

>> 2015-2019 State Health Improvement Plan

Final Progress Report



Oregon
Health
Authority
PUBLIC HEALTH DIVISION

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Executive Summary

The State Health Improvement Plan (SHIP) advances OHA's vision for a state where a healthy life is within reach for all people in Oregon. The 2015-2019 SHIP was focused on seven priorities. When identified in 2014, these priorities represented the leading causes of death in Oregon and areas where Oregon could make significant progress to improve the health of everyone in the state.

- Prevent and reduce tobacco use
- Prevent and reduce obesity
- Improve oral health
- Reduce harms associated with alcohol and substance use
- Prevent deaths from suicide
- Improve immunization rates
- Protect the population from communicable diseases

Each priority area included interventions in three broad categories: population health, health systems, and health equity. To measure progress, the Oregon Health Authority (OHA) identified 27 targets across the seven priorities. As of January 2020, across the priority targets:



5 were achieved



11 were on the right track



12 were moving in the wrong direction

More complete information can be found online at www.healthoregon.org/ship.

Introduction

History

The State Health Improvement Plan (SHIP) outlines Oregon's health priorities, with policy, systems and environmental interventions needed to advance improvement and indicators to measure progress. Developed every five years, the SHIP is a guiding strategic document for the Oregon Health Authority (OHA). This plan informs OHA's work with other partners in governmental and community public health agencies, Coordinated Care Organizations (CCOs), hospitals, health systems, and other state agencies.

The goal of the 2015-2019 SHIP was to make measurable improvements in health outcomes for each of the seven priority areas:

- Prevent and reduce tobacco use
- Prevent and reduce obesity
- Improve oral health
- Reduce harms associated with alcohol and substance use
- Prevent deaths from suicide
- Improve immunization rates
- Protect the population from communicable diseases

These priorities were identified based on data from the State Health Assessment (SHA) and feedback from partners and stakeholders collected during community engagement sessions held in 2014. The seven priority areas were selected because they were leading causes of death and disability, were issues that were worsening over time, were issues where Oregon ranked worse compared to other states, or because they had been identified by the Centers for Disease Control (CDC) as a winnable battle. Each priority area contained evidence-based strategies for the entire population and within the health system. Each area also included health equity strategies directed at populations that experience a disproportionate burden of disease.

Implementation and accountability

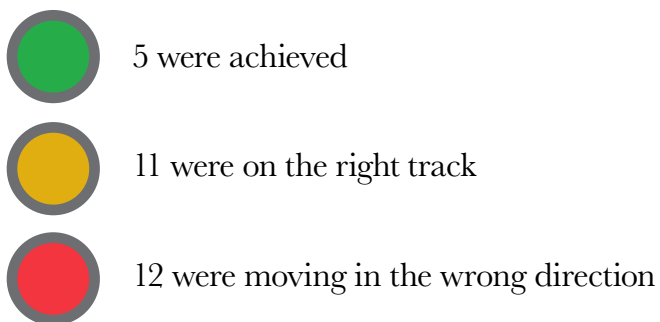
The Oregon Health Authority - Public Health Division (OHA-PHD) provided leadership for implementation and reporting progress, which occurred through a variety of mechanisms. OHA-PHD programs took the lead on strategy implementation of policy, system and environmental changes. OHA-PHD staff were identified as owners for each of the priority areas, charged with development and implementation of annual work plans. Priority owners gathered on a bi-monthly basis to share challenges and successes. Owners and other OHAPHD staff also contributed to annual progress reports, [the SHIP website](#), and ongoing communications that were shared on the Oregon Health Authority Facebook and Twitter accounts.

The Public Health Advisory Board (PHAB) is the accountable body for governmental public health in Oregon. PHAB provides oversight for the OHA-PHD's strategic initiatives, including the SHA and SHIP. The PHAB received quarterly updates about the SHIP and provided feedback for improvement. Progress on the priority targets was reported annually to the PHAB as well.

Summary of accomplishments and challenges

The 2015-2019 SHIP saw areas of accomplishment and many persistent challenges. Overall improvements were witnessed in areas of oral health, adult tobacco use, HIV, and immunizations, while issues related to suicide, substance use, sexually transmitted infections, youth tobacco use and obesity continued trending in the wrong direction. More specific details about gains in the seven priority areas can be found in this report.

To measure progress, the OHA tracked and identified 27 targets across the seven priorities. As of January 2020, across the priority targets:



Indicator		Baseline	2019	Target
Achieved	Cigarette smoking among 11th graders	10%	5%	7.5%
	Binge drinking among 11th graders	17.7%	12.8%	13%
	Third graders with cavities in their permanent teeth	15.5%	7.6%	14%
	11th graders with cavities	74.0%	64.6%	70.3%
	Adolescents with oral health problems	17.5%	10.8%	15.8%
Moving in the right direction	HIV infections per 100,000	6.1	5.5	4.5
	HIV viral load	68%	81%	90%
	Hospital onset C. Difficile (Standardized Infection Ratio)	.73	.71	.57
	E. coli cases per 100,000	2.3	1.9	.6
	Tuberculosis cases per 100,000	1.9	1.9	1.4
	Tobacco use among adults	17%	16%	15%
	Binge drinking among adults	17.4%	17.4%	16%
	Childhood vaccinations	60%	69%	80%
	HPV vaccinations	28%	51%	80%
	Flu vaccinations	42%	45%	70%
	Older adults who have lost all their teeth	17.7%	13.7%	12%
	Opium related deaths per 100,000	6.8	7.0	3.0
Moving in the wrong direction	Alcohol related car crashes	110	150	98
	Gonorrhea infections per 100,000	57.8	142.7	72
	Syphilis infection per 100,000	10.4	17.2	11.1
	Vaping among 11th graders	18%	24%	15%
	Heavy drinking among adults	7.7%	8.7%	6.6%
	Suicide per 100,000	18.7	19	16
	Suicide attempts among 11th graders	7.9%	10%	7%
	Obesity among 2-5 year olds	15.4%	16.6%	14.5%
	Obesity among youth	11%	14%	10%
	Obesity among adults	27%	30%	25%
	Diabetes among adults	8.1%	9.8%	8%

Accomplishments

While OHA struggled to achieve many of the intended targets, OHA made other accomplishments in alignment and communication about overall priorities, and our understanding of health disparities.

The priorities of the 2015-2019 SHIP were framed by the social determinants of health, or the economic, social and economic factors that affect people's health. Since the 2015-2019 SHIP was published, public health's attention to not only the social determinants of health, but the social determinants of equity, has evolved. In addition to working across systems like housing, education, and economic development, OHA needs to be breaking down the systemic bias that disadvantages communities based on race or ethnicity, income, gender identity, sexual orientation, ability, and other identities. To that end, the health equity strategies were significantly revised in 2018 to better address race and ethnicity-based disparities.

While PHAB provides oversight to OHA-PHD, the [Oregon Health Policy Board \(OPHB\)](#) is the policy and oversight board of OHA. In 2010, the OHPB created the [Action Plan for Health](#) to address urgent health care issues in our state. This plan was refreshed in 2017 to consider the reforms that had taken place through implementation of the Affordable Care Act and start-up of Coordinated Care Organizations (CCOs). In the spirit of alignment, the 2017-2019 Action Plan for Health highlighted the need to work in tandem with the SHIP. This alignment helped to foster momentum and clear direction for OHA in its work to achieve a healthy Oregon. CCOs provided important opportunities to advance collective effort among low-income communities. During implementation of this SHIP, CCO incentive measures were in place or in development for six of the seven priority areas. To assist CCOs with successful achievement of incentives, OHA's Transformation Center provided training and technical assistance in alignment with many of the priorities. The SHIP also helped to inform CCO performance improvement projects aimed at reduction of opioid prescriptions.

2015-2019 SHIP & CCO Incentive Measure Alignment

SHIP measure	CCO incentive measure
Prevent and reduce tobacco use	Cigarette smoking prevalence (2016-2019)
Improve oral health	Dental sealants on permanent molars (2015-2019) Oral evaluation for adults with diabetes (2019)
Reduce harms associated with alcohol and substance use	Drug and alcohol screening (2015-2016, 2019)
Prevent deaths from suicide	Depression screening and follow-up plan (2015-2019) Follow up after hospitalization for mental illness (2015-2017)
Improve immunization rates	Childhood immunization status (2016-2019)
Slow the increase of obesity	Weight assessment and counseling for children and adolescents (2018-2019)
Protect the population from communicable disease	Metrics related to HIV and Hepatitis C screening were proposed to the Health Plan Quality Metrics Committee, but did not move forward.

The SHIP was also intended to be used as a guiding document for Community Health Improvement Plans (CHIPs) implemented by local public health authorities (LPHAs), CCOs and hospitals. While CCOs and non-profit hospitals are required by law to implement CHIPs, LPHAs do so voluntarily as part of the national public health accreditation process. OHAPHD staff worked closely with colleagues in OHA's Transformation Center, the Office of Rural Health and the Association of Oregon Hospitals and Health Systems to encourage alignment of priorities across the state. For example, [an online map](#) was created to enable sharing of Community Health Assessments (CHAs) and CHIPs across the state, and progress updates were frequently shared via these partners. There was significant overlap in CHIP and SHIP priorities; top priorities among CHIPs included substance use, chronic disease management, obesity and oral health.

Public health modernization also bolstered the priorities of the SHIP and shifted public health practice. The development and implementation of the SHIP is a core system function of the policy and planning foundational capability, and relies heavily on the other foundational capabilities. Increased investments in the foundational program of communicable disease control contributed to quality improvement, improved data collection, and partnership development, particularly in areas related to immunizations, health care acquired infections and sexually transmitted infections. Increased capacity in foundational capabilities helped strengthen health equity interventions. The SHIP also informed creation of the Public Health Accountability Metrics, a series of metrics used to track progress towards the modernization of Oregon's public health system. Four of the eight accountability metrics align with a SHIP priority target.

While OHA provided leadership for the SHIP, the achievements are a result of partnerships with other state and local agencies, such as Regional Health Equity Coalitions, LPHAs, CCOS, and the Department of Human Services (DHS), Department of Transportation (ODOT) and the Department of Education (ODE). OHA is grateful for these partners as we work collectively to improve health in our state.

Challenges

Even in priority areas where gains were made, unjust and unacceptable disparities persisted, especially among communities of color. These disparities exist due to current

2015-2019 SHIP & Public Health Accountability Metric Alignment (* indicates alignment)

Communicable disease control

- Two-year-old immunization rates*
- Gonorrhea rates*

Environmental health

- Active transportation
- Drinking water standards

Prevention and health promotion

- Adults who smoke cigarettes*
- Opioid overdose deaths*

Access to clinical preventive services

- Effective contraception use
- Dental visits for 0-5 year olds

and historical racism and disinvestment in communities of color. OHA recognizes that the design of this SHIP did not include communities nor a broad spectrum of partners, thus these priorities may not resonate with communities and have not effectively addressed health inequities from a systemic level. In recognition of these shortcomings, OHA is shifting the way data are collected, priorities are selected and strategies are designed for the 2020-2024 SHIP.

OHA is committed to improving its relationship with communities that have experienced systemic racism and oppression by building trust and co-creating culturally responsive public health interventions. The 2020-2024 SHIP will further our steps in this direction.

