



February 26, 2014

Public Health

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Communicable Disease

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Chronic Disease Prevention

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Environmental Health

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Maternal Child Health

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Vital Records

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WIC

Room 210
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Jan Kaplan, MSW
Principal Executive Manager E
Office of Community Liaison
OHA Public Health Division
800 NE Oregon Street, Suite 930
Portland, OR 97232

Dear Jan,

Attached electronically is Lane County's Public Health Authority Plan for FY 2014-15. The narrative annual plan includes the following sections: Adequacy of Local Public Health Services; Provision of Five Basic Services; Adequacy of Other Services; Budget Information; and an Action Plan.

Other required documents attached are Lane County's Community Health Assessment, Minimum Standards for Local Health Departments; the Reproductive Health Plan; and the Organizational Chart. Two other documents which we would like posted with the required elements are the Lane County WIC Nutrition Education Plan and Lane County's Healthy Future (Community Health Improvement Plan).

The Lane County Board of County Commissioners reviewed and approved the Lane County Public Health Authority Plan for FY 14-15 on February 25, 2014. Please contact me at karen.gillette@co.lane.or.us or 541-682-3950 if you need further information or clarification regarding our documents. Thank you.

Cordially,

Karen Gillette

Karen Gillette, M.S.
Program Manager
Lane County Public Health Division

Cc: Karen Gaffney, Acting Director, Public Health Administrator

Lane County Community Health Assessment

Spring 2013 – Version 1.0

A Collaborative Project between Lane County Public Health, Peace Health Oregon West,
Trillium CCO, and United Way of Lane County



PeaceHealth





Lane County Community Health Assessment

Spring 2013 – Version 1.0

Overview

Lane County Public Health, Peace Health Oregon West, and Trillium, Lane County’s Coordinated Care Organization, launched a comprehensive community health assessment and planning process in spring 2012. Undertaken in collaboration with many community partners, the overall goal of this work was to identify key priority areas where the community can take action to improve overall population health. The assessment and improvement plan also fulfills public health accreditation and health care regulatory requirements.

Improving the health and wellbeing of Lane County residents is core work of the partnering organizations. How to improve health and quality of life in a community is always a challenge as many social, economic, environmental, and individual factors impact health and wellness. The Lane County Community Health Assessment team initiated the Community Health Assessment process in order to both examine these factors and engage community members in discussions around health.

Using the Mobilizing for Action through Planning and Partnerships (MAPP) tool made available by NACCHO, the Community Health Assessment team analyzed public health data, engaged with community members to solicit feedback around priority areas and key concerns, interviewed key community leaders, and presented the data across the county, all in the hopes of engaging a diverse group

MAPP Method

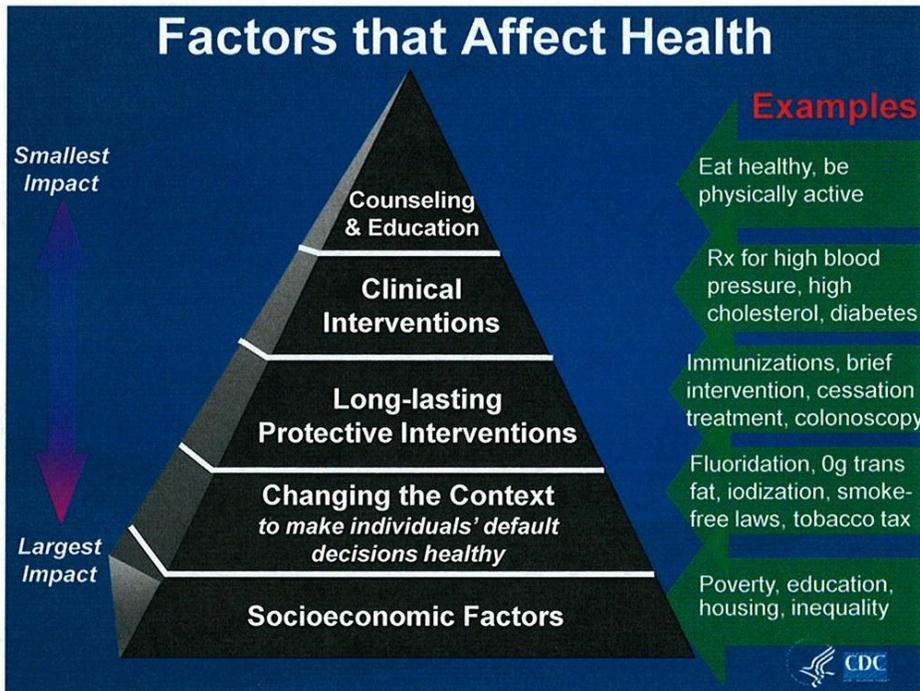


- Over 30 data and process presentations to community partners
- Community health survey of over 700 residents
- Key informant interviews with community leaders



of people dedicated to improving health in Lane County.

Special attention was given to identifying the social and economic factors that impact individual's ability to achieve and maintain health. These factors include income/poverty, educational attainment, discrimination, and the built environment, among many others.



Steering Committee

Dan Reese, LCSW, Peace Health Manager Network of Care

Rick Kincade, MD, Network V.P. for Medical Affairs

May Anne McMurren, Administrator, Cottage Grove Hospital

Rick Yecny, CEO, Peace Harbor Hospital

James Boyle, Senior Analyst, PeaceHealth Oregon West

Jennifer Jordan, MPH, Lane County Public Health

Ellen Syverson, MPH, Lane County Public Health, Trillium Health Plan

Chelsea Clinton, United Way of Lane County 100% Access Coalition

David Parker, Trillium Community Advisory Council

Tara DeVee, Trillium Community Advisory Council

Anne Celovsky, Lane County Public Health

Lindsey Adkisson, Lane County Public Health

Mardel Chinburg, Public Health Advisory Committee, University of North Carolina MPH Practicum Student

Jody Corona, Health Facilities Planning & Development Consultant for Peace Health

Lane County Public Health Prevention Team

Lane County Community Members



Summary of Findings

Community Health Status

- Lane County residents' overall physical health tends to be better than the state or nation
- Despite good physical health, Lane County residents are much more likely to experience poor mental health and substance abuse issues than the rest of Oregon or the nation
- Cost remains a significant barrier to access for many residents
- Tobacco use among pregnant women has increased in recent years and is a major concern for the health of both mother and child
- Childhood vaccination rates in Lane County are too low to effectively protect against some communicable diseases like pertussis and measles

Forces of Change and Community Themes

- Certain communities in Lane County have a significantly older population than the rest of the county/state/nation
- Lane County is growing more ethnically diverse, with an increasing Hispanic population
- In community forums, residents identified behavioral health, tobacco use, obesity, and diabetes as the most pressing needs in Lane County
- Increased access to oral health care was identified by both consumers and providers as a priority
- Due to budgetary constraints and the economic downturn, Lane County and other community service providers have been forced to cut back on services

Priority Areas for Community Health Improvement

- Advance and Improve Health Equity
- Prevent and Reduce Tobacco Use
- Slow the Increase of Obesity
- Prevent and Reduce Substance Abuse and Mental Illness
- Improve Access to Health Care



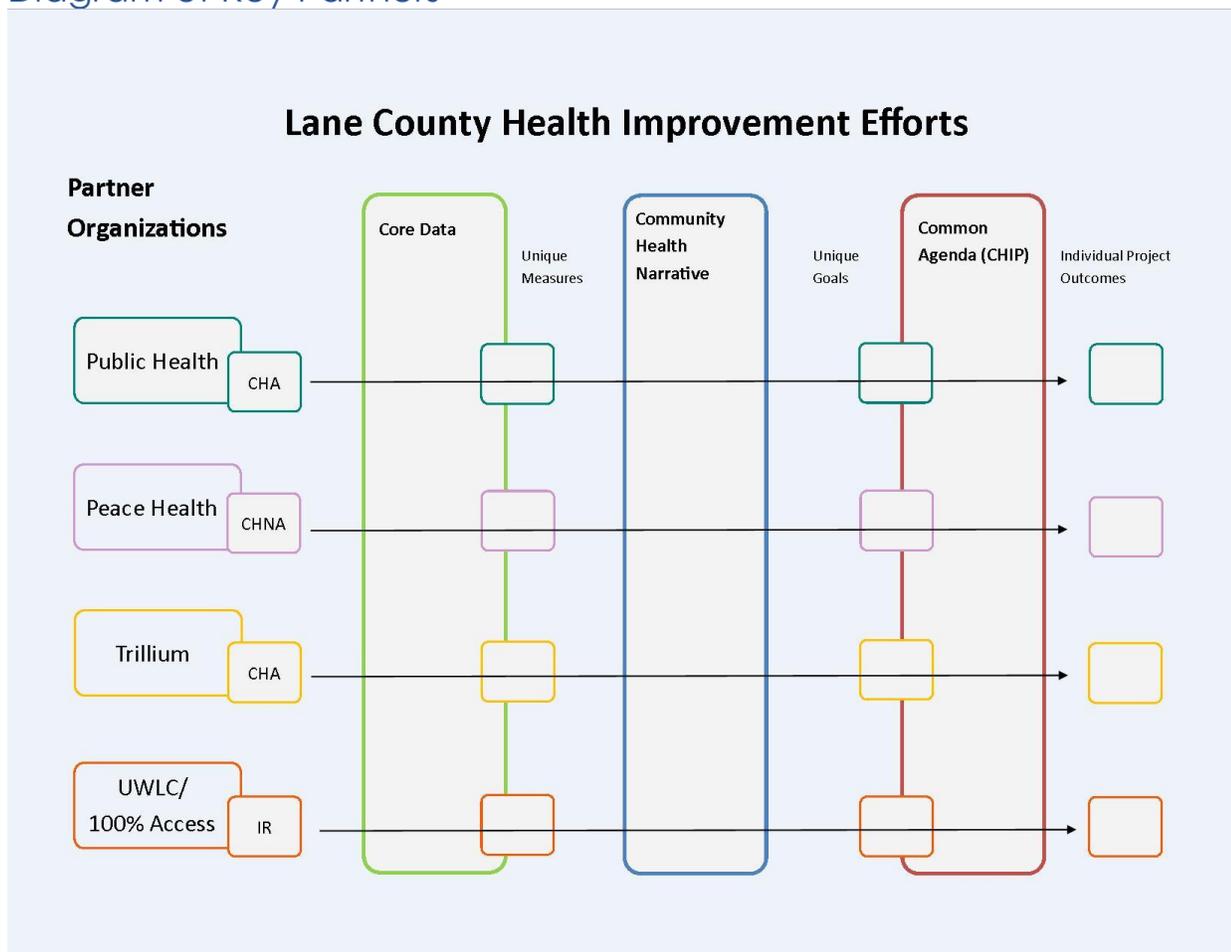
Overview of CHA Process

Narrative

In the early 2012, staff from Lane County Public Health and the Peace Health Oregon hospital system met to discuss the new incentives for each organization to engage in a Community Health Assessment and Improvement Planning process. The newly formed Public Health Accreditation Board (PHAB) released Standards and Measures requiring every health department seeking accreditation to complete a comprehensive Community Health Assessment in partnership with other health and social services organizations. The hospitals had also been newly incentivized by the Affordable Care Act, which included new IRS requirements that non-profit hospitals complete Community Health Assessments in conjunction with the local public health department. Staff members from both organizations attended a MAPP seminar in Denver in the Spring of 2012. Presented by NACCHO staff, this seminar provided invaluable assistance in understanding and utilizing the MAPP tool within Lane County.

When the Coordinated Care Organization for Lane County, Trillium, was formed in 2012, language was included in its governing documents that requires the CCO to participate in this Community Health Assessment as well.

Diagram of Key Partners





Method

The assessment process utilized by the Lane County partnership was adapted from the national Mobilizing for Action through Planning and Partnerships (MAPP) model, an evidence-based community-wide strategic planning process for improving community health. MAPP was developed by the National Association of County and City Health Officials (NACCHO) in order to help communities improve health through collaborative, community-driven strategic planning.

Rather than focusing on medical health outcomes and indicators to assess community health, MAPP takes a comprehensive approach of looking at the myriad factors that affect individual, family, and community health. Through a series of different assessments, the Lane County Health Assessment team looked at data that addressed quality of life, socioeconomic factors, systems and policy level infrastructure, as well as traditional physical and mental health indicators. By considering such wide-ranging information, the Lane County Health Assessment gives a full picture of health in our community.

MAPP includes four different community assessments: the Community Health Status Assessment (looking at data), the Community Themes and Strengths Assessment (surveys, key informant interviews, and conversations with the community), the Forces of Change Assessment (identifying the broad forces that would help or hinder the implementation of a Community Health Improvement Plan), and a Local Public Health System Assessment (assesses the capacity of the entire community public health system). To date, Lane County has completed the first two assessments. As we develop the action plan to implement the Community Health Improvement Plan, the Forces of Change and Local Public Health System Assessments will be completed and added to this report as an addendum.

Community Presentations

During the course of the collecting information for the Community Health Assessment, the Lane County Community Health Assessment Team presented community health data and information on the assessment process to over thirty (30) community groups. Responses from the various audiences were tallied and are reflected in the Community Themes and Strengths Assessment at the end of this document.

	Group	Date
1.	100% Access Coalition	8/30
2.	Cottage Grove Health & Human Services Coalition	9/11
3.	PeaceHealth Clinical Council	9/17
4.	PeaceHealth Health & Wellness Committee	9/26
5.	Emerald Rotary	10/10
6.	Cottage Grove Hospital Foundation	10/10
7.	Cottage Grove Community Foundation	10/11

Lane County Community Health Assessment



8.	Trillium Community Advisory Council	10/15
9.	Volunteers in Medicine Board Retreat	10/18
10.	Eugene Metro Rotary	10/23
11.	Cottage Grove Hospital Leadership Team	10/24
12.	Governing Board of CGCH & Clinics	10/25
13.	PeaceHealth Bridge Assistance Team	10/30
14.	Springfield Rotary	10/31
15.	Florence Area Coordinating Council	11/7
16.	Cottage Grove Rotary	11/7
17.	Primary Care Breakfast Group	11/13
18.	Florence Rotary	11/13
19.	Lane Livability Consortium	11/13
20.	Lane County Public Health Advisory Committee	11/13
21.	Lane County Board of Commissioners/Board of Health	11/20
22.	Trillium – open forum	11/29
23.	Public Health Management	11/30
24.	Trillium’s Rural Advisory Council	12/6
25.	Cottage Grove Rotary	12/6
26.	Lane County Public Health Staff	12/6
27.	Local DHS Managers	12/7
28.	Lion’s Club	12/13
29.	Springfield City Club	12/20
30.	All Non-Profits Chamber of Commerce Cottage Grove	1/8
31.	Eugene City Council	
32.	Springfield City Council	
33.	Springfield School Board	2/11
34.	Lane County Mental Health Advisory/Local Alcohol & Drug Planning Committee	1/23
35.	UW Community Conversation	



Demographics of Lane County

Lane County has a population of 351,715 residents according to the 2010 U.S. Census. The Eugene-Springfield area is the third-largest Metropolitan Statistical Area in the state. The Eugene-Springfield area is home to roughly 60% of Lane County residents and contains the majority of county health and social services. Lane County is 4,722 square miles, or roughly the size of the state of Connecticut. The county extends from the Pacific Ocean on the west to the Cascade mountain range on the east. Outside of the Eugene-Springfield area, Lane County is largely rural and unincorporated. The large geographic area of the county creates disparities in social service delivery, distance to health care facilities, and in access to healthy foods or safe environments to walk or bike between rural and urban community members.

Socioeconomic Indicators

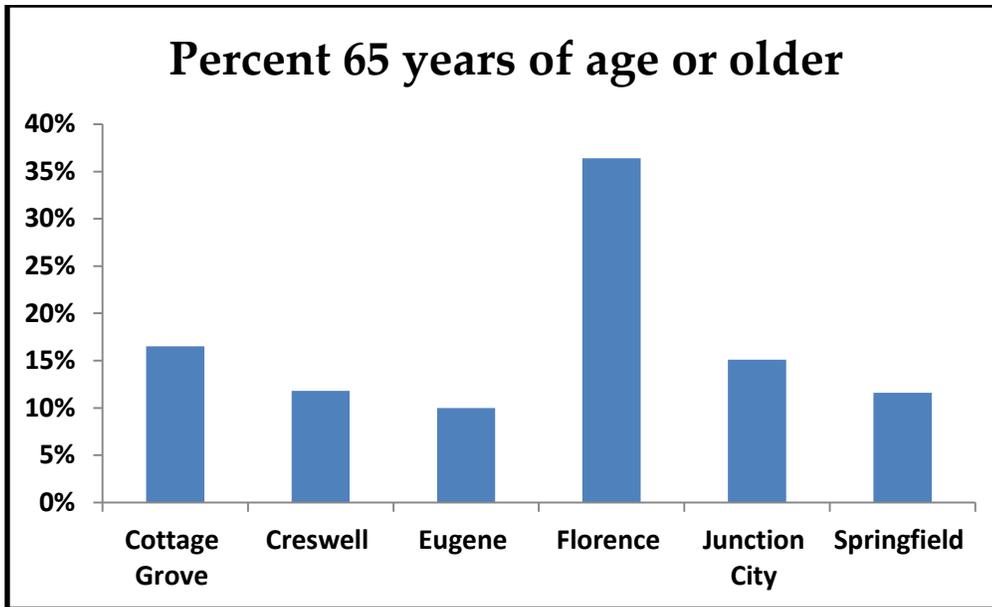
Race/Ethnicity/Age

While Lane County as a whole is predominately white, several communities have much larger populations of Hispanic residents. The Springfield and Eugene metro area, along with several communities in south Lane County, are projected to continue this trend of an increasing Hispanic population.

Race and Ethnicity of Lane County Residents, 2010							
City	Total Population	White	Black	American Indian	Pacific Islander	Asian	Hispanic
Cottage Grove	9,686	90.4%	0.3%	1.3%	0.1%	1.1%	8.0%
Creswell	5,031	89.6%	0.4%	1.0%	0.1%	1.0%	8.6%
Eugene	156,185	85.8%	1.4%	1.0%	0.2%	4.0%	7.8%
Florence	8,466	92.5%	0.3%	1.3%	0.3%	1.0%	5.4%
Junction City	5,392	90.4%	0.7%	1.3%	0.1%	0.6%	9.0%
Springfield	59,403	85.9%	1.1%	1.4%	0.3%	1.3%	12.1%
Lane County	351,715	88.3	1.0%	1.2%	0.2%	2.4%	7.4%
Oregon	3,831,074	83.6%	1.8%	1.4%	0.3%	2.4%	11.4%
United States	308,745,538	72.4%	12.6%	0.9%	0.2%	4.8%	16.3%

Source: United States 2010 Census

Several rural communities in Lane County have significantly older populations than the county as a whole. While in Eugene only 10% of residents are 65 years of age or older, in Florence 36.4% of residents are 65 or older. Aging populations require different (and increasing) services and care than communities of younger residents.



Income/Poverty

Poverty is correlated with poor health. In Lane County the poverty rate is slightly higher than both the state and nation, with several communities experiencing significantly higher rates of poverty. Racial and ethnic minority groups, women, and children are disproportionately impacted by poverty. Half of all children in Lane County are enrolled in the Oregon Health Plan, Oregon’s Medicaid program.

City	Median Household Income	Per Capita Income	Percent living below the poverty line	Percent on Oregon Health Plan line
Cottage Grove	\$41,720	\$19,605	15.6%	36.6%
Creswell	\$45,956	\$21,090	16.9%	31.9%
Eugene	\$51,233	\$27,141	20.7%	17.8%
Florence	\$33,586	\$24,663	12.7%	
Junction City	\$40,195	\$20,496	13.4%	40.4%
Springfield	\$36,198	\$19,023	19.0%	29.5%
Lane County	\$42,923	\$23,869	16.7%	17.7%
Oregon	\$49,260	\$26,171	14.0%	
United States	\$51,914	\$27,334	13.8%	---

Source: United States 2010 Census; LIPA enrollment data

Education

An individual’s income and education level are known to be linked to health status, quality of life, and longevity. Those individuals with a college degree live an average of seven (7) years longer than those



who don't finish high school¹. While more educated individuals are more likely to have “good health behaviors” this does not entirely account for the difference in health status. They are also more likely to have better access to health care.

In general, Lane County residents are more likely than the state or nation as a whole to complete high school, Springfield being the notable exception with only 83.9% of residents holding a high school diploma. Eugene, home to the University of Oregon, has the highest number of adults over the age of 25 holding a bachelor's degree.

Educational Attainment in Lane County		
City	Percent with High School Diploma	Percent with Bachelor's Degree
Cottage Grove	88.0%	11.7%
Creswell	86.0%	12.3%
Eugene	89.3%	40.2%
Florence	90.5%	19.6%
Junction City	86.1%	11.5%
Springfield	83.9%	15.3%
Lane County	89.9%	27.7%
Oregon	88.6%	28.6%
United States	85.0%	27.9%

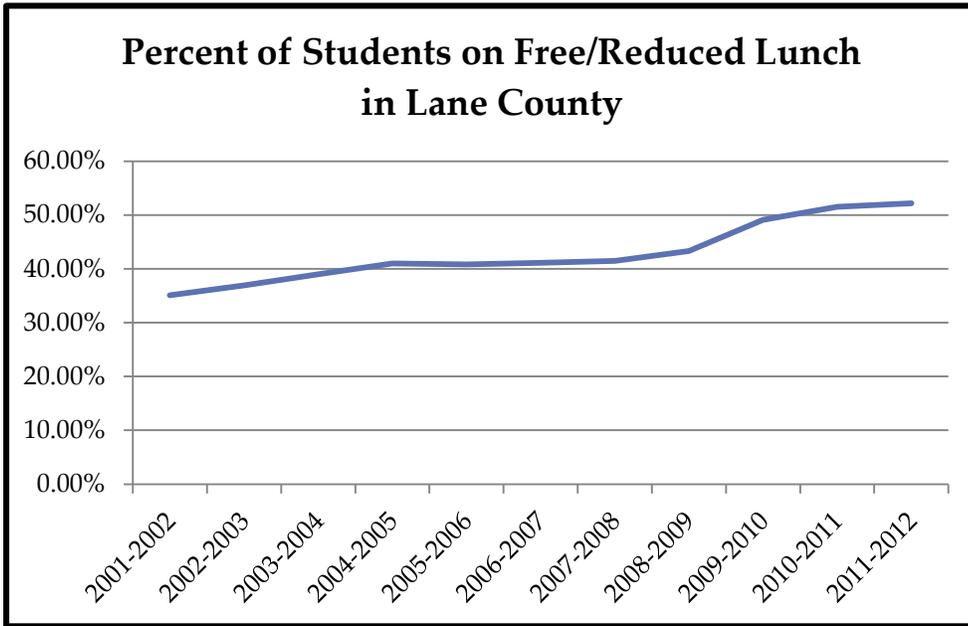
Source: United States 2010 Census

¹ Meara et al, 2008.



