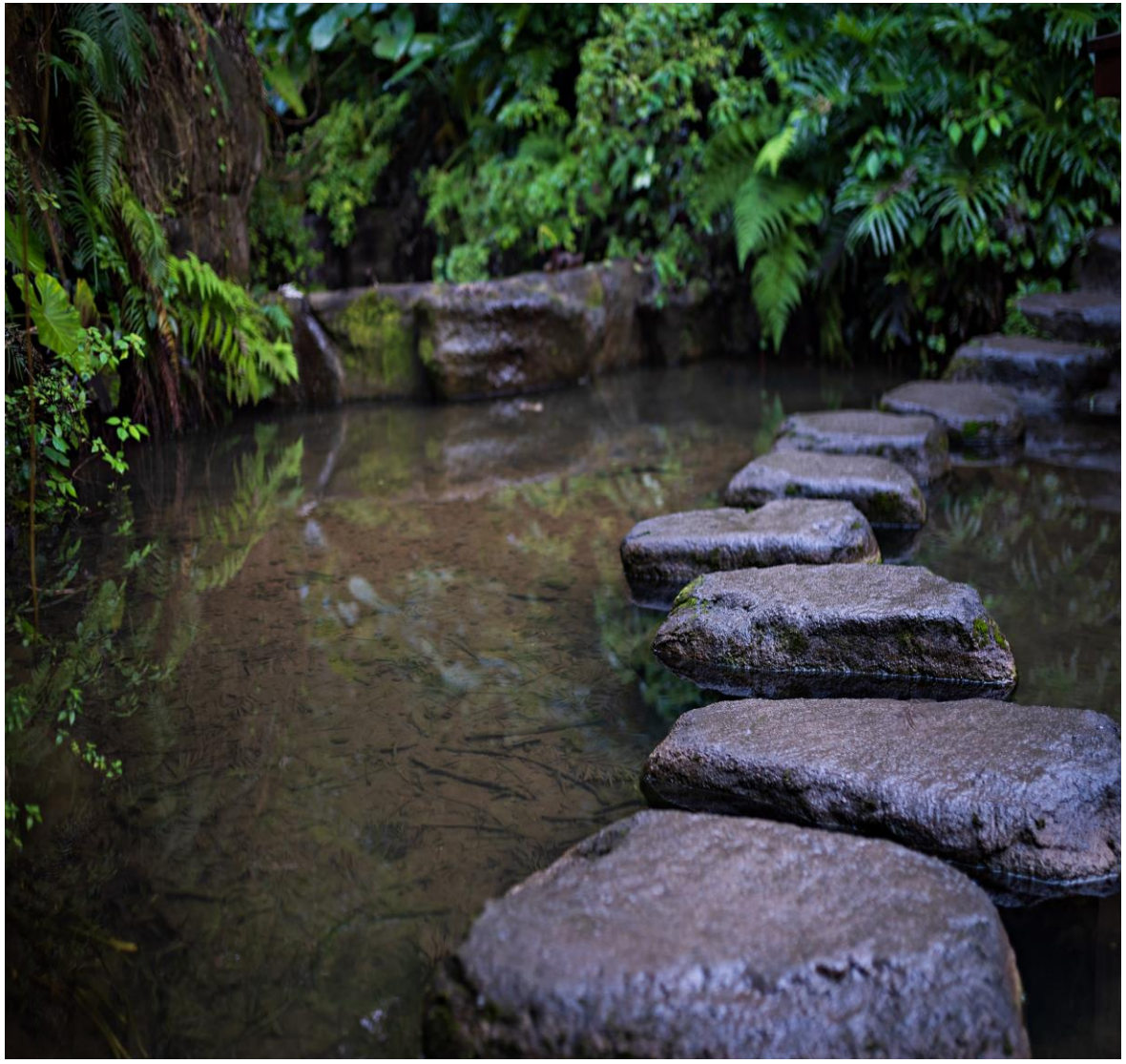
Jonathan Schwabish and Alice Feng

Urban Institute, 2021

CORE

Big Ideas for Today:

- Asking the questions
- Including context
- Choosing language
- Choosing imagery
- Understanding perspective
- Involving communities
- Communicating with your audience



Data, particularly data collected about people, are not neutral or objective: they reflect a human act that was done by someone for a specific purpose and intent (Correll 2019; Lupi 2017).

Correll, Michael. 2019. "Ethical Dimensions of Visualization Research." In Proceedings of the 2019 CHI Conference on Human Factors in Computing Systems, by Association for Computing Machinery. New York: Association for Computing Machinery. Ethical Dimensions of Visualization Research | Proceedings of the 2019 CHI Conference on Human Factors in Computing Systems (acm.org)

Lupi, Giorgia. 2017. "Data Humanism: The Revolutionary Future of Data Visualization." PrintMag, January 30, 2017. Data Humanism: The Revolutionary Future of Data Visualization – PRINT Magazine

Questions to Consider:

- How were these data generated?
- Are these data demographically representative?
- Who is included and who is excluded from these data?
  (and how and who will communicate to those who are excluded?)
- Whose voices, lives, and experiences are missing?
- How much can this data be disaggregated by race, gender, ethnicity, etc.?
- Why were these data collected?
- Who stands to benefit from these data?
- Who might be harmed by the collection or publication of these data?

Source: do-no-harm-guide.pdf (urban.org)

Including context

- The goal is to have a holistic understanding of the story behind the data.
- **Include important context for your reader** in graphs and figures, keeping in mind who your audience is.
- Add notes that explain why data is not inclusive or representative.

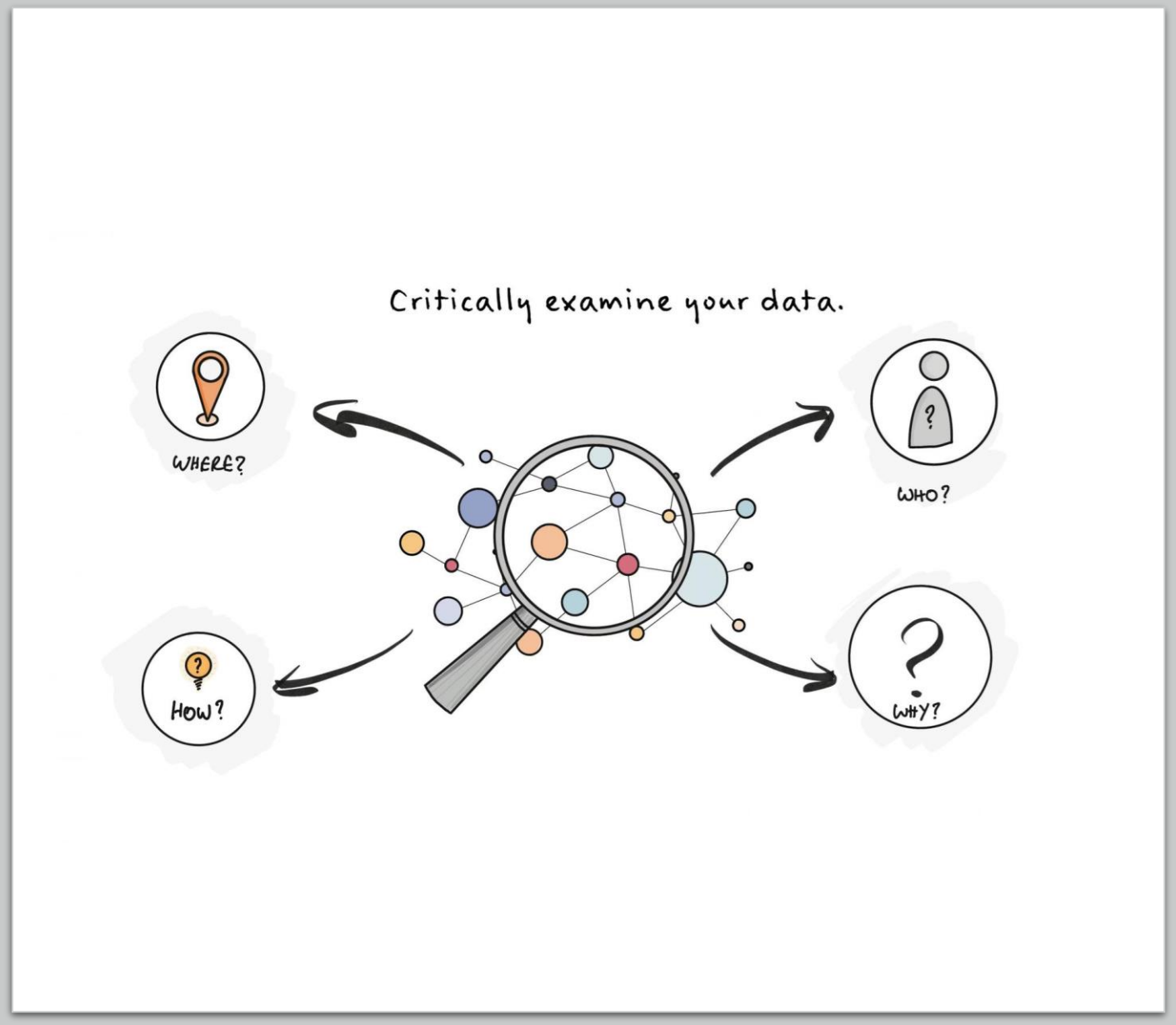


Image Source: Do No Harm Guide Transcript (tableau.com)