Challenges in implementation have also highlighted a continued need to effectively influence policy and systems change, especially in areas that lay outside of traditional public health, such as housing or education. While improving health is the job of OHA, it is not OHA's job alone, especially as public health grows in its understanding of the social determinants of health and equity. By increasing public health's capacity in the foundational capabilities such as community partnership development, policy and planning, and leadership competencies, OHA can strengthen its relationship with sectors whose work also influences health.

While the social determinants of health framed the priorities of the 2015-2019 SHIP, the 2020-2024 SHIP will move even farther upstream with increased emphasis on the impacts of institutional bias, trauma and toxic stress and economic drivers of health such as housing, poverty and food security.

Prevent and Reduce Tobacco Use

Tobacco use remains the number one cause of preventable death in Oregon. Tobacco use kills approximately 8,000 Oregonians each year, and contributes to lung cancer, heart disease and other chronic illnesses. Cigarette smoking among adults and youth decreased overall; however, this was overshadowed by a dramatic increase in use of e-cigarettes among youth.

Population & Strategies

- Increase the price of tobacco
- Prohibit free sampling of tobacco products, tobacco coupon redemption and other price reduction strategies
- Increase the number of tobacco-free environments

The 2015-2019 SHIP influenced significant policy wins aimed at reducing tobacco use. In 2018, Oregon's Tobacco 21 law went into effect. This law raised the minimum age for a person to buy tobacco products or e-cigarettes from 18 to 21. In 2019, Governor Brown signed HB 2270 into law. The initiative was referred to Oregon voters by the legislature and will appear on the November 2020 ballot. The most effective way to help people quit tobacco and prevent kids from starting is to raise the price of tobacco.

At the local level, five counties in Oregon now require retailers to have a license to sell tobacco. This policy is gaining momentum in other counties, driven by a national outbreak of e-cigarette and vaping associated lung injury in 2019, and a dramatic rise in youth e-cigarette use.

Although Oregon saw a decrease in cigarette smoking among youth, this decrease was overshadowed by a significant increase in youth e-cigarette use. The types of e-cigarettes and vaping products on the market expanded rapidly in the past five years. These products are flavored, inexpensive, and heavily marketed to youth. Emerging evidence suggests that e-cigarettes are not an effective way for adults to quit smoking. And the science is clear that the new generation of e-cigarette products is addicting youth to nicotine who would not otherwise have tried a tobacco product. Addressing youth e-cigarette use will continue to be a priority for OHA.

Figure 1

Cigarette smoking among adults

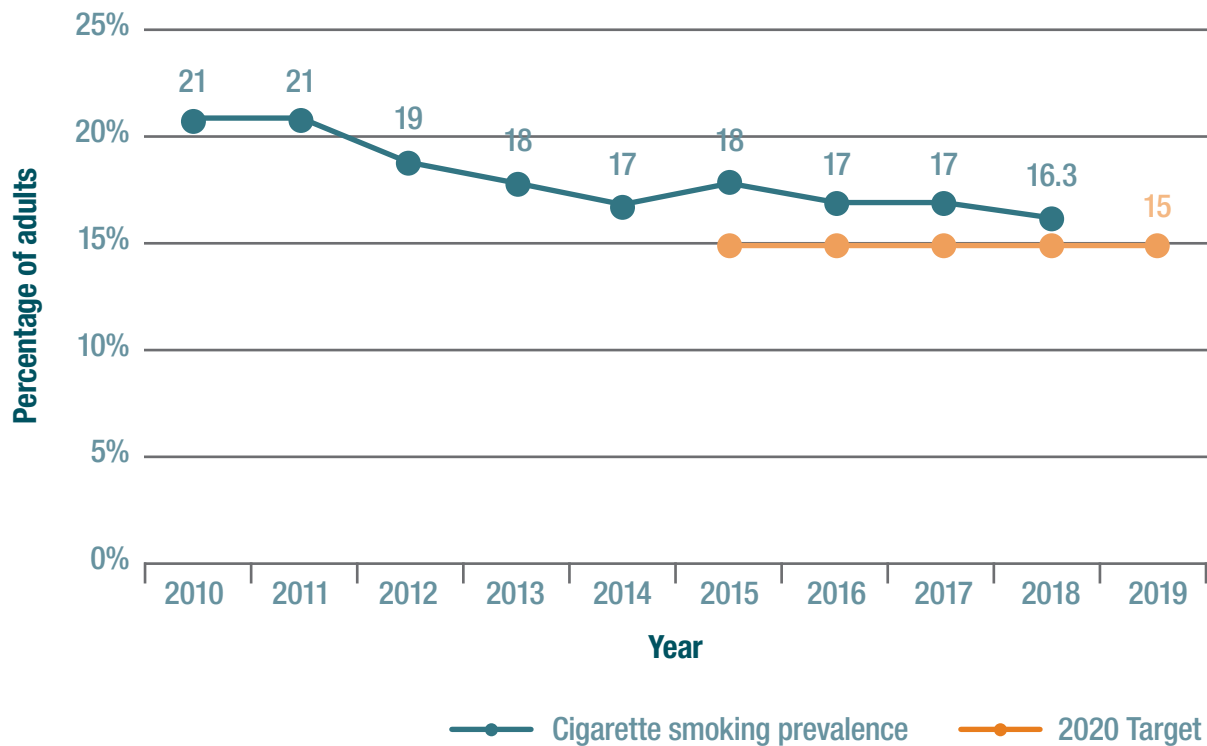
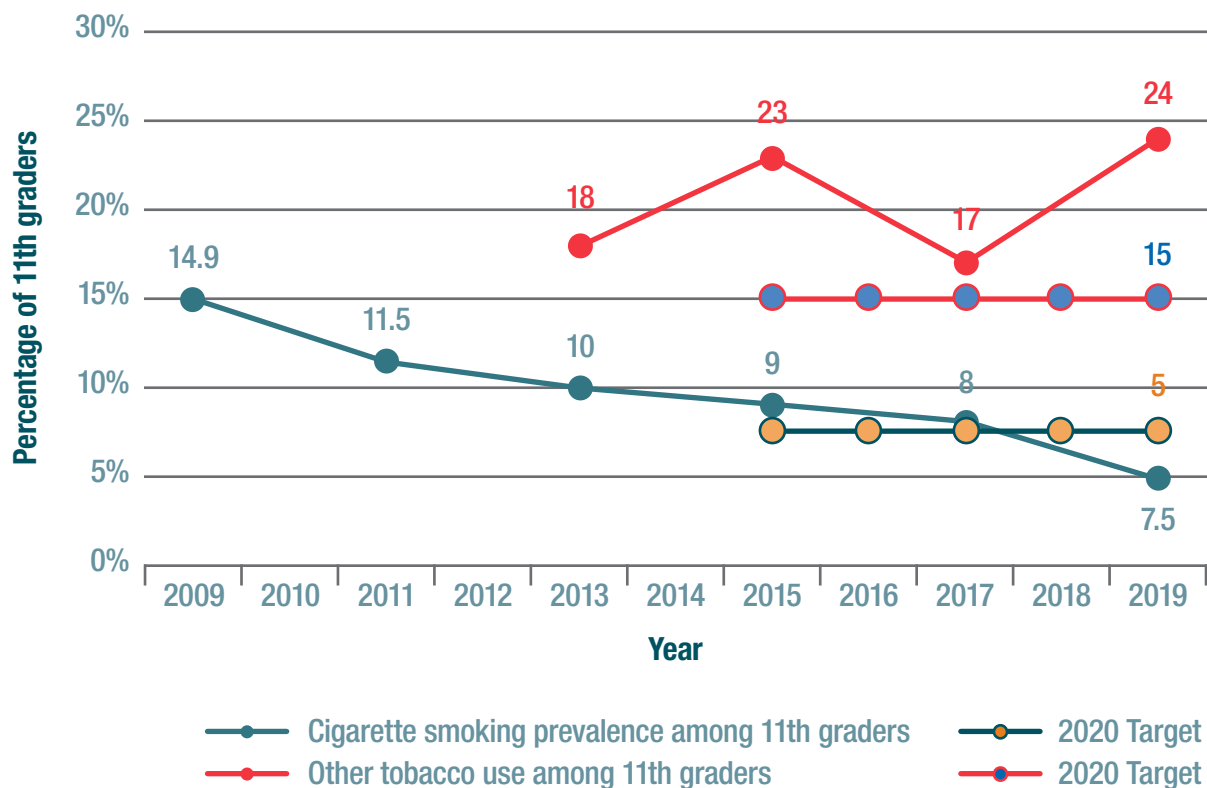


Figure 2

Tobacco use among youth



Health Equity Strategies

- Increase protections for secondhand smoke among low-income and service-industry employees
- Increase the number of DHS and OHA mental and behavioral health service providers that adopt tobacco-free campus policies, adopt tobacco-free contracting rules and refer clients and employees who smoke to evidence-based cessation services
- Build capacity among culturally specific organizations and communities disproportionately affected by tobacco industry targeting.
- Increase the number of American Indians/Alaska Natives accessing Quit Line services.

The burden of tobacco use falls hardest on lower-income Oregonians and communities of color. This is due, in great part, to tobacco industry advertising that disproportionally targets low income communities.

One in seven workers are still exposed to secondhand smoke in their workplaces, with low-income and service industry workers being most at risk. Counties, tribes, community-based organizations and other partners went to Salem during legislative sessions to express support for maintaining and expanding indoor clean air protections to ensure equal access to smoke-free environments. Since 2015, five jurisdictions in Oregon have passed policies that expand protections beyond Oregon's Indoor Clean Air Act.

OHA continued implementation of the Tobacco Free Facilities and Services policy (formerly Tobacco Freedom). The policy sets requirements for addictions and mental health facilities licensed and funded by OHA to provide tobacco-free environments; promote healthy alternatives to using tobacco; increase access to peer-based and other tobacco cessation supports; and improve discharge planning to promote sustained tobacco cessation in recovery.

During the last five years, OHA continued to fund Tribes and Regional Health Equity Coalitions (RHEC) to build policy capacity among culturally specific organizations and communities disproportionately affected by tobacco industry targeting. For example, OHA developed the Community Policy Leadership Institute model to bring together community leaders, health departments and decision makers to co-lead local policy and system change among communities affected by health inequities.

OHA also worked with the Northwest Portland Area Indian Health Board, the nine federally recognized tribes, the Native American Youth and Family Center, NARA and Chemawa to co-develop the Oregon Tobacco Quit Line, a culturally-relevant commercial tobacco cessation program to meet the needs of American Indian and Alaska Native populations. The program, launched in 2019, is designed to include high intensity behavioral and pharmacological support provided by a team of dedicated Quit Coaches with experience

working with Oregon-specific AI/AN populations. Additionally, OHA co-created culturally specific communications materials featuring members of Oregon's tribal communities to promote the new service.

Health System Strategies

- Create incentives for private and public health plans and health care providers to prevent and reduce tobacco use
- Ensure availability of comprehensive cessation benefits through private and public health plans
- Create tobacco-free private and public health plans

Public health plans in Oregon are now required to provide comprehensive tobacco cessation services. CCOs provide comprehensive cessation services that align with the standards established by the Affordable Care Act (ACA), including no prior authorization or co-pays. Public health plans offered through the Public Employees' Benefit Board (PEBB) and Oregon Educators' Benefit Board (OEBB) also meet these ACA standards. In 2016, OHA introduced an incentive metric for CCOs to reduce cigarette smoking among members. The metric provides financial incentives to CCOs to offer or improve comprehensive cessation benefits and reduce tobacco use among members. In 2018, 15 of 16 CCOs met an improvement or benchmark metric related to tobacco prevention services. In addition, two CCOs invested significant resources in tobacco prevention and cessation campaigns to further reduce use among their members.