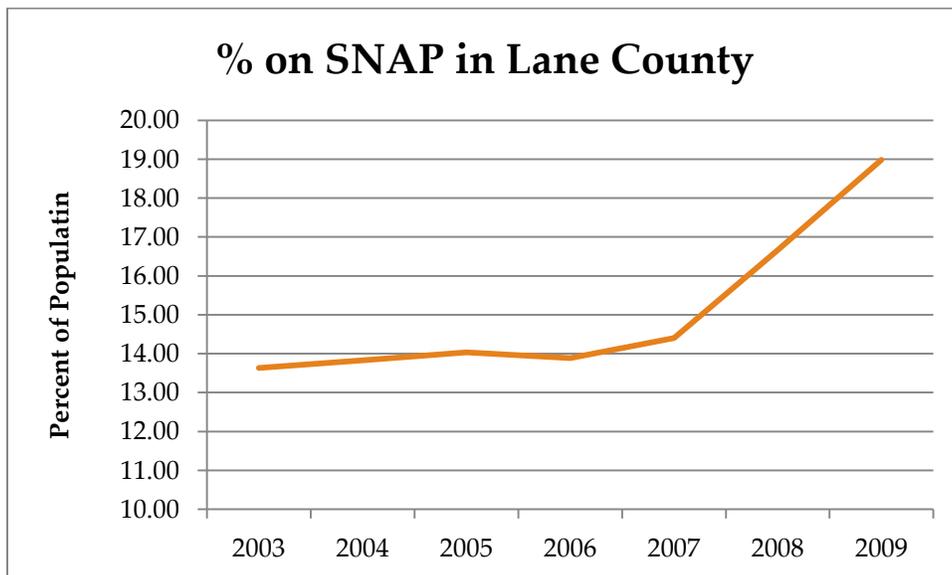
Food Security

The number of school children receiving free or reduced price school lunches is a strong indicator of childhood and family poverty within a community. The percent of students receiving such lunches at school has risen steadily over the last decade. Currently more than half of children in Lane County receive free or reduced price school lunches.



Source: Oregon Department of Education, CNP Statistics

The number of individuals enrolled in the Supplemental Nutrition Assistance Program (sometimes referred to as “food stamps”) has increased dramatically in recent years. In 2009 (the most recent available data) 18.9% of Lane County residents received some SNAP benefits.



Source: Economic Research Service, US Department of Agriculture

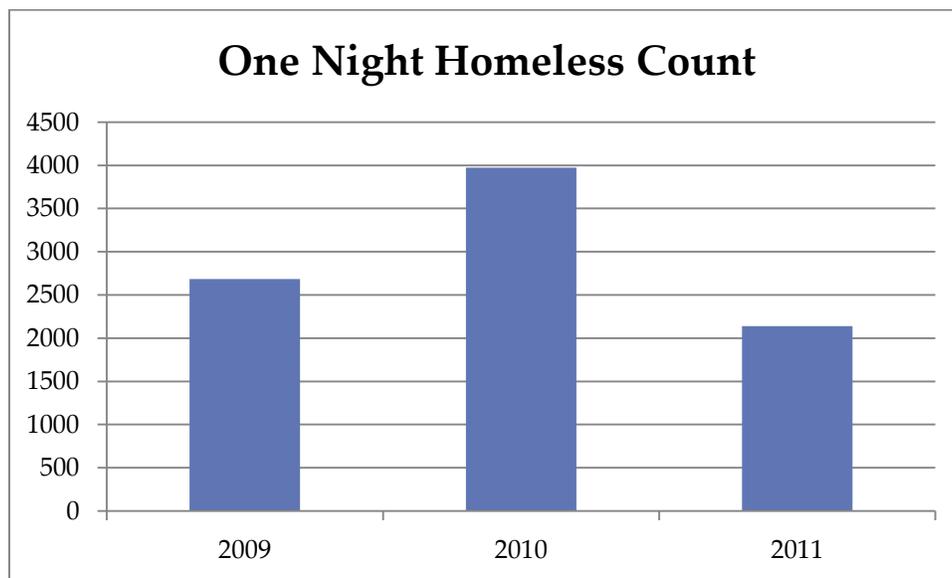


Unemployment

The economic recession of the mid-2000s caused significant unemployment in Lane County and has contributed to the decline in services provided by municipalities, government agencies, and non-profit organizations. While unemployment is slowly improving, many families in Lane County continue to experience economic distress.

Homelessness

Homelessness is a significant issue in several Lane County communities. In the 2010-2011 school year 5% of students (2285 children) were homeless (source: Oregon Department of Education). Additionally, an annual count in January of homeless individuals (both sheltered and unsheltered) enumerates thousands of unhoused individuals in Lane County.

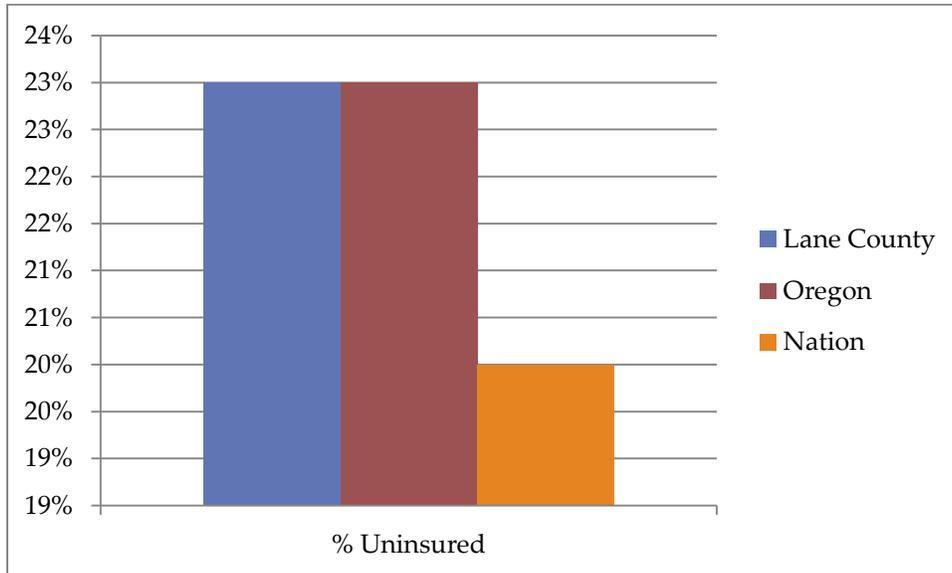


Source: Lane County Human Services Commission; One Night Homeless Count 2009-2011



Access to Care – Health Insurance

In comparison to the Nation, Lane County and Oregon residents are more likely to be uninsured, with 23% of residents uninsured. In 2014, The Affordable Care Act could make a dramatic impact on these rates.



Source: Oregon BRFSS 2006-2009; National BRFSS 2010

Oregon Health Plan Members

Lane County’s CCO, Trillium, manages the Oregon Health Plan, OHP, benefits for Lane County residents. Due to the eligibility criteria for OHP, Trillium’s members represent a much larger share of children and young people less than 18 years of age than is reflected in countywide data. One in five members is under the age of six. Demographic differences include:

Demographic	Trillium	Lane County
Working Age Individuals	34%	53%
Seniors	6%	15%
Females	55%	50%
White/Non-Hispanic	80%	84%
Under 18 years of age	51%	19%

Although the five identified priorities for the county assessment apply to OHP members, strategies to address these priorities specifically for this population may take a more preventive approach. Behavioral health, tobacco use, chronic diseases and are the leading healthcare cost drivers and most common health conditions reported among all Trillium consumers. Most of these conditions are preventable. Given that more than half of Trillium consumers are children, there is substantial potential to improve targeted prevention activities for youth that would improve health outcomes later in life.



Assessment Findings

This section details the community health indicators that were considered by the Lane County Community Health Assessment team. Data was compiled from national, state, and local sources and include a broad sampling of community health measures.

In Lane County, as throughout the rest of the nation, health status and quality of life are intimately tied to numerous social and environmental factors including income, poverty, race/ethnicity, education level, geographic location, and employment status. These factors are known as the *social determinants of health*. Individuals who are experiencing poverty, unemployment, are less educated, or are Hispanic, Black, or Native American are more likely to experience poorer health, have higher rates of chronic conditions such as obesity and diabetes, and are more likely to smoke than those individuals of a higher socioeconomic status. Concerted efforts aimed at reducing these health disparities will be a priority area for the Lane County community moving forward in health improvement efforts.

The following table lists health indicators included on the annual County Health Rankings published by the Robert Wood Johnson Foundation. “Strengths” reflect the indicators on which Lane County performed better than the state and national averages or benchmarks. Those indicators under “Room for Improvement” were similar to the Oregon averages but are areas of concern for certain Lane County communities. “Challenges” are areas where Lane County is doing worse than Oregon and the nation and where additional attention is needed.

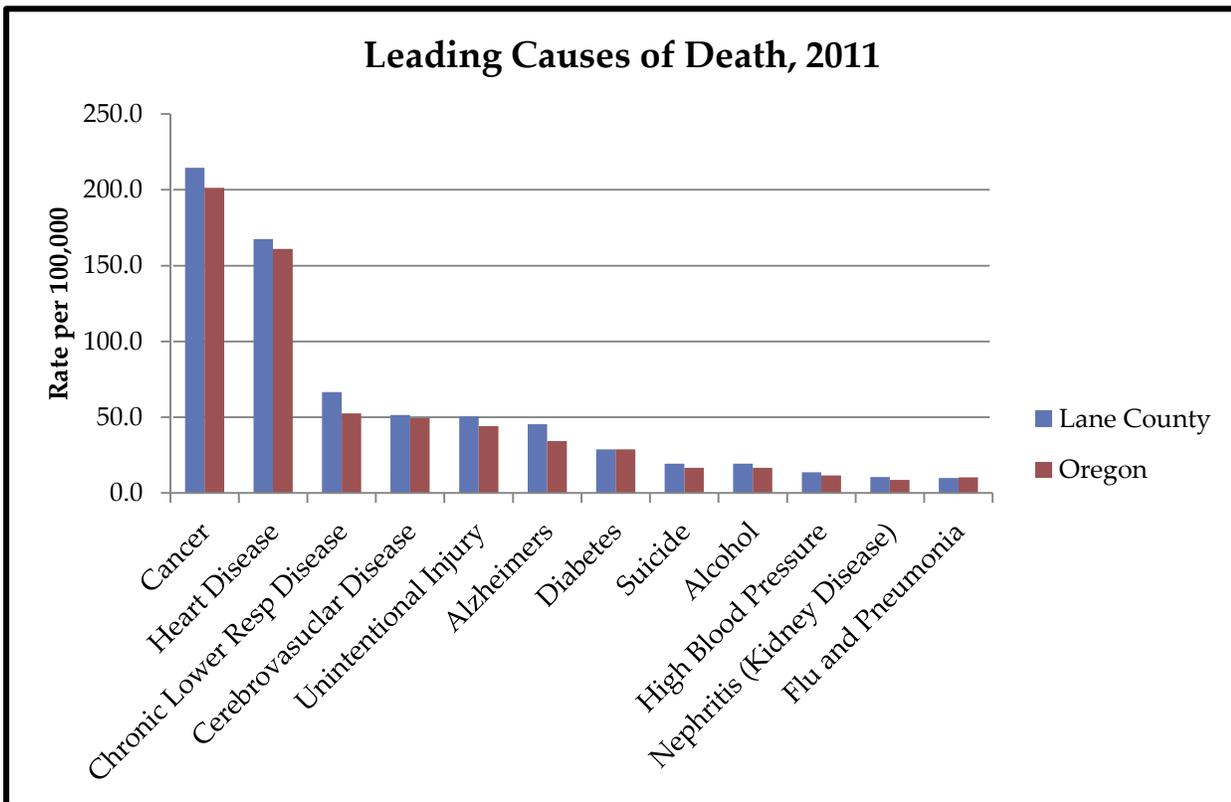
	Strengths	Room for Improvement	Challenges
Mortality	Premature death rate		
Socioeconomics		Unemployment High School Graduation Inadequate social support	Children in poverty Violent Crime Rate Children in single-parent households
Environment		Fast food restaurants Daily fine particulate matter Limited access to healthy foods	
Health Behaviors and Outcomes	Teen birth rate Physical activity		STIs (Chlamydia) Adult smoking Adult obesity
Clinical Care	Preventable hospital stays	Mammography screening Primary Care Physicians Diabetic screening Dentists	Uninsured



Community Health Status

Leading Causes of Death

The leading causes of morbidity and mortality in Lane County are chronic diseases such as cancer, heart disease, respiratory illness, and Alzheimer’s. Behavioral risk factors such as physical inactivity, poor nutrition, and tobacco and substance abuse contribute to many of these cases of chronic disease. Tobacco and obesity are the two leading root causes of death in both Lane County and Oregon.

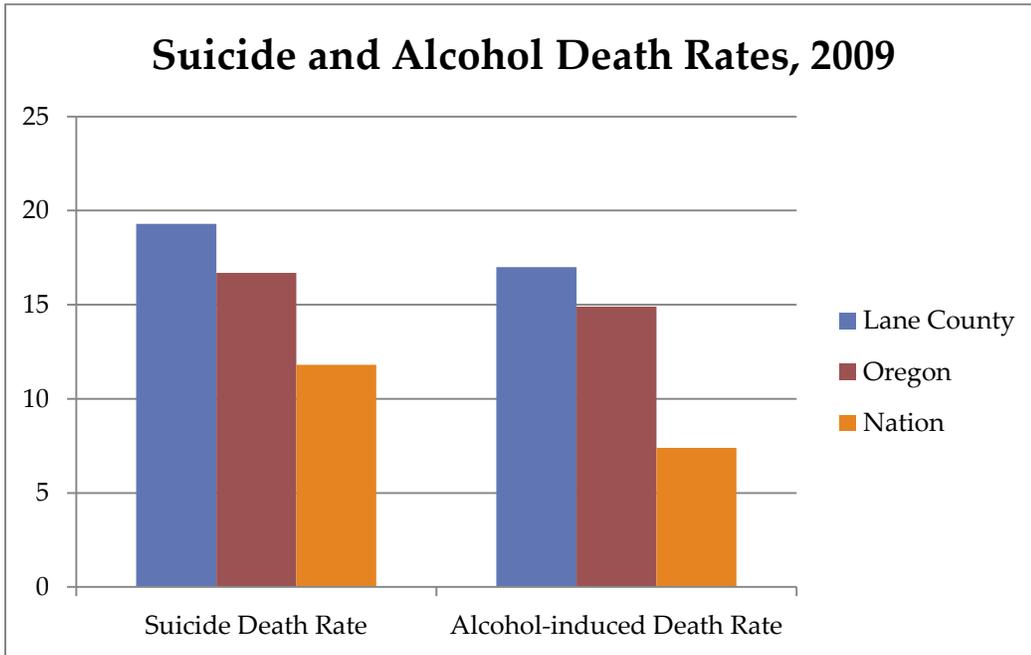


Source: Oregon Vital Statistics County Databook, 2011



Suicide and Alcohol-Related Deaths

Lane County has significantly higher rates of suicide and alcohol-induced deaths than the nation as a whole. These high rates indicate a heavy burden of mental illness and substance abuse within the community.

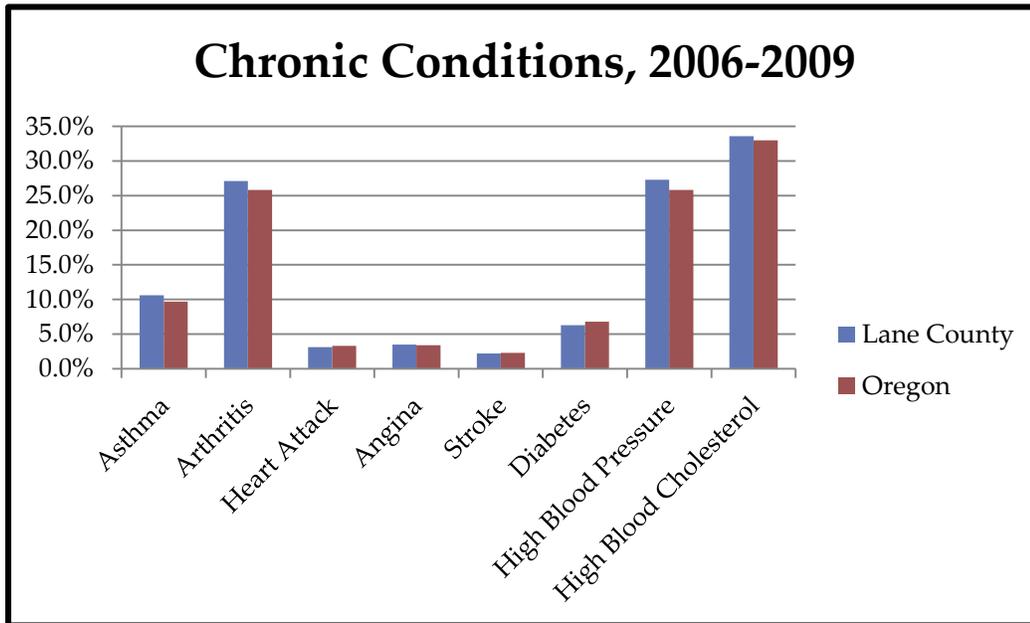


Source: Oregon Vital Statistics County Databook 2009; National Vital Statistics Report 2009



Chronic Conditions Prevalence

Chronic conditions are those illnesses and conditions that individuals live with for years. These conditions can have a significant effect on quality of life. Chronic conditions are more prevalent as individuals age. As the population of Lane County grows older, management and mitigation of chronic conditions will continue to be an important aspect of community health work.

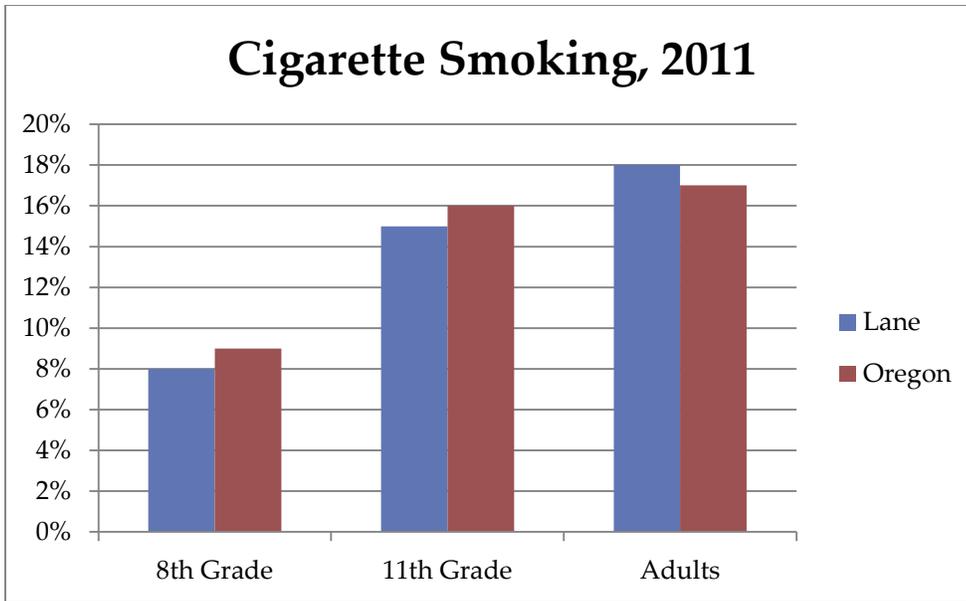


Source: Oregon BRFSS, 2006-2009 County Results

Tobacco

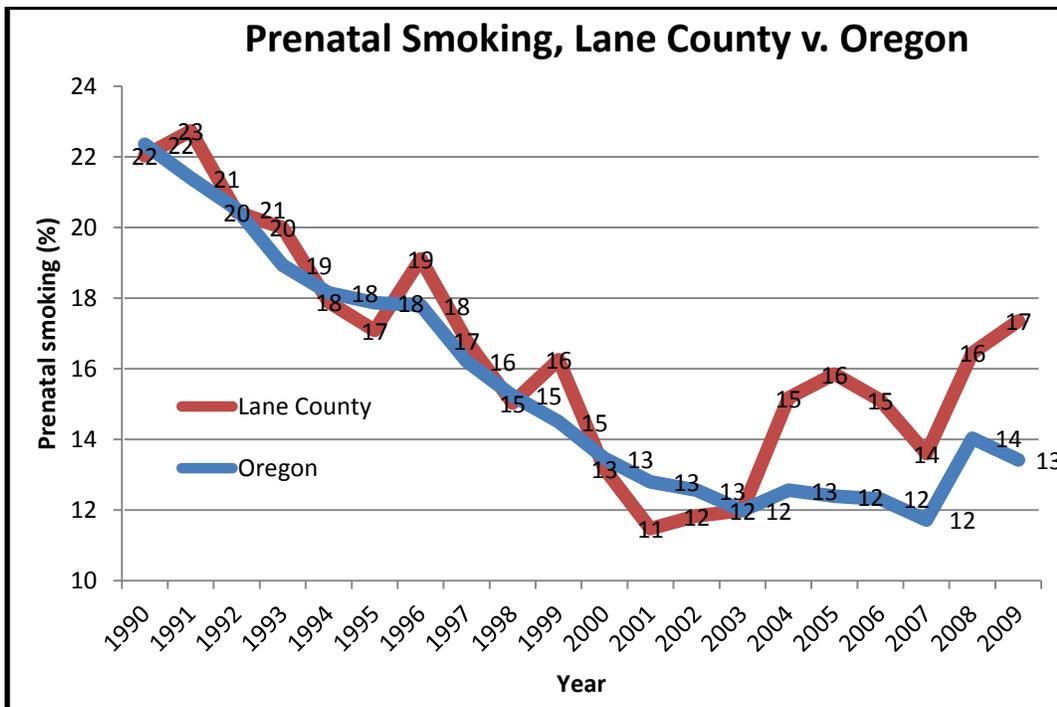
Tobacco remains the leading cause of preventable death in Lane County, contributing to 23% of all deaths in the county. 18% of Lane County adults report being current smokers. Use of tobacco is significantly higher among persons experiencing poverty, mental illness, and substance abuse. Statewide data indicate that smoking rates vary significantly by income: over 30% of residents with an income under \$15,000 smoke, while fewer than 10% of residents with an income of at least \$50,000 are current smokers. Ethnic minorities are also more likely to smoke – over 30% of Native Americans and 29% of African Americans smoke in comparison to 14% of non-Hispanic whites².

² Oregon Tobacco Facts and Laws, 2011



Source: Lane County Tobacco Fact Sheet, 2011

Prenatal smoking is of particular concern to the Lane County community as reflected in both the data and in responses from community members and leaders. While the state of Oregon has seen a general decrease in the rate of tobacco use among pregnant women, the rate in Lane County has begun climbing upwards once more, reaching 17% in 2009 compared with a rate of 13% for the state.