CHA/CHIP example of including context: Healthy Columbia Willamette Collaborative

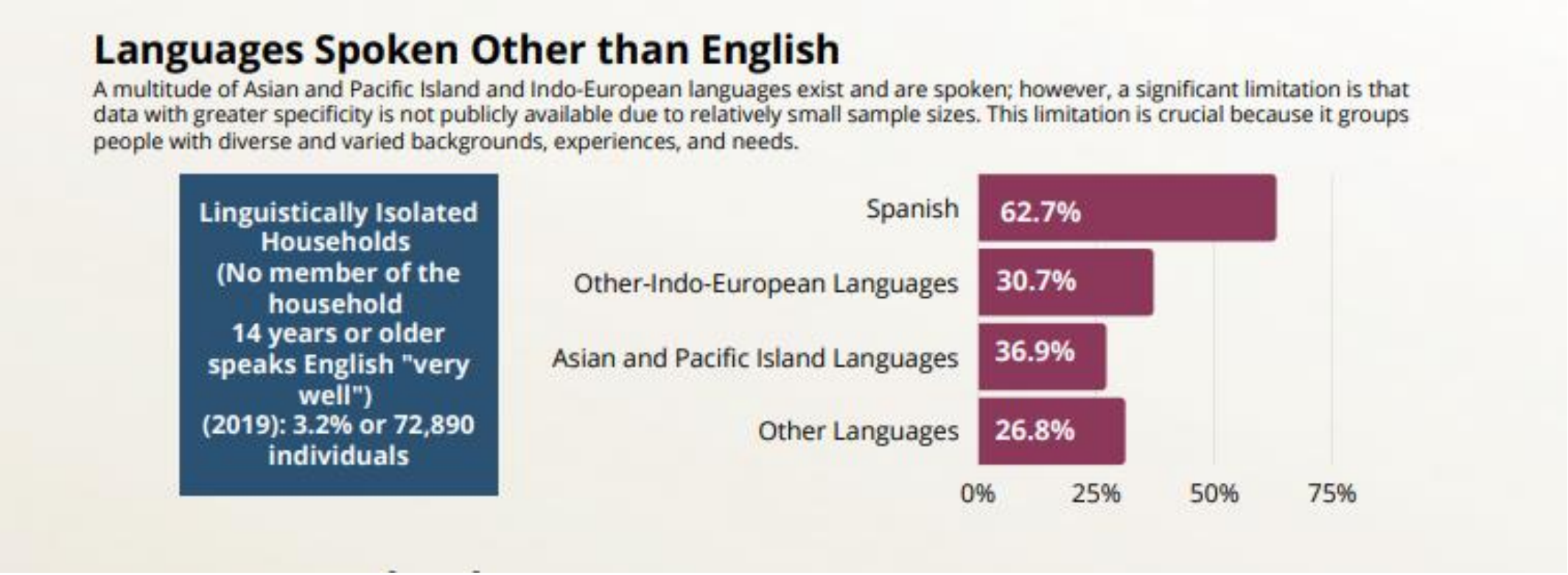
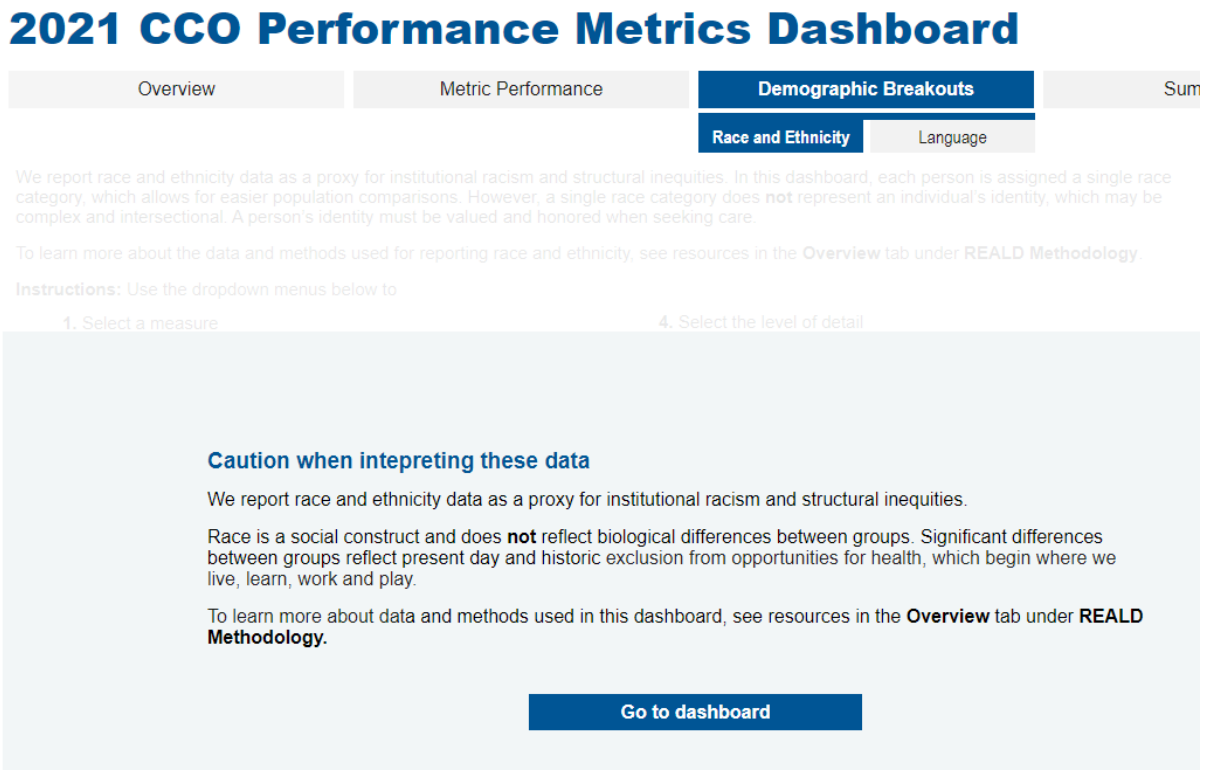


Image Source: [Healthy Columbia Willamette Collaborative Community Health Needs Assessment 2022]

OHA Metrics Dashboard: Including Context



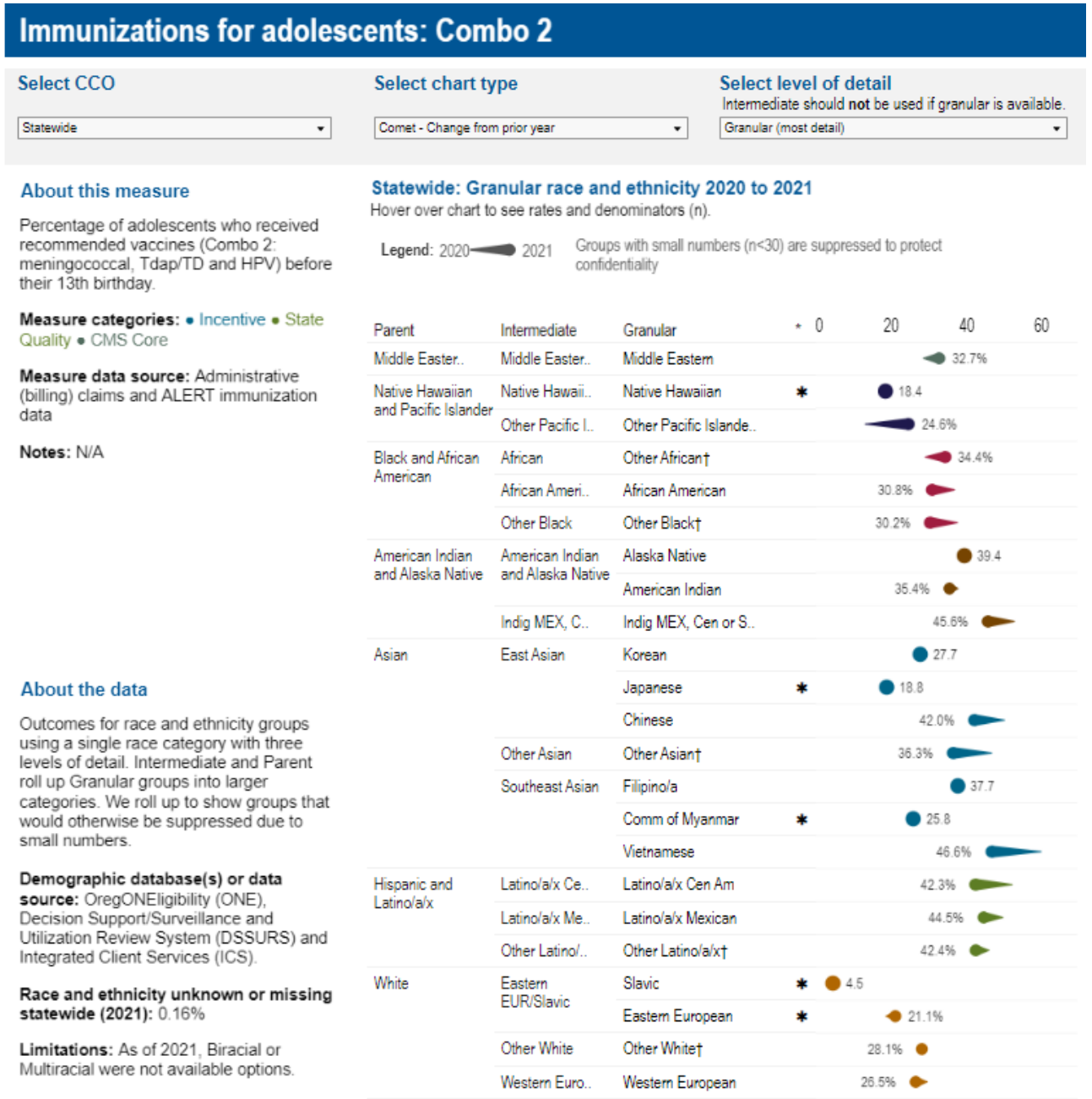
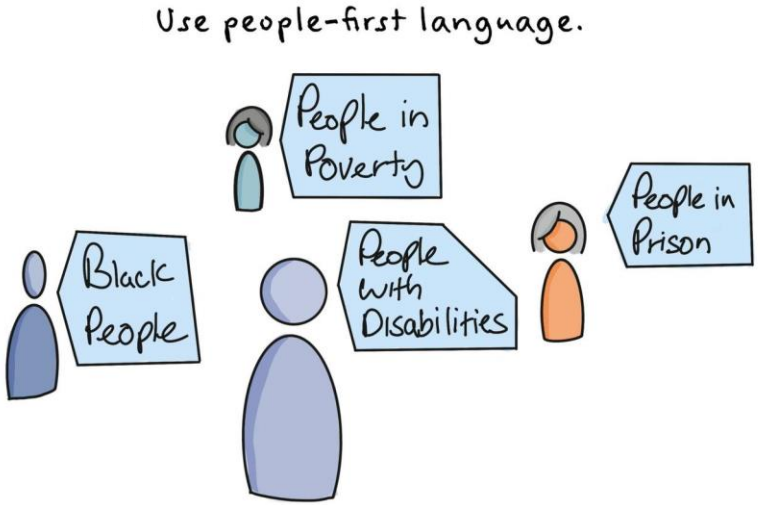