Prevent and Reduce Obesity

Obesity is the number two leading cause of preventable death in Oregon, second only to tobacco use. Obesity related conditions account for 1,500 deaths in Oregon each year. Preventing obesity among Oregonians lowers the risk of diabetes, heart disease, stroke, cancer, high blood pressure, high cholesterol, arthritis, stress and depression. Obesity rates have continued to increase over the past five years.

Population & Strategies

- Increase the price of sugary drinks
- Increase the number of private and public businesses and other places that adopt standards for healthy food and beverages, physical activity and breastfeeding
- Increase opportunities for physical activity for adults and youth
- Improve availability of affordable, healthy food and beverage choices

Due to lack of specific funding, action on the intended policy strategies was challenged, as seen by worsening obesity rates over the past five years. No movement was made on increasing the price of sugary drinks through taxation due to minimal political support. However, in 2019 Healthy Active Oregon (HAO), a statewide obesity prevention coalition was established. One of HAO's priority initiatives is to reduce consumption of sugary beverages. While progress was made in advancing individual state agency workplace policies for physical activity, healthy food and beverages, and especially breastfeeding, no state agencies adopted a comprehensive nutrition, physical activity and breastfeeding policy.

The Farm Direct Nutrition Program (FDNP) aims to increase the amount of fruits and vegetables purchased by families who receive WIC benefits. In 2017, the Oregon legislature increased FDNP funding. Despite the increase in funding, the amount of fruits and vegetables purchased remained flat or declined slightly over the five-year period.

To increase opportunities for physical activity among children and adults, PHD leveraged partnerships with the Safe Routes National Partnership to promote Safe Routes to Schools and Safe Routes to Parks programs in Oregon. The Oregon Arthritis Program funded three Safe Routes to Parks projects and PHD staff partnered with ODE and ODOT to promote Safe Routes to School programs across the state. PHD staff also continued to provide policy guidance to state and local transportation agencies on health supportive transportation policies. In addition, in the last five years, the Oregon Legislature passed a number of bills to increase

Figure 3

Obesity prevalence among youth

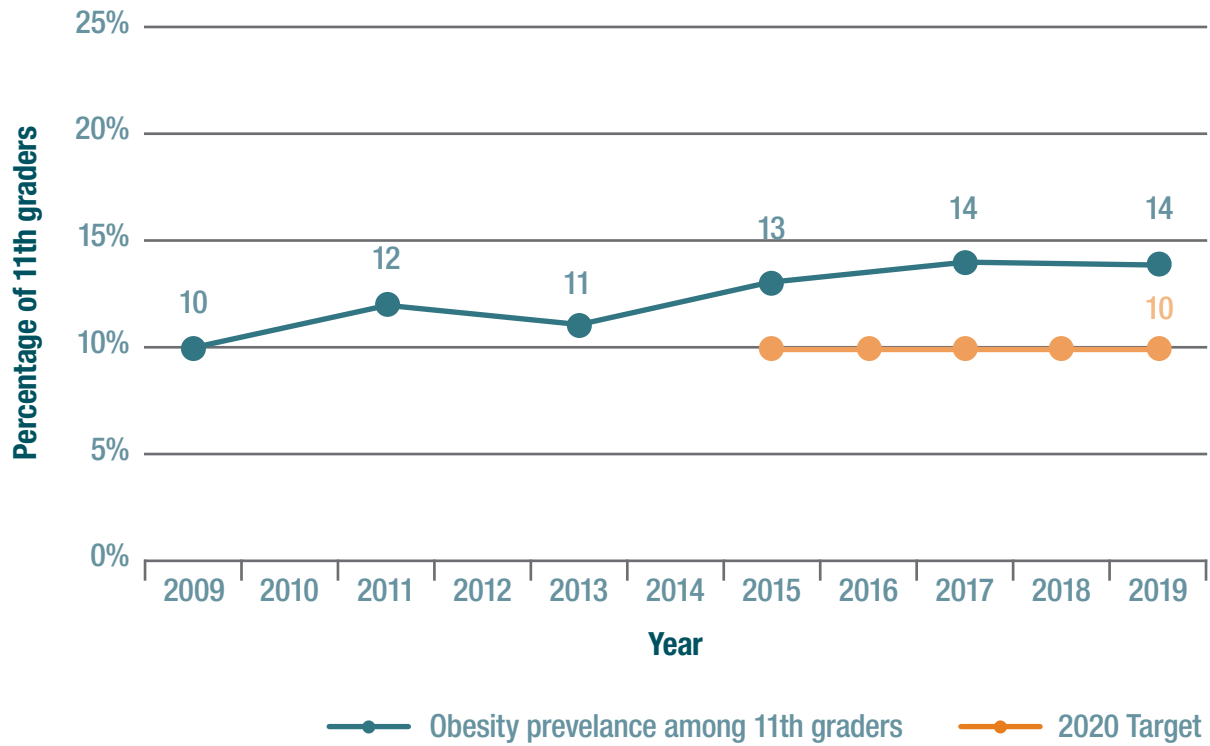
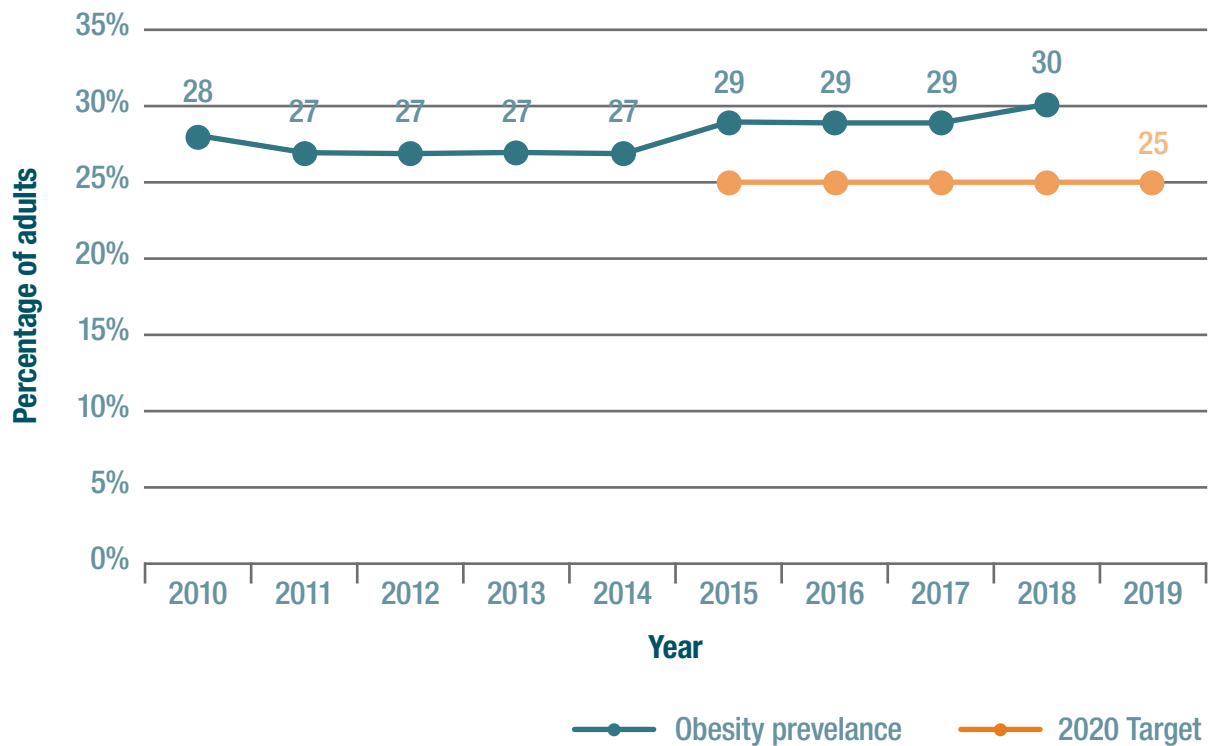


Figure 4

Obesity among adults



physical activity: SB 4 (2017) – strengthened physical activity requirements in schools; HB 2017 (2017) – Keep Oregon Moving provides investments in public transportation and infrastructure to support walking and biking; and HB 3427 (2019) – The Student Success Act allows for grants from the Student Investment Fund to be used to broaden curricular options, including access to physical education classes.

Health Equity Strategies

- Increase the number of DHS and OHA mental and behavioral health service providers that adopt standards for healthy foods and beverages, physical activity and breastfeeding for clients and employees
- Increase the number of people at high risk of type 2 diabetes who participate in the National Diabetes Prevention Program
- Increase the number of American Indian/Alaska Natives participating in evidence-based lifestyle change programs, including the Diabetes Prevention Program.
- Increase access to healthy foods in low income communities and with poor access to healthy foods
- Build capacity among culturally specific organizations and communities disproportionately affected by sugary beverage industry marketing.

Low-income communities, and some communities of color, are disproportionately affected by obesity. This is in large part due to the traumatic impacts of systemic racism and oppression, compounded by sugary beverage industry marketing, and state disinvestment in communities to ensure access to safe, active transportation and affordable, healthy food.

WIC increased availability of culturally appropriate foods in the food package benefit, enabling participants to access foods that are part of their traditional diet, such as tofu, yogurt, corn tortillas, bulgur and increased variety of dried beans.

The Diabetes Prevention Program (DPP) DPP is an evidence based, self-management program for people at risk of developing type 2 diabetes. In 2018, DPP became a covered benefit for people insured by Medicaid, PEBB and OEBC. While the number of people enrolled in DPP increased from 63 (2014) to 7,345 (2018), the number of American Indians/Alaska Natives identified participants remained stable at approximately 35 people per year. To increase access to services, OHA is funding the Northwest Portland Area Indian Health Board to work with Tribes and tribal health organizations to conduct an assessment to better understand what specific support is needed for National DPP implementation in tribal communities. Additional efforts include a Tribal Diabetes Community of Learning to determine a pathway for billing through a new Traditional Health Worker provider type, Tribal Lifestyle Coach, training new tribal lifestyle coaches and technical assistance for Medicaid billing and reimbursement processes.

Regional Health Equity Coalitions (RHEC) developed and advanced culturally appropriate and equity informed policy, system, and environment change strategies aimed at helping members of their community's eat better and move more.

Health System Strategies

- Create incentives for private and public health plans and health care providers to decrease the prevalence of obesity
- Increase the number of hospitals that meet baby-friendly standards
- Ensure coverage for weight management and chronic disease self-management programs by private and public health plans
- Adopt and implement standards for food and beverages sold or available at private and public health plans, clinics and hospitals.

OHA partnered with CCOs and other payers to support multi-sector interventions that address physical activity and nutrition. OHA conducted a pilot test of an obesity metric for CCOs and is developing implementation and evaluation plans to support a multi-sector intervention obesity prevention formal incentive metric.

Breastfeeding is a protective factor for obesity, and hospitals play an important role in breastfeeding initiation. Births in Baby Friendly Hospitals, which meet standards that support breastfeeding, increased from 32.4% in 2016 to 52.6% in 2018 according to CDC's Breastfeeding Report Card.

Reduce Harms Associated with Alcohol and Substance Use

Oregon continues to have one of the highest rates of alcohol and substance use in the country.