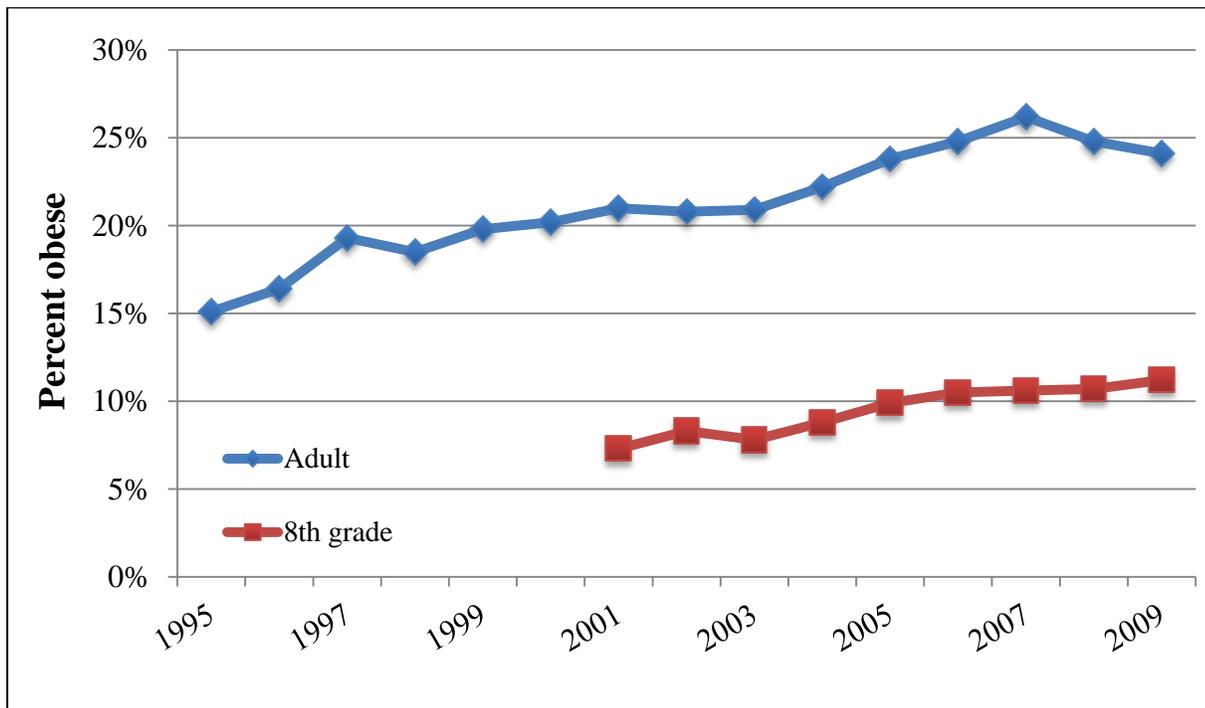
Source: Oregon Vital Records data



Youth smoking rates in Lane County are similar to those of the state. Cigarette smoking among youth has been declining in recent decades. 8.4% of Lane County 8th graders and 15% of 11th graders report smoking cigarettes in the past month³

Obesity

Overweight and obesity together are the second leading cause of preventable death in Oregon. Obesity is a major contributing factor to many chronic conditions such as diabetes, heart disease, high cholesterol, and mobility problems. Obesity rates in Lane County have followed the national trend of dramatic increases over the past two decades. Over half of adults in Lane County are obese or overweight; these rates are projected to continue to increase in the future.



Source: Oregon BRFSS

Obesity and overweight are inequitably distributed throughout our society, impacting low-income minority populations at higher rates. Persons with mental illnesses are also far more likely to be obese than those without such conditions. Major depressive disorder and bipolar disorder symptoms often disrupt appetite, motivation, energy, and sleep, all of which can contribute to weight gain⁴ Efforts to

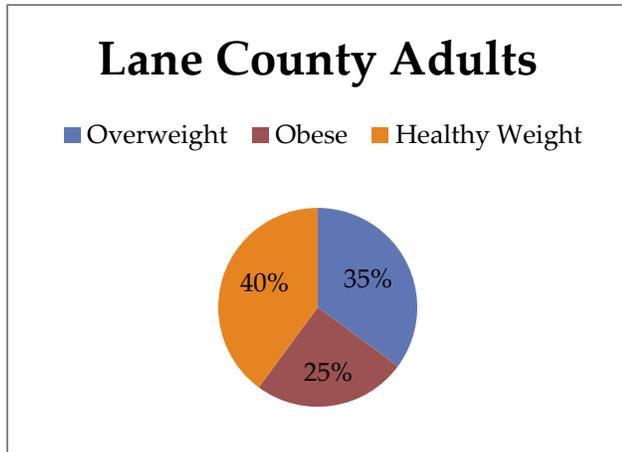
³ Oregon Healthy Teens survey 2007-2008 combined data

⁴ Taylor, Valerie MD. "Beyond Pharmacotherapy: Understanding the Links Between Obesity and Chronic Mental Illness." *Canadian Review of Psychiatry*, 2012 January; 57(1): 13-20.

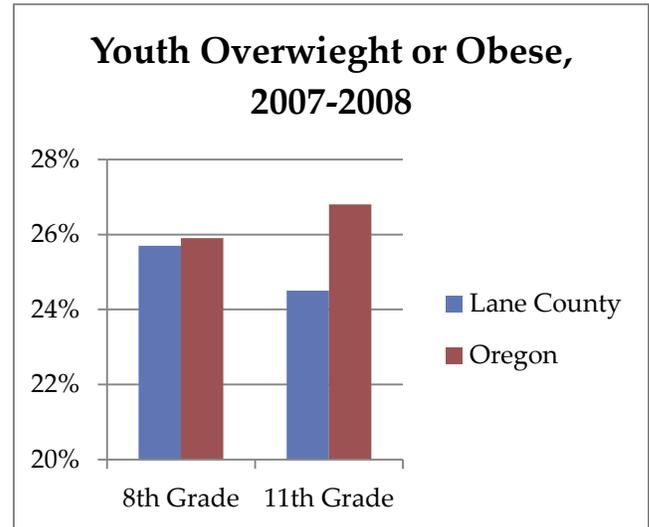


drive the obesity rate down must target specific populations and the environments in which those individuals conduct their lives.

Statewide, Oregon Health Plan consumers are roughly 50% more likely to be obese than the general population; this difference is expected to be similar although somewhat less pronounced in Lane County due to the demographic make-up of the county.



Source: Behavioral Risk Factor Surveillance System, 2006-2009 age-adjusted



Source: Oregon Healthy Teens Survey

Oregon and Lane County youth have not been immune to the rising rates of obesity. Approximately 25% of youth in both 8th and 11th grades are either overweight or obese. Lack of physical education in schools, excess consumption of sugar-sweetened beverages, poor nutrition, and increased time in front of computer and television screens have all contributed to this increase in youth overweight.

Substance Abuse

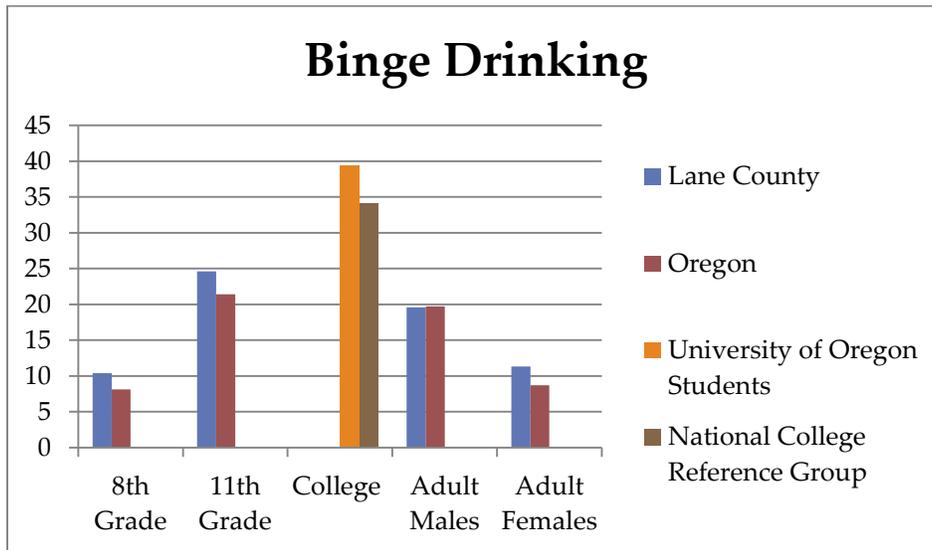
Alcohol

Alcohol is the most commonly used/abused drug among youth in the United States; more than tobacco, marijuana and methamphetamine. Preventing underage drinking is important because of the consequences associated with underage drinking; including accidents, unplanned or unwanted sexual activity, legal problems, effects on brain development and the potential for developing other lifelong problems. People who start drinking before the age 15 are five (5) times more likely to develop abuse or dependence later in life than those who start after age 21.

Additionally, binge drinking is a significant risk factor for injury, violence, and chronic substance abuse, and is of particular concern in Oregon given the high number of alcohol-induced deaths. Binge drinking is defined as 5 or more drinks (4 for females) in a single sitting. More than 90% of the alcohol youth drink is while binge drinking. Binge drinking generally results in a Blood Alcohol Content (BAC)

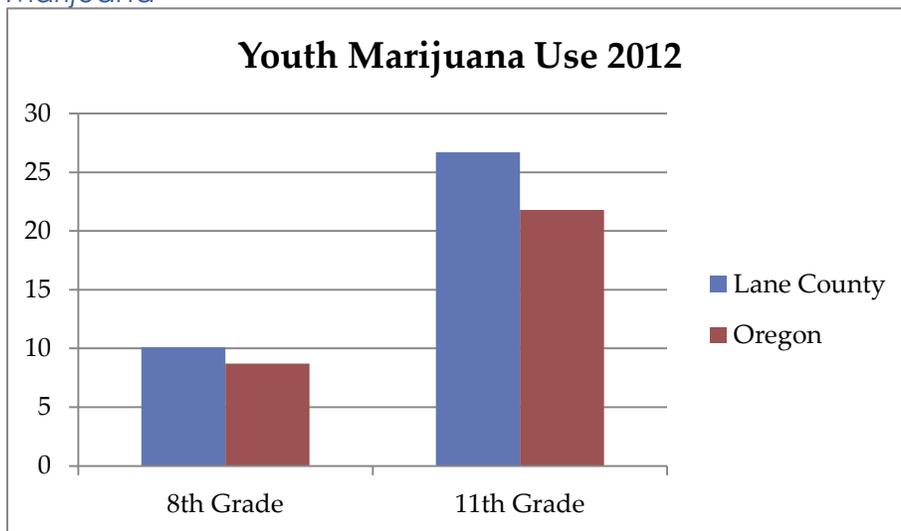


of at least 0.8 (the legal limit for driving). People who binge drink are 14 times more likely to report drinking and driving⁵ than those who do not.



Source: Oregon Student Wellness Survey; American College Health Association National College Health Assessment; Oregon Behavioral Risk Factor Surveillance System

Marijuana



Use of marijuana among youth in Lane County is higher than the rates of the state. Over 26% of Lane County 11th graders report smoking marijuana in the past 30 days compared to 21.8% of Oregon teens on average.

Source: Oregon School Wellness Survey, 2012

⁵ CDC Vital Signs Binge Drinking, 2012



Dental/Oral

Access to dental care has been identified by medical and social services providers as a significant problem in Lane County. In 2005-2006 there were 6,718 emergency department visits for dental problems; 48% of these patients were uninsured. From 2002-2007 tooth decay, untreated tooth decay, and rampant decay among Oregon 1st and 2nd graders worsened, and there is no reason to suspect that Lane County children were immune from this decline.

Mental Health

Mental illness refers to a wide range of mental conditions, including disorders that affect mood, thinking and behavior. Mental illness can be highly stigmatized, often underdiagnosed and undertreated. According to 2011 Client Process Monitor System, CPMS, data, Lane County provided mental health treatment services to over 14, 000 residents; 8,628 adults and 5,532 youth. Individuals with a current mental illness are more than twice as likely to smoke cigarettes and more than 50% more likely to be overweight/obese than those without a mental illness.⁶ Mental illnesses have significant impacts on an individual’s quality of life, often negatively affecting employment, family ties and social networks, physical health, resiliency to stressors, and connection to the community. Prejudice and discrimination are major barriers to recovery for people who have mental health problems. They are among the reasons why nearly two-thirds of all people with diagnosable mental illness do not seek treatment.⁷

Depression

Depression can have a significant impact on one’s life. It can affect your physical health, sleep, increase weight, withdrawal from social contact, increase use and abuse of alcohol and other drugs and increase suicidal tendencies. 64.1% of Lane County adults reported that they had no poor mental health in the past 30 days, compared to 66.4% of Oregon adults⁸. 25% of Lane County adults reported limitations in their usual activities due to poor physical or mental health.

BRFSS Fair/Poor Mental Health Days: “For how many days during the past 30 days was your mental health not good?”

Lane County	Oregon	National Benchmark
3.7	3.3	2.3

Lane County youth experience depression at a higher rate than the state average. According to the 2011 Student Wellness Survey, 21.3% of 6th graders, 24% of 8th graders and 29% of 11th graders

⁶ Compton, MT. “Cigarette smoking and overweight/obesity among individuals with serious mental illnesses: a preventive perspective.” *Harvard Review of Psychiatry*. 2006 July-August; 14(4):212-22

⁷ SAMHSA ADS Center, 2008

⁸ Oregon Behavioral Risk Factor Surveillance Survey, 2006-2009 (age-adjusted)



answered 'Yes' to the question: 'During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?'

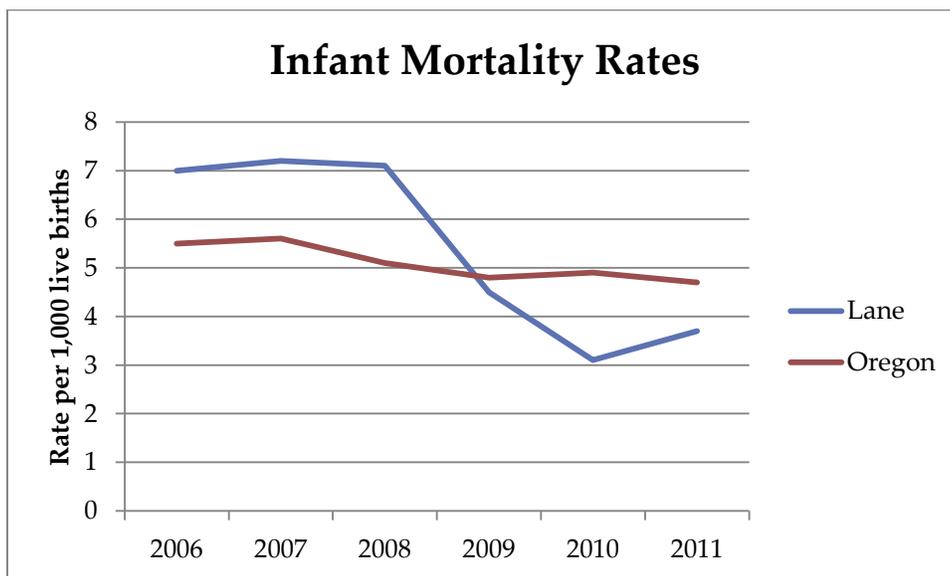
Depression has been identified as a top priority for Trillium, Lane County's Coordinated Care Organization. Depression is the most common illness/condition for which Oregon Health Plan members seek care (9% of OHP members were treated for depression between August 2011 and August 2012).

The county is required to submit a Biennial Mental Health and Addictions Plan to the State Oregon Health Division. The 2013-2015 plan was submitted earlier this year and includes more detail on the needs, gaps and priorities regarding these issues.

Maternal/Child Health

Infant Mortality

Infant mortality rates are a traditional measure of maternal health and wellbeing. Infant mortality is intricately tied to prenatal care, smoking during pregnancy, and poor nutrition. The recent trend in Lane County is very promising, with declining rates of infant mortality in the past few years from well above the state average to slightly below.

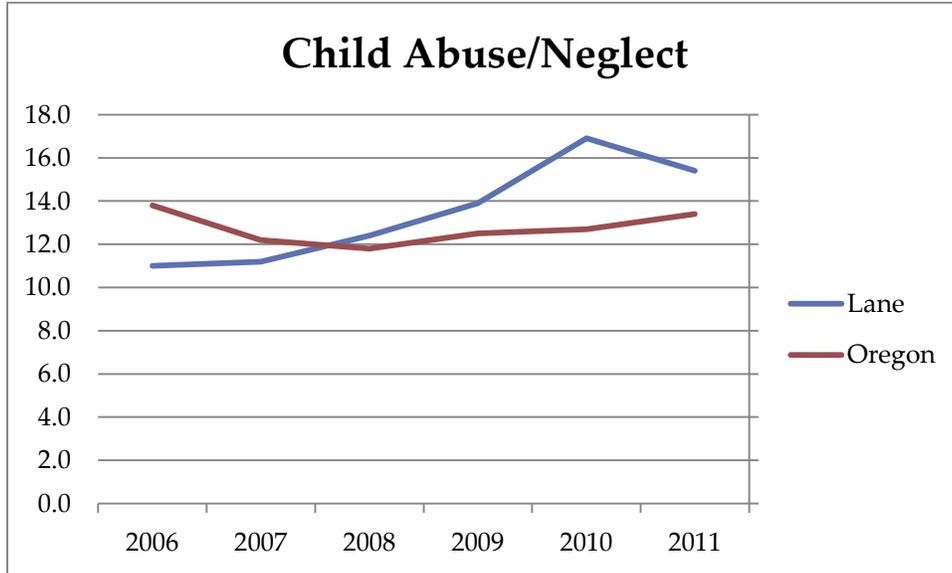


Source: Oregon Vital Statistics County Databook



Child Abuse/Neglect

Child maltreatment is a serious concern in Lane County, one that is reflected in both the data and in conversations with community members and local leaders. Rates of victimization in Lane County have been higher than the state for the past several years, as seen the chart below.



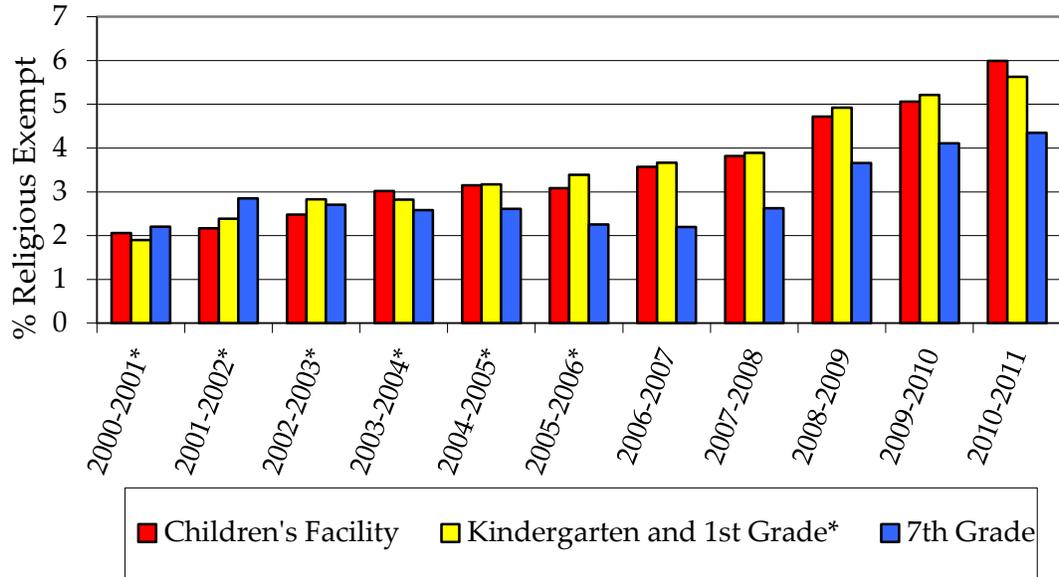
Source: Oregon Child Welfare Data Book, Oregon CAF; rate is per 1,000 children

Immunizations

Effective vaccines have played a crucial role in the reduction in child mortality seen in the past hundred years. Many of the diseases that children are vaccinated against are highly contagious and spread quickly through unvaccinated populations. In Lane County, 77.2% of two-year-olds receive the MMR vaccine which is insufficient to prevent outbreaks of measles (a vaccination rate of between 83-94% is required). Lane County has one of the highest rates of religious exemptions in the state, placing the community at a heightened risk of outbreak among unvaccinated groups. OHP members, however, are somewhat more likely to be immunized than non-OHP members.



Religious Exemption Rates, 2000-2011





OHP Population – Most Prevalent Conditions

Oregon Health Plan members, while generally in line with the health trends and concerns of the general county population, have several unique health burdens and priority areas. Depression is the most common health condition for which OHP members seek medical care (9% of all members). As these statistics were compiled from claims data, they are under-representative of the true burden of these conditions in the OHP population.

Adult smoking rates among Oregon Health Plan adult consumers are almost twice as high as non-OHP consumers. Statewide, OHP consumers are nearly twice as likely to have asthma as the general population.

ACA Condition	Number of Members	% of Members
Depression	4919	9%
Asthma	3886	7%
Bipolar Disorder	3658	7%
Tobacco Use	3205	6%
PTSD	2615	5%
Attention Deficit Disorder	2325	4%
Child Obesity	2238	4%
Diabetes	2238	4%
Chemical Dependency	1920	3%
Adult Obesity	1865	3%

Source: ACA Conditions in the Trillium Community Health Plan Medicaid Population, 2012



Community Themes and Strengths Assessment

Presentation feedback/questionnaires

When the Lane County Community Health Assessment team began presenting data to community groups in August of 2012, attendees were asked to respond to the presentations and suggest additional areas of focus for the team. Over 50 responses were returned, with a wide range of suggested priorities and additional data sources. The vast majority of these suggested priorities closely mirrored the themes that emerged from the data. Respondents were asked eight open-ended questions and encouraged to write their responses during the presentations. Below is a snapshot of the most prevalent responses.

1. Are there vulnerable populations that were not mentioned that we should look at?

Populations that were recommended for additional focus included veterans, the homeless, undocumented persons, single-parent households, people with mental and behavioral health issues, rural residents, and the un/under-employed.

2. What drivers or root causes of these deaths should we focus on?

Top drivers were: tobacco prevention and cessation, healthy nutrition and eating, physical activity, poverty and socioeconomic status, and mental illness.

3. What chronic conditions are of particular concern to you?

Those conditions mentioned most frequently were diabetes, obesity, depression/mental health, asthma, chronic pain, and addiction.

4. Which social determinants of health (those factors of our social, economic, and physical environments that improve or impede a healthy lifestyle) should we focus on?

Respondents indicated that affordable housing, poverty, education, access to health care, food security, and local economic development all had a significant impact on health in the community.

5. What, if any, healthcare access issues not addressed in the presentation are of particular interest to you?

Transportation, dental care and lack of providers, mental health & substance abuse treatment, access to naturopathic care, recruitment of providers, access to care for rural patients, and affordability of medications were cited as additional access issues in Lane County.

6. Which behavioral risk behaviors are of most concern to you?



Drug use, inadequate physical activity, tobacco, diet, alcohol, and prenatal smoking were the behavioral risk factors of most concern to respondents.

7. Are there other areas concerning maternal/child health that we as a community need to address?

Tobacco, prenatal drug/alcohol exposure, contraception access, parenting education and guidance, poverty, maternal obesity, immunization rates, and adverse childhood events (ACEs) were all requested as areas for additional focus.