Image Source: [Workbook: CCO Performance Metrics (state.or.us)]

Choosing language

- Data reflects the lives of real people
- Use people-first language
- Labels matter and should be chosen carefully
- Labels and hierarchies have meaning
  - Orders can reinforce “white” and “male” as norms
  - Consider alphabetical order
- Alternatives to labeling the “other” catch-all category



Alternatives to labeling the “other” catch-all category:

- Another
- Another race
- Additional groups
- All other self-descriptions
- People identifying as other or multiple races
- Identity not listed
- Identity not listed in the survey
- Identify which groups comprise the category

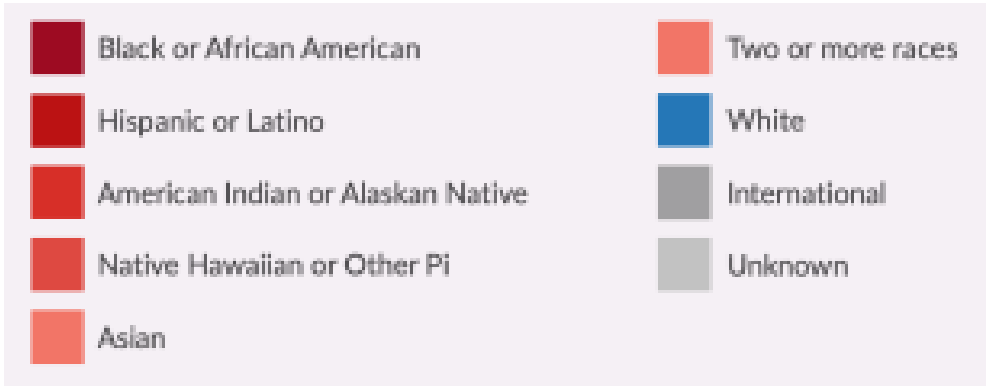
Image Source: Do No Harm Guide Transcript (tableau.com)

Choosing imagery

- Colors, icons, and shapes can be associated with stereotypes
- Avoid using a graduated color palette for categorical data.

FIGURE 12

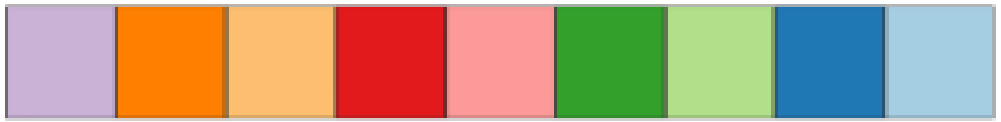
Legend showing a problematic color scheme applied to data on race and ethnicity.



Source: Recreated based on the June 2020 version of the *Diversity Dashboard* from the Massachusetts Institute of Technology, Office of the Provost.

FIGURE 14

Example color palette that avoids gradients and hierarchies.



Source: Created with the ColorBrewer online tool.

Image Source: [Do No Harm Guide Transcript (tableau.com)]

Community data example of language/imagery

Mapping access to care

Percent of people who speak English' Less than very well, page 28

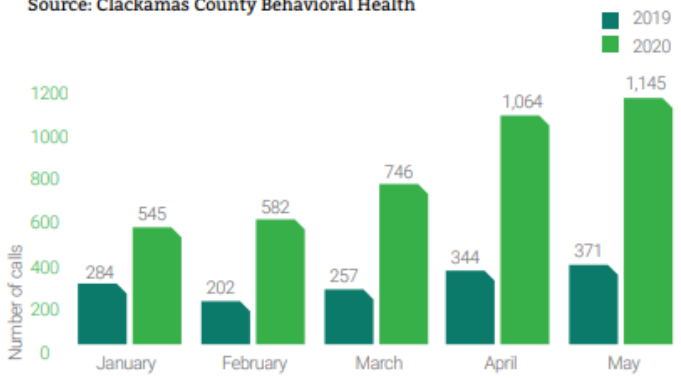
Often referred to as linguistic isolation, lack of English proficiency can severely impact one's ability to access care and vital services. While Clackamas County works to provide information in many languages and offer translators whenever needed, there remain barriers to non-English speakers in maneuvering through the health care and social service system.

Percent of children on Medicaid in 2018, page 29

98.2% of children in Clackamas County have health insurance (ACS, 2017) thanks largely to the Oregon Health Plan (OHP). OHP provides Medicaid to children who need it – a higher percentage of which reside in the county's rural census tracts within the Estacada Health Equity Zone, as well as speckled across more densely populated areas.

Senior Loneliness Line – Clackamas County

Source: Clackamas County Behavioral Health



Providers	
There is 1 primary care provider per 1,111 people	2017
There is 1 dentist per 1,250 people	2018
There is 1 mental health provider per 322 people	2019

Image Source: Blueprint for a Healthy Clackamas County 2020-2023

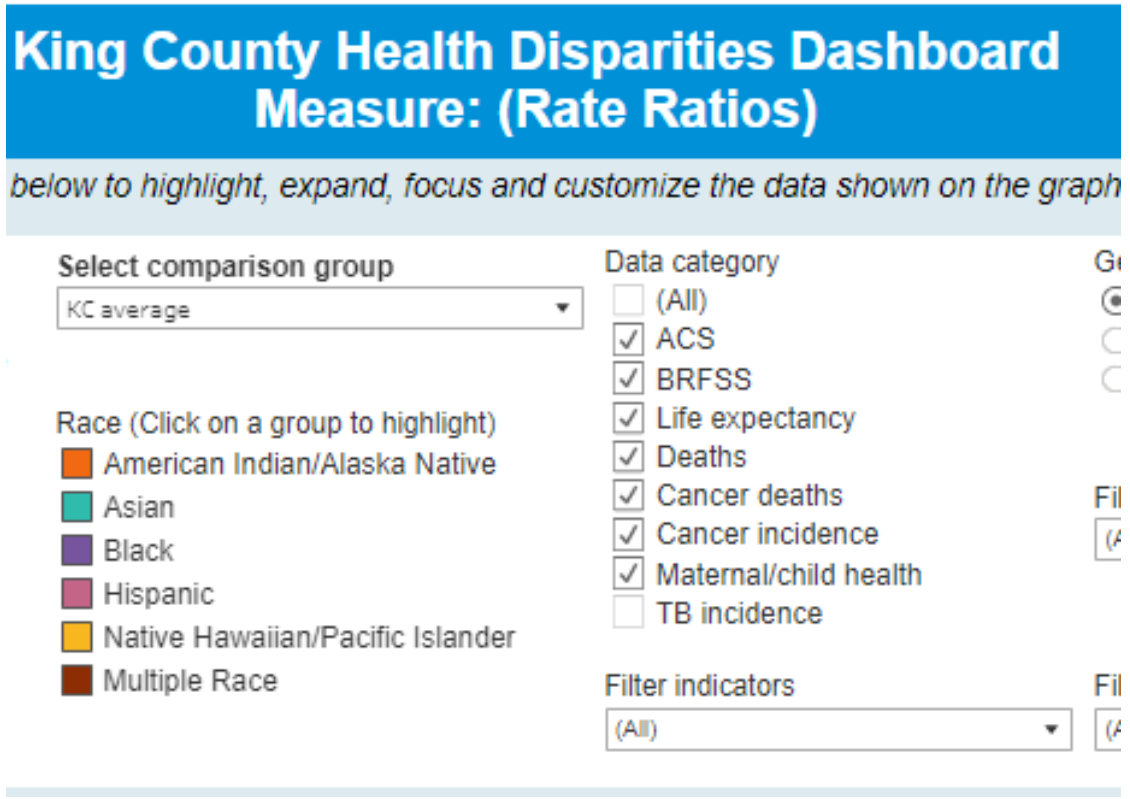


Image Source: King County Health Disparities Dashboard

Understanding perspectives

- Visuals do not speak for themselves
  - It is impossible to avoid interpretation
  - Ask questions: “if someone saw the graph or figure by itself, would they draw the right conclusions?”
- Be transparent about the positionality and viewpoint of your team
- Seek multiple perspectives