Population Strategies

- Increase the price of alcohol.
- Maintain Oregon's state alcohol beverage control
- Increase the number of jurisdictions covered by alcohol marketing, promotion and retail restrictions such as limiting outlet density, price promotions, and limits on days or hours of sale and point of purchase interventions
- Increase the number of colleges and universities with restrictions on alcohol promotion, sale or sponsorship at college or university events

Increasing the price of alcohol and maintaining state control are effective strategies to reduce excessive drinking, including youth and adult binge drinking, and related harms such as motor vehicle crashes, violence, intimate partner violence and liver disease and various cancers. In 2018, OHA put forth a legislative concept to increase the retail price of beer, cider, and wine by 10%. While this concept did not move forward for consideration, it sought to increase taxes on alcohol and direct new revenues to alcohol and other drug prevention.

While Oregon was able to maintain control over the sale and regulation of alcoholic beverages, specifically distilled spirits, the Oregon Liquor Control Commission has a liquor outlet expansion plan that aims to expand liquor sales and increase liquor outlet density in communities throughout the state. Higher density of places that sell alcohol is associated with an increase in alcohol-related problems such as violence, crime and injuries. There is a continued public health and safety need to balance the availability of alcohol with the maintenance of state alcohol control.

In 2018, OHA conducted the Tobacco and Alcohol Retail Assessments, a statewide assessment of tobacco and alcohol advertising, marketing and promotion in locations where people shop daily. The assessment exposed the ways in which the alcohol industry targets Oregonians, particularly youth, through flavor offerings and low prices. The assessment provides a foundation to discuss how communities can take steps to limit youth access to alcohol and reduce excessive drinking by changing the rules for where and when alcohol can be sold.

Figure 5

Binge drinking among youth and adults

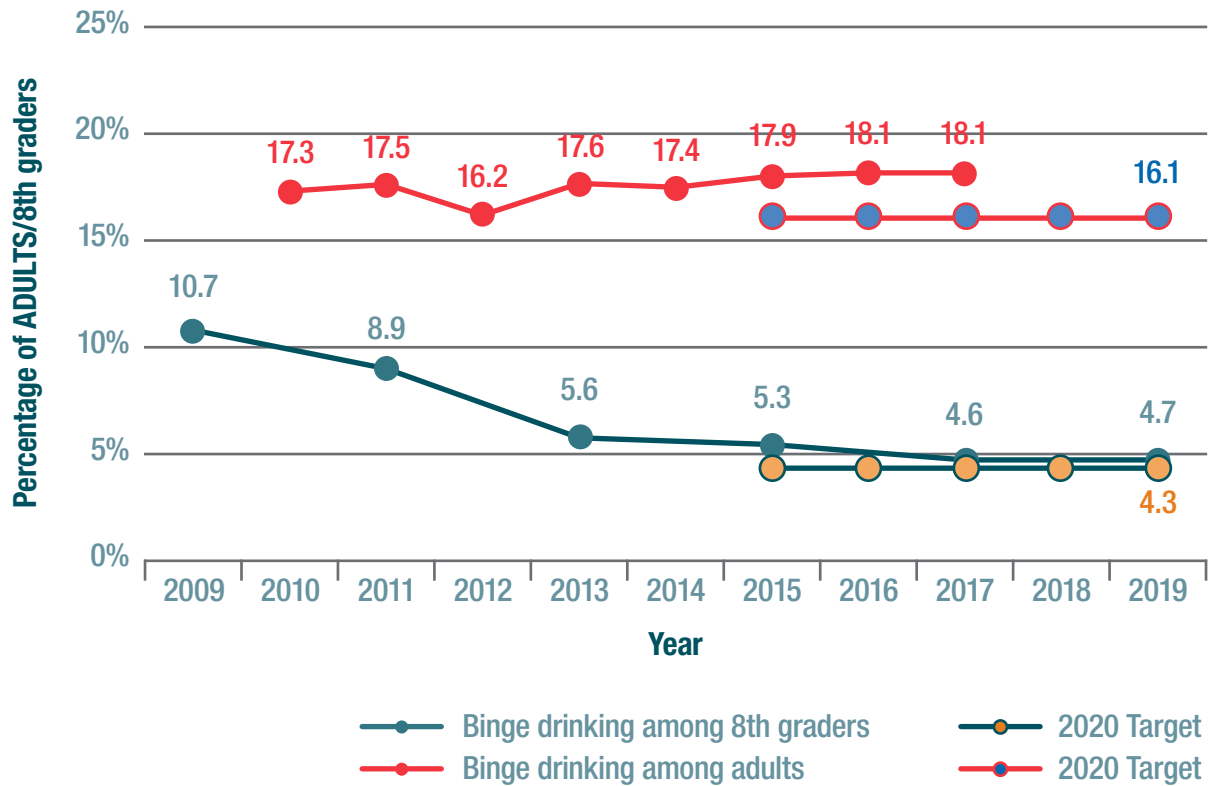
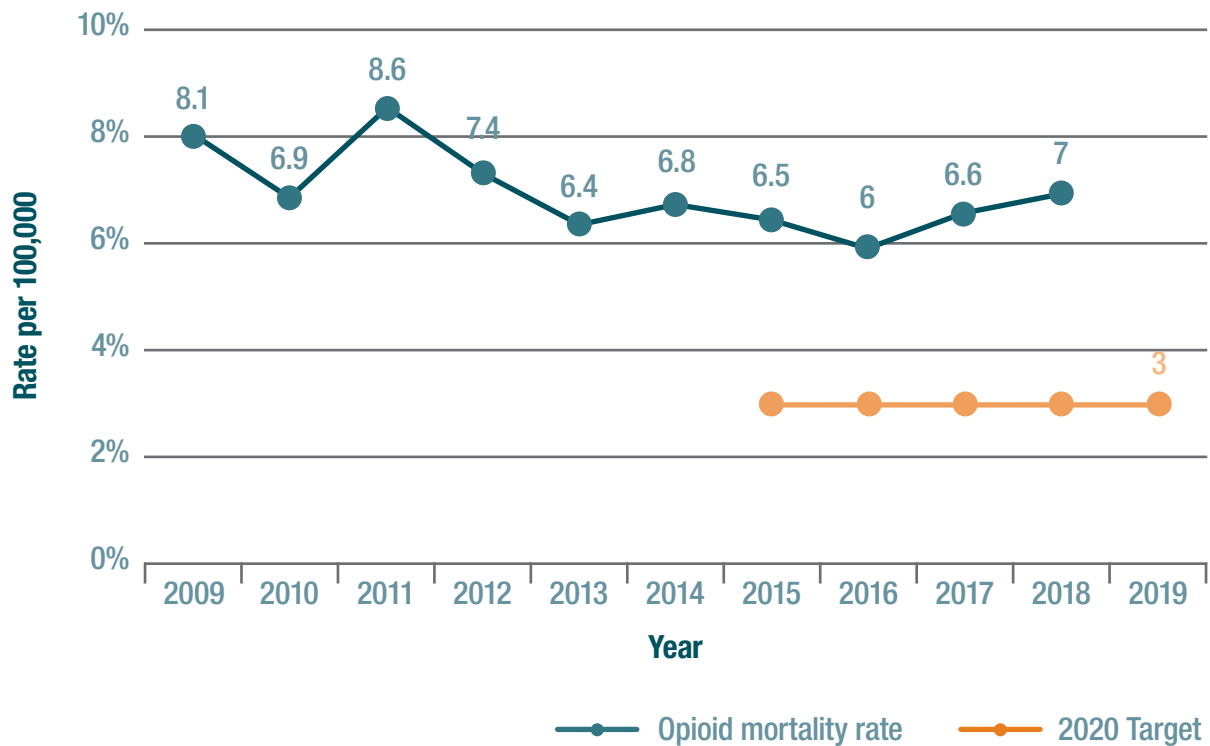


Figure 6

Opioid deaths



Health Equity Strategies

- Build capacity among culturally specific organizations and communities disproportionately affected by alcohol industry targeting
- Reduce opioid overdose deaths among American Indian/Alaska Natives

RHECs are exploring evidence-based strategies related to alcohol outlet density, pricing policies and restrictions on alcohol promotion and point of purchase interventions in communities. The OHA-PHD also sustained funding to nine federally recognized Tribes to plan and implement culturally relevant alcohol and other drug prevention strategies.

Many efforts were in place to address the disproportionate number of opioid overdose deaths experienced by American Indian/Alaska Natives. The OHA-PHD Prescription Drug Overdose Prevention Program sponsored training, planning and capacity building related to opioid prevention, treatment and recovery for nine federally recognized tribes, [Native American Rehabilitation Association \(NARA\)](#), [Northwest Portland Area Indian Health Board \(NPAIHB\)](#), [Indian Health Service](#) and Local Public Health Authorities. The 2018 Oregon Tribal Summit on Opioids and Other Drugs had 224 attendees who attended conference and planning sessions. The 2019 Oregon Tribal Opioid Training Academy provided training on a variety of topics to more than 140 attendees, including tribal best practices for wellness and recovery, addiction pharmacology, adult and youth Mental Health First Aid, community emergency response, naloxone rescue, trauma informed care, pain science, medication assisted treatment, acu-detox and the Heal Safely pain management education campaign. The annual Oregon Conference on Opioids, Pain, and Addiction Treatment included a Tribal Best Practices track, with 429 attendees in 2018 and 416 attendees in 2019. In 2019, the nine tribes and NARA also received grants of \$25,000 each to support implementation of projects supporting opioid prevention, treatment and recovery.

Finally, the OHA-PHD worked with Brink Communications to launch two media campaigns related to the opioid epidemic, Heal Safely (www.healsafely.org) and Reverse Overdose Oregon (www.reverseoverdose.org). Heal Safely supports safe and effective non-opioid pain management with culturally responsive messaging for communities disproportionately affected by the overdose epidemic. Reverse Overdose Oregon is a bystander training initiative on the administration of naloxone, focused on workplaces. Brink Communications worked closely with Tribes to ensure developed materials were culturally responsive and centered in Tribal traditions. Confederated Tribes of Siletz Indians, Confederated Tribes of the Umatilla, Klamath Tribes and the Native American Rehabilitation Association (NARA) are planning to distribute a total of 2,600 naloxone-ready kits in their local communities.

Health System Strategies

- Create incentives for private and public health plans and health care providers to prevent alcohol and substance use disorders
- Reduce high risk prescribing
- Ensure public health plans expand evidence-based alternative pain management therapies for patients with chronic non-cancer pain and patients with history of substance use disorder and mental health problems
- Ensure public health plans cover a full spectrum of inpatient and outpatient services for alcohol use disorder
- Ensure availability of medication-assisted treatment for opioid use disorder
- Reduce alcohol use around the time of pregnancy

The health care system has been an important partner in addressing substance use. The Screening, Brief Intervention and Referral to Treatment (SBIRT) was a CCO incentive metric for 2015, 2016 and in 2019. SBIRT is an evidence-based practice that identifies and helps individuals who are drinking above recommended amounts. The U.S. Preventive Services Task Force, as well as many other organizations, have recommended that the SBIRT be implemented for all adults, in primary healthcare settings.

High risk prescribing of opioids has meaningfully decreased in the last five years across all measures. OHA developed Oregon Opioid Prescribing Guidelines in 2017, followed by an online pain education module for health care professionals and pain education resources for patients. The module helps both incoming clinicians and seasoned professionals develop a new understanding of pain and pain treatment. To date, more than 15,000 clinicians have completed the course, and over 70% of completers report that they plan to change their treatment approach.