Community Advisory Coalition Feedback

The Community Advisory Coalition (CAC) has been involved throughout much of the Community Health Assessment and Community Health Improvement Plan (CHIP) process. CAC members participated in the health assessment where appropriate and took the surveys back to their home organizations for distribution. Two CAC consumer members were part of the larger agency planning workgroup, and the CAC also has a workgroup focused specifically on the health assessment and health improvement plan. This workgroup of the CAC has been giving input throughout the process and most recently has been discussing how to prioritize the CHIP for the Trillium population. The larger CAC as well as the Rural Advisory Committee (RAC) have heard presentations about the health assessment and more recently about the CHIP. At a March CAC meeting, members, including the three RAC members on the CAC, heard a formal presentation about the CHIP, and the advisory council had the opportunity to share their input, ideas and feedback.

Since the CAC is looking at the community health assessment from the perspective of the Oregon Health Plan (OHP) population, particular health issues stood out and were concerning to members.

- Tobacco use is among the top five reported claims for Trillium, and the prevention workgroup of the CAC has already put forth a tobacco prevention plan to address this issue that was approved by the Trillium Board of Directors.
- From the data, we also know that depression and other behavioral health conditions pose a significant, preventable health burden for OHP members.
- Statewide, OHP consumers are 50% more likely to be obese than the general population and this difference is expected to be fairly similar in Lane County. Obesity is one of the more commonly diagnosed conditions among OHP consumers.



- Qualitative data from the community health needs assessment points to affordable transportation options, access to care for rural consumers to be greater needs for OHP consumers than for the general population.

Key Informant interviews

Between August 27 and October 15, 2012, thirty-six key informants with strong leadership and policy knowledge were personally interviewed using a questionnaire instrument made available through NACCHO resources.

The key informants were selected from the following sectors: social services, medical services, law, business, government, education, environment, faith, media, emergency services, philanthropy, and community service. The average length of residence in Lane County was slightly over 32 years and the average number of years in their current position exceeded 14 years except for those key informants who were currently retired. Nearly two-thirds of the key informants were female.

Key informants by sector (percent of total):

Social Services	19.4
Medical Services	16.7
Law	11.1
Business	11.1
Government	8.3
Education	8.3
Community	8.3
Environment	5.5
Faith	2.8
Media	2.8
Emergency Services	2.8
Philanthropy	2.8
TOTAL	99.9

Regarding whether our residents' health and quality of life have improved, stayed the same, or declined, the majority opinion concluded that there has been a decline over the past few years. A quarter of the interviewees thought things were about the same and a few informants expressed a rosier view with improvements in our health and quality of life.

Nearly two-thirds of the responses were overwhelmingly centered on social determinants of health factors including employment, poverty, access to affordable healthcare and housing due to the stressful economic recession and cuts in services as the basis for their opinions regarding health and quality of

Lane County Community Health Assessment



life in Lane County. There was a small set of positive responses (17.4%) about our county’s improvements, including improving air quality, increased access to tobacco free sites, tourism and recreational opportunities, and appreciation for community collaborative efforts. Behavioral risk factors were also cited as basis for opinions regarding declining health and quality of life, including obesity, substance abuse, stress, tobacco use, and mental health concerns.

Q: In general, how would you rate health and quality of life in Lane County?

	Number	%
Good to Excellent	11	30.5
Fair – Medium – Moderate	6	16.7
Better than Other Places	9	25
Depends on SES	10	27.8
TOTAL	36	100

Q: Why do you think it has improved, declined, or stayed the same?

	Number	%
Social Determinants Total	37	64.9
Employment	16	28.0
Poverty/Access to Healthcare	11	19.3
Child Mistreatment	4	7.0
Education	3	5.3
Affordable Housing	3	5.3
Behavioral Risk Factors Total	8	14.0
Obesity	3	5.3
Stress	2	3.5
Alcohol/drug/Mental Health	2	3.5
Positive Comments Total	7	12.3
Smoking Bans	1	1.8
Improved Behavioral Risks	1	1.8
Fewer in hazardous jobs	1	1.8
Access improved	1	1.8
More social cohesion	1	1.8
New hospital	1	1.8
Air quality improved	1	1.8
Other Factors Total	5	8.8
Infant Mortality	2	3.5
Air Quality still bad	1	1.8
Hard to implement change	1	1.8



Loss of sense of community	1	1.8
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The key informants were unanimous in their recognition that our county has groups of people whose health or quality of life is not as good as others . When asked to describe who is not as healthy or likely to have as good a quality of life, over 60% of the opinions centered on the conditions in which people live and how poverty, employment, access to affordable housing, educational opportunities, and child maltreatment affect them. In addition, there was nearly equal concern expressed for those struggling with the behavioral risk factors of substance abuse, obesity, and tobacco use and other factors, primarily the elderly and disabled vulnerable populations.

Further, the key informants clearly recognized poverty and obesity issues as the top critical issues for our county with nearly equal responses given (22.1% and 19.5%, respectively). The key informants clearly voiced support for interventions to prevent obesity (17.2%) and opportunity for increased community collaborations to improve health and quality of life in Lane County (15.5%) (q.8). When probed for additional priorities, key informants continued to select obesity prevention as critical with substance abuse prevention as the second top concern (17.1% and 14.6%, respectively). , increasing employment opportunities, access to affordable housing, strengthening educational opportunities, poverty and access to health and dental care, and improving our funding for the above with a reliable tax base were also identified as critical to improving our communities.

Q: What barriers, if any, exist to improving health and quality of life in Lane County?

	Number	%
Income/Employment	21	30.4
Lack of access to & knowledge for healthy practices; lack of resources for policy changes thereof	10	14.5
Access to healthcare	9	13.0
Education	8	11.6
Affordable housing	5	7.2
Transportation	4	5.8
Lack of funding for services	4	5.8
Drug Abuse	3	4.3
Elderly & Disabled Srvs.	2	2.9
Rural/isolated	2	2.9
Non-English speaking	1	1.4

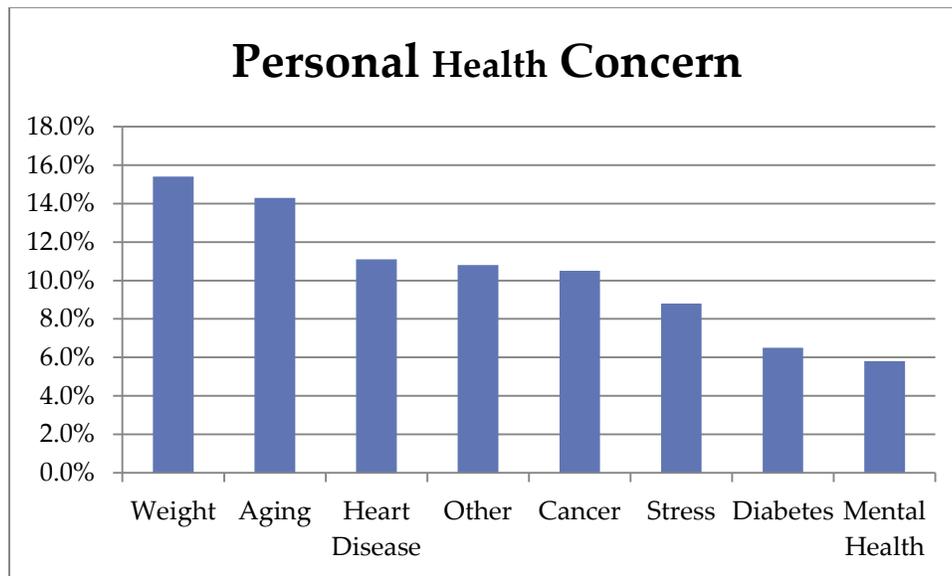
Community Survey

In order to solicit additional community feedback on health, wellbeing, and quality of life in Lane County, the CHA Team distributed a Quality of Life survey at all presentations of the data, as well as at

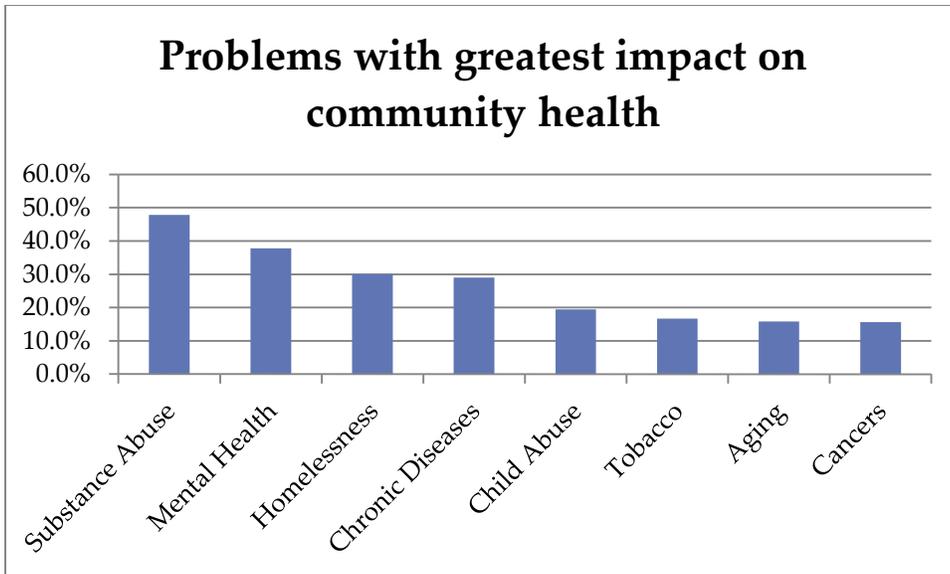


local social service agencies, non-profits, and other community locations. 732 completed surveys were returned. As the survey was conducted via convenience sampling (i.e. non-random), the demographics of the survey population are not entirely representative of the county at large. The Eugene-Springfield area is heavily represented within the survey with fewer responses from the rural and unincorporated areas of the county. The majority (67.3%) of respondents were female; a limited number of responses were from young residents (only 16.8% of responses were from residents younger than 40 years old). However, the surveys do provide some insight into community opinions and perceptions of health in the county.

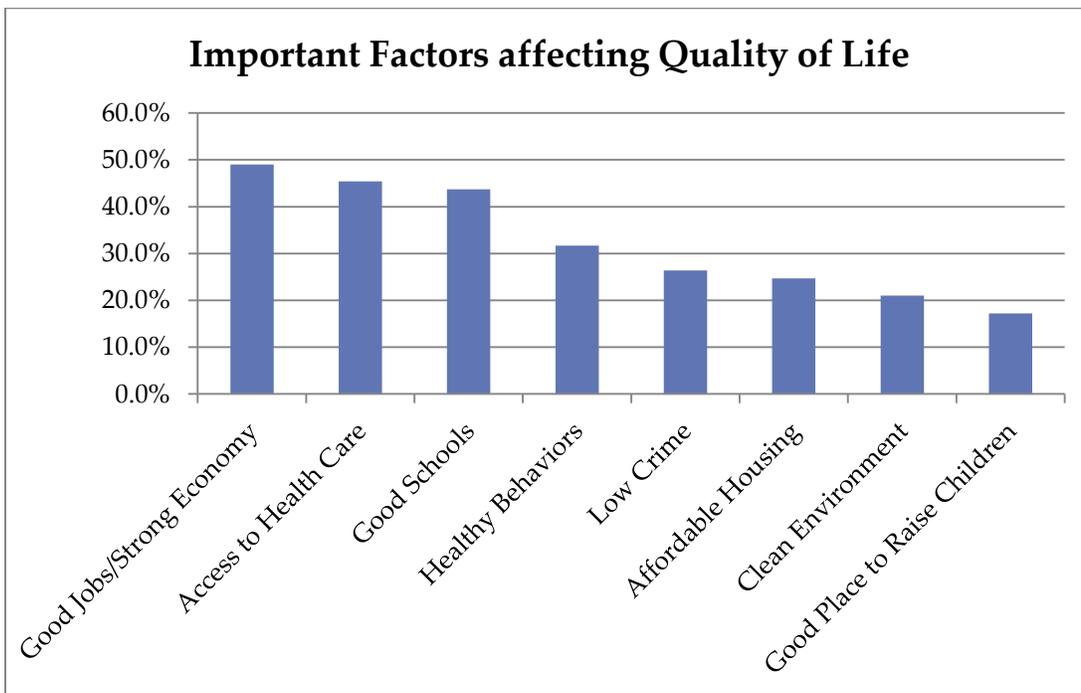
When asked about their most pressing personal health concern, the top responses were:



When asked what they thought the top health concerns were for the community as a whole, substance abuse and mental health jumped to the top of the list. Homelessness and child abuse also emerged as significant concerns, reflecting some of the data presented in the socio-economic indicators section of this report. As respondents could choose up to three factors, the percentages add up to more than 100%.



Respondents were also asked about which socio-economic factors help to make up a “Healthy Community”:



United Way Community Conversations

United Way of Lane County (UWLC) staff and volunteers have conducted dozens of Community Conversations across the County over the last two years. Community Conversations, a model



developed by the Harwood Institute, are facilitator-led discussions with community members from various walks of life.

UWLC staff and volunteers have hosted several Community Conversations focused on health and wellness in our community over the last six months. These Conversations included speaking with community members from low-income housing from across the county, community members from Florence, and Spanish-speaking community members from Cottage Grove and Creswell. The purpose of the conversations was to inform the Community Health Needs Assessment and Improvement Plan about the aspirations and concerns of different groups in the community regarding health and wellness.

**United Way is asking people from across Lane County –
*What do you want health and wellness to be like
in our community?***

Here's what we heard:



Local Public Health Authority:

Date:

Minimum Standards – Lane County FY 14/15

To the best of your knowledge, are you in compliance with these program indicators from the Minimum Standards for Local Health Departments?

I. Organization

1. Yes No A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes No The Local Health Authority meets at least annually to address public health concerns.
3. Yes No A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.
4. Yes No Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes No Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes No Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes No Local health officials develop and manage an annual operating budget.
8. Yes No Generally accepted public accounting practices are used for managing funds.
9. Yes No All revenues generated from public health services are allocated to public health programs.
10. Yes No Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes No Personnel policies and procedures are available for all employees.
12. Yes No All positions have written job descriptions, including minimum qualifications.

Local Public Health Authority:

Date:

13. Yes No Written performance evaluations are done annually.
14. Yes No Evidence of staff development activities exists.
15. Yes No Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes No Records include minimum information required by each program.
17. Yes No A records manual of all forms used is reviewed annually. Documents used are reviewed annually within programs – we are working on a manual which includes all forms for the division.
18. Yes No There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes No Filing and retrieval of health records follow written procedures.
20. Yes No Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes No Local health department telephone numbers and facilities' addresses are publicized.
22. Yes No Health information and referral services are available during regular business hours.
23. Yes No Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.
24. Yes No 100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.
25. Yes No To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes No Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes No Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.

Local Public Health Authority:

Date:

28. Yes No A system to obtain reports of deaths of public health significance is in place. We contact the Deputy Medical Examiner in the District Attorney's Office.

29. Yes No Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.

30. Yes No Health department administration and county medical examiner review collaborative efforts at least annually. Note: this has not happened on an annual basis. Public Health does receive death information as needed from the county medical examiner.

31. Yes No Staff is knowledgeable of and has participated in the development of the county's emergency plan.

32. Yes No Written policies and procedures exist to guide staff in responding to an emergency.

33. Yes No Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.

34. Yes No Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.

35. Yes No Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.

36. Yes No A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

Control of Communicable Diseases

37. Yes No There is a mechanism for reporting communicable disease cases to the health department.

38. Yes No Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.

39. Yes No Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received. Note: Following the Investigative Guidelines our CD team connects with the reporting provider and collaborate on a case by case basis.

Local Public Health Authority:

Date:

40. Yes No Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.
41. Yes No There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
42. Yes No There is a mechanism for reporting and following up on zoonotic diseases to the local health department.
43. Yes No A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
44. Yes No Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
45. Yes No Immunizations for human target populations are available within the local health department jurisdiction.
46. Yes No Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

47. Yes No Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes No Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes No Training in first aid for choking is available for food service workers. Note: the training is available in our food handler manual.
50. Yes No Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
51. Yes No Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
52. Yes No Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

Local Public Health Authority:

Date:

53. Yes No Compliance assistance is provided to public water systems that violate requirements.
54. Yes No All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
55. Yes No A written plan exists for responding to emergencies involving public water systems.
56. Yes No Information for developing a safe water supply is available to people using on-site individual wells and springs. Note: Staff provide referral information to local labs for information – public health deals with systems with multiple connections.
57. Yes No A program exists to monitor, issue permits, and inspect on-site sewage disposal systems. Note: Lane County Public Works handles the on-site sewage questions.
58. Yes No Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes No School and public facilities food service operations are inspected for health and safety risks.
60. Yes No Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes No A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste. Note: Lane County Public Works manages solid waste issues.
62. Yes No Indoor clean air complaints in licensed facilities are investigated.
63. Yes No Environmental contamination potentially impacting public health or the environment is investigated.
64. Yes No The health and safety of the public is being protected through hazardous incidence investigation and response. Note: Public Health works with the local HazMat team for this
65. Yes No Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control. Note: Public Health works within the ICS structure in responding to emergency situations, which includes working with other jurisdictions in maintaining the safety of people living in Lane County.
66. Yes No All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

Local Public Health Authority:

Date:

Health Education and Health Promotion

67. Yes No Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.

68. Yes No The health department provides and/or refers to community resources for health education/health promotion.

69. Yes No The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.

70. Yes No Local health department supports healthy behaviors among employees.

71. Yes No Local health department supports continued education and training of staff to provide effective health education.

72. Yes No All health department facilities are smoke free.

Nutrition

73. Yes No Local health department reviews population data to promote appropriate nutritional services. Note: Public Health provides nutritional information through the WIC and MCH programs.

74. The following health department programs include an assessment of nutritional status:

- a. Yes No WIC
- b. Yes No Family Planning
- c. Yes No Parent and Child Health
- d. Yes No Older Adult Health
- e. Yes No Corrections Health

75. Yes No Clients identified at nutritional risk are provided with or referred for appropriate interventions.

76. Yes No Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.

77. Yes No Local health department supports continuing education and training of staff to provide effective nutritional education.

Local Public Health Authority:

Date:

Older Adult Health

78. Yes No Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.

79. Yes No A mechanism exists for intervening where there is reported elder abuse or neglect.

80. Yes No Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.

81. Yes No Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education. Note: Public Health refers people to these services as requested.

Parent and Child Health

82. Yes No Perinatal care is provided directly or by referral.

83. Yes No Immunizations are provided for infants, children, adolescents and adults either directly or by referral.

84. Yes No Comprehensive family planning services are provided directly or by referral.

85. Yes No Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.

86. Yes No Child abuse prevention and treatment services are provided directly or by referral.

87. Yes No There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.

88. Yes No There is a system in place for identifying and following up on high risk infants.

89. Yes No There is a system in place to follow up on all reported SIDS deaths.

Local Public Health Authority:

Date:

90. Yes No Preventive oral health services are provided directly or by referral.

91. Yes No Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.

92. Yes No Injury prevention services are provided within the community.

Primary Health Care

93. Yes No The local health department identifies barriers to primary health care services.

94. Yes No The local health department participates and provides leadership in community efforts to secure or establish and maintain adequate primary health care.

95. Yes No The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.

96. Yes No Primary health care services are provided directly or by referral.

97. Yes No The local health department promotes primary health care that is culturally and linguistically appropriate for community members.

98. Yes No The local health department advocates for data collection and analysis for development of population based prevention strategies.

Cultural Competency

99. Yes No The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.

100. Yes No The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services. Note: Public Health is completing an updated strategic plan, based upon the Community Health Assessment and Community Health Improvement Plan.

101. Yes No The local health department assures that advisory groups reflect the population to be served. Note: Advertisement for openings on the Public Health Advisory Committee is distributed to the community and we endeavor to have a cross-section of members serving whenever possible.

102. Yes No The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

Local Public Health Authority:

Date:

b. Yes No The local health department Supervising Public Health Nurse meets minimum qualifications:

Licensure as a registered nurse in the State of Oregon, progressively responsible experience in a public health agency;

AND

Baccalaureate degree in nursing, with preference for a Master's degree in nursing, public health or public administration or related field, with progressively responsible experience in a public health agency.

If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.

c. Yes No The local health department Environmental Health Supervisor meets minimum qualifications:

Registration as an environmental health specialist in the State of Oregon, pursuant to ORS 700.030, with progressively responsible experience in a public health agency

OR

a Master's degree in an environmental science, public health, public administration or related field with two years progressively responsible experience in a public health agency.

If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.

d. Yes No The local health department Health Officer meets minimum qualifications:

Licensed in the State of Oregon as M.D. or D.O. Two years of practice as licensed physician (two years after internship and/or residency). Training and/or experience in epidemiology and public health.

If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.

Local Public Health Authority:

Date:

Agencies are **required** to include with the submitted Annual Plan:

The local public health authority is submitting the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431.375–431.385 and ORS 431.416, are performed.

Local Public Health Authority

County

Date

Agencies are **required** to include with the submitted Annual Plan:

The local public health authority is submitting the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431.375-431.385 and ORS 431.416 are performed.

 Local Public Health Authority	<u>Lane</u> County	<u>2/26/14</u> Date
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LANE COUNTY PUBLIC HEALTH AUTHORITY
COMPREHENSIVE PLAN SUBMITTED MARCH 2014
FOR FISCAL YEAR 2014/15

Adequacy of Local Public Health Services

The budget approved for FY 13/14 maintained the local public health authority, a value deeply held by the Board of County Commissioners. LCPH began the budget process for FY 14/15 in December 2013. We continue to work with the Community Health Centers (CHC) of Lane County, a division of the H&HS Department, to strategize how to maximize billing options under the CHC, especially for our MCH and CD programs. For FY 11/12 we developed a different billing strategy which provided us the opportunity to reduce the need for MCH general funding by \$175,000 while projecting that amount of funding via the billing process with the CHC. The Budget Committee for FY 14/15 has not begun its deliberations on the budget so we wait for further direction at both the state and federal levels for budget information. We continue to work with the CHC as well in regards to the provision of STD clinical services and to provide immunization services in the primary care setting by a portion of our Communicable Disease Public Health Nurses. This strategy is allowing us to raise the immunization levels in Lane County. Lane County continues to work on strategies to fund prioritized services when the much needed Secure Rural Schools (timber funds) are no longer provided. Without the timber funds, our Communicable Disease, Maternal Child Health and WIC programs are dramatically affected in maintaining the required level of service and protection for the community.

LCPH has a Public Health Supervisor on-call at all times (24/7/52). The on-call supervisor is reached through an answering service. This supervisor is able to call on other management and nursing staff resources as needed to manage the public health need. Presently, due to the support of the county general fund, the communicable disease team is able to meet current expectations unless we have a large event or outbreak which would quickly overwhelm the local resources at public health. Through our effort with the H1N1, we have been able to seek volunteer nurses as well as extra help nurses to provide vaccinations, but to also have a cadre of nurses available should we need to call for additional assistance for any future outbreaks.

The Maternal Child Health Program continues to receive many referrals for Maternity Case Management for pregnant women and teens at risk of poor pregnancy and birth outcomes, Babies First! Targeted Case Management for infants at risk for developmental delays, and CaCoon Targeted Case Management for medically-fragile infants and their families. Beginning in August 2011, the MCM home visiting billing process came under the Community Health Centers of Lane County. This has provided revenue to make up for some of the loss of county general funds. The MCH team is working on new strategies to increase the number of home visits nurses can provide.