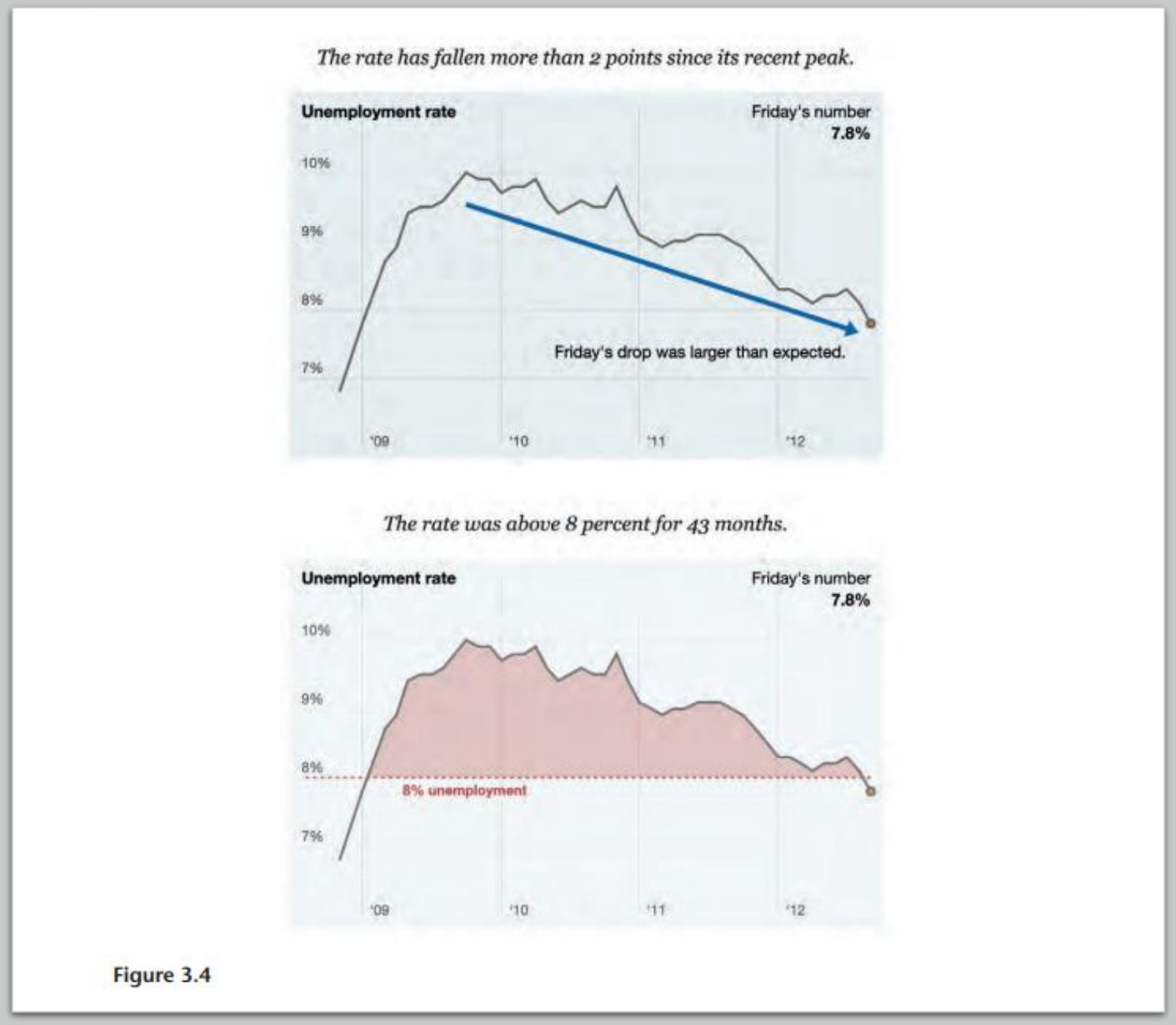


Image Source: D’Ignazio and Klein. Data Feminism (2020)

Examples of including perspective: Columbia Gorge

Transportation barriers means people go without transportation when they really need it or go without basic needs like healthcare and food due to transportation or distance. Transportation is the highest unmet need.

% of Households going without Transportation

Image Source: [Columbia Gorge Regional Community Health Assessment, 2019]

King County, WA

Feeling Safe At School

Students of color and LGB+ students are less likely to feel safe at school.

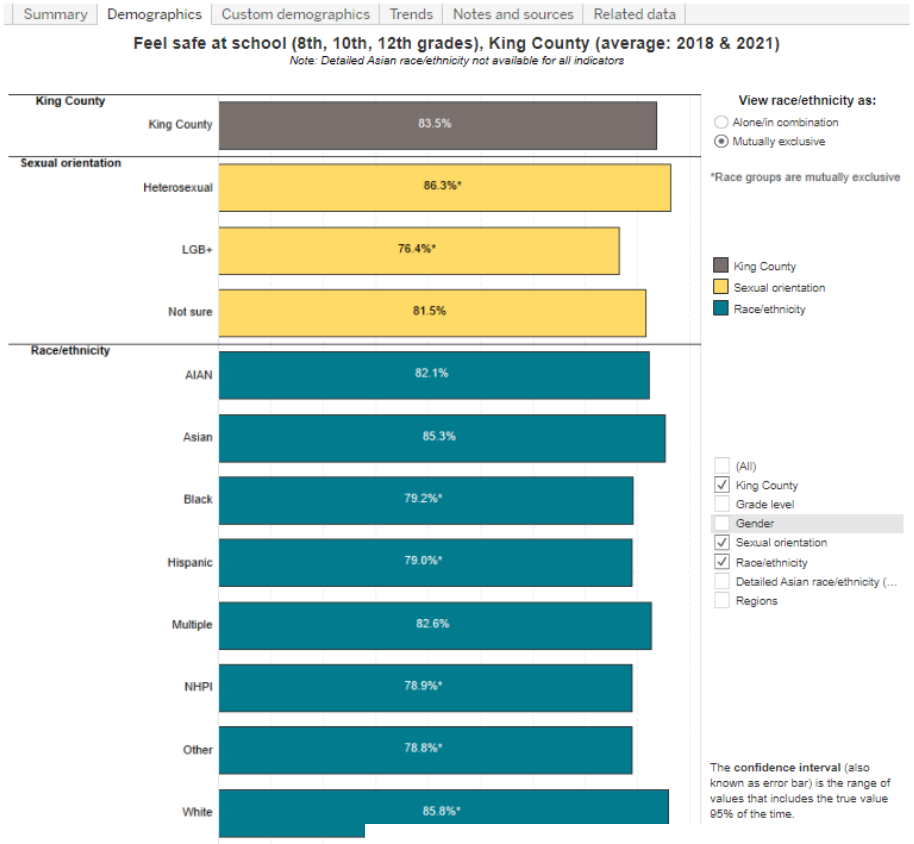
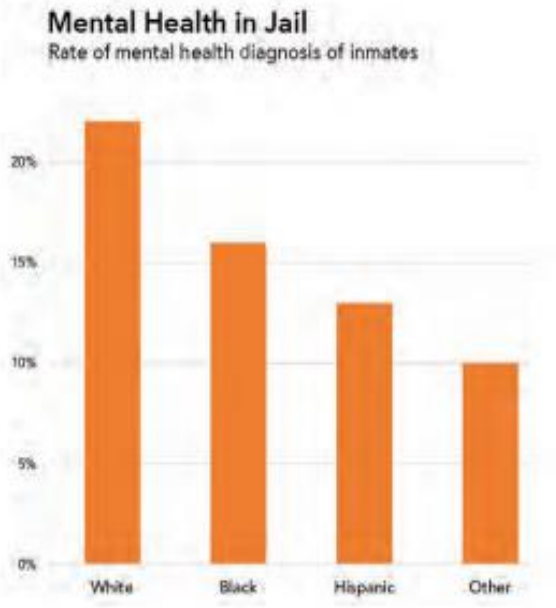


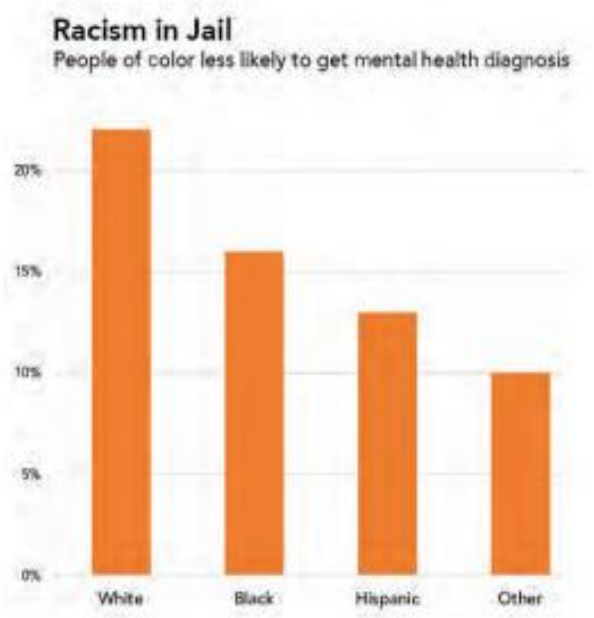
Image Source: [Communities Count, Data for King County Communities]

Example of shaping the story with perspective

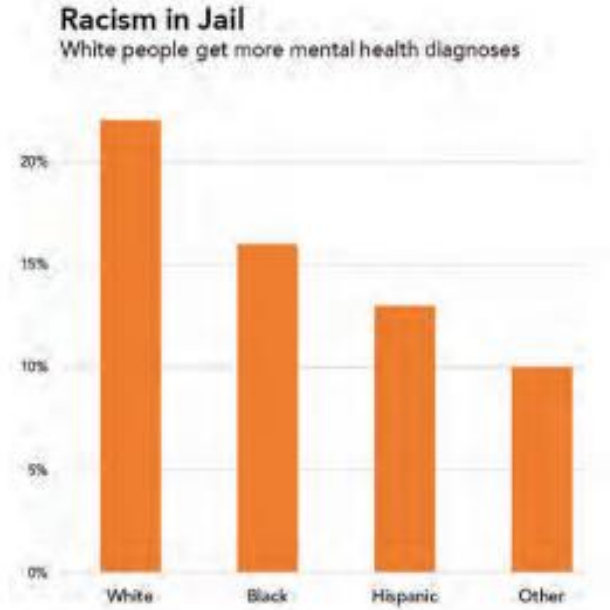
This study looks at the medical records of more than forty-five thousand first-time incarcerated people and finds that some groups are more likely to receive treatment, while others are more likely to receive punishment. More specifically, white people are more likely to receive a mental health diagnosis, while Black and Latinx people are more likely to be placed in solitary confinement. The researchers attribute some of this divergence to the differing diagnosis rates experienced by these groups before becoming incarcerated, **but they also attribute some of the divergence to discrimination within the jail system.**



‘Inmates’ is not people first language



Deficit-based perspective



Perspective focuses on the unfair advantage of dominant group

CORE

Image Source: [do-no-harm-guide.pdf (urban.org)]

Evidence *for* Change

Involving communities

- Relationships with communities is essential
- Reflect lived experiences
- Examples:
- What's a Data Dive? – Best Starts for Kids Blog (beststartsblog.com)
- Regional Health Assessment & Regional Health Improvement Plan 2019 (colpachealth.org)