Clinics have undertaken a variety of quality improvement efforts to decrease the number of prescriptions and increase alternative pain treatments for patients. OHA also expanded availability of treatment for Opioid Use Disorder by collecting data on the number of providers licensed to prescribe buprenorphine. As of April 2020, 1,300 providers fit this criterion and 57% had prescribed buprenorphine at least once. OHA expanded treatment availability to 21 opioid treatment programs (OTPs) in Oregon, with the highest concentration of buprenorphine waived providers and OTPs geographically located along the I-5 corridor.

Improve Oral Health

Oral health has improved since 2015. The SHIP has increased awareness about the importance of oral health for overall health and well-being for all ages. Oral diseases affect what people eat, how people communicate, the way people look, people's ability to learn, and how people feel about themselves.

Population Strategies

- Increase the number of fluoridated public water districts

Oregon's largest challenge in oral health is the number of people residing in areas served by optimally fluoridated water. Community water fluoridation is the controlled adjustment of fluoride in a public water supply to prevent cavities and dental disease. Oregon has the third lowest amount of fluoridation in community water systems nationwide - 21.9% in 2018.

Community water fluoridation is an evidence-based practice recommended by the Community Preventive Services Task Force, Centers for Disease Control and Prevention (CDC), Association of State and Territorial Dental Directors (ASTDD), and Healthy People 2020. Increasing access to fluoridated water is also a significant health equity intervention since it reduces dental cavities and disease across the entire population, regardless of age, race or ethnicity, insurance coverage, access to a dentist, or the ability to pay for care. It is especially beneficial for older adults who may not have access to dental care since routine dental care is not covered under traditional Medicare.

Figure 7

Oral health among children

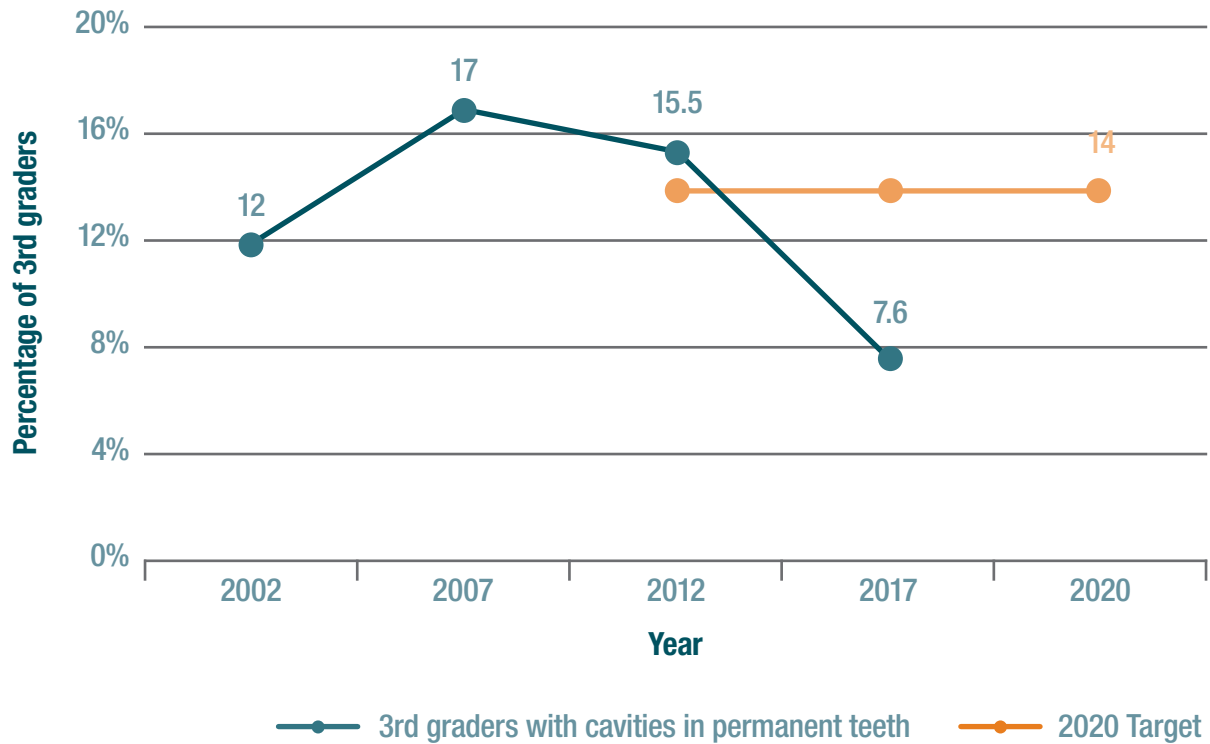
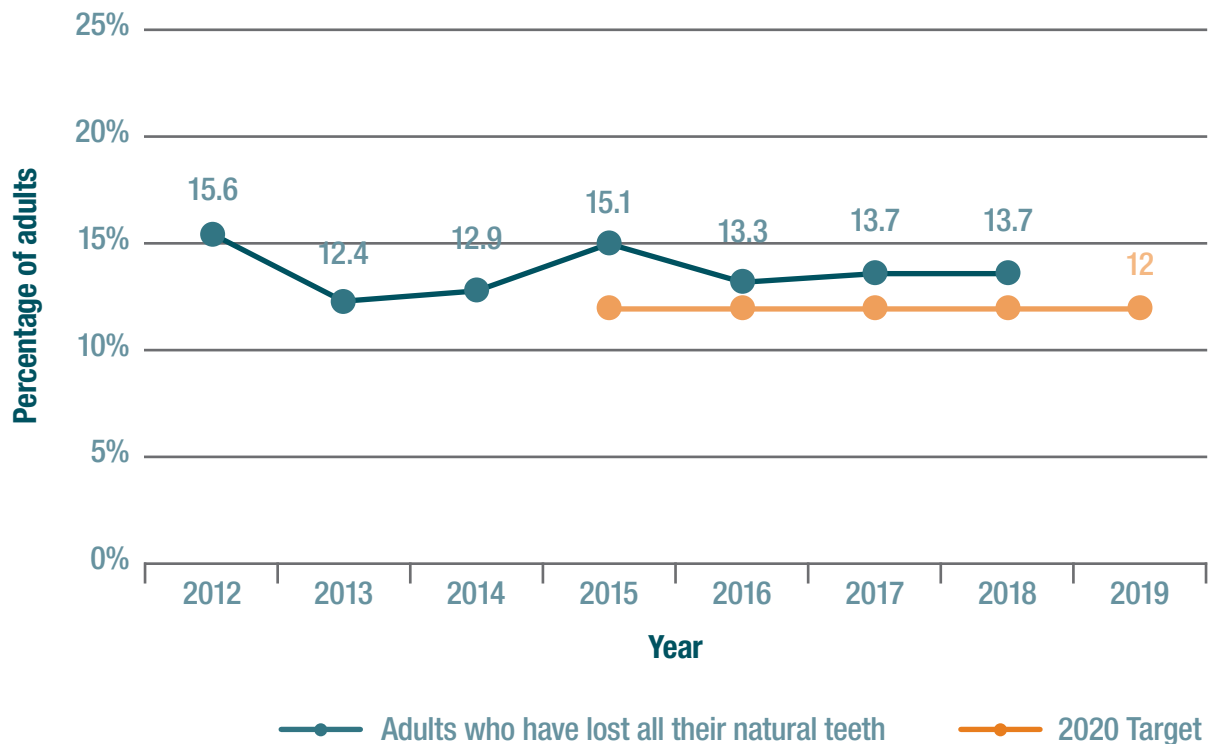


Figure 8

Oral health among adults



Health Equity Strategies

- Assess data needs for racial and ethnic disparities
- Provide oral health educational materials for racial and ethnic communities
- Provide dental sealants in schools that serve students at high risk of tooth decay
- Enhance oral health services through community clinics, including School-Based Health Centers
- Ensure that Oregon has an adequate number of oral health professionals
- Reduce the number of dental-related visits to emergency departments

Oral health services in school settings have significantly expanded. Nearly all schools with a higher proportion of children receiving free or reduced cost meals are now being offered dental sealant services. This is largely due to the CCO financial incentive metric for sealants and the ability to coordinate efforts statewide through the mandatory certification program for local school dental sealant programs.

Over the past five years, Oregon saw an improvement in oral health indicators for children ages 6-9 years old. Despite overall improvements in oral health, substantial disparities exist for children and adults based on geographic residence, household income, and race and ethnicity. The OHA Oral Health Program has applied a health equity lens, particularly in school oral health programs. Data on race, ethnicity, language and disability (REAL-D) is being voluntarily collected from those served by the statewide OHA School-based Dental Sealant Program. OHA trains school dental sealant program staff and dental hygienists from across the state on trauma informed care, health literacy, plain language and cultural responsiveness.

Health System Strategies

- Create incentives for private and public health plans and health care providers to improve oral health
- Increase early preventive care for children
- Include oral health in chronic disease prevention and management models
- Ensure dental benefit packages cover care and treatment to ensure optimal oral health maintenance

From 2015-2019, CCOs were accountable to an incentive metric for application of dental sealants, and public health had a modernization developmental accountability metric around dental visits for children ages 0-5. The message that children should have their first dental visit by age one is being widely accepted, as evidenced by an increase in children who

have received a preventive dental visit during their first two years (49.2% in 2017 compared to 43.9% in 2016). This has been most important for children insured by Medicaid due to disparities in access. In 2018, 44.6% of Medicaid children ages 0-5 had a dental visit in the past year.

OHA has been working with CCOs and LPHAs on oral health integration into physical and behavioral health, as well as chronic disease systems of care. Beginning in 2019, CCOs are accountable to an incentive metric around oral evaluation for adults with diabetes. OHA now collects body mass index (BMI) data for the Oregon Smile & Healthy Growth Survey that is conducted every five years to monitor the oral health and overweight/obesity status of Oregon children in grades 1-3. Efforts are underway to decrease HPV-associated oropharyngeal (mouth and throat) cancer. Oregon is the first state to allow dentists to administer all types of vaccinations as of January 1, 2020. OHA is partnering with the Oregon HPV Prevention Alliance and American Cancer Society to capitalize on this opportunity and increase HPV vaccination rates among dentists.

Protect the Population from Communicable Diseases

Over the last five years, there have been significant advancements in control of communicable disease.

Population Strategies

- Reduce infections caused by pathogens commonly transmitted through food
- Reduce spread of emerging pathogens
- Reduce non-judicious antibiotic prescriptions
- Reduce and control the spread of Tuberculosis
- Identify people living with HIV who have not been receiving HIV-proficient care, and support engagement in care

On World AIDS Day 2016, OHA unveiled the [End HIV Oregon plan](#), an ambitious plan aimed at ending all new HIV infections within five years. While the rate of new infections has remained stable, the number of people who are virally suppressed is increasing.