Lane County was awarded a grant to begin a Nurse Family Partnership (NFP) program in 2012. NFP is an evidence-based, community health program that helps transform the lives of vulnerable mothers pregnant with their first child. The goals of the NFP program are to improve pregnancy outcomes by helping women engage in good preventive care; improve child health and development by helping parents provide responsible and competent care; and to improve the economic self-sufficiency of the family by helping parents develop a vision for their future, plan pregnancies, continue their education, and find work. Because of the grant, we were able to hire two additional nurses and are able to serve more pregnant women. The NFP program was launched in August 2012 following rigorous training by NFP staff at the National Service Office. NFP trained public health nurses enroll clients into the program early in the client's pregnancy and work with these families until their child is age two. Research based on the NFP program over the last 30 years indicates that nurse home visiting needs to begin early in pregnancy and continue until the child is two years old. So far, we have had 91 mothers enrolled in this program. We hope to expand the service as the caseload demand increases.

Our WIC staff provides an exemplary level of service to the families they serve. The team has been able to incorporate creative strategies to keep the caseload numbers up including development of streamlined schedules and processes in order to provide the nutrition education, assessment and voucher distribution needed. The myriad of required complexities within the WIC program continues to challenge us in serving the number of clients who qualify for the program. At this time, it is apparent that the need for WIC services has increased along with other service needs accompanying the economic downturn. In 2012, 13,367 women, infants and children participated in the Lane County WIC Program. That number included 9,271 infants and children under the age of 5 and 4,096 pregnant, breastfeeding and postpartum women. The number also represents 5,537 families served (62% are working families). In Lane County, 49% of all pregnant women are served by WIC while the statewide percent is 46.

The Environmental Health program staff is presently able to tend to all the required inspections of the licensed facilities in the county. In addition, work continues on maintaining an electronic food handler testing program as well as walk in services for reading and testing for food handler cards. The Environmental Health Specialist staff has successfully built positive working relationships with the food industry as well as tourist and travel industry. The Environmental Health program leads the state in the number of food manager training courses (ServeSafe) provided in Lane County and will host classes in March and September of 2014. The Environmental Health program continues an effective State Drinking Water Program.

Provision of Five Basic Services (ORS 431.416)

Communicable Disease

Epidemiology

Public Health communicable disease surveillance and reporting activities vary with the year.

The annual flu season for the fall and winter of 2012 and 2013 was more normal than the previous year of the H1N1 pandemic. Surveillance during the current flu season (fall and winter of 2012 and 2013) indicates that the circulating influenza viruses are, largely, well matched to the current trivalent vaccine which includes H1N1 as a component of the seasonal vaccine. The ongoing challenge is to assure an appropriate level of understanding and respect for influenza, leading to appropriate prevention activities even during low incidence years.

In 2013, Lane County Public Health (LCPH) recorded 2446 reportable communicable diseases, including sexually transmitted diseases (STDs). Chlamydia is the most reportable condition in Lane County, followed by past or chronic Hepatitis C.

Another communicable disease of note is the continued presence of cases of pertussis, or Whooping Cough, in our community as well as in outbreaks in other parts of the country. LCPH received 112 reports of pertussis in 2013. This undoubtedly underrepresents the burden of this highly contagious disease in Lane County. It is significant that pertussis is a vaccine- preventable disease that carries significant risk to young children and individuals with certain chronic illnesses and immune disorders. Some of these individuals cannot be immunized, or do not mount an effective immune response when vaccinated. It is important the community around them maintain a high level of vaccination to reduce the chance that the most vulnerable individuals are protected.

Among the sporadically reported diseases were two cases of Malaria, a mosquito-borne tropical illness, four cases of Legionellosis associated with travel and one case of Shigellosis. The majority of our work was related to the more common diseases including pertussis, salmonellosis, hepatitis C, Giardiasis, and campylobacteriosis. With increasingly sophisticated laboratory testing and reporting capabilities, local health departments are often able to determine if cases or outbreaks are related to cases in other jurisdictions or part of a wider outbreak requiring a coordinated public health response.

In June 2013, LCPH responded to a potential Hep A outbreak associated with consumption of "Townsend Organic Farms" frozen berries. Three programs within LCPH - the Communicable Disease, Environmental Health, and Preparedness Programs - worked quickly and effectively with Costco. LCPH administered over 40 doses of Hepatitis A vaccine to non-immune customers of Costco who had consumed

the implicated product. The effective public health outbreak effort required a rapid and sustained response for 2 weeks. Communicable disease nurses, Preparedness coordinators, supervisors and support staff were fully occupied with this effort during that time.

The capacity to rapidly respond and sustain an effective response is crucial to controlling the spread of disease and preventing or reducing the serious consequences including deaths.

The LCPH Communicable Disease Team must participate in regular trainings covering multiple disciplines, in order to remain current and prepared to respond safely and effectively to public health events and to provide clinical services including immunizations, STD treatment, tuberculosis case management, and laboratory services.

Following is a listing of many of the mandatory or essential trainings that designated members of the LCPH Communicable Disease team participate in order to stay current in response capability.

- Respiratory Protection Plan & Fit testing
- LCPH Emergency Response Plans
- Blood Borne Pathogen
- Health Alert Network
- Communicable Disease (epidemiology) 101
- Communicable Disease (Outbreak Investigation) 303
- Forensic Epidemiology
- Isolation & Quarantine
- Outbreak exercises
- Laboratory packaging
- Hazardous Materials training
- Media and risk communication trainings
- Immunization Data Registry trainings
- Vaccine Eligibility coding
- Immunization Delegate Site Review
- STD Clinical Update
- Disease specific trainings such as tuberculosis and *Cryptococcus gattii*
- Position specific preparedness trainings including
 - FEMA Communication & Information Management
 - FEMA - Resource Management
 - FEMA – Multiagency Coordination
 - Introduction to Incident Command

LCPH continues to receive ongoing training with the state ORPHEUS database for communicable disease reporting. With strict confidentiality protections in place, the database has improved the cooperative reporting between the county and the state as

well as with surrounding counties in select situations involving more than one jurisdiction.

Tuberculosis

Lane County continues to be a low incidence area for active tuberculosis. Four Tuberculosis cases in 2013 were both foreign born and domestic with one case resulting from an exposure in another state. The travel and immigration patterns of Lane County residents in recent years make the constant surveillance and effective response to even one case of tuberculosis in our community essential. We had one death from TB meningitis in 2013.

The purpose and responsibilities of the LCPH Communicable Disease Program, Tuberculosis section is:

- To prevent the spread of active tuberculosis disease to people in Lane County
- To prevent outbreaks of tuberculosis in specific groups and populations. Recent examples of Lane County specific outbreaks include residential facilities, private workplaces, and schools.
- To reduce the development of active tuberculosis disease in the pool of latent tuberculosis infected individuals

These responsibilities are carried out by LCPH using the evidence-based standards of tuberculosis control in conjunction with the Oregon Health Authority HIV-STD-Tuberculosis Program.

- To identify and report each case or suspected case of active tuberculosis disease in the county
- To assure initiation and completion of treatment of every case of active tuberculosis disease in the county, called “Tuberculosis Case Management” – a six month to one year process for each case.
- To complete an extensive case investigation for each case of active tuberculosis disease in order to identify exposed contacts to the case, those infected, and assure completion of preventative medication treatment.

Effective and sufficient response requires a knowledgeable and resource-adequate response at a local and state public health level in conjunction with local health care providers in the private sector. Delay in identifying or adequately meeting these responsibilities in even one case of active, infectious, tuberculosis disease can result in spread to the immediate population contacts of the case, and from there into the wider community, exponentially increasing both the burden of disease and the medical and economic costs to the individuals and wider community.

TB Case Management is a service that only local public health provides. It is the cornerstone of effective evidence based control of tuberculosis and consists of the following work:

- Identification of the disease by a sophisticated, multifaceted process including, local and state laboratory identification at specific intervals from suspicion of disease, through confirmation 4-6 weeks later. During this interval, the case is managed and treated by LCPH as if the active disease is present.
- Assuring the client has a health care provider (pulmonologist, infectious disease doctor, internist, family practice doctor, nurse-practitioner, or physicians assistant) – whether or not the client is able to pay for the service. This can be a complex and ongoing process throughout the course of treatment.
- The LCPH Nurse TB Case Manager acts in collaboration with the provider, providing education for those who may have limited or no experience in treating a client with tuberculosis, assuring adequacy and completion of treatment.
- Consultation and collaboration with LCPH Health Officer and state tuberculosis program including participation in TB cohort review process.
- Nurse TB Case Manager home/hospital visits with the client and family to provide initial education and expectations for the period of treatment. These initial visits are challenging since the individual is learning that their activities (work, church, social, and family) will be restricted until it is demonstrated that they are no longer contagious. The individual also learns that LCPH will be providing daily, observed, 4 drug therapy through this period followed by twice weekly therapy until the documented end of treatment many months later.
- DOT – Directly Observed Therapy is the evidence based international standard for treatment of active tuberculosis disease. Examples of the places that LCPH has provided DOT include: homeless shelters and river camps, private homes from Florence to rural East Lane County, and worksites throughout the County.
- Ongoing LCPH nurse evaluations to assure that the client is not experiencing serious side effects (including vision and hepatic) from the treatment, assure that the client is keeping appointments with the provider and obtaining required X-rays and laboratory testing.
- Contact Investigation involves identifying the contacts of all active cases and screening them all for TB infection, both immediately upon identification and two months later. Frequently it is necessary to provide TB education to those involved to try to minimize misunderstanding and anxiety. Case management services often need to be provided in a culturally sensitive manner and in languages other than English.

LCPH provides consultation, assessment and control services to community members and organizations to aid the identification and prevent the spread of tuberculosis. We provide billable tuberculosis testing for employers and treatment centers. We also provide twice yearly LCPH nurse inspections of the ultraviolet light system at the Eugene Mission which were installed during a homeless shelter outbreak in Lane County. We provide consultation to other organizations which are developing their own tuberculosis prevention programs. We have developed and maintain a comprehensive Respiratory Exposure Prevention Protocol including initial tuberculosis testing of all public health employees and annual fit testing of respiratory protection equipment for employees whose work may put them at risk of exposure. Finally, we continue to

provide ongoing B Waiver tuberculosis evaluations and follow-up for those referred from immigration services.

Sexually Transmitted Disease Control Measures

The majority of reported cases of STDs come from private providers and not from public health clinics. Lane County Public Health, unlike private providers, is the entity responsible for assuring treatment of contacts of reportable STDs and, therefore, reducing the spread of these diseases throughout the population.

Chlamydia remains the disease with the highest case counts of any reportable communicable disease in Lane County. In 2013, LCPH received 1,368 reports of chlamydia. In addition, with most cases of chlamydia being asymptomatic, it is estimated that the true case count is three to four times greater.

There were 216 reports of gonorrhea in 2013 and 28 cases of syphilis for the same reporting period. Obviously Lane County was experiencing an STD outbreak with 140 cases of gonorrhea reported July-December 2013 and 22 cases of syphilis reported July-December 2013. The recognition of the increase in gc and syphilis cases prompted a dedicated STD clinic in the Charnelton Community Health Center and the availability of STD clinic appointments in Communicable Disease.

Surveillance reports show that the greatest burden of disease is in those people less than 25 years of age. These numbers do not reflect the increased morbidity, including hospitalizations or fertility impacts such as increased ectopic pregnancies, in those who sustain complications from chlamydia or gonorrhea infection.

LCPH uses the statewide ORPHEUS database for STD reporting. This is facilitating confidential communication and morbidity reporting with the state as well as with other counties. In addition, database security and access has improved communication between the LCPH staff and the off site state Disease Information Specialist who investigates high risk STD cases such as gonorrhea, chlamydia in pregnant women, and syphilis.

Immunizations

The purpose of the LCPH Communicable Disease Immunization Program is to prevent and mitigate vaccine preventable diseases in the community. LCPH services includes a comprehensive program of community vaccination assessment, delegate immunization partner education and management, health care provider technical assistance, community education, provision of direct immunization services, vaccine management, and enforcement of school immunization requirements. The LCPH Immunization Program operates in partnership with the Oregon Public Health Division Immunization Program, health care providers in the county, and with schools and day cares.

LCPH provides immunization support to seven delegate clinics. At present these include three school based health centers, three Community Health Centers of Lane County, and Health Associates in Florence. White Bird Medical Clinic will be added in 2014. The services that LCPH provides to these delegate sites include:

- Technical assistance for providers, nurses, and administrative support staff to provide safe, effective, and accurate immunization services
- Initial, annual, and ongoing training on vaccine eligibility, coding, and billing
- Training and ongoing support for vaccine storage and management
- Access and follow-up support and training for the ALERT IIS Immunization data Registry – an evidenced based best practice for assuring and improving childhood immunization rates
- Training and support for vaccine reporting to assure compliance with requirements for use of state and federal vaccine
- Access to federal and state programs providing state of the art vaccine refrigerators and monitoring equipment and assistance in setting up and using this equipment.

In calendar year 2013, LCPH directly provided 3,415 non-flu immunizations. Our delegate clinics provided 9,909 non-flu immunizations in 2013.

A total of 53,504 school immunization records were reviewed for the 2012/2013 school year for all children in public and private schools and in preschools and certified day care facilities. We worked with 147 school and 159 children's facilities to address omissions in immunization records. On February 2, 2012, school exclusion letters were issued for 2,090 students. Of these, 92 students were excluded from school until immunization records were documented as being in compliance with state requirements.

The LCPH Communicable Disease team, including the County Health Officer and Nurse Supervisor, are continuing to analyze the Religious Exemption and Up-to-Date figures to assess and address the increased local risk for outbreaks of vaccine preventable diseases including measles, mumps, pertussis, and varicella. The Religious Exemption (RE) from required school immunizations remained steady across Lane County at 5.7%. The religious exemption rate for Kindergarteners was 7.5% in 2013, a slight increase from the 2012 rate of 7.3%.

Our School Immunization Coordinator works with each school's representative to update them on immunization and reporting requirements, educate them on the vaccines and their importance, and provide them with tools and evidence-based resources to help counsel families who are weighing the decision to vaccinate or claim religious exemption. She has had some measurable successes with several schools whose improved rates of up to date records are reflected in the report.

Dr. Patrick Luedtke, Lane County Public Health Officer, presented at the Peace Health Pediatric Grand Rounds on the “Rising Number of Religious Exemptions in Lane County”. In an effort to keep immunizations in the media, Dr. Luedtke also held a Town Hall Meeting on immunizations and spoke at the City Club November 16, 2012 and has provided numerous presentations on religious exemption rates in Lane County.

In 2013, four University of Oregon graduate students did a Capstone Project on religious exemptions. The students conducted focus groups and compiled survey results and completed an extensive literature search. Recommendations from the project were: 1. LCPH can aid clinicians in having constructive, respectful, two-way conversations with parents, and should explore additional training programs to this end. 2. LCPH should provide parents with more transparent information about all aspects of immunization’s ingredients, potential side effects, and schedules. 3. The Oregon Department of Health should explore alternative state-level policies to reduce the non-religious motivations for pursuing religious exemptions.

LCPH remains a good steward of our expensive and fragile vaccine resources. Our immunization program continues to exceed the performance measure target of 95% in vaccine accountability.

The LCPH Communicable Disease Program is also collaborating with the Community Health Centers of Lane County to identify opportunities to work together to coordinate and improve immunization services for Community Health Center patients and to support the broader LCPH Immunization Program.

HIV

The LCPH HIV Program continues to focus program resources and efforts on testing and prevention services to populations at greatest risk for disease. This emphasis is reflected in both our in-house and outreach efforts at LCPH and in our support and collaboration with our subcontracted agency, HIV Alliance. As funding at both the state and local level continue to decrease, we continue to strive to increase accessibility to members of these vulnerable populations.

HIV Counseling Testing and Referral Services (CTRS) are provided by appointment and, when possible, for clients who drop-in. In 2013, LCPH provided these services in-house and also at Willamette Family Treatment Service sites. Outreach and testing was also provided at Buckley Detox & Sobering Station. After the retirement of the long standing HIV counselor, the number of testing sites decreased to LCPH, Willamette Family Treatment and HIV Alliance. Wednesday afternoons remain a reserved and promoted time for testing men who have sex with men (MSM) at LCPH. In addition, the LCPH HIV counseling and testing staff member collaborate with HIV Alliance to provide HIV testing at special events such as Project Homeless Connect, the University of Oregon during times dedicated to awareness and services to African American/Black and Latino communities, and to Latino clients at Centro Latino Americano.

LCPH has a Performance Measure to focus at least 65% of our HIV testing on populations at increased risk of HIV including MSM, injection drug users (IDU), and sex partners of people in these populations. In 2013, LCPH and its subcontracted partner together exceeded this goal every month. In 2013 a total of 1,074 HIV tests were provided. LCPH itself provided 330 of these HIV tests, exceeding our goal of 260.

LCPH continues to actively support and participate in the Lane County Harm Reduction Coalition (LCHRC) which consists of private and public partners with the purpose of reducing the impact of injection drug use and other substance abuse on public safety, community health, and individual health.

Funding for HIV Prevention from the Centers for Disease Control and Prevention is being restructured to align with national priorities to increase resources to areas where there is an increased prevalence of HIV. Oregon is a low incidence state and will receive reduced funding. Within Oregon, Lane County is one of seven counties with the highest incidence and prevalence of HIV. It is anticipated that Lane County will continue to receive some HIV Prevention Funding, although in decreasing amounts over the next 4 years. Prevention activities that are to be undertaken with these funds include: HIV testing; comprehensive prevention with positives; condom distribution; and policy and structural initiatives. When the funding figures are known, LCPH will need to determine where the required core components can best be met. Careful evaluation of both the LCPH HIV Program and the subcontracted services at HIV Alliance is being undertaken.

Both HIV Alliance and LCPH have seen a decrease in numbers of clients testing positive for HIV. For 2013, LCPH performed 330 tests with no test positives. HIV Alliance performed 744 tests and had 21 test positive. Tests at HIV Alliance are completed on targeted groups and those most likely to be high risk for HIV while 70% of the tests performed at LCPH are on high risk individuals.

LCPH Communicable Disease Program Summary

In summary, the work of the LCPH Communicable Disease Program consists of population focused services and programs in the following areas:

- Communicable Disease – prevention, surveillance, reporting, treatment
- Outbreak management
- Tuberculosis
- Sexually Transmitted Diseases
- Immunizations
- HIV prevention, surveillance, and testing

Four Community Health Nurses and one Community Services Worker, supported by a Public Health Officer, Deputy Public Health Officer, Nursing Supervisor, Senior Stores Clerk, and 1.5 Office Assistants, provide all the client services, community and provider education, planning, enacting, and reporting for all of these programs. To address

specific community health issues, they serve on multiple state and local committees including: CLHO/CD, CLHO/HIV, Lane Harm Reduction Coalition, Lane County Head Start Committee as well as on program, division, and Lane County H&HS department committees to address the priorities of our organization.

Parent and Child Health Services

The Oregon Mothers' Care (OMC) program helps uninsured and under-insured pregnant women establish health insurance coverage with Oregon Health Plan (OHP) allowing earlier initiation of prenatal care with local providers and pregnancy support centers. Prenatal access works in collaboration with hospitals and private providers to increase access to early prenatal care; and works in collaboration with Maternal Child Health nurses and WIC staff to provide a system of services for vulnerable families. Approximately 65% of mothers that were enrolled in OMC initiated prenatal care within the first trimester during 2013. Lane County enrolled 707 pregnancy women, 467 of which were in their first trimester. The clients enrolled via Lane County's liaison received coverage within two business days after their application was submitted to OHP, regardless of gestational age.

The Maternal Child Health (MCH) program provides nurse home visiting, education, support, and referral to appropriate medical and developmental services for families at risk of poor pregnancy, birth, or childhood outcomes. MCH services are provided by public health nurses throughout Lane County. Pregnant women, infants, and young children at highest risk and greatest need are given priority when decisions about which families to serve have to be made. In 2013 MCH nurses provided home visiting for 529 clients. Of these, 259 received maternity case management, 91 of which were enrolled in Nurse Family Partnership program; 233 received Babies First and 37 received CaCoon services. The Maternity Case Management program provides nurse home visiting services for high-risk pregnant women; and, helps assure access to and effective utilization of appropriate health, social, nutritional, and other services during the perinatal period. The Babies First program provides assessment and early identification of infants and young children at risk of developmental delays or other health related conditions. The CaCoon program provides services for infants and children, who are medically fragile or who have special health or developmental needs, by helping their families become as independent as possible in caring for the child and by helping families access appropriate resources and services. Of particular concern for the MCH program is that although we receive 150 high risk referrals per month, we are able to serve only those at highest risk.

Fetal-Infant Deaths: After 5 years of the FIMR (Fetal Infant Mortality Review) analysis, a number of common issues have been identified: a lack of pre-pregnancy health, health care, and reproductive planning; significant alcohol, tobacco and drug use immediately before and during pregnancy; a lack of understanding regarding the negative impact that the use of alcohol, tobacco and other drugs has on fetal health and development; a lack of consistent and comprehensive prenatal risk screening and follow up for psychosocial issues, alcohol, tobacco, and other drug use, domestic violence and

mental health issues; and significant unsafe infant sleep practices and confusion around co-sleeping. We continue to promote awareness of these issues through our current patient education curriculum.

Family Planning

As of July 1, 2006, the Family Planning (FP) program was moved from the Public Health Division of the Lane County Department of Health and Human Services to the Community Health Centers, then a component of the Human Services Commission, another Division of the Lane County Department of Health and Human Services. The FP clinic is now within the Federally Qualified Health Center (FQHC), also known as the Community Health Centers of Lane County. Goals for the FY 14/15 year for the Family Planning Program which fit within the Title X requirements are: 1. By June 30, 2015, Chlamydia testing on all sexually active women < 25 years of age will increase by 10%. 2) By June 30, 2015, increase by 5% and 10% respectively, the proportion of established adolescent (18 years and under) clients who receive STD/HIV prevention and relationship safety counseling at least once a year. (Plan sent as attachment)

Collection and Reporting of Health Statistics

Lane County Public Health provides statistical information to Oregon Health Authority/Public Health Services on a regular basis – including CD reporting on each case investigation; blood work sent to the state lab; inspections conducted by the environmental health staff; HIV program reporting requirements; IRIS, the WIC data system; the immunization data system ALERT; and ORCHIDS MDE for women and children's data.

Health Information and Referral Services

Lane County Department of Health and Human Services and Lane County Public Health (LCPH) publicize location, phone numbers and listing of services. We have developed a web site for the department that has specific information regarding each program within the department. During 2012, a Public Information Officer has been contracted to work specifically with the Health and Human Services Department rather than through the county PIO. This has been a significant assistance to the department for all types of media work as well as letting the community know what the department does. The contracted PIO has provided a good deal of support to the Public Health Division, especially with disseminating up-to-date information regarding any public health issue in which the community may be interested. The PIO has a section on the general county website for public health issues, such as smallpox, H1N1 and West Nile Virus, providing easy access for citizens. LCPH has available brochures, the mission statement, and a handout with clinic services, times and locations.