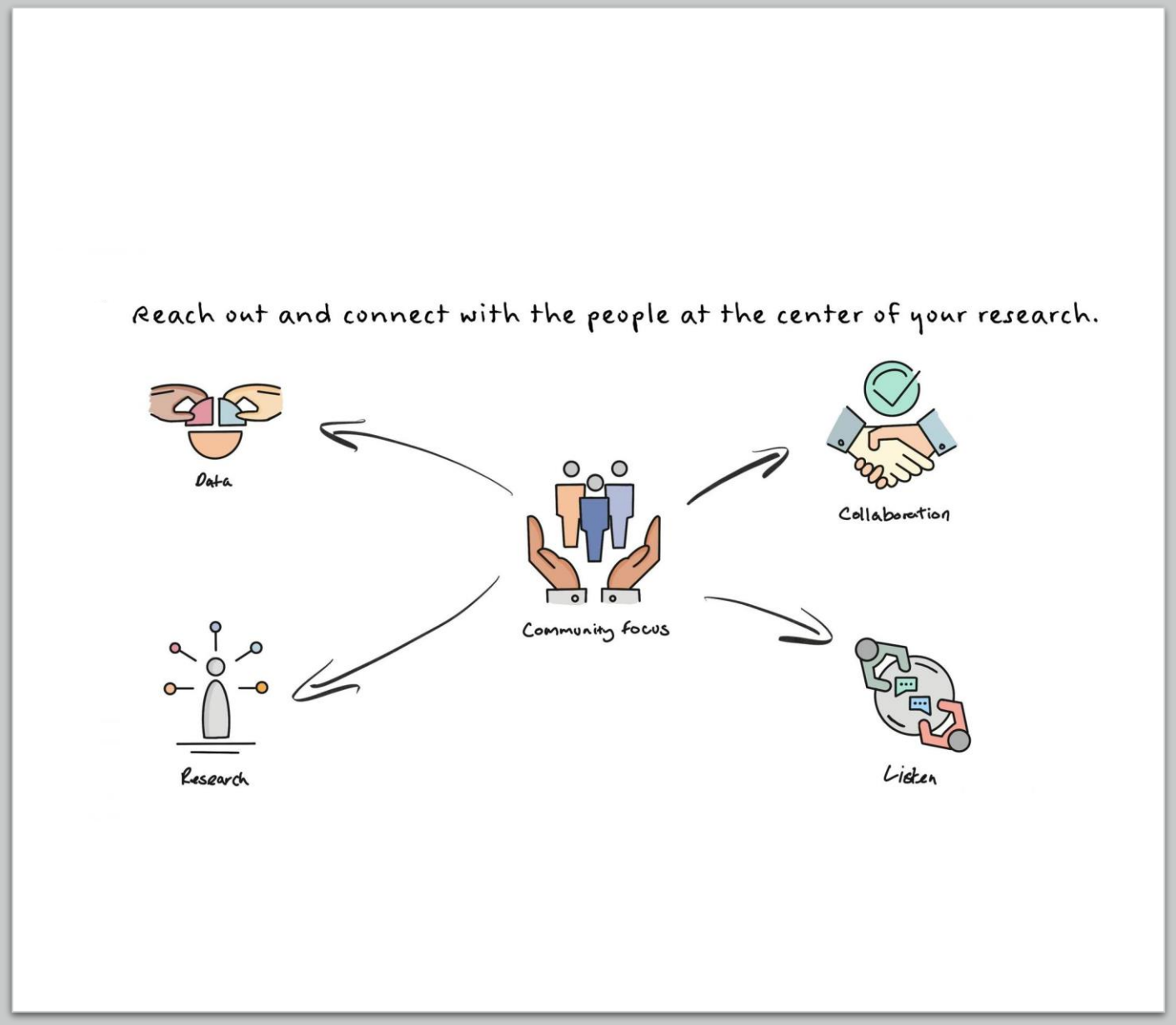


Image Source: Do No Harm Guide Transcript (tableau.com)

Example of involving the community

Oregon Health Plan clients contributed 508 of the stories collected. Figure 15 details the specific feelings (not emotional tone) respondents associated with their story about a health care experience.

In Figure 16, characterizations of flexibility of care (on the x axis) are compared with positive or negative association with the care (y axis). The example clearly demonstrates that extremely structured care was associated with negative emotions about the experience, and conversely, flexible care was associated with positive emotions about the experience.

Figure 16: Characterizations of and positive/negative associations with flexibility of care

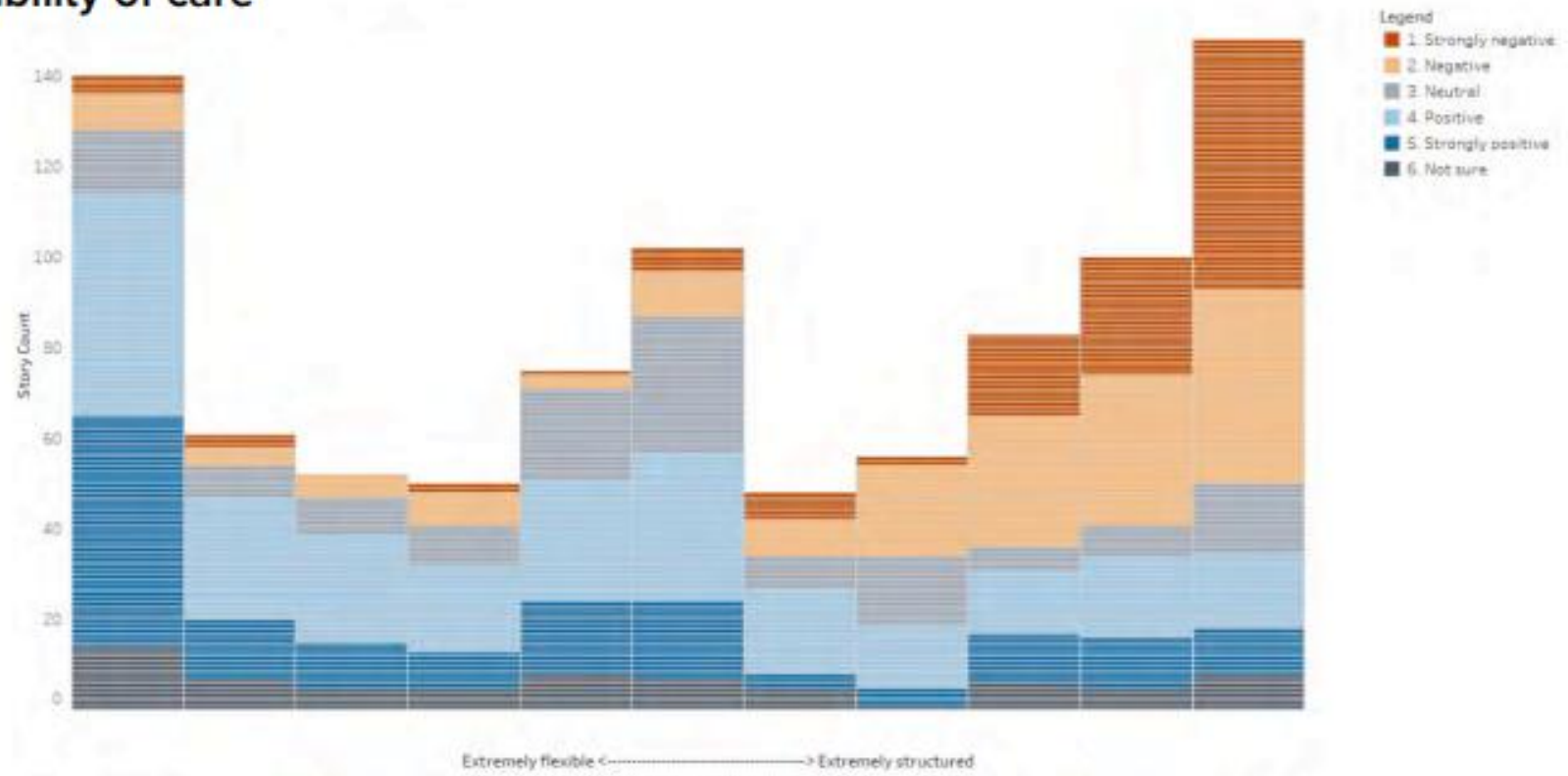


Image Source: [Columbia Pacific Regional Health Assessment & Regional Health Improvement Plan 2019]

Communicating with your audience

- Data is valuable if it can be shared and understood
- Examine whether content is clear, unambiguous, useful to readers
- Consider whether format, technology, and language is useful