Health Equity Strategies

- Reduce new hepatitis C virus-associated mortality among African Americans, American Indians and other disproportionately affected groups.
- Reduce norovirus infections in long-term care facilities
- Promote routine syphilis screening for men who have sex with men
- Improve capacity to perform interviews for foodborne outbreaks with non-English Speakers
- Reduce hospital-onset *Clostridioides difficile* infection (CDI) in healthcare settings serving populations with limited access to care
- Collaborate with Tribal partners to promote communicable disease investigation and reporting to protect the health of Native Americans
- Understand HIV prevalence, risk and protective behaviors, and impact of stigma and resilience among African-American and Hispanic/Latino-identified individuals at elevated risk for HIV, including men who have sex with men.
- Improve collection of race and ethnicity data for foodborne illness cases

Figure 9

Syphilis incidence

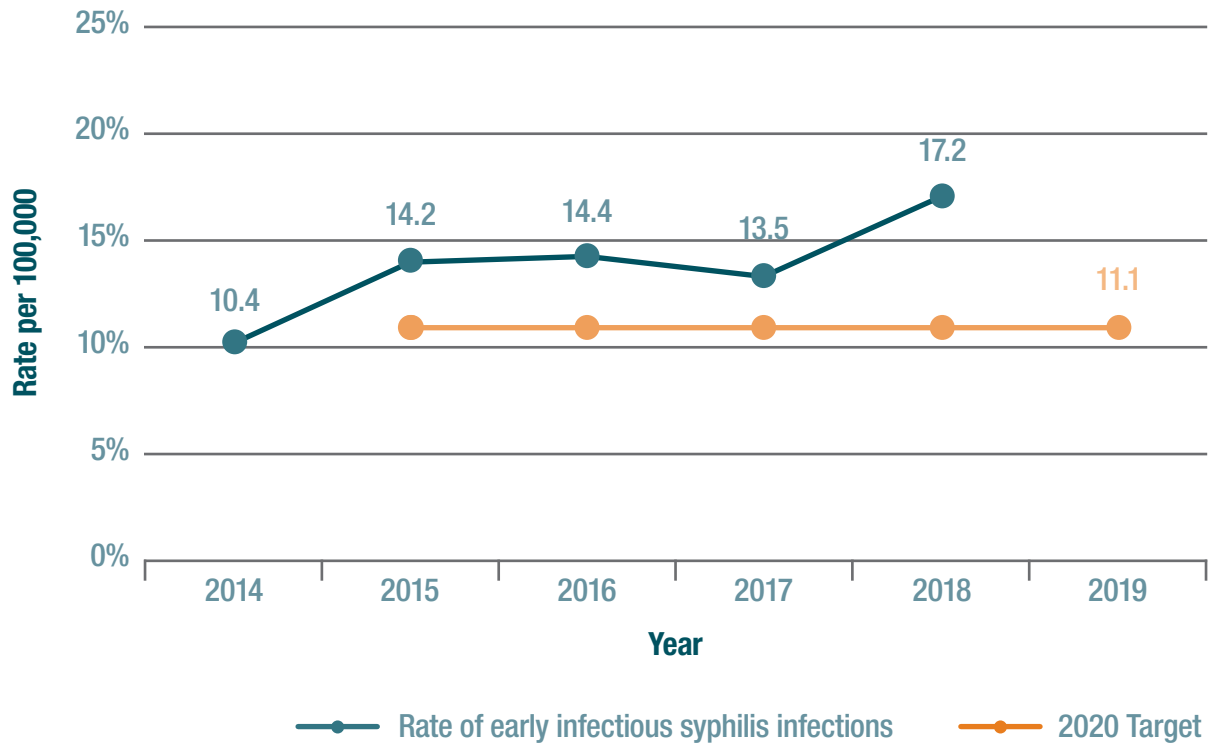
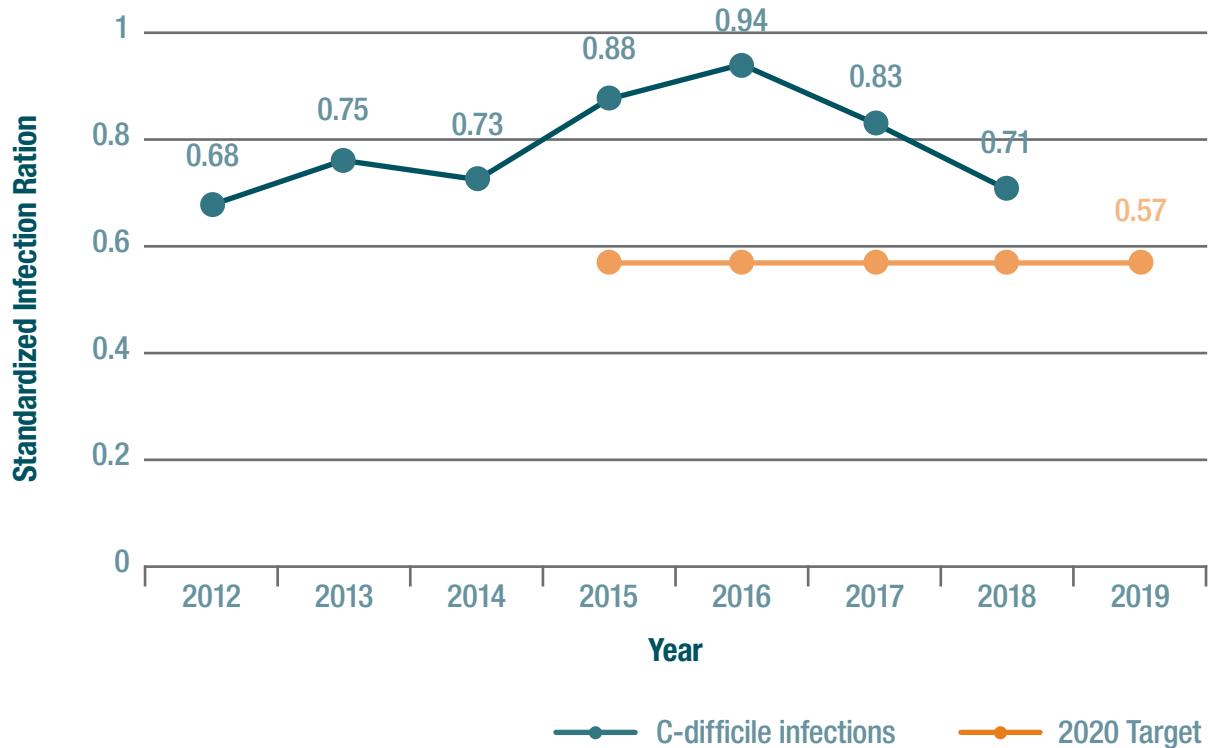


Figure 10

C-difficile early infectious infections



Deaths from chronic hepatitis C in Oregon have declined to 478 in 2018. OHA reduced barriers for use of direct-acting antiviral agents in Oregon Medicaid patients, and provided technical assistance to LPHAs, substance use disorder treatment facilities, and other non-profit organizations to promote harm reduction strategies. Despite this progress, racial disparities persist, with hepatitis C death rates highest in African Americans, American Indians, and Alaska Natives.

Over the last 5 years OHA worked with long-term-care facilities in Oregon and provided assistance with infection-control measures to improve norovirus detection and control. Through investigations, OHA confirmed the primacy of person-to-person transmission in these facilities; and provided training to improve infection-control capacity.

The state sexually transmitted disease (STD) program launched several initiatives promoting syphilis screening for men who have sex with men (MSM) while also advancing provider and public awareness of the current epidemic. STD testing was expanded for uninsured and underinsured individuals who meet certain risk criteria. The STD program issued “Dear Colleague” letters with updated syphilis screening recommendations in 2015 and 2016, timed to coincide with the launches of “SyphAware” campaigns in Portland and Lane Counties. These campaigns included public-service ads on TriMet buses and trains and development of the www.SyphAware.org website. Lastly, the two-day 2017 Syphilis Summit invited the participation of numerous stakeholders to discuss a range of issues; 63 persons attended.

Over the past two years, OHA worked with Oregon-based Tribes, the NPAIHB, and the Indian Health Service Portland Area Office to develop memoranda of understanding (MOUs) with eight of the nine Federally recognized tribes. These MOUs detail collaboration for laboratory services, immunization services, and communicable disease investigation and reporting.

OHA improved the ability to collect race and ethnicity data to identify disparities in foodborne illness. OHA now collects REAL-D -compatible data and provides training to LPHAs for collecting this information.

Health System Strategies

- Create incentives for private and public health plans and health care providers to prevent Communicable Disease
- Promote annual chlamydia screening of women aged 15-24 by health care providers
- Promote use of expedited partner therapies by health care providers and local health departments
- Improve hospital capacity to detect and prevent health care-associated infections

Critical access hospitals (CAHs) serve populations with limited access to care. From 2015 to 2018, CAHs decreased healthcare-onset *Clostridium* infections (CDI) from 1.32 to 0.51. This corresponds to 49% fewer infections than was predicted and it exceeds the 2020 U.S. Department of Health and Human Services (HHS) reduction target of 0.70. Over the past five years, we engaged more than 20 Oregon hospitals in the “targeted assessment for prevention” (TAP) strategy aimed at identifying gaps in CDI-related prevention practices to assist in implementing needed prevention strategies. Additionally, we recruited more than 20 hospitals to report antimicrobial-use data to the National Healthcare Safety Network (NHSN).

Patient-delivered partner therapy (EPT) was permitted for use to treat gonorrhea in 2015 and new protocols and educational materials for patients and providers were produced. In 2019 OHA began planning for implementation of a statewide pilot project to distribute EPT through LPHA sites beginning in 2020. The rate of chlamydia screening among young women as measured through HEDIS remained steady throughout the last five years but increased slightly from 64% in 2014 to 65.4% at the end of 2019. Finally, OHA promoted use of short course regimens for treatment of latent TB infection by offering education for medical providers and online toolkits.

Improve Immunization Rates

Many quality improvement efforts have led to increasing rates of immunizations, among children, adolescent and adults. Significant efforts are still needed to address the needs of communities with low childhood vaccination rates and address other immunization disparities within Oregon.

Population Strategies

- Increase the percentage of children who are fully vaccinated
- Increase the percentage of adults who receive annual influenza vaccine
- Increase the percentage of adolescents who complete the HPV vaccine series

Over the past five years, SHIP vaccination rates in children and adolescents improved. The number of providers participating in the adolescent Assessment, Feedback, Incentives, and Exchange (AFIX) quality improvement program increased significantly, including more than 20% of certified School-Based Health Centers (SBHCs). OHA and the American Cancer Society (ACS) hosted the 2nd annual HPV summit with broad participation from providers across the state. ACS also worked with the Oregon Pacific Area Health Education Center to host Oregon's first HPV vaccination week.

In addition to these initiatives, the HPV vaccination schedule was reduced from three doses to two in 2016, making it easier to complete the HPV vaccine series in a timely fashion. HPV vaccination rates increased steadily from 28% in 2015 to 51% in 2019.