Environmental Health Services

The Environmental Health (EH) program includes the inspections of licensed facilities, primarily food service facilities. In 2013, EH staff licensed and inspected a total of 2756

facilities. These includes 2024 Food Service facilities (restaurants/mobile units/temporary event restaurants), 108 Tourist Facilities (hotels/motels/organizational camps. RV camps), 282 Pools and Spas and 342 miscellaneous facilities such as schools, day cares, group homes, jails, sororities/fraternities. The EH and CD teams work closely together as needed to ensure safe food and tourist accommodations. In 2013, the following are some of the violations found upon general inspections: improper holding temperatures (374), contaminated equipment (343), and poor personal hygiene (177). Food borne illness continues to be a concern when food is not prepared, served or stored in a safe and sanitary manner. Ongoing monitoring of facilities and training of food service personnel can prevent food borne illness. The EH food handler testing program issued 78,498 food handler cards in counties across the state through intergovernmental agreements. In addition to the above services, EH also provides Drinking Water Program surveillance to 311 public water systems in Lane County. Approximately 52-55 water system surveys are conducted yearly throughout Lane County. In response to the public's demand for restaurant inspection scores, EH staff worked with Lane County Information Services to activate an on-line Restaurant Inspection Scores application. This site lists restaurant inspection score results and violations on every active restaurant in Lane County since 2006. The application is accessible through www.LaneCounty.Org – <http://apps.lanecounty.org/RIS/>.

Adequacy of Other Services

Accreditation – Community Health Assessment and Community Health Improvement Plan Work

Using the NACCHO MAPP process as a guide, Lane County Public Health completed a Community Health Assessment (CHA) and a three-year Community Health Improvement Plan (CHIP) in the spring of 2013. These processes were completed in collaboration with our local nonprofit hospital system (PeaceHealth with three nonprofit hospitals in Lane County), our local Coordinated Care Organization (Trillium Community Health Plan), and the United Way of Lane County. The MAPP process also provided the framework to include significant community input through a variety of methods (surveys, key informant interviews, focus groups). By the end of June 2013, each of the four entities' governing boards had endorsed the CHIP and agreed to participate in its implementation. Recognizing the similarity of health problems at the state and Lane County level and the value of collaboration between the state and local public health, the Lane County Community Health Improvement Plan (Lane County's Healthy Future) is in close alignment with the state Public Health Division's State Health Improvement Plan (Oregon's Healthy Future). Lane County's CHIP focuses on policy strategies to improve community health in Lane County in five key areas: Health Equity, Tobacco Prevention; Obesity Prevention; Substance Abuse Prevention and Mental Health Promotion; and Access to Care.

Since July of 2013, the CHA and CHIP leadership workgroup (called the "Core Team" and including representatives from all four key agencies) has worked together to establish eight additional workgroups, including: A Steering Committee comprised of key agency leaders; a Communications Committee; a Metrics and Evaluation

Committee; and give additional workgroups focusing on the five improvement areas named above. Each of these committees has adopted a workgroup charter and are currently staffed with both subject matter experts and meeting organizers/facilitators.

Public Health Strategic Plan Work:

Since August 2013, LCPH has been engaged in a process to develop a strategic plan describing how the Division will support the implementation of our CHIP. We contracted with the Portland-based consulting firm Rede Group to facilitate this process. To date, Rede Group has facilitated four strategic planning sessions with the Public Health Strategic Planning Leadership Team (includes Public Health Manager, all Public Health Supervisors, Public Health Officer, Epidemiologist and Senior Community Health Analyst acting as the coordinator for the accreditation prerequisites and process. The leadership team will review and provide final input on the strategic plan in January 2014.

Next steps in the process will be submitting a grant proposal to State Public Health to further our work towards accreditation. The proposal will describe next steps in the process between March and August of 2014.

Prevention

Lane County Public Health Prevention Program has made significant changes in the past two years. The program is now an integrated prevention program including behavioral health, which might be considered to be traditional public health chronic disease and wellness promotion, and prevention strategies to support Trillium Coordinated Care Organization. Previously, the Chronic Disease Prevention Program consisted of two dedicated staff, addressing issues of tobacco and obesity prevention. A separately funded and operating prevention program was located in Administration in the Department of Health and Human Services for years, addressing problem behavior prevention, including substance abuse and problem gambling, as well as mental health promotion and suicide prevention efforts. Less than two years ago, the two programs merged under Public Health, creating one comprehensive prevention and health promotion program. In addition to the two prevention programs merging, the program also expanded with supported prevention positions from Trillium Coordinated Care Organization. Trillium funds three positions: an epidemiologist, a prevention specialist dedicated to supporting the community advisory committees, a prevention specialist dedicated to researching and recommending prevention best practices to support, and most recently, a newly created prevention specialist position to liaison with and support school based prevention best practices. At full capacity, the prevention program will include twelve prevention specialists and one supervisor.

Chronic Disease Prevention

While tobacco continues to be the leading cause of preventable death in the U.S., Oregon and Lane County, obesity and the lack of physical activity and poor nutrition are the second leading cause of death in Lane County. Prevention program staff are currently involved in key efforts in the community which are addressing this issue.

Reducing the level of obesity is a high priority of the Community Health Improvement Plan and two staff are involved in the work group developing strategies and metrics for this work. Additionally, obesity was identified as a priority area for the CCO Health Transformation Plan. Prevention staff developed a comprehensive obesity reduction proposal which Trillium CCO adopted. The plan includes policy work, community engagement and implementation of evidence-based school based curriculum.

Primary Health Care

In regards to primary health care a division within the Lane County Department of Health and Human Services was established – Community Health Centers (CHC) of Lane County. The central office is called RiverStone Clinic, located in Springfield. A second location for the clinic is in the “Charnelton” Building, the building where all public health services are now located (as of July 2010). Having a primary care clinic in the same building as a public health service has been helpful to the people we serve and provides for continued coordination of services between the two divisions. The CHC provides family planning, pediatrics, internal medicine, family practice, integrated behavioral healthcare and prenatal care.

Medical Examiner

The Deputy Medical Examiner program was moved out of the Lane County Department of Health & Human Services in 2002 to the District Attorney’s Office. This seemed to be a more prudent link for the work that is done with the enforcement activities. The Deputy Medical Examiner continues to work with LCPH and the Department in regards to SIDS and those deaths of significant public health concern (e.g. heroin overdoses, adolescent suicides, injuries).

Emergency Preparedness

Preparedness for disasters, both natural and man-made, is a public health priority. The Public Health Emergency Preparedness (PHEP Program) develops and maintains the capacity of the department to rapidly mount an effective response to an emergency and to prevent, investigate, report and respond to outbreaks or the spread of communicable diseases. The PHEP program addresses public health mitigation, preparedness, and response and recovery phases of emergency response through plan development, training and exercise, and plan revision. The program also galvanizes the community to tackle local preparedness needs, and specifically focuses planning for the needs of the community’s most vulnerable populations. The program is actively monitored to assure the attainment of professional standards and state/federal guidelines and to evaluate the program’s success.

The following objectives have been identified for the PHEP Program:

1. Maintain and update the Lane County Emergency Operations Plan describing the functions, capabilities and procedures necessary to mitigate, respond and recover from a local emergency.
2. Update and implement the Lane County Public Health exercise and training program, including testing of the Health Alert Network at least two times per year,

providing regular training opportunities and at least two exercises that increase in complexity and adhere to Homeland Security Exercise and Evaluation Program (HSEEP) guidelines.

3. Convene and facilitate the Central Lane Healthcare Preparedness Coalition to increase collaboration between local healthcare providers to prepared for emergencies and provide support to hospitals in a disaster. Members include local hospitals, primary care, paramedics and emergency responders and other health agencies and organizations.
4. Complete, submit and comply with the Oregon Public Health Emergency Preparedness Workplan to maintain or achieve the Centers for Disease Control and Prevention's national standards of Public Health and Healthcare Preparedness Capabilities. Submit semi-annual reports to State and meet with PHEP State program liaison twice monthly.
5. Provide Planning, Public Information and Incident Management support to other Public Health programs during activation of Incident Command structure to manage events or situations.
6. Share program accomplishments and lessons learned by presenting at professional conferences.
7. Continually strengthen communications and relationships with local responding partners to enhance ability to respond as a system and for improved community resiliency.

III. Action Plan

Communicable Disease Program

- **Current condition or problem:**

1. TB case management and DOT for all active TB cases as defined in Program Element 03 of IGA with DHS/Oregon Health Authority.
2. Continued elevated rates of chlamydia, gc and syphilis.
3. Countywide immune rates for 24-35 month olds (4-3-1; 3-3-1) was just 69.2% in 2012 – the last year that information is available. State wide the percentage is 67.1%.
4. LCPH clinic up-to-date immunization rate for the same antigens in this population was 65% in December 2013.
5. Maintain currency of required staff preparedness trainings.
6. Continued immunization delegate support for 8 clinics.
7. High religious exemption rates for immunizations in certain populations. (See Immunization Action Report)

- **TB Control Measures:**

Goals:

1. Prevention of TB outbreaks at homeless shelter.
2. Provide culturally competent TB case management for all clients.
3. Meet state performance measures in Program Element 03.
4. At least 90% of individuals within LPHA's jurisdiction with newly diagnosed TB, who are identified by or reported to LPHA and for whom therapy for one year or less is indicated, complete therapy within 12 months of the identification or report.
5. Contacts are identified for at least 90% of newly reported or identified sputum AFB-smear positive TB cases within LPHA's jurisdiction.
6. At least 95% of Contacts to reported or identified sputum AFB-smear positive TB cases within LPHA's jurisdiction are evaluated for infection and disease.
7. At least 85% of infected Contacts to reported or identified sputum AFB-smear positive TB cases within LPHA's jurisdiction who are started on treatment for latent TB infection will complete therapy.
8. Assure TB case management staff remain current with standards of care.
9. Assure health and safety of staff when providing TB case management care.

Activities:

1. Continued twice yearly inspection of the ultra-violet light system at the homeless shelter (system was installed Fall of 2003.)
2. Assure availability of professional staff with appropriate language skills. Staff will complete required annual diversity trainings. Individualized assessment of client needs include cultural appropriateness of services.

3. Maintain up to date reporting to state to demonstrate required performance measures for Program Element 03 are being met.
4. CD nursing staff and Public Health Officer participate in regular state and in-house TB case management reviews.
5. Participate in webinars for staff as offered.
6. Annual review of the LCPH Respiratory Protection Plan and fit testing of designated staff.

Evaluation:

1. Biannual evaluation of UV lights and monthly logs will show homeless shelter staff following procedures for light maintenance.
2. Continue surveillance and monitoring of TB cases as noted in Program Element 03 of IGA with DHS/Oregon Health Authority.
3. Triennial program review with state and local staff completed September 2013.

• **STD Control Measures:**

Goals:

1. Prevent and control spread of STD's in Lane County.
2. Meet program requirements in Program Element 10.
3. Increase direct STD services to clients.
4. Address STD investigations locally.

Activities:

1. Annual review of STD protocols to ensure the protocols are in line with CDC and state guidelines.
2. Ongoing CD team review of LCPH STD clinic process.
3. Increase LCPH capacity to provide STD case management.
4. Maintain STD surveillance and reporting process using established community links, local trained staff, and the ORPHEUS data system.
5. Target outreach and clinic availability, in conjunction with local partners, to clients at high risk for STD's.
6. Work with local medical providers to optimize community resources in provision of services.

Evaluation:

1. Staff will enter and monitor program output and outcomes data as part of the countywide performance measure tracking. STD performance measures provide data on reportable STD incidence rates.
2. LCPH STD reporting process will meet state standard for timeliness and completion.
3. LCPH will continue collaboration with state STD program, the Community Health Centers of Lane County, and Planned Parenthood to assure access to STD services during both normal public health activity levels and during times of surge efforts on other communicable disease work.

- **Continued integration and training of applicable preparedness activities and staff with Communicable Disease (CD) program.**

Goals:

1. CD team members will understand and maintain current on preparedness training.
2. Develop and maintain surge capacity preparedness for CD staff.
 - a. Expand, organize and document CD team preparedness trainings.
 - b. CD team will participate in drafting, reviewing and exercising preparedness plans.
 - c. CD team members will meet trainings required as outlined in preparedness program elements of IGA with DHS/Oregon Health Authority.

Activities:

1. CD nurses will participate in quarterly preparedness staff meetings.
2. Preparedness staff will provide updates during bimonthly communicable disease staff meetings.
3. CD staff will complete required trainings according to the Public Health Training Plan for staff positions.
4. CD staff will continue to participate in preparedness planning.
5. Participate in preparedness exercises and drills.
6. Participate in partnership with local hospitals, educational institutions and others in response and community exercises and trainings.

Evaluation:

1. Preparedness staff will enter and monitor program output and outcome data as part of the countywide performance measure tracking.
2. At least annually, training records will be examined for progress, development of maintaining plan, and achievement of standards by the CD supervisor.
3. Evaluation of exercises, drills and actual events will be documented in a "Hot Wash" and After Action Reports with the CD team.
4. CD staff will review training records quarterly to be certain records are accurate.

- Continue to focus on increasing overall immunization rates of 24-35 months olds (served by LCPH).

Goals:

1. Maintain state immunization performance measures.
2. Continue to assure current and accurate data in ALERT IIS.
3. Provide information/resources that address provider concerns and parent hesitations regarding vaccines.
4. LPHA shall improve the 4:3:1:3:3:1 immunization series coverage rate by one (1) percentage point each year and/or maintain a rate of > 90% (4 DTaP, 3 IPV, 1 MMR, 3 Hep B, 3 Hib, 1 Varicella). (PE 43 of IGA)
5. LPHA shall reduce their Missed Shot rate by one (1) percentage point each year and/or maintain the rate of < 10%. (PE 43 of IGA). While this

remains a state and county goal, LCPH's unique immunization clinic population includes many parents with vaccine hesitancy. Staff continues to work to provide information and education to these families about each recommended and school required immunization. None-the-less, nurses provide all the recommended immunizations that the parent will accept, even if this means that we have missed shots recorded.

6. 95% of all state-supplied vaccines shall be coded correctly per age-eligibility guidelines (PE 43 of IGA).
7. 80% of infants in LPHA's Service Area exposed to perinatal hepatitis B shall be immunized with the 3-dose hepatitis B series by 15 months of age. (PE 43 of IGA).
8. 80% of all vaccine administration data shall be entered within 14 days of administration. (PE 43 of IGA)

Activities:

1. Use AFIX reports to clarify areas of concern.
2. Evaluate specific areas, i.e. missed dose rate in AFIX report and obtain name list from state immunization staff to facilitate record evaluation.
3. Review AFIX report with staff and determine if there are areas where staff training/update would be beneficial.
4. Review monthly vaccine accountability report.
5. Systematic monitoring and follow-up of perinatal hepatitis B cases.
6. Data entry of all immunizations given within 14 days of administration.
7. LCPH partner with state in discussions to provide information/resources to providers regarding vaccine hesitancies.

Evaluation:

1. Complete review of AFIX report monthly for missed doses and up to date information compared to goal.
2. Discussion of AFIX findings at Communicable Disease Team meeting annually.
3. Review state evaluation of perinatal hepatitis B cases and address discrepancies.
4. Compare monthly report of vaccine coding and compare to goal in contract performance measures.

HIV Program

Current condition or problem:

1. The population in Lane County includes residents at high-risk of acquiring and spreading HIV infection.
2. Lane County Public Health (LCPH) has a well-established HIV counseling and testing program which includes outreach and education to members of groups at increased risk for HIV.
3. LCPH maintains a contractual relationship with a community-based organization (HIV Alliance) for further provision of services to clients with HIV and those at risk.
4. LCPH is an active participant in Lane County Harm Reduction Coalition.

Goals:

1. Prevent spread of HIV Disease.
2. Provide HIV Core Component Prevention services in alignment with CDC priorities.
3. Increase rates of testing for populations at high-risk for HIV infection.
4. Link at risk individuals with other LCPH prevention services.
5. Provide counseling, testing information and referral services to individuals within targeted high-risk groups.
5. Individuals who are HIV positive are linked to case management services at contracted agencies.

Activities:

1. Provide confidential and anonymous HIV counseling and testing per DHS/Oregon Health Authority contract per minimum service requirements.
2. Review current program plans with the state HIV program and adjust based on new CDC guidance of priorities and Core Components as well as spending reductions.
3. Provide HIV counseling and treatment to MSM and injecting drug populations and education in the community to prevent the transmission of the HIV virus.
4. Through participation on the Harm Reduction Coalition, LCPH will continue to provide leadership and partnership with other organizations to support programs and events that help prevent the spread of HIV infection.
5. Continue to support subcontracted agency on their best practice programs, including counseling and testing and needle exchange activities.
6. Provide clinical services for STD exams and treatment and/or referrals such as HIV case management per IGA with DHS/Oregon Health Authority.

Evaluation:

1. HIV program staff will maintain data as required by DHS/Oregon Health Authority and CDC, per the intergovernmental agreement (IGA).
2. CD staff will enter and monitor program output and outcome data as part of countywide performance measure tracking.
3. Ongoing coordination and contract monitoring regarding HIV prevention services with subcontracted agency.
4. CD staff will meet the state performance measure goal of 80% testing for high-risk populations (CDC Workbook).

Collection and Reporting of Health Statistics

Current condition or problem:

Vital Records is within the Public Health Division and housed in the Administrative Offices of the Department of Health and Human Services. Open hours were increased so the office is open Monday through Friday, 9:00 am to 4:30 pm.

Goal:

Maintain current data entry in order that all statistics are up to date and provided to the state in timely manner.

Activities:

1. 100% of death certificates submitted by Lane County Dept. H&HS are first reviewed by the local deputy registrar for accuracy and completeness per Vital Records office procedures. (Per change in policy directive from state, birth certificates are no longer reviewed.)
2. All vital records and all accompanying documents are maintained in a confidential and secure manner.
3. Certified copies of registered birth and death certificates are issued immediately upon request at the walk-in counter or optimally within two business days of receipt by mail when all required documentation is available from the state. Staff is available from 9:00 am to 4:30 pm five days per week.
4. Vital Records staff provide fetal death reports to nurse supervisor for ongoing FIMR work to reduce fetal/infant mortality.
5. Staff continue to answer many inquiries regarding obtaining birth certificates six months of age and older from the state vital records office.

Evaluation:

1. Public Health staff will continue to verify the accuracy and completeness of death certificates.
2. Public Health staff will continue to monitor that mailed requests for certificates are issued within two working days of request when required documentation is available from the state.
3. Public Health staff will monitor data entry and ensure that entries are done in a timely manner and that revenue is received on a monthly basis due to the data entry.

Environmental Health Program

Current condition or problem:

1. There are more than 2,700 facilities in Lane County providing eating, living and recreational accommodations for public use.

2. The EH and CD teams of LCPH collaborate regarding food borne investigations, animal bites and more currently with increased incidence of noro-virus in nursing care facilities.
3. The EH team is actively involved in preparedness training and interagency exercises. One Environmental Health Specialist (EHS) is trained as an emergency preparedness Public Information Officer. One EHS is the representative from Lane County Public Health on the local LEPC (Local Emergency Planning Committee for Hazardous Materials).
4. One EHS personnel will attain national training in Pool Operator Certification.
5. The EH program includes inspections of 311 State Drinking Water systems.

Goals:

1. Ensure licensed facilities in Lane County are free from communicable diseases and health hazards.
2. Continue to focus attention on food and supervisory personnel training.
3. Continue to work on FDA Voluntary Program Standards.
4. Update electronic inspection program to a web-based platform in cooperation with the State Environmental Health Program.
5. Ensure all state drinking water systems in Lane County are free from communicable diseases and health hazards as noted in the State Drinking Water (SDW) IGA.
6. Conduct inspections of licensed facilities in a timely manner as required in the State Food Program (SFP) IGA.
7. Coordinate food-borne investigations with CD team.
8. Continue follow-up on citizen complaints in a timely manner as noted in the SFP IGA.
9. Continue to provide nursing home training regarding prevention of noro-virus.
10. Conduct inspections of state drinking water systems in a timely manner as required by the SDW IGA.
11. Follow-up on drinking water alerts and non-compliance issues as required by the SDW IGA.

Activities:

1. Conduct health inspections of all licensed facilities as required by the State Food Program (SFP) IGA.
2. Conduct inspections of unlicensed facilities as requested by those facilities (certified day cares, group homes, jails, sororities, fraternities).
3. Maintain on-line and walk-in testing and licensing for food handlers and managers in Lane County as required by SFP IGA.
4. Perform investigations for citizen complaints on potential health hazards in licensed facilities as required by SFP IGA.
5. Perform epidemiological investigations related to public facilities as requested.

6. Provide environmental health education to the public as requested.
7. Document, follow-up and communicate with local animal control services and Oregon Health Authority on animal bites as required by DHS. Coordinate with local jurisdictions regarding animal bites.
8. The EH supervisor will continue work with interns on FDA Standards.
9. The EH supervisor will continue work with the Information Services Department, Conference of Local Environmental Health Supervisors (CLEHS) and Oregon Health Services Environmental Health program regarding option of electronic inspection program.
10. The EH Supervisor will work with CD Nurse Supervisor to develop norovirus prevention training for nursing homes.
11. The EH Supervisor will ensure that staff is properly trained and oriented to the responsibilities of the State Drinking Water Program.
12. The EH Supervisor will work with the State Drinking Water Program staff to ensure that all elements of the program are met.

Evaluation:

1. There will be a record and numerical score for each food service inspection. The record will be maintained in the EH database. In addition, a file will be maintained for each facility as required by the SFP IGA.
2. A triennial review of the Drinking Water and Food and Lodging Programs resulted in no findings in the food program and one finding in the drinking water program which was corrected.
3. Performance measures will be recorded against set targets in the Lane County ScoreCard system.

Family Planning

ANNUAL PLAN FOR July 1, 2014 to June 30, 2015

Objective: By June 30, 2015, Chlamydia testing on all sexually active women < 25 years of age will increase by 10% (current status 24.3%).

Planned Activities:

1. Review current recommendations and screening guidelines with providers and support staff.
2. Specifically review current documentation of our statistics and review documentation process with staff.

Evaluation:

1. March 14 staff meeting for providers and at a meeting for support staff (date undecided at this point).
2. Review Ahler's data for improvement in 6 months.

Objective: By June 30, 2015, increase by 5% and 10% respectively, the proportion of established adolescent (18 years and under) clients who receive STD/HIV prevention and relationship safety counseling at least once a year.

Planned Activities:

1. Review and encourage use of state for “Know Your Risk for STDs”
2. Utilize “Bright Futures” and state information for relationship safety counseling.
3. Evaluate current documentation process.
4. Work with pediatric teams on documentation of Reproductive Health visits and counseling using the client visit record.

Evaluation:

1. Begin work with pediatric teams ASAP for improving documentation and counseling at Reproductive Health visits.
2. Review Ahler’s data for statistical improvement in 6 months.

Health Information and Referral Services

Current condition or problem:

Lane County Public Health provides health information and referral services five days a week in all Eugene program offices

Goal:

To continue providing up-to-date health information and referral services to people who call or come into the public health offices.