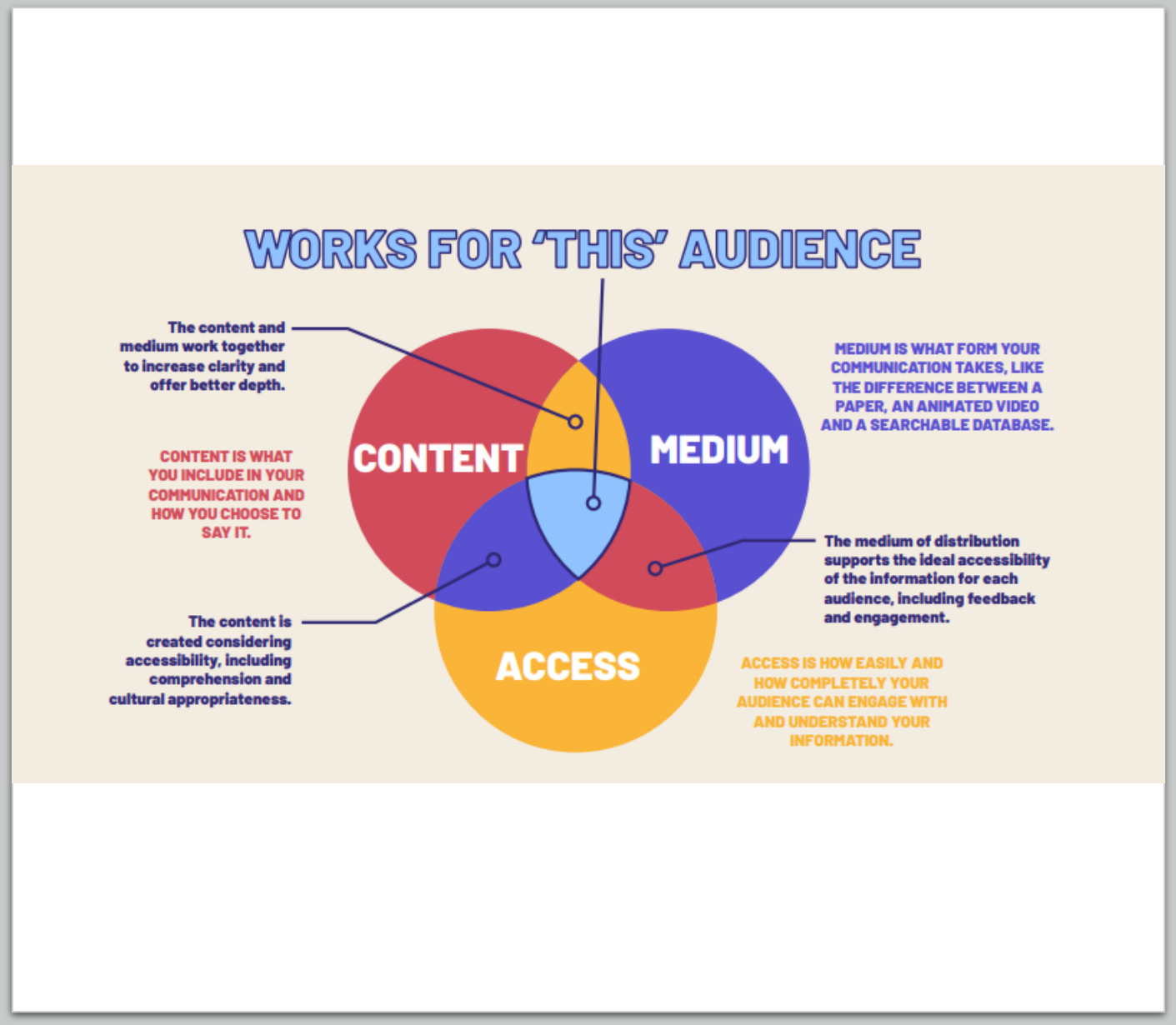


Image Source: We All Count, Distribution and Audience

Communication Example

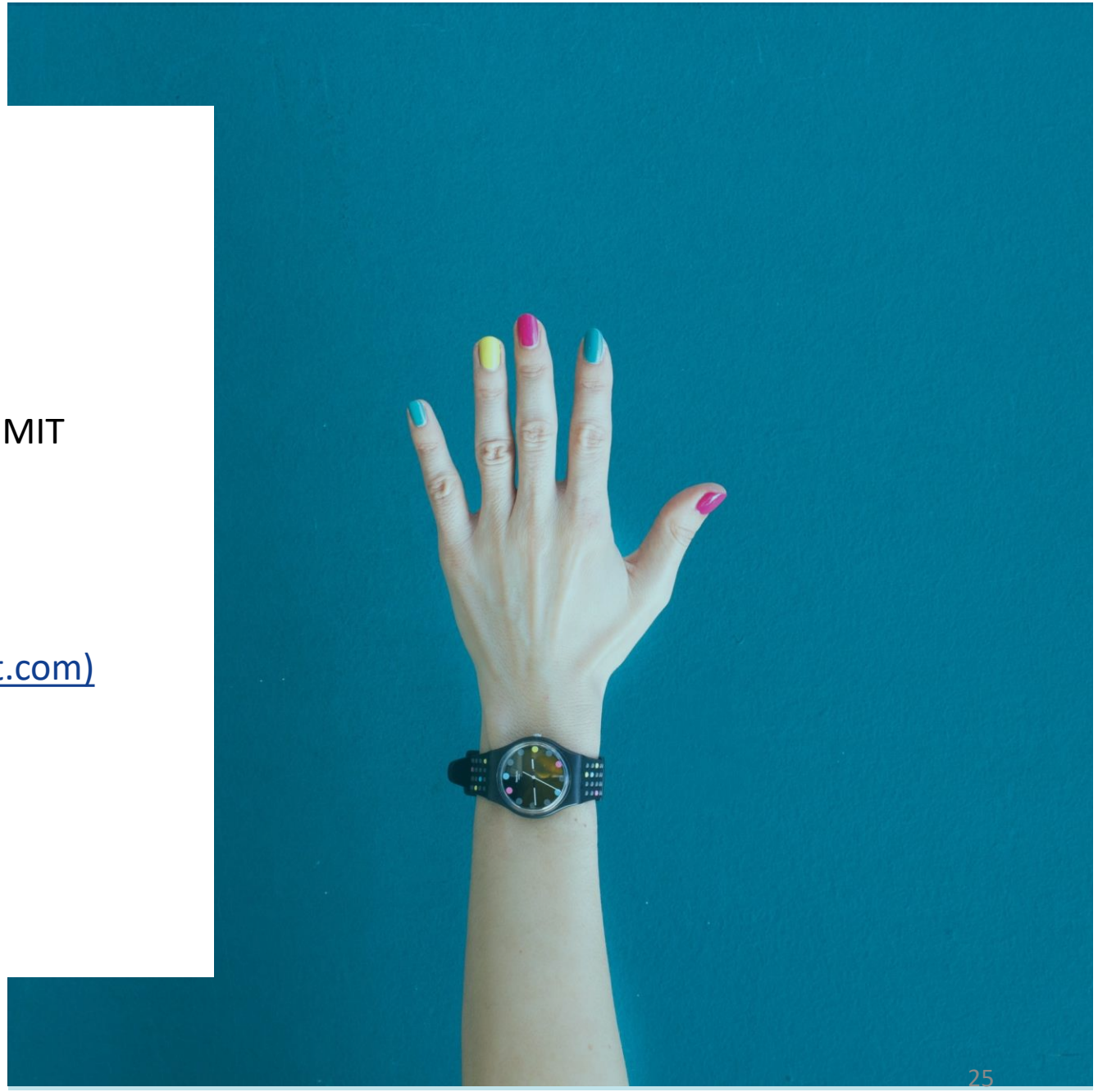
Image Source: [Central Oregon Health Council :: Indicators :: 2020-2024 Regional Health Improvement Plan (RHIP) Measures]

Resources

Do No Harm Guide: Applying Equity Awareness in Data Visualization, Urban Institute, June 2021
do-no-harm-guide.pdf (urban.org)

Data Feminism, Catherine D'Ignazio, Laura F. Klein, The MIT Press, 2020.
Data Feminism | Books Gateway | MIT Press

Foundations of Data Equity Tool Guide, We All Count
Foundations-of-Data-Equity-Tool-Guide.pdf (weallcount.com)



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Washington County Region Perspectives

Alicia Lee, MPH
Senior Program Coordinator,
Washington County
Department of Health and
Human Services

Lane County Region Perspectives

Kayla Watford
Community Engagement Coordinator, Lane County Public Health, Community Partnerships Program

Jennifer Webster
Epidemiologist, Lane County Public Health, Prevention

Questions?

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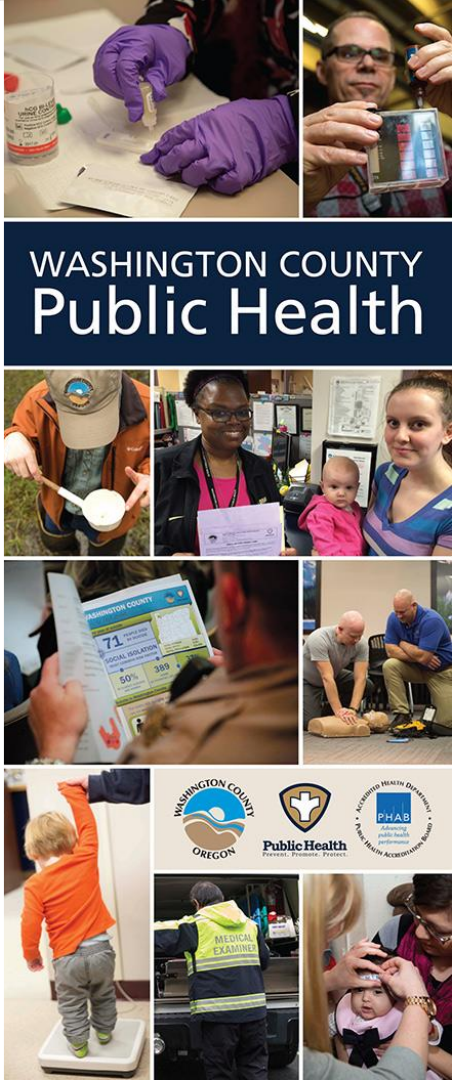
May 2023

Washington County Public Health: Strategies in Sharing Health Equity Data



Healthy People, Thriving Communities

Overview

- Washington County Context
- Healthier Together Dashboard
- Community Profiles
- Future community engagement and data-sharing in preparation for next CHIP planning cycle

Why a dashboard?

- Data is vital to the work we do
  - It can be hard to understand and interpret
- Transparency and accountability
  - We want to share both the highlights and the struggles
- Partnerships
  - Sharing information in a respectful and intentional way

Project Background

- Collaborative project with VAN and HHS
- Goal to provide community partners with information about health in the county
- Beta phase of website live April 1
- Iterative

Project phases/timeline

- Phase 1: Initial roll out and beta page build out
  - April 1, 2019!
- Phase 2: Sharing site widely. Updating/adding to existing pages with additional information based on feedback.
  - Rest of 2019
- Phase 3: Build out additional content areas.
  - Early 2020
- Phase 4: Increase local data and stories and expand scope
  - Late 2020

Let’s take a look!

WASHINGTON COUNTY
OREGON
Department of Health and Human Services

Demographics and Diversity

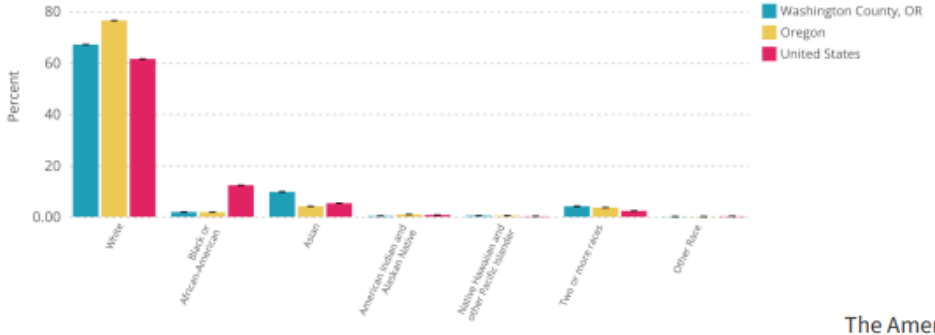
Washington County is the second most populous county among Oregon's 36 counties, and we celebrate the fact that we are the most diverse one. Our residents include American Indians and Alaska Natives (0.6%), Black or African Americans (1.9%), Asians (9.7%), Hispanic or Latino of any race (16.4%) and Non-Hispanic white (67.1%). Ten percent of the population have a disability; 17% are born out of the United States; and 24% speak languages other than English.

Washington County is also home to several universities and colleges and enjoys one of the highest levels of educational attainment in the state, where over 91% have a high school diploma or GED, and 42% have a bachelor's degree or higher.