Health Equity Strategies

- Increase flu vaccination in priority areas and populations.
- Improve Tdap and flu vaccinations in pregnant women.
- Increase the rate of 2-year-old who are fully vaccinated by race and ethnicity
- Increase adolescent (13 - 17) HPV completion rate by race and ethnicity

Figure 11

HPV vaccination rates among youth

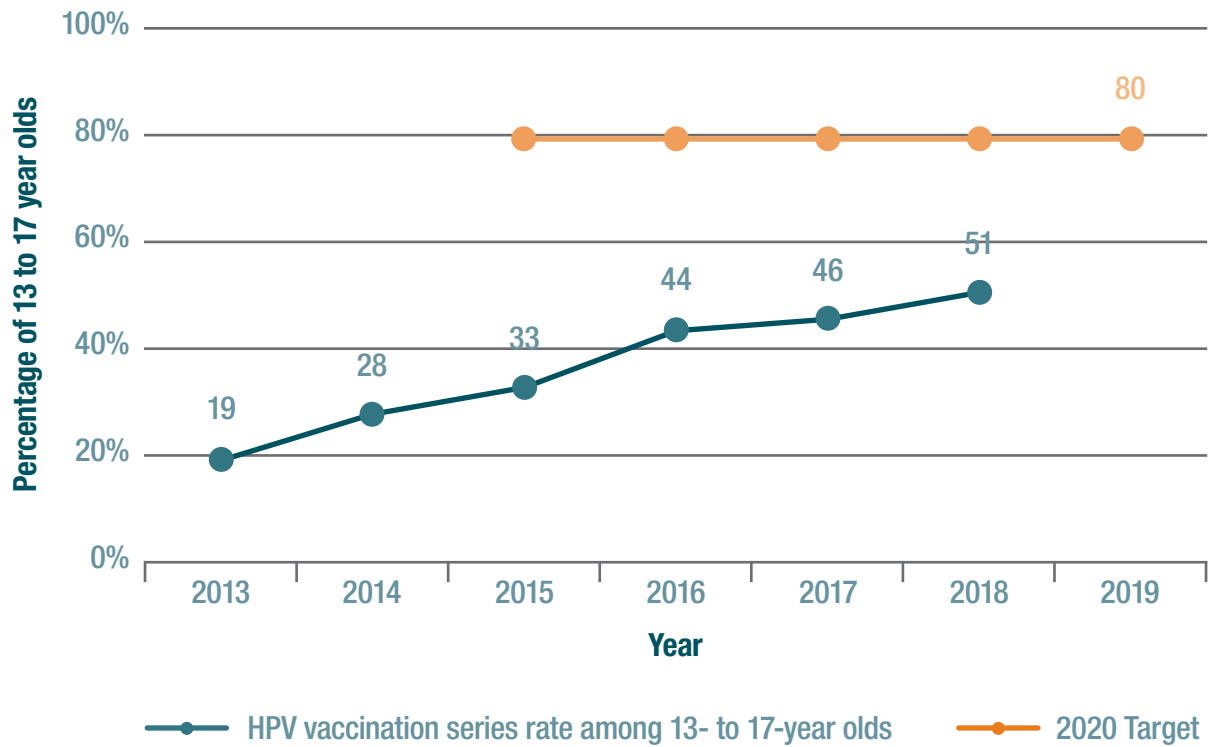
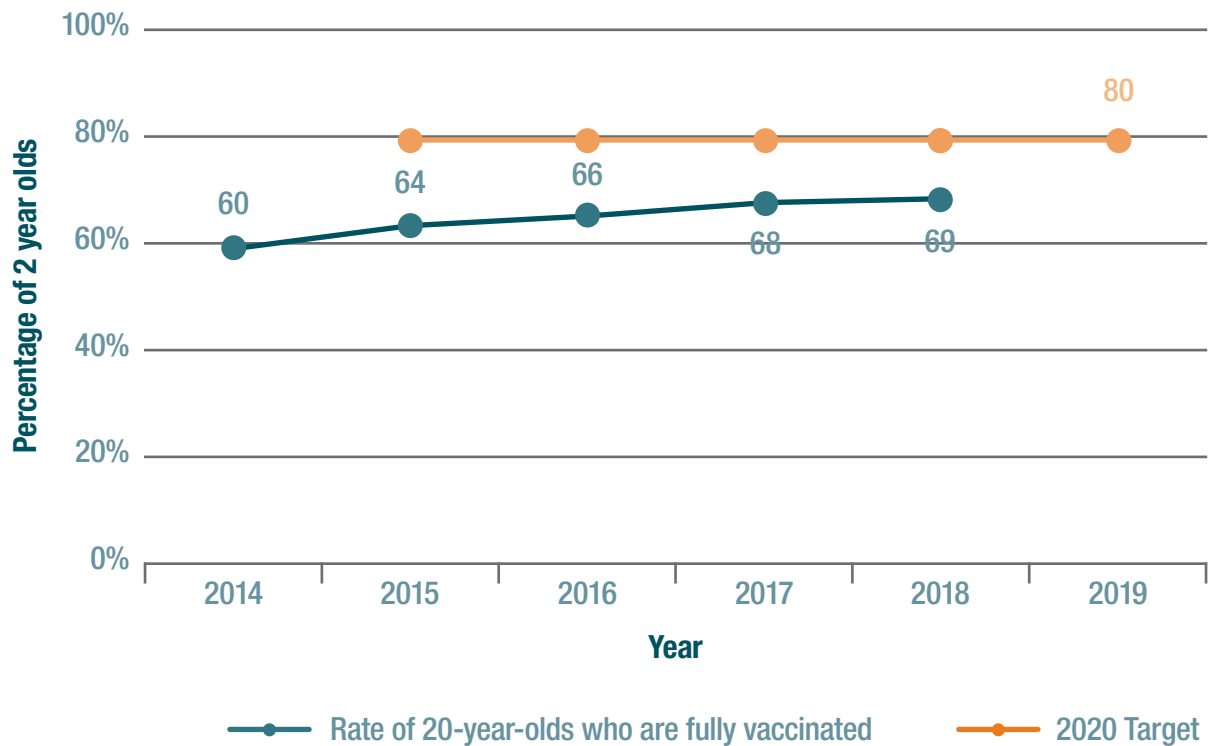


Figure 12

Immunization rate among 2 year olds



OHA and many clinical and health system partners throughout Oregon have worked to make flu vaccine available to uninsured adults and vulnerable populations through the OHA Flu Pool project. The flu pool program has grown each year since 2016 and helped foster partnerships with LPHAs and clinics focused on improving flu vaccination rates and access for people who are unable to afford it. During the 2019-2020 flu season, more than 60 providers participated in this project and OHA distributed more than 9,500 doses of flu vaccine. Disparities in flu vaccination rates between Latinx and other populations have led to culturally tailored flu messaging for Latinx communities. OHA partnered with Univision for an add campaign during the 2018-19 and 2019-20 flu seasons that corresponded with an increase in flu vaccine uptake in Latinx communities.

Health System Strategies

- Create incentives for private and public health plans and health care providers to increase immunization rates
- Promote strategies for health care providers to increase delivery of on-time immunizations
- Increase flu vaccination rates among health care workers

CCOs and LPHAs participated in the AFIX and Immunization Quality Improvement for Providers (IQIP) programs. AFIX and IQIP are programs that assist providers with analyzing rates, reviewing clinic workflow, and implementing evidence-based interventions to increase immunization rates. Eleven CCOs improved their 2-year-old vaccination rates with seven meeting their more stringent improvement targets for 2018.

Prevent Deaths from Suicide

While Oregon's suicide rate has continued to increase, major funding and infrastructure improvements over the last five years show promise for future decreases.

Population Strategies

- Promote Use of the National Suicide Lifeline
- Ensure communities implement an array of services and programs to promote safe and nurturing environments

In 2014, OHA received a SAMHSA Garrett Lee Smith Youth Suicide Prevention (GLS) grant to provide suicide prevention, intervention and postvention (support after a suicide or suicide attempt) for youth to five counties (Deschutes, Jackson, Josephine, Umatilla and Washington). This work included coalition building, gatekeeper (lay person) training, continuity of care work with schools and healthcare systems and public awareness events. OHA was awarded an additional five years of funding to build on this work through 2024.

Also in 2014, the Oregon HB4124 created the Oregon Youth Suicide Intervention and Prevention Plan (YSIPP). In 2016, the Alliance to Prevent Suicide was formed to support YSIPP implementation and ensure that stakeholders, including youth and those with lived experience, are providing their perspectives and input. During the 2019 legislative session, more than \$6 million was allocated through Policy Option Package 402 to fund the YSIPP. OHA also established an annual Oregon Suicide Prevention Conference since 2016. Enhanced advocacy by suicide prevention partner organizations has led to additional legislation in the past five years.

- HB 3090 (2017): Requires hospitals to conduct an assessment, safety planning, case management, and follow-up with people who present to an emergency department with a mental health crisis.
- Extreme Risk Protection Order (2017): Prevents a person who is at risk of suicide from having or getting deadly weapons, including firearms through a court order.
- SB 561 (2017), SB 918 (2019), and SB 485 (2019): Requires Local Mental Health Authorities (LMHAs) to work with other sectors and county partners to provide postvention communication and response planning in the case of a youth suicide with the goal of providing support to affected family, friends and community and prevent suicide contagion.
- SB 52 (2019): Referred to as Adi's Act, mandates every school district to write suicide prevention plans before the start of the 2020/2021 school year.