Activities:

1. Maintain bilingual (English/Spanish) support staff to answer telephone calls and greet people in the office and to provide current health information and referral services as requested.
2. Coordinate information between particular teams within public health and the support staff in order that information is current.
3. Maintain current information regarding clinic hours and services provided through written and oral format as well as website.
4. Maintain current information regarding eligibility and access to services provided by public health.
5. Continue communication with community agencies and medical providers in rural areas of the county for information and referral services in those areas.
6. Maintain current website information.

Evaluation:

1. Structure of support staff schedule will be reviewed to ensure availability of staff to provide health information and referral services.
2. Minutes of public health program team meetings will be kept and shared with support staff to keep up to date information regarding services.
3. Clinic schedules will be reviewed periodically for accuracy – schedules will be provided in English and Spanish.
4. Staff will be encouraged to check the Lane County Public Health website often to make sure the information is accurate. One person maintains website changes and suggestions in order to keep fidelity in the website information.

Parent and Child Health

- **Prenatal Access, Oregon Mothers Care:**

Current condition or problem:

1. The percentage of Lane County pregnant women receiving first trimester care in 2013 was 79.2%, a slight improvement. The Oregon percentage in 2011 was 75.1%. The Oregon Benchmark goal is 95%.
2. Lane County's prenatal access program, Oregon MothersCare (OMC) assists pregnant teen and adult women access Oregon Health Plan (OHP) coverage and early prenatal care by helping remove barriers, per program element in the Intergovernmental Agreement with DHS.
3. The local OMC provides education regarding importance of dental care during pregnancy and encourages pregnant women to access dental care.

Goals:

1. Increase the number of pregnant women who access prenatal care during the first trimester as noted in the program element for OMC. (Noted in Program Element 42 in Oregon Health Authority IGA.)
2. Increase the number of OHP eligible pregnant and postpartum women who access dental care services.

Activities:

1. Provide pregnancy testing and counseling, assist in gaining OHP coverage and prenatal care, and referral to MCH and WIC (Special Supplemental Nutrition Program for Women, Infants, and Children).
2. Provide community outreach regarding the need for early prenatal care and the local OMC program as noted in the OMC Program Element.
3. Continue collecting and submitting client data quarterly to state as noted in OMC Program Elements in the IGA with DHS.
4. At each appointment with pregnant woman, staff will address healthy behaviors and importance of taking prenatal vitamins: vitamins will be provided to pregnant women at no charge.
5. Continue collaboration with Community Health Centers of Lane County in assisting pregnant women to access OHP services.

Evaluation:

1. OMC staff will continue to send data to the state in agreed upon manner.
2. OMC staff will record program outputs and outcomes as part of the countywide performance measure process.
3. Excel spreadsheet will be maintained to track distribution of brochures and other outreach materials. Noted in OMC Program Elements in IGA with DHS.

• **Maternal Child Health, Maternity Case Management (MCM), Babies First!**

Current condition or problem:

1. Lane County's fetal-infant mortality rate has slowly decreased below the state and national levels as a result of the PPOR assessment performed over the last five years. Targeted message campaigns were developed to educate the public on some of the most frequent preventable risk factors. According to the study, 40% of infant deaths were the result of unsafe sleep practices. Information on SIDS and safe sleeping positions has since been incorporated into our educational curriculum for our home visitation programs and with other providers and community partners.
2. Collaborative partnerships with health providers and other service agencies have resulted in continued referrals for MCH services.
3. Public Health Nurses (PHNs) provide comprehensive Maternity Case Management (MCM) and Nurse Family Partnership (NFP) home visiting services for many women who are at risk of poor pregnancy and birth outcomes.
4. PHNs provide Babies First! services for infants and young children at significant risk of poor health or developmental outcomes.
5. PHNs provide CaCoon services to help families become as independent as possible in caring for their child with special health or developmental needs and help in accessing appropriate services.
6. PHNs provide support and assistance for families who have experienced a child's death by SIDS (Sudden Infant Death Syndrome). The Fetal Infant Mortality Review group case team reviews all fetal/infant deaths.

Goals:

1. Continue to monitor the CDC statistics for fetal-infant mortality rates for Oregon and Lane County.
2. Increase the number/rate of births that are full-term (≥ 37 weeks) and appropriate weight (≥ 6 lbs.)
3. Decrease the number of pregnant women who use alcohol, tobacco, or illicit drugs during pregnancy.
4. Optimize birth and childhood outcomes for at-risk families through education, referral and support.
5. Prevent and mitigate early developmental delays, ensure early intervention of delays that are identified, and optimize each child's potential capacity.
6. Increase family independence in caring for children with special needs.

7. Maintain up-to-date data entry into ORCHIDS.

Activities:

1. Facilitate the community initiative for the reduction of fetal-infant mortality.
2. Provide comprehensive, quality MCM and NFP nurse home visiting by well-trained and capable PHNs for at risk pregnant teen and adult women. (As noted in Program Element 42 of Oregon Health Authority IGA.)
3. Provide quality Babies First and CaCoon nurse home visiting services by well trained and capable PHNs. (As noted in Program Element 42 of Oregon Health Authority IGA.)
4. Provide nurse home visiting support for families who have experienced a SIDS death. (As noted in Program Element 42 of Oregon Health Authority IGA.)
5. Work closely with WIC to ensure a system of public health services for families in need.
6. Ensure staff assigned to do data entry into ORCHIDS for current client data to state. (As noted in Program Element 42 of Oregon Health Authority IGA.)

Evaluation:

1. MCM, Babies First!, and CaCoon data will be recorded in ORCHIDS MDE, the statewide MCH system.
2. MCH referral logs will be maintained to track referrals for MCH services and identify referral sources.
3. PHNs will maintain a case log that indicates the outcome of client contact.
4. PHNs, with the assistance of ancillary staff, will record program outputs and outcomes as part of the countywide performance measure process.

Tobacco Prevention Program Objectives

The following program objectives are listed in the Lane County Tobacco Prevention Program plan for FY 13/14.

- By June 2014, Lane County Public Health (LCPH) will continue ongoing monitoring and evaluation of tobacco use and prevention policies and provide ongoing technical assistance to community partners to address emerging issues.
- By June 2014, Lane County will create a Tobacco-Free Campus Committee composed of key leaders from each department and union and convene meetings to actively work toward adopting and implementing a policy prohibiting tobacco use on all Lane County owned and leased properties.
- By June 2014, Lane County Health and Human Services (H&HS) will transition its remaining campuses to tobacco-free status, and each division will adopt or adapt and implement the formal H&HS tobacco-free campus policy and communicate the policy to all staff, clients, and visitors.

- By June 2014, LCPH will respond to all complaints of violations of the Smokefree Workplace Law and perform all enforcement functions according to the terms and conditions specified in the Intergovernmental Agreement (IGA) with the state.
- By June 2014, Lane Community College will have internal conversations to determine feasibility and timing of revising current “Tobacco Free Core Campus” policy to eliminate designated smoking areas in parking lots, therefore making the campus 100% Tobacco-Free.
- By June 2014, LCPH will complete an assessment of health indicators and readiness for policy change in Downtown Eugene, present assessment results to key city staff, and discuss appropriate and feasible policy options to address issues identified.
- By June 2014, LCPH will identify state properties within Lane County and provide support for implementation of the governor-mandated tobacco-free state properties policy.
- By June 2014, LCPH will identify all Oregon Addictions and Mental Health Division residential mental health and substance abuse treatment facilities and support implementation and promotion of the Tobacco Freedom Policy.
- By June 2014, Trillium Community Health Plans (the Coordinated Care Organization in Lane County) will adopt and implement a tobacco-free campus policy and encourage its contract providers to do the same.
- By June 2014, United Way of Lane county will adopts and implement a tobacco-free campus policy.
- By June 2014, LCPH will conduct an assessment of all park districts within Lane County, including the identification of district, the number of parks, total acreage, etc.
- By June 2014, LCPH will integrate the Oregon Tobacco Quit Line into every smoke and tobacco-free initiative.
- By June 2014, LCPH will promote the Quit Line and available quit supports as part of every earned and social media opportunity.
- By June 2014, Lane County will develop and implement an organizational policy to regularly promote the tobacco cessation benefits included in the county’s health insurance plan to covered employees, beneficiaries and covered retirees. The Oregon Tobacco Quit Line will be simultaneously promoted to county employees and family members ineligible for county health insurance.
- By June 2014, Lane County H&HS will conduct an assessment of what each division is doing to address tobacco, identify barriers and opportunities for improving, including what changes are feasible in each division to help identify clients who are tobacco users and refer those interested in quitting to the Quit Line.
- By June 2014, LCPH will evaluate success of Quit Line promotion and new fax referral systems by reviewing Quit Line reports and periodically following up with partners and ensuring materials are being distributed effectively.
- By June 2014, LCPH will include information about the physical and economic harm of tobacco in all earned and social media opportunities.

- By June 2014, Lane County H&HS will develop and integrate local tobacco prevention messaging into public health communication and medial plan.
- By June 2014, Lane County H&HS will share information with community leaders and local and state decision makers about the importance of reducing exposure to the number of tobacco outlets, advertisements, and promotions in the community, especially among youth and low-income populations.
- By June 2014, Lane County H&HS will conduct an assessment of local jurisdictions and tobacco retail license ordinances.
- By June 2014, Lane County H&HS will conduct a point of sale assessment of the local tobacco retail environment.
- By June 2014, Lane County H&HS will educate and assess the community regarding attitudes, options and knowledge of tobacco point of sale strategies.
- By June 2014, LCPH will incorporate information on the public health benefits of increased tobacco taxes and policies to reduce tobacco advertising and promotion into presentations with local leaders, decision-makers and policy makers.

IV. Additional Information

1. The Lane County Board of County Commissioners serves as the Board of Health. Minimally, they convene two times per year to receive the Lane County Department of Health and Human Services biannual Board of Health Report. This report includes all divisions of the department, ranging from Public Health to Behavioral Health to Family Mediation. The report is a public document and available to anyone who requests it and is posted on the department's website. In addition, when requested by our Department Director/Health Administrator, the Board of Health convenes on public health policy issues. With the assistance from our County Counsel, the Board of Health has developed better understanding of its authority to pursue and set policy at the local level to ensure improved community health. The Board of Health meetings are public meetings, with notice to the community. The Department Director and Assistant Director (Health Administrator) of Health and Human Services reports to the County Administrator and the Board of County Commissioners.
2. Lane County Public Health has an Advisory Committee (PHAC) which meets the second Tuesday evening of each month (5:30 p.m.-7:00 p.m.). The Committee consists of 12 members: seven at-large and five persons licensed by the State of Oregon as healthcare practitioners. Committee members have assisted Lane County Public Health with its five-year strategic plan, the Healthy Babies Healthy Communities Coalition work, chronic disease prevention, and herbicide spraying issues, to name a few. The committee is provided program updates from Public Health staff. In its 2013-2014 annual report to the Board of County Commissioners, to which they are advisory on public health matters, PHAC has identified the following major themes/work: continued work with the Tap Water Coalition; support the Board of County Commissioners' efforts for the improvement of community health, particularly in the area of health in all policies; continue to be apprised of potential

changes to the Ambulance Service Area Plan; continue work on improving oral health care for pregnant women; improvement of childhood immunization rates; continue support of Lane County's tobacco-free campus policy; gather information on e-cigarettes; schedule joint meetings with the Lane County Mental Health Advisory Committee.

Budget Information:

The contact person for the approved annual budget for Lane County Public Health is Lynise Kjolberg, Administrative Services Supervisor, Department of Health & Human Services. Her phone number is (541) 682-3968; e-mail is lynise.kjolberg@co.lane.or.us. The budget is presented by individual programs and will be submitted to the state per each of the program required timelines. Fiscal year budget can be found at [www.LaneCounty.org/Department/County Administration/Budget and Planning](http://www.LaneCounty.org/Department/CountyAdministration/BudgetandPlanning)

Standards for Local Health Departments:

Lane County Public Health meets the current Standards for Local Health Departments (ORS 431.345) in regards to the program provisions (OAR 333-014-0050) and staffing.

Agencies are **required** to include with the submitted Annual Plan:

The local public health authority is submitting the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431.375-431.385 and ORS 431.416 are performed.

Local Public Health Authority

County

Date

TABLE OF CONTENTS

Acknowledgements.....	Page 3
Executive Summary.....	Page 4
Background & Introduction/Framework.....	Page 7
Health Priority One: Health Equity.....	Page 10
Health Priority Two: Tobacco.....	Page 16
Health Priority Three: Obesity.....	Page 26
Health Priority Four: Substance Abuse and Behavioral Health.....	Page 34
Health Priority Five: Access to Health Care.....	Page 43
Conclusion.....	Page 49

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- James Boyle, PeaceHealth, Senior Analyst, PeaceHealth Oregon West
- Anne Celovsky, AmeriCorps VISTA Volunteer, Lane County Public Health
- Mardel Chinburg, Lane County Public Health Advisory Committee Member & University of North Carolina Practicum Student with Lane County Public Health
- Chelsea Clinton, MS, MPA Health Program Specialist, United Way of Lane County/100% Access Coalition
- Jody Corona, Health Facilities Planning & Development, Consultant for PeaceHealth
- Tara DeVee, Trillium Community Advisory Committee
- Jennifer Jordan, MPH, Senior Community Health Analyst, Lane County Public Health
- Rick Kincade, MD, PeaceHealth, Network V.P. for Medical Affairs
- Patrick Luedtke, MD, MPH, Public Health Officer, Lane County Public Health
- Mary Anne McMurren, Administrator, PeaceHealth, Cottage Grove Hospital representing the Cottage Grove Community
- David Parker, Chair, Trillium Community Advisory Committee
- Dan Reece, LCSW, PeaceHealth, Peace Health Manager Network of Care
- Ellen Severson, MPH, Community Health Analyst, Lane County Public Health/Trillium Community Health Plans
- Rick Yecny, CEO, PeaceHealth, Peace Harbor Hospital, representing the Florence area community
- Lane County Public Health Prevention Team
- Lane County Community Members



Lane County, Oregon

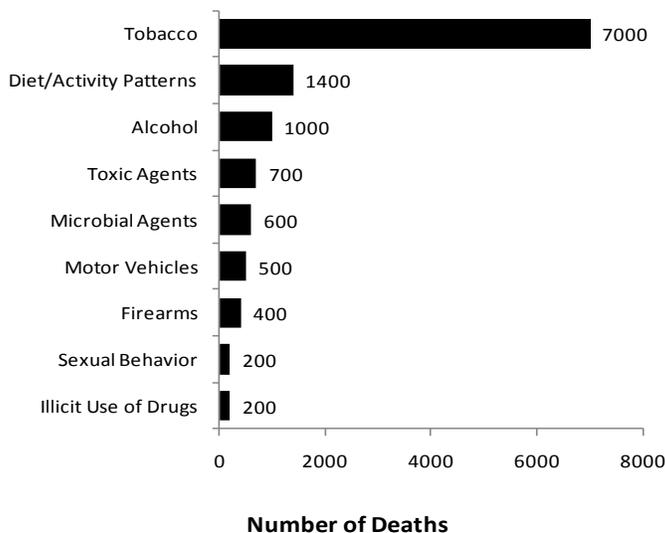
Executive Summary

WELCOME TO LANE COUNTY’S HEALTHY FUTURE!

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

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

Actual Causes of Death in Oregon*



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

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

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

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

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

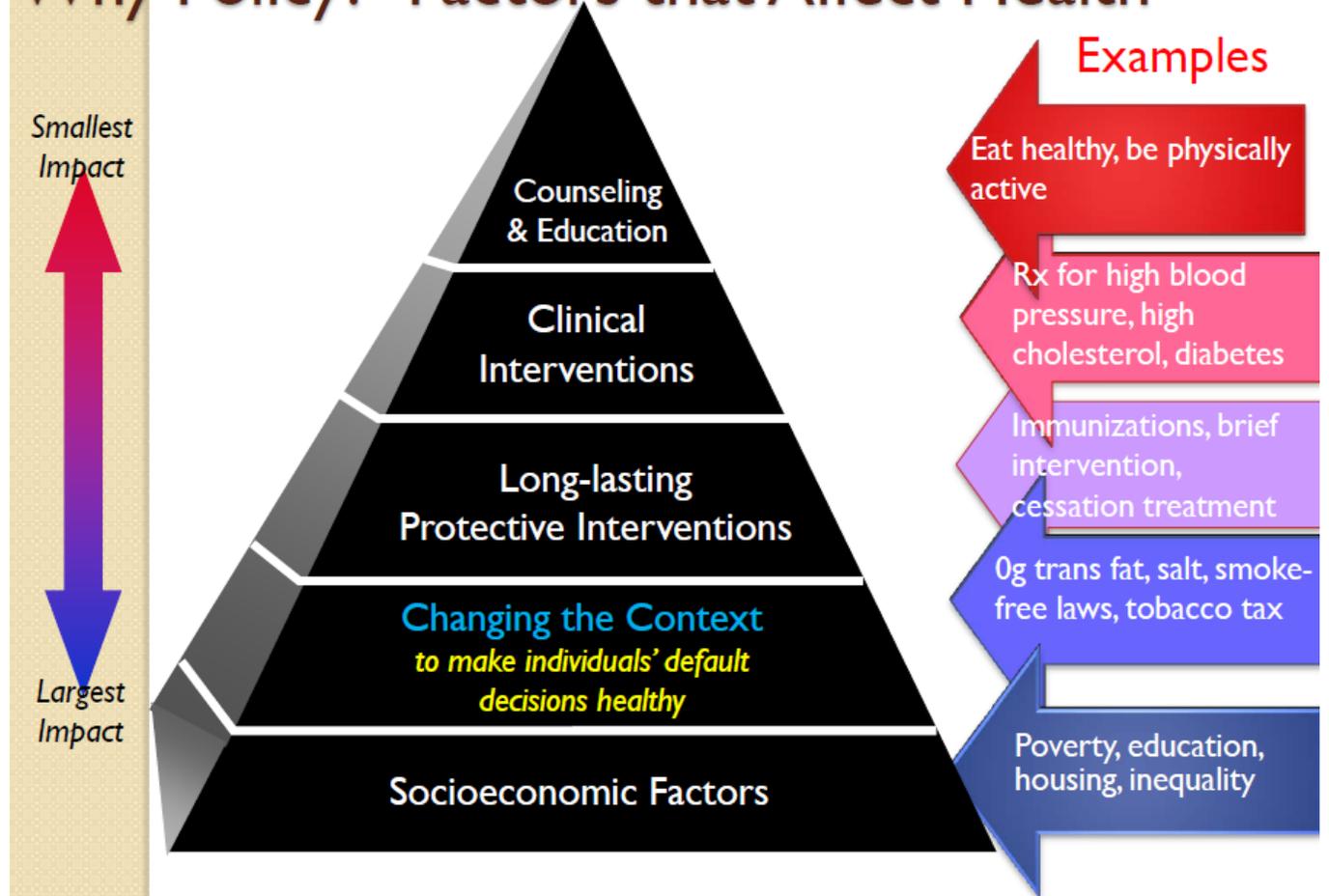
These priorities were chosen based on which accomplishments would offer the greatest improvements in lifelong health, advance health equity, and promote equal access to conditions

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

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

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

Why Policy? Factors that Affect Health



Socioeconomic Factors:

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

Changing the Context to Make Individuals’ Default Decisions Healthy:

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

According to CDC Director Dr. Thomas Frieden:

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

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

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

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

HEALTH PRIORITY ONE:

ADVANCE AND IMPROVE HEALTH EQUITY

Background

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

Health disparities are population-specific differences in health outcomes. Examples of health disparities are when a specific population (defined by race/ethnicity, income, education or other factors) has an increased likelihood of using tobacco, having heart disease or dying prematurely. Some health disparities cannot be eliminated, for example, older adults are more likely to have heart disease than younger adults.

Health inequities are the unfair, avoidable and unjust social and community conditions that lead to disparities in health outcomes. Examples of health inequities include neighborhoods with less access to healthy food options, areas with higher air pollution, communities with lower-achieving schools, and populations that have less access to appropriate health care.

Achieving health equity requires structural, social and political changes to equalize the conditions that promote health for all people, especially populations that have experienced historical injustices or face socioeconomic disadvantages.

According to the most recent U.S. Census, Oregon's population is becoming more racially and ethnically diverse. From 2000 to 2010, the total population of Oregon increased 12%, while the population of Oregon's communities of color increased 46%, almost four times as fast. Communities of color now comprise 22% of the total state population, up from 16% in 2000. This trend is likely to continue, as 34% of Oregon youth under 18 years old are members of communities of color. Among the population receiving services from the Oregon Health Plan (Medicaid), 40% are from communities of color.

Effects of health inequities

Health inequities result in unnecessary loss of life and also increase the costs of the health care system. A national study by Johns Hopkins University and University of Maryland researchers found that almost one-third of the medical care expenditures for African Americans, Asians and Hispanics were excess costs due to health inequities.¹

Data from Oregon's State Health Profile show the extent of some current health disparities. For example, adult obesity rates are higher for Latinos (31%), American Indians/Alaska Natives (30%), and African Americans (29%) compared to non-Latino whites (24%). The prevalence of asthma is twice as high for economically disadvantaged adults (defined by educational attainment and household income) compared to non-economically disadvantaged adults. Compared to the overall adult smoking prevalence of 20%, the smoking prevalence is higher for adults who are economically disadvantaged (33%), American Indian/Alaska Native (38%), and African American (30%).

Factors that influence health equity

There are many causes for the adverse health outcomes experienced by certain communities. Populations experiencing health disparities may be less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive the appropriate care when seeing a health care provider. Equity must be considered in all health issues, spanning from preconception to the end of life.

Health outcomes are also strongly influenced by factors that are not always seen as directly related to health. Such factors include housing, transportation, economic development and educational opportunities. It is critical to address equity in all the areas that affect a person's health. And, it should be recognized that health affects a person's ability to succeed in other areas. For example, a healthy youth is more likely to do well academically, and a healthy adult can be a more productive worker.

Equity lens

An equity lens process is a method for identifying and addressing health inequities. The equity lens is used to assess policies and programs for disproportionate effects on specific populations. Then, necessary modifications can be made that would improve health equity. The equity lens process is an intentional method for making more informed decisions and moving toward the goal of achieving health equity. An equity lens can be applied to any policy or program that affects health.

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

For example, the equity lens was used to review the improvement strategies for the four other health priorities in this plan relating to tobacco, obesity, oral health and substance abuse/behavioral health. Among the improvement strategies developed for these four health priorities, the following strategies have the greatest potential to promote health equity, although they are not strategies that have been adopted into the identified health equity priority strategies.