589.0k	229.7k	36.9	80.9k Dollars
Total Population 2017 Washington County, OR	**Total Housing Units** 2017 Washington County, OR	**Median Age** 2017 Washington County, OR	**Median Household Income** 2017 Washington County, OR

WASHINGTON COUNTY
OREGON
Department of Health and Human Services

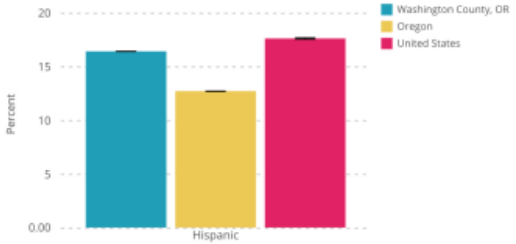
Population Distribution: by Race



ACS 5-year estimates, 2013-2017. Table DP05.

The American Community Survey adheres to definitions of race and ethnicity set forth by the 1997 Office of Management and Budget (OMB) standards. These categories are based on self-identification and are "not an attempt to define race biologically, anthropologically or genetically," according to the Census Bureau.

Hispanic Population (2013-2017)

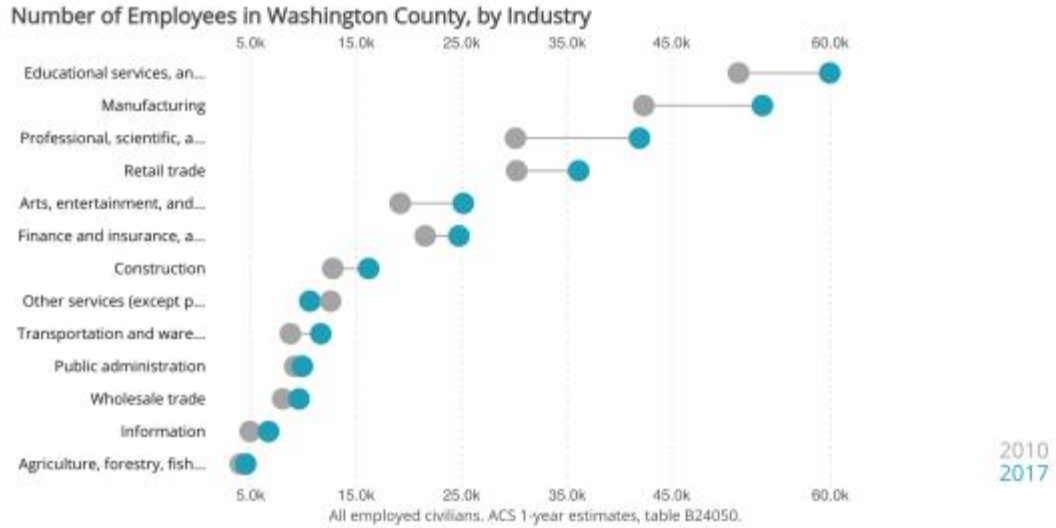


ACS 5-year estimates, 2013-2017. Table DP05.

According to the OMB standards, the category of "Hispanic" maps to the concept of *ethnicity*, not *race*, and so is not included in this chart. A person who identifies as Hispanic may be of any race or combination of races.

Employment

Washington County is home to some of the largest employers in the region that play an important role in the local development and economy, along with other small and medium-size businesses in the county. The vibrant nature of the local economy is reflected by the fact that more than 84% of civilian employed population 16 years and over work in the private sector. Other employers include government (10%) and self-employment (5%).



This chart shows how the number of employees in each major industry sector has changed between 2010 to 2017. Hover over a sector to see more details.

The **Community Health Improvement Plan** (CHIP) is a strategic community work plan that defines how Washington County Public Health (WCPH) and community partners come together to develop a culture of health and to address priority health issues identified by a comprehensive assessment of local Washington County data.

Many factors affect the health of individuals and communities. The complexity of these factors makes it essential to work collaboratively with many partners across sectors to address the unique needs of the community.

In addition, Washington County's diversity increases the need for cross-sector strategic partnerships to improve health. The CHIP addresses the social and environmental determinants of health by engaging partners from across the community to tap in to expertise, knowledge and resources.

WASHINGTON COUNTY
OREGON
Department of Health and Human Services

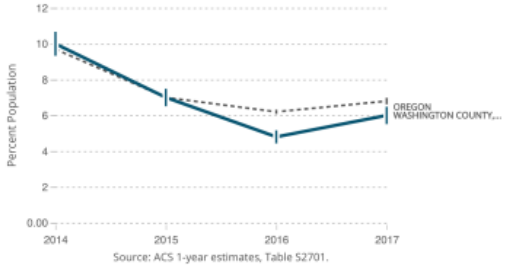
Priorities for the current CHIP:

Improve Access to Health Care

Including primary care, behavioral health and oral health services

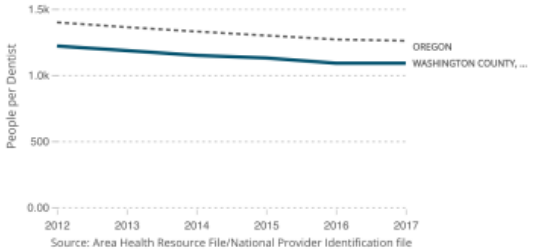
Percent of Population Without Health Insurance Coverage

Coverage Status: Uninsured



Source: ACS 1-year estimates, Table S2701.

People per Dentist



Source: Area Health Resource File/National Provider Identification file

542

Number of Dentists
2017
Washington County, OR

Strategies:

- Increase the percent of the population with a regular health care provider.
- Increase the number of providers in the community.
- Increase the number of adults with insurance.

WASHINGTON COUNTY
OREGON
Department of Health and Human Services

What Comes Next in sharing our Data: Community Health Profiles

- The Community Health Profiles (CHP) will include internal and public-facing dashboard that provide visualizations across geography, time, and populations of interest (i.e. race-ethnicity, education, income level) for Washington County using a health equity lens.
- The dashboards will explore health and social determinants of health at the county and sub-county levels, when available.
- Domains will include: physical health, maternal child health, injury, environmental health, build environment, communicable disease, and socio-demographics.

About Me

INTERNAL USE ONLY

Methodology and Data Sources

About the American Community Survey:
The American Community Survey (ACS) is an ongoing nationwide survey sampling 3.5 million addresses selected at random. The survey is administered and collected by the U.S. Census Bureau. It produces information on the social, economic, housing, and demographic characteristics of our nation's population every year. Estimates are produced for households (related and unrelated people who share a housing unit) and the population (individuals). For a full list of topics covered please review the Census Bureau's website: https://www.census.gov/programs-surveys/acs/guidance/subjects.html. Data are available at two temporal frequencies: 1-year and 5-year intervals. All 5-year intervals are data collected over the course of 60 months. Data (e.g., households, families, or individuals) are aggregated and available at the national, state, county, city, zip code, census tract, block groups, and other geographic levels for select years and topics. Data available in this dashboard are aggregates of individuals.

Uses:
ACS is used by many public and private agencies to understand their communities and is widely considered one of the most reliably data sources of its kind. These data can be used for descriptive purposes to understand and estimate the representation of characteristics in our county. These data should not be used to measure the efficacy of a program implemented at any geographic level or for any particular group.

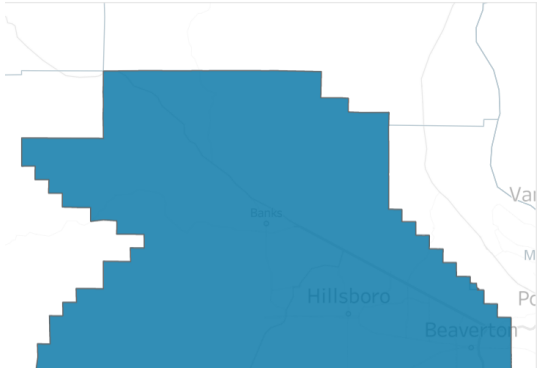
Methodology:
The percentages and counts reported in these visuals exclusively use 5-year estimates that approximate the population in Washington County and are not a full enumerations of the county's population. For the specific methodology of the ACS, please go to https://www.census.gov/programs-surveys/acs/methodology.html.

English Language Proficiency

(Excluding English-Only Speakers)

English Language Proficiency by County for 2011-2015

Select a County to filter the other visuals. Change Geography and Year using the filters below.



Language Spoken at Home by English Proficiency

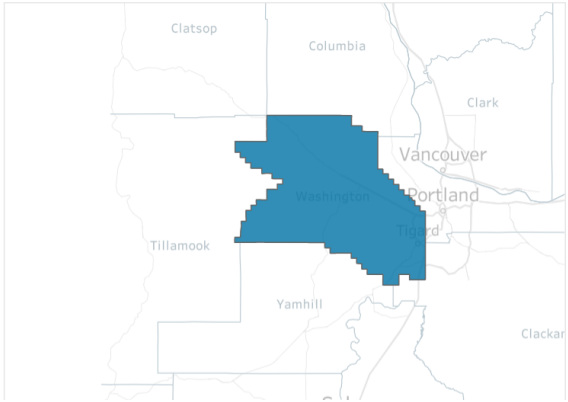
Select an Language Spoken to filter the other visuals.

	Speak English very well	Speak English less than very well	Speak English very well	Speak English less than very well
Amharic Somali or othe..	159	37	81.1%	18.9%
Arabic	76	26	74.5%	25.5%
Armenian	253	117	68.4%	31.6%
Bengali	534	50	91.4%	8.6%
Chinese (incl. Mandarin ..	763	869	46.8%	53.2%
French (incl. Cajun)	1,536	326	82.5%	17.5%
German				
Greek				
Gujarati				
Haitian				
Hebrew				
Hindi				
Hmong				
Ilocano Samoan Hawai				

Demographics - Age, Sex, and Race

Population by County for 2011-2015

Select a County to filter the other visuals. Change Geography and Year using the filters below.



Population by Sex

Select a Sex to filter the other visuals.