Figure 13

Suicide attempts among youth

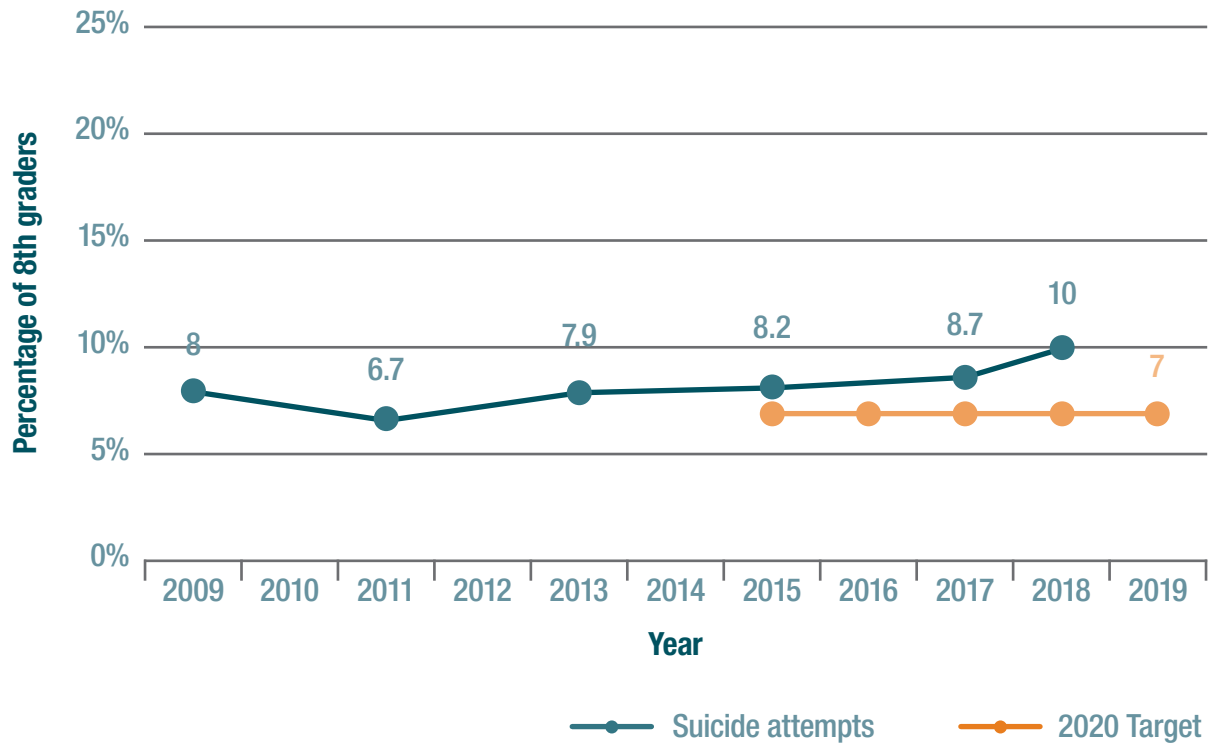
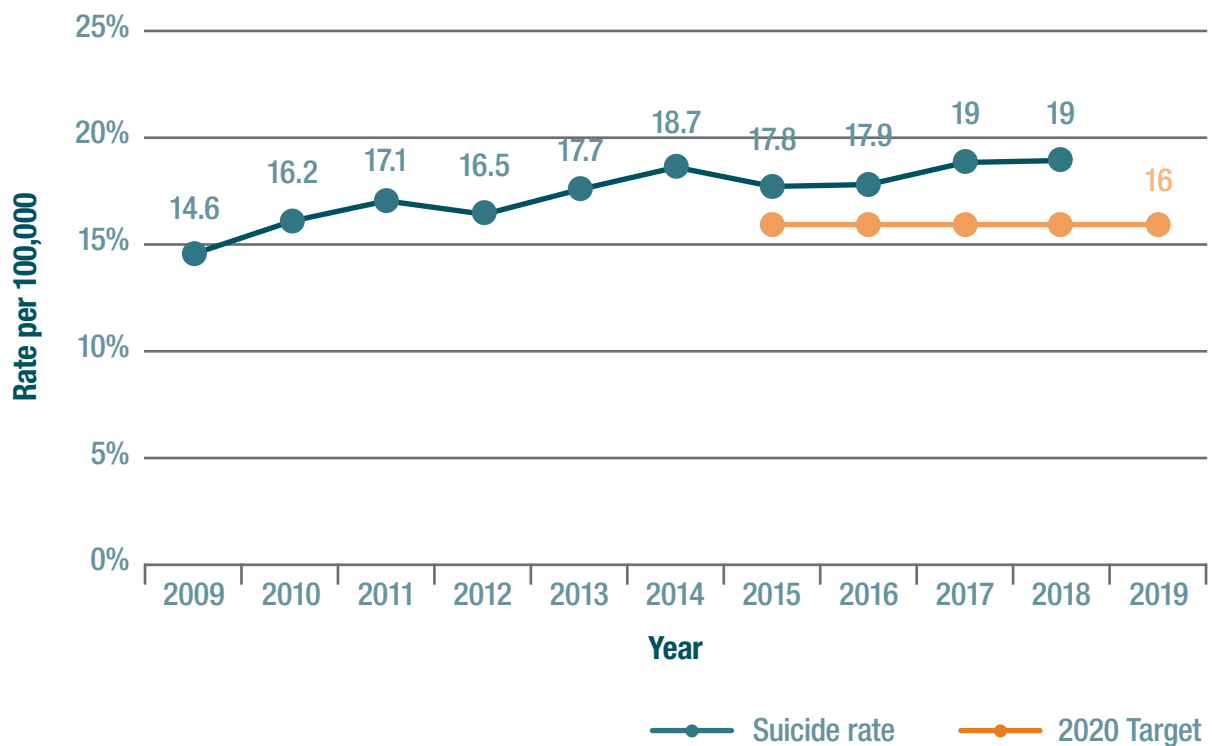


Figure 14

Suicide rate



Health Equity Strategies

- Reduce the disparity of suicide among American Indian/Alaska Natives

American Indian/Alaska Natives experience significant inequity in suicide deaths. Oregon Tribes and tribal entities were invited to attend the OHA hosted Zero Suicide Academy in September 2018. Two tribal entities, Native American Rehabilitation Association of the Northwest, Inc. (NARA) and Yellowhawk Tribal Health Center, sent teams to the two-day Academy. The Oregon Suicide Prevention Conferences have dedicated space for tribal focused presentations. These have included tribal veterans, utilizing health camps, Native American Evidence Based Practices, culture as prevention, social media for adults working with native youth, and Native American lived experience. Finally, during the 2019 legislative session, Policy Option Package 402 allocated \$450,000 for tribes to increase suicide prevention efforts.

Health System Strategies

- Create incentives for private and public health plans and health care providers to prevent deaths from suicide
- Ensure training for health professionals is available to address suicide risk

In 2016, OHA began engaging healthcare systems in Zero Suicide, a bold commitment to provide suicide safer care in health and behavioral health care. Sixteen healthcare organizations attended the 2018 Zero Suicide Academy. OHA facilitated a Community of Practice (CoP) for Better Suicide Care through September 2019 and provided mini-grants to selected healthcare organizations to move Zero Suicide efforts forward. Evaluation of health care organizations participating in Zero Suicide showed substantial overall progress in Zero Suicide implementation, particularly in gaining leadership support and buy-in, training staff, and supporting patients as they transition from different levels of support and/or to other organizations for care. OHA support for Zero Suicide implementation in Oregon health care systems will continue with 2019-2024 GLS funding.

Researchers worked with both primary care providers and firearm owners in rural Central Oregon to develop and test culturally appropriate education and outreach materials on lethal means reduction. These included [four brief videos for providers and clinicians](#) about how to address firearm safety with patients at risk of suicide, which will be available for Continuing Medical Education (CME) credit in early 2020. A brochure for firearm owners

and a tip sheet for primary care providers are now available. An online course offering CME for providers on this research and its practical application, including practical implementation tools, is available online at <https://www.oregonsuicideprevention.org/zero-suicide/firearm-safety/>

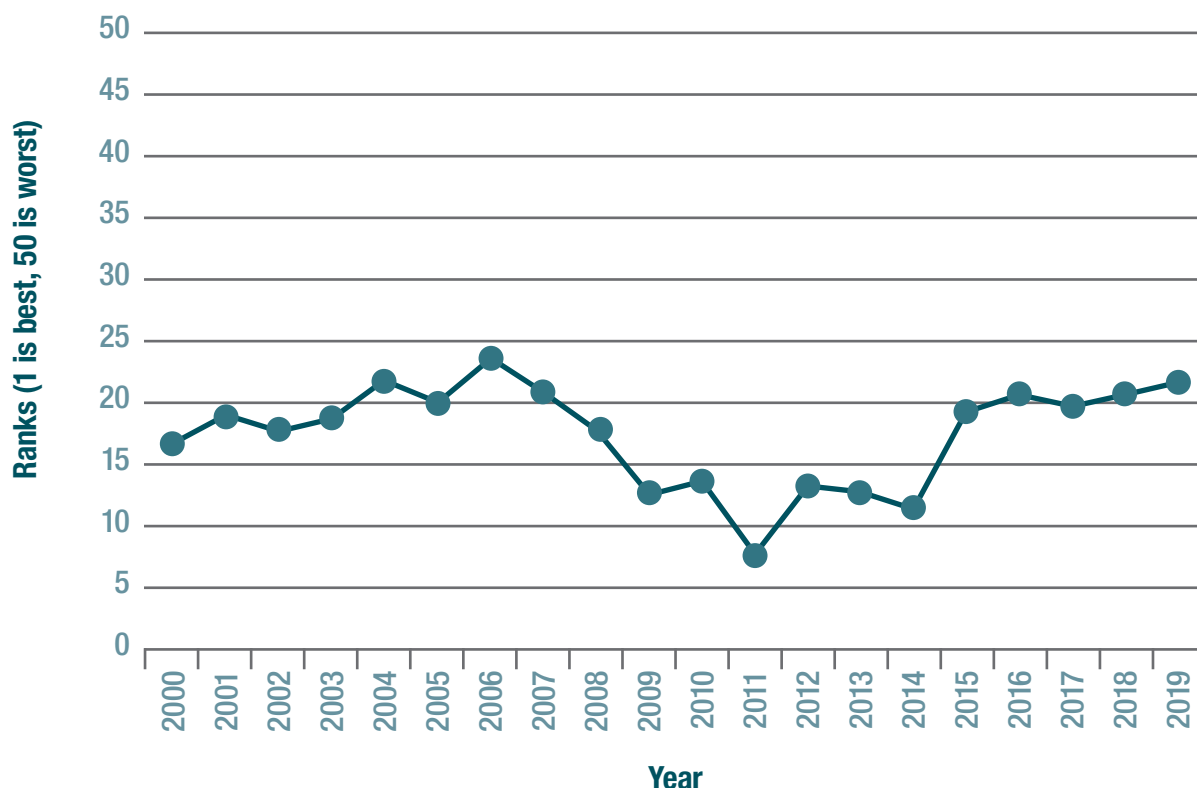
Looking forward and the 2020-2024 SHIP

Oregon currently ranks 22nd among U.S. states for overall health (America's Health Rankings, 2019). This is down from 12th at the time the 2015-2019 SHIP was written. Although OHA had some significant gains in the last five years, OHA had difficulty turning trends in many areas. Witnessing health improvement can take decades, and many of the policy, system and environmental wins from these past five years will lead to decreased illness and saved lives in the coming years. However, even when improvement is seen in a population, that does not necessarily mean improvement for specific communities. Persistent disparities, especially based on race and ethnicity, are an important reminder of where OHA needs to focus efforts.

OHA has a clearer understanding of how it can affect change on the social determinants of health and inequities. Social determinants of health, like quality education, safe homes and neighborhoods, living wage jobs, and health care, are the primary reasons people are healthy, or not. Because of systemic oppression, discrimination and bias, people of color, people with low-income, people who identify as LGBTQ+, and people with disabilities face considerable barriers in accessing the social determinants of health. These barriers create great health disparities across the state of Oregon. More must be done to reduce the health inequities experienced by marginalized communities. Improving the health of everyone in Oregon is complex and takes time, and no single sector or agency can do this work on its own.

Figure 15

Oregon - State Health Ranking



The established planning process for the 2020-2024 SHIP is a primary example of a modern public health approach. The 2020-2024 SHIP will use an evidence based planning framework called [Mobilizing for Action through Planning and Partnerships \(MAPP\)](#). MAPP is a community-driven strategic assessment and planning process for improving health. The [State Health Assessment \(SHA\)](#), published in 2018, is a result of this process. The SHA will provide primary data for the 2020-2024 SHIP.

MAPP is not an agency-focused process; rather, it relies on principles of collective impact. Collective impact uses a collaborative framework that brings together partners from a variety of sectors to enact change on an issue. Given the need to move upstream to improve health, working with other state and local agencies is critical. The collective impact framework has already enabled OHA to strengthen existing partnerships and create new ones as we work together to improve health.

The priorities of the 2020-2024 SHIP look very different than the seven priorities of the 2015-2019 SHIP. Rooted in data and community voice, the 2020-2024 SHIP will address: institutional bias; adversity, trauma and toxic stress; access to equitable preventive health care; behavioral health; and economic drivers of health, including issues related to housing, living wage, food security and transportation. Public health's work in the seven priorities of the 2015-2019 SHIP will not end here as federal and state mandates and funding mechanisms that direct much of our work will continue. Furthermore, the priorities of this 2015-2019 SHIP are all downstream health outcomes of upstream social determinants. When trauma and toxic stress are addressed, rates of substance use will decrease. When institutional bias is addressed, sexually transmitted infections and suicide attempts will decrease. In fact - the priorities of the next SHIP are all interconnected. Working collectively towards change in these priority areas will improve health exponentially. And most importantly, working to eliminate disparities will lift us all to better health.



You can find complete information, including progress made on specific interventions and strategies online at www.healthoregon.org/ship.

You can get this document in other languages, large print, braille or a format you prefer. Contact Oregon Health Authority at 971-673-1300 or email publichealth.policy@dhsosha.state.or.us. We accept all relay calls or you can dial 711.