Female	282,467	50.8%
Male	273,743	49.2%

Population by Age

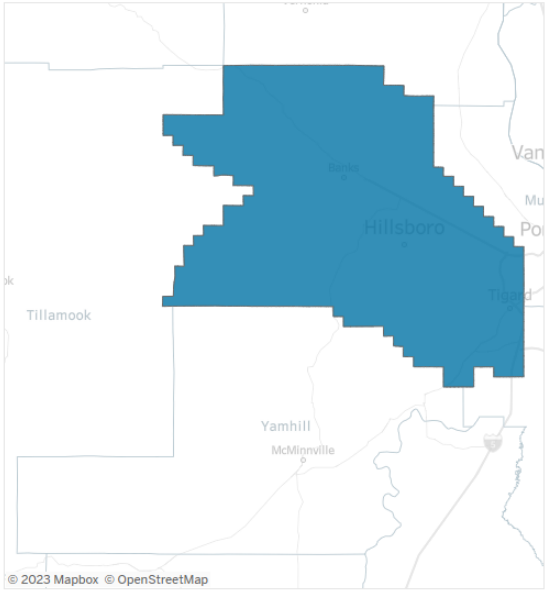
Select an Age Group to filter the other visuals.

Under 5 years	37,207	6.7%
5 to 9 years	38,124	6.9%
10 to 14 years	39,080	7.0%
15 to 17 years	22,350	4.0%
18 and 19 years	12,541	2.3%
20 to 24 years	33,316	6.0%
25 to 29 years	41,268	7.4%
30 to 34 years	44,064	7.9%
35 to 44 years	84,169	15.1%
45 to 54 years	76,261	13.7%
55 to 64 years	64,538	11.6%
65 to 74 years	36,934	6.6%
75 to 84 years	17,500	3.1%

Demographics - Hispanic/Latino

Hispanic/Latino Population by County for 2006-2010

Select a County to filter the other visuals. Change Geography and Year using the filters below.



Estimate

County
County Subdivision
Census Tract
Place

ACS Survey 5-Year: 2006-2010

Hispanic or Latino: Hispanic or Latino

Hispanic/Latino Population by Sex

Select a Sex to filter the other visuals.

Female	36,883	47.5%
Male	40,776	52.5%

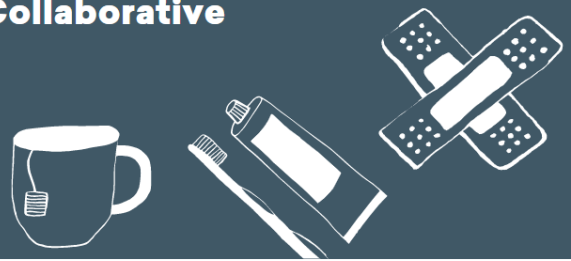
Hispanic/Latino Population by Age

Select an Age Group to filter the other visuals.

Under 5 years	9,924	12.8%
5 to 9 years	8,750	11.3%
10 to 14 years	8,159	10.5%
15 to 17 years	4,118	5.3%
18 and 19 years	2,459	3.2%
20 to 24 years	6,431	8.3%
25 to 29 years	7,897	10.2%
30 to 34 years	7,929	10.2%
35 to 44 years	11,793	15.2%
45 to 54 years	6,043	7.8%
55 to 64 years	2,609	3.4%
65 to 74 years	991	1.3%
75 to 84 years	323	0.4%
85 years and over	233	0.3%

Source: ACS 5 Year Estimates, Census Table ID: B01001

Healthy Columbia Willamette Collaborative



Assessing Community Needs, Improving Health

The Healthy Columbia Willamette Collaborative (HCWC) is a unique public-private partnership of 12 organizations in Clark County, Washington, and Clackamas, Multnomah and Washington counties in Oregon.

HCWC is dedicated to advancing health equity in the quad-county region. It serves as a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of local communities.

WASHINGTON COUNTY
OREGON
Department of Health and Human Services

Leveraging the Healthy Columbia Willamette Collaborative for Washington County CHIP Planning

HCWC Process

- Design Phase
  - Needs assessment planning
  - Directing the assessment
  - Defining the indicators
  - Data collection planning
- Data Collection Phase
  - Drafting questions and recruitment methods
- Data Analyses Phase
- Data Reporting and Communication

Figure 1. HCWC Process

Five partners came together to ensure a community-centered CHA process.

THE COMMUNITY ACTION TEAM (CAT)	THE PEER REVIEW GROUP	OREGON HEALTH EQUITY ALLIANCE (OHEA)	HEALTH MANAGEMENT ASSOCIATES (HMA)	THE HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE (HCWC)
Comprised of leaders representing the diverse communities within the four-county region. The CAT met monthly to guide every step of the CHA, helping to ensure community voice, wisdom, and experience were central.	A collection of data professionals of color who have expertise in engaging in decolonized, community-centered, data approaches and/or are deeply connected to an anti-racist, Indigenous practice of doing health equity work.	A people of color-led collaborative, organized to center and uplift the wisdom of communities of color through racial justice informed health equity policies and practices. As one of six regional health equity coalitions across the Oregon, OHEA has deep roots in communities most impacted by health inequities, and experience in convening and engaging these communities.	Supports communities with tackling the problems that impact health outside the walls of hospital, provider, and payer offices, such as inadequate housing and food access, health equity and disparities, violence, discrimination, unemployment and underemployment.	A partnership comprised of health systems, public health partners, and Coordinated Care Organizations that jointly funded this CHA across the four-county region of Clackamas, Multnomah, and Washington Counties, Oregon and Clark County, Washington.

Identification of Priority Areas

- Qualitative analysis led to identifying themes during the 37 community engagement sessions and paired down by the CAT from 8 themes to 4
- Data (quantitative and public) were analyzed to identify supporting evidence for themes identified during conversations with community members and community survey
- Washington County-specific representation
  - Community Action Team (CAT) (N = 13, Washington County, n = 3)
  - Community Engagement Sessions (37 sessions, N=311, Washington County, n = 53)[A]
  - Community Survey (N = 510, Washington County, n = 87)

HCWC Identified Priority Areas

Vision

By collaborating to leverage community strengths and resources and honoring lived expertise, we support our community to improve our own health.

Close

Using an Equity Lens to assess and measure progress: CHA development & indicators

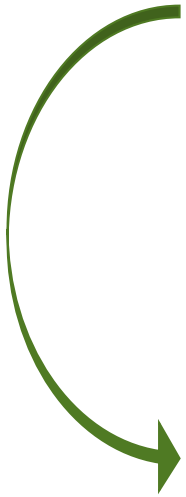
CHA/CHIP Learning Collaborative

May 4, 2023

Jennifer Webster, Epidemiologist, Community Partnerships
Kayla Watford, Community Engagement (CAC) Coordinator, Prevention

Live Healthy Lane

CHA/CHP collaborative



Community Health Assessment (CHA): Identifies health issues through data collection and analysis.

Community Health Improvement Plan (CHP): CHA results are used to develop a CHP, which is a plan for addressing priority health issues.

CHA/CHP Timeline

Last CHA Completed 2018-19

- Conduct assessments
- Identify themes
- Identify the cause of health problems

CHP development 2020

- Work with the community to develop ideas for health improvement
- Write CHP and seek approval
- Develop Health Equity Report

Current Phase

CHP implementation 2021-25

- Develop CHP indicators (measurable information used to track progress)
- Work with the community to take action

CHA Development & Implementation 2023-24

- Develop assessment plan
- Convene assessment workgroups
- Conduct assessments
- Summarize findings to support 2026-30 CHP development

Lane County Community Health Improvement Plan 2021-2025

Priorities	Ensure incomes are sufficient to meet costs of living	Establish community conditions that support behavioral health and physical well-being	Address current and historical injustices that produce disparities
Goal	**Create the community conditions necessary to promote behavioral health and physical wellness across the lifespan for all people in Lane County**		
Strategies	Support economic development that ensures sufficient income and affordability of basic living costs (i.e., housing, childcare, food, transportation, etc.) for all people in Lane County.	Ensure systems of care address the health needs - physical, behavioral, and spiritual - of the whole person and are accessible to all people across the lifespan. Implement community and organizational policies that support healthy choices and mental well-being	Transform current institutions, polices, and resource allocations that perpetuate racism in order to correct current and historical injustices and ensure equity in the future

What is an equity lens?

A set of questions we ask ourselves when we plan, develop, or evaluate a policy, program, or decision in order to ensure that we are deliberately inclusive and explicit in working towards more equitable outcomes.

Example equity lens

- What are we trying to do? What is our goal?
- Who will be impacted? Are they included in this process?
- How will this work impact inequities?
- How will we ensure participation in an inclusive and culturally sensitive manner of those who are impacted?
- How will we know if we have accomplished our goal?

Lane County's equity lens: https://cdnsm5-hosted.civiclive.com/UserFiles/Servers/Server_3585797/Image/Government/County%20Departments/County%20Administration/Advisory%20Committees/Equity%20and%20Access/Lane%20County%20Equity%20Lens%20Two%20Pager%20Updated%2010.25.21%202nd.pdf

Applying an equity lens to Lane County's 2020 Heath Equity Report

- Started with data from the Community Health Status Assessment to identify indicators that could be disaggregated by race, ethnicity, disability and other identities that have been systematically marginalized.
- Once data was compiled, convened an ad-hoc committee of community members that were recruited from the Lane Equity Committee, Community Advisory Council, Lane County Equity and Access Advisory Committee, and other community organizations to review the data, help with framing the story, and advise on making the data presentation accessible

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

LiveHealthy LANE

Introduction

Health outcomes

Health behaviors

Social determinants

About the data

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.

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**

PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

https://public.tableau.com/views/LCPH_HealthEquityReport_2020/D2?%3Alanguage=en&%3Adisplay_count=y&publish=yes&%3Atoolbar=n&%3Aorigin=viz_share_link%20&%3AshowVizHome=no_#1

2021-2025 CHP Indicators | Tableau Public

Ensure incomes are sufficient to meet basic needs

- Basic needs inaccessible due to cost
- Housing cost burden
- Gap between median income and basic costs

Community conditions support behavioral and physical health across the lifespan

- Adult rates of chronic disease
- Adult and youth mental health
- Measures of student success
- Substance use
- Unmet mental health needs

Address current and historical injustices that produce disparities

- Educational attainment
- Homeownership
- Premature death

Additional resources for understanding how to use data to create equity

- Principles of Data Feminism
- Principles of ecosocial theory of disease distribution from Epidemiology and the People's Health
- Urban Institute's Do No Harm Guide on data visualization

Thank you!

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