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

Health Priority #1: Improving Health Equity															
Health outcomes	Age-adjusted death rates by race/ethnicity														
Measurable Objectives	<p>A few examples of baseline data the state is considering and which we might also consider (additional work in this area to be completed by to-be-established Health Equity Advisory Group)</p> <p>High school graduation rates by race/ethnicity – baseline state data (2010), targets to be determined</p> <table> <tbody> <tr> <td>African American</td> <td>49.8%</td> </tr> <tr> <td>American Indian/Alaska Native</td> <td>59.3%</td> </tr> <tr> <td>Asian/Pacific Islander</td> <td>76.1%</td> </tr> <tr> <td>Hispanic</td> <td>55.2%</td> </tr> <tr> <td>White</td> <td>69.9%</td> </tr> </tbody> </table> <p>Percentage of babies with low birthweight babies by race/ethnicity – baseline state data (2010), targets to be determined</p> <table> <tbody> <tr> <td>African American</td> <td>10.9%</td> </tr> <tr> <td>American Indian/Alaska Native</td> <td>7.4%</td> </tr> </tbody> </table>	African American	49.8%	American Indian/Alaska Native	59.3%	Asian/Pacific Islander	76.1%	Hispanic	55.2%	White	69.9%	African American	10.9%	American Indian/Alaska Native	7.4%
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	Asian 7.8% Hawaiian/Pacific Islander 11.1% Hispanic 6.1% White 6.0% Incarceration rates per 100,000 by race/ethnicity – baseline state data (2005), targets to be determined African American 2,930 Hispanic 573 White 502		
Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
Strategy 1: Examine the implementation of all Community Health Improvement Plan strategies through an “equity lens” to assess any disproportionate impacts on specific populations and make any necessary modifications to improve health equity	TBD by Health Equity Advisory Group	TBD by Health Equity Advisory Group	CHIP Leadership Team, Health Equity Advisory Group, all people and organizations working on the underlying health priority

Health Priority #1: Improving Health Equity

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

Health Priority #1: Improving Health Equity

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

HEALTH PRIORITY TWO:

PREVENT AND REDUCE TOBACCO USE

Background

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

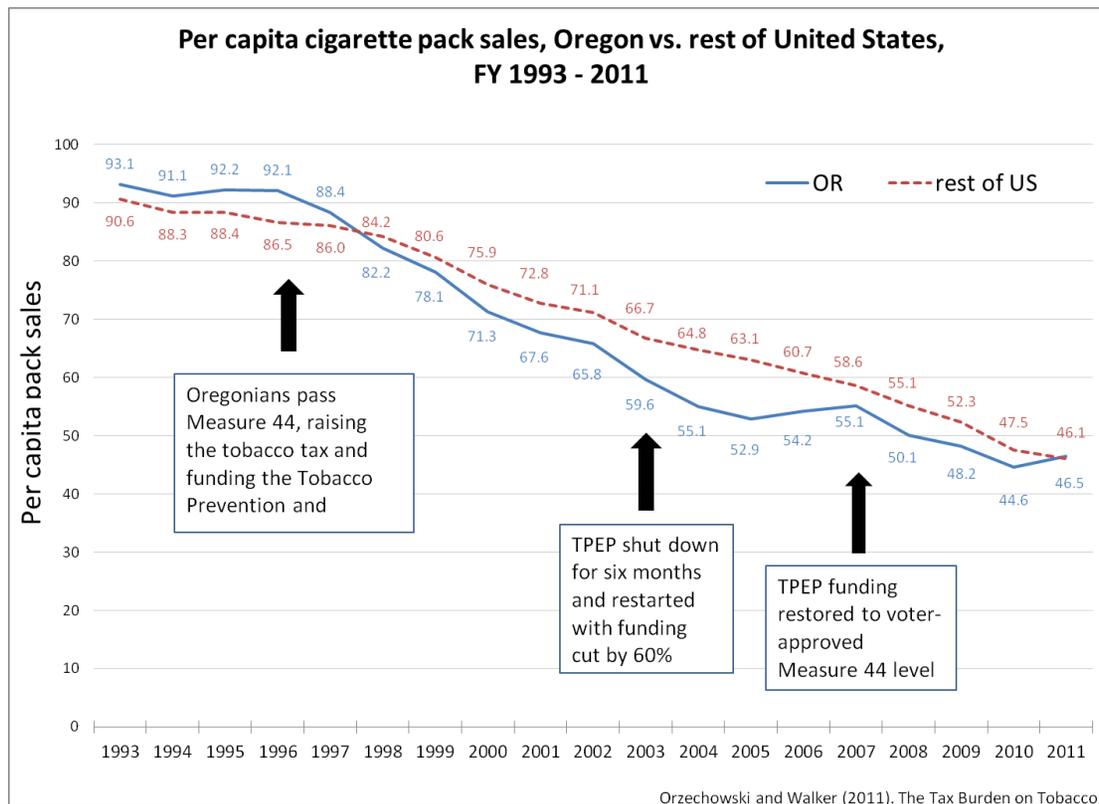
In order to get a sufficient sample size, it is often necessary to combine multiple years of county-level data. Data availability can also lag behind a few years depending upon sample size, participation levels, and data analysis resources. The data below were the most recent data available at the drafting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

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

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

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

Oregonians voted in 1996 for Measure 44, which raised cigarette taxes and funded the Tobacco Prevention and Education Program. As shown in the chart below, cigarette consumption has declined in Oregon during the past 15 years.



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

Tracking and Monitoring Policy, Systems and Environmental Change

The performance measures recommended in the table below will be tracked by Lane County Public Health’s Tobacco Prevention and Education Program staff and shared with the local community health improvement plan leadership team, the community and the Oregon Public Health Division’s Health Promotion and Chronic Disease Prevention Section. Oregon’s public health system routinely collects and analyzes data on the prevalence of diseases and risk factors across the population and among sub-populations, and monitors state and local policies that prevent disease and support healthy living. To capture local and state policies, the Health Promotion and Chronic Disease Prevention Section established a policy database to track local and state policies to prevent tobacco use, obesity, and active living. Components of the database include, but are not limited to:

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

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

Measurable Objectives	<p>Reduce the percentage of adults who smoke</p> <ul style="list-style-type: none"> • Baseline: 18.1% (2008-2011 BRFSS) <p>Reduce the percentage of 8th and 11th graders who smoke</p> <ul style="list-style-type: none"> • Baseline: 8th graders: 8% (2007/2008, OHT) • Baseline: 11th graders 15% (2007/2008, OHT) 		
<p>Strategy 1: Build community leaders and decision makers understanding of the WHO MPOWER framework for tobacco control, the history of tobacco control in Lane County and the strategies below</p>	<p>Key community leaders and decision makers understand and support local implementation of the WHO MPOWER framework for tobacco control</p>	<p>Key leaders and decision makers participate in a process to build understanding of the WHO MPOWER framework</p>	<p>CHIP leadership team</p>
<p>Strategy 2: Engage in efforts to encourage support for statewide legislation to increase the price of cigarettes by \$1/pack excise tax (and proportionate amount on other tobacco products) and dedicate 10% (\$40 million) to comprehensive and effective efforts at the state and local levels to reduce tobacco use and exposure in adults and children</p>	<ul style="list-style-type: none"> • The amount of state tax on a pack of cigarettes • Allocations to the Tobacco Use Reduction Account are secured 	<ul style="list-style-type: none"> • \$2.18 tax/pack <p>Baseline: \$1.18 (2013)</p> <ul style="list-style-type: none"> • Approximately \$20 million annually allocated to the Tobacco Use Reduction Account <p>Baseline: \$12.5 million (2009-2011 Biennium)</p>	<p>CHIP leadership team, Tobacco-Free Lane County Coalition, new community leader champions to be developed, Statewide tobacco control advocacy partners: American Heart Association, American Cancer Society, and American Lung Association, Campaign for Tobacco Free Kids</p>

Health Priority #2: Prevent and Reduce Tobacco Use

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
<p>Strategy 3: Increase the number of environments where tobacco use is prohibited:</p> <ul style="list-style-type: none"> • City & county operated campuses • Parks and outdoor recreational spaces • Early through higher education campuses • Places where people connect with physical and mental health services and support services • Worksites 	<ul style="list-style-type: none"> • Number of local government entities that adopt and implement tobacco-free campus policies • Number of public places that are tobacco-free including parks and recreational properties • Number of early through higher education properties that are tobacco free • Number of places where people connect with physical and mental health services and support services that are tobacco-free • Number of other worksites that are tobacco-free 	<ul style="list-style-type: none"> • All Lane County worksite properties are tobacco-free <p>Baseline: All Lane County Health and Human Services Department properties will be tobacco-free by June 30th, 2013</p> <ul style="list-style-type: none"> • Increase the number of cities in Lane County that adopt and implement tobacco-free campus policies <p>Baseline: No cities in Lane County have adopted tobacco-free campus policies</p> <ul style="list-style-type: none"> • Increase the number of local park jurisdictions in Lane County that adopt 	<p>CHIP leadership team (Lane County, PeaceHealth, Trillium, United Way), Lane County Public Health’s Tobacco Prevention and Education Program Team, parks district staff, county and city government officials, education officials, large employers, physical, mental, dental and social service providers, Tobacco-Free Lane County Coalition, new community leader champions to be encouraged</p>

Health Priority #2: Prevent and Reduce Tobacco Use

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		<p>and implement tobacco-free parks policies</p> <p>Baseline: No park jurisdictions in Lane County are tobacco-free; assessment of recreational properties policies needed</p> <ul style="list-style-type: none"> • Increase the number of places where people connect with physical and mental health services and support services that adopt and implement tobacco-free campus policies <p>Baseline: All four PeaceHealth hospitals in Lane County are tobacco-free, Planned Parenthood is tobacco-free but may not have a written policy, McKenzie-Willamette</p>	

Health Priority #2: Prevent and Reduce Tobacco Use

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		<p>hospital allows smoking in designated areas, all state-funded residential addictions and mental health facilities are required to be tobacco-free by June 30th, 2013 but may need support, assessment of policies at other places where people connect with physical and mental health services and support services needed</p> <ul style="list-style-type: none"> • All early through higher education properties are tobacco-free <p>Baseline: All K-12 schools in Oregon are tobacco-free, the University of Oregon adopted a tobacco-free campus policy in September of 2012, Lane</p>	

Health Priority #2: Prevent and Reduce Tobacco Use

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		<p>Community College allows smoking in designated areas, Head Start campuses are tobacco-free, assessment of other properties needed</p> <ul style="list-style-type: none"> • Increase the number of other worksites that adopt and implement tobacco-free campus policies <p>Baseline: Assessment of current policies needed</p>	
<p>Strategy 4: Support adoption and implementation of tobacco-free multi-unit housing complex policies (indoors)</p>	<ul style="list-style-type: none"> • Number of multi-unit housing properties that are tobacco-free 	<ul style="list-style-type: none"> • Increase number of multi-unit properties that adopt tobacco-free indoor policies <p>Baseline: The Housing and Community Services Agency of Lane County implemented a tobacco-free policy banning smoking inside all of their complexes in 2010;</p>	<p>CHIP leadership team, Lane County Public Health’s Tobacco Prevention and Education Program, Tobacco-Free Lane County Coalition, new community leader champions to be developed</p>

Health Priority #2: Prevent and Reduce Tobacco Use

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		assessment of other multi-unit property policies needed	
<p>Strategy 5: Promote the Oregon Tobacco Quitline as part of every local tobacco-free initiative</p>	<ul style="list-style-type: none"> • Number of calls to the Oregon Tobacco Quitline from Lane County residents • Number of Lane County residents using the Quitline’s web-based service 	<ul style="list-style-type: none"> • Increase the number of tobacco users from Lane County who call the Quitline to at least 2% <p>Baseline: In FY 11/12 1.2% of tobacco users in Lane County called the Quitline</p>	<p>Lane County Public Health’s Tobacco Prevention and Education Program, CHIP leadership team, new community leader champions to be encouraged, physical, mental, dental and social service providers through referrals</p>
<p>Strategy 6: Promote the Oregon Tobacco Quitline and incorporate Healthy Communities, Healthy People messaging developed by the state Public Health Division’s media contractor into all earned media and other communications</p>	<ul style="list-style-type: none"> • Number of times Healthy People, Healthy Communities messaging appears in local media • Number of times Oregon Tobacco Quitline messaging appears in local media 	<ul style="list-style-type: none"> • Increase the number of times Oregon Tobacco Quitline messaging appears in local media <p>Baseline: System to track messaging needed</p> <ul style="list-style-type: none"> • Increase the number of times the Healthy Communities, Healthy People messaging appears in local media <p>Baseline: Messaging has not yet been used with</p>	<p>CHIP Leadership Team, local and statewide advocacy organizations, community members</p>

Health Priority #2: Prevent and Reduce Tobacco Use

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		media	
<p>Strategy 7: Support and encourage the City of Eugene to conduct annual compliance inspections of all licensed tobacco retail outlets and ensure enforcement action is taken against those outlets out of compliance.</p>	<ul style="list-style-type: none"> • Number of licensed tobacco retail outlets in Eugene receiving an unannounced site inspection • Number of licensed tobacco retail outlets in Eugene that received enforcement action taken against them for being out of compliance 	<ul style="list-style-type: none"> • 100% of tobacco retail outlets will be inspected Baseline: None • Enforcement action will be taken against 100% of tobacco retail outlets found out of compliance Baseline: None 	<p>CHIP Leadership Team, Lane County Tobacco Prevention and Education Program, City of Eugene</p>

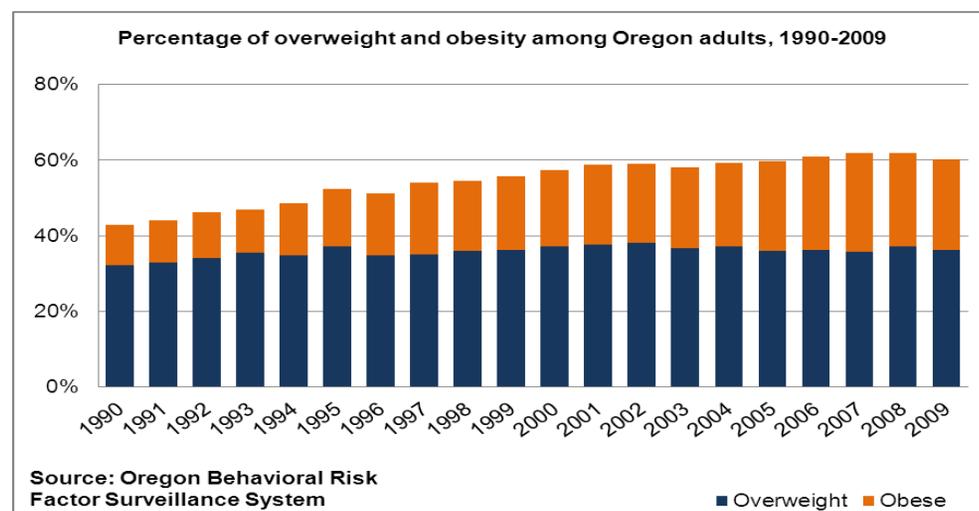
HEALTH PRIORITY THREE:

PREVENT AND REDUCE OBESITY

Background

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

Preventing obesity among Lane County residents lowers the risk of diabetes, heart disease, stroke, high blood pressure, stress and depression. Children and adolescents who are obese are at increased risk for becoming obese as adults and face a lifetime of negative health consequences.



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

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

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

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

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

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

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

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

- 23 percent participated in daily physical education

Each year, Oregon spends about \$1.6 billion (\$339 million paid by Medicaid) in medical expenses for obesity-related chronic diseases, such as diabetes and heart disease. Annual medical costs of persons who are obese are estimated to be \$1,429 higher per person than those of persons who are not obese (Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012).

Chronic diseases account for approximately \$.085 of every \$1.00 spent on health care costs. For Lane County to achieve success with health system transformation and attain better health and reduce health care costs, Lane County must reduce and prevent obesity.

Health Priority #3: Prevent and Reduce Obesity	
Health outcomes	Reduce the prevalence of asthma, arthritis, cancer, diabetes, heart disease, and stroke among children and adults
Health equity focus	Ensure that policy, systems and environmental strategies are prioritized to address specific populations (e.g. racial and ethnic minorities, pregnant women, people with mental illness, low income people) and reduce health disparities
Measurable Objectives	<p>Adoption and implementation of public and organizational policies:</p> <ul style="list-style-type: none"> • Type of policy • Date policy adopted and implemented • Population-reach • Jurisdiction • Contact Information <p>Decelerate the increase in obesity:</p> <ul style="list-style-type: none"> • Adults to 30% or less (2008-2011: 27%) • 11th graders to 11% or less (2009 11%) • 8th graders to 10% or less (2009: 10%)

Health Priority #2: Prevent and Reduce Obesity

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
<p>Strategy 1: Build community leaders and decision makers understanding of a public health approach to obesity prevention and the history of obesity prevention efforts in Lane County and across the nation and of the obesity prevention strategies below</p>	<ul style="list-style-type: none"> Key community leaders and decision makers understand a public health approach to obesity prevention and support local implementation of this plan 	<p>Key leaders and decision makers participate in a process to build understanding of obesity prevention and this plan</p>	<p>CHIP leadership team</p>
<p>Strategy 2: Support adoption and implementation of healthy meetings and events policies for food and beverages provided to staff, partners and the public at local government agencies, schools, health care facilities, social service organizations, community organizations and worksites at meetings and events including eliminating the provision of sugary drinks</p>	<ul style="list-style-type: none"> Percentage of local government agencies, local school districts, universities, community colleges, health and social service agencies, community organizations and other worksites with written policies requiring that foods and beverages served meet certain criteria 	<ul style="list-style-type: none"> At least one of each of the categories of organizations listed will have adopted a policy regarding the food they provide to staff, partners and the public at meetings and events including eliminating the provision of sugary drinks <p>Baseline: In 2011 Lane County Public Health</p>	<p>CHIP Leadership Team, local and statewide advocacy organizations, old and new local obesity prevention champions</p>

Health Priority #2: Prevent and Reduce Obesity

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		<p>adopted a policy with nutrition standards for food and beverages served at meetings and events for items that are purchased using any public health funds</p>	
<p>Strategy 3: Support adoption and implementation of healthy food and beverage policies for items sold in vending machines, in on site restaurants cafeterias and cafes, and in on site stores at local government agencies, schools, health care facilities, social service organizations, community organizations, and other worksites including eliminating the sale of sugary beverages on site</p>	<ul style="list-style-type: none"> Percentage of local government agencies, local school districts, universities, community colleges, health and social service agencies, community organizations and other worksites with written policies requiring that foods and beverages sold served meet certain criteria 	<ul style="list-style-type: none"> At least one of each of the categories of organizations listed will have adopted a policy regarding the food available for sale to staff, partners and the public at their worksites including eliminating the sale of sugary drinks <p>Baseline: All K-12 schools in Oregon are required to sell only items that meet nutrition standards outlined in HB 2650/Oregon Law</p>	<p>CHIP Leadership Team, local and statewide advocacy organizations, old and new local obesity prevention champions</p>

Health Priority #2: Prevent and Reduce Obesity

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		<p>336.423 during school hours; PeaceHealth Oregon Region adopted a healthy vending machine policy in 2013; the City of Eugene’s Library, Cultural and Recreation Services Department is on the cusp of adopting a similar policy; some baseline assessment conducted recently, but additional assessment needed</p>	
<p>Strategy 4: Build local support for legislative efforts to raise the price of sugary drinks through a statewide excise tax. Dedicate a portion of proceeds to reach recommended funding (\$22 million/year) for comprehensive efforts to reduce obesity and chronic disease in adults and children, especially in</p>	<ul style="list-style-type: none"> • The amount of state tax on sugary beverages 	<ul style="list-style-type: none"> • Sugar sweetened beverages taxed and funding to obesity prevention allocated • Baseline: No current tax 	<p>CHIP Leadership Team, local and statewide advocacy organizations, old and new local obesity prevention champions</p>

Health Priority #2: Prevent and Reduce Obesity

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
<p>populations experiencing disparities including implementation of best and promising practice interventions by the county, schools, coalitions, and community-based organizations</p>			
<p>Strategy 5: Build local support for implementation of the 2017 legislative PE mandate</p>	<ul style="list-style-type: none"> Participate in local and statewide efforts to ensure that the overall health and academic contributions of physical education are recognized, valued and supported 	<ul style="list-style-type: none"> All school districts in Lane County are on track to meet minimum PE requirements (grades K-5 = 150 minutes/week grades 6-8 225 minutes/week) outlined in ORS 329.496 by 2017 deadline <p>Baseline: Statewide data from 2011-2012 school year suggests that schools have a long way to go before meeting mandates, local assessment needed</p>	<p>CHIP Leadership Team, local Superintendents, parents, PE champions, local and statewide advocacy organizations, old and new local obesity prevention champions</p>

Health Priority #2: Prevent and Reduce Obesity

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
<p>Strategy 6: Support statewide efforts to secure funds to support active transportation projects, such as public transit, inter-city rail, and bicycle and pedestrian projects</p>	<ul style="list-style-type: none"> Participate in statewide efforts to secure \$50 million each biennium in dedicated funds to support active transportation projects outside of the road right of way, such as public transit, inter-city rail, and bicycle and pedestrian projects 	<p>\$50 million (in state budget) dedicated annually</p>	<p>CHIP Leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions</p>
<p>Strategy 7: Promote and support physical activity throughout the work and school day for employees and students including accessible stairs, breaks for stretching, walking meetings, recess, and after school play time</p>	<ul style="list-style-type: none"> Number of workplaces and schools that consistently promote and support physical activity throughout the work and school day for employees and students 	<ul style="list-style-type: none"> Increase the number of worksites and schools that consistently promote and support physical activity throughout the work and school day for employees and students Baseline: Unknown, assessment needed 	<p>CHIP Leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions</p>

Health Priority #2: Prevent and Reduce Obesity

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
<p>Strategy 8: Support statewide legislative efforts to fund the Farm to School, Farm to Institution, School Gardens Nutrition Programs and similar legislative efforts</p>	<ul style="list-style-type: none"> • Legislation passed and/or sustaining legislation passed 	<ul style="list-style-type: none"> • Farm to School funding legislation renewed and Farm to Institution legislation developed and passed 	<p>CHIP leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions</p>
<p>Strategy 9: Explore feasibility of healthy food zoning policies near schools</p>	<ul style="list-style-type: none"> • Conduct local political feasibility assessment 	<ul style="list-style-type: none"> • Assessment summary document 	<p>CHIP Leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions</p>
<p>Strategy 10: Incorporate Healthy Communities, Healthy People messaging developed by the state Public Health Division’s media contractor into all earned media and other communications</p>	<ul style="list-style-type: none"> • Number of times Healthy People, Healthy Communities messaging appears in local media 	<ul style="list-style-type: none"> • Increase the number of times the Healthy Communities, Healthy People messaging appears in local media • Baseline: need to develop tracking system 	<p>CHIP Leadership Team, local and statewide advocacy organizations, old and new obesity local prevention champions</p>

HEALTH PRIORITY FOUR:

PREVENT AND REDUCE SUBSTANCE ABUSE AND MENTAL ILLNESS

Background

Untreated behavioral health issues, including substance abuse and mental illness, substantially contribute to disease and premature death in Oregon. Behavioral health is a general term that encompasses the promotion of emotional health; the prevention of substance abuse and mental illness; and treatments and services for substance abuse and mental illness, according to the Substance Abuse Mental Health Services Administration (SAMHSA). The Oregon State Health Profile shows that Oregon's death rates were higher than those of the overall U.S. death rates for liver disease (28% higher) and suicide (36% higher). Suicide kills more people in Oregon than motor vehicle crashes. The majority of Oregon suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death. Efforts to treat behavioral health and reduce the abuse of alcohol, opioids (painkillers), and other drugs, will decrease deaths from liver disease and suicide and improve Oregonians' overall health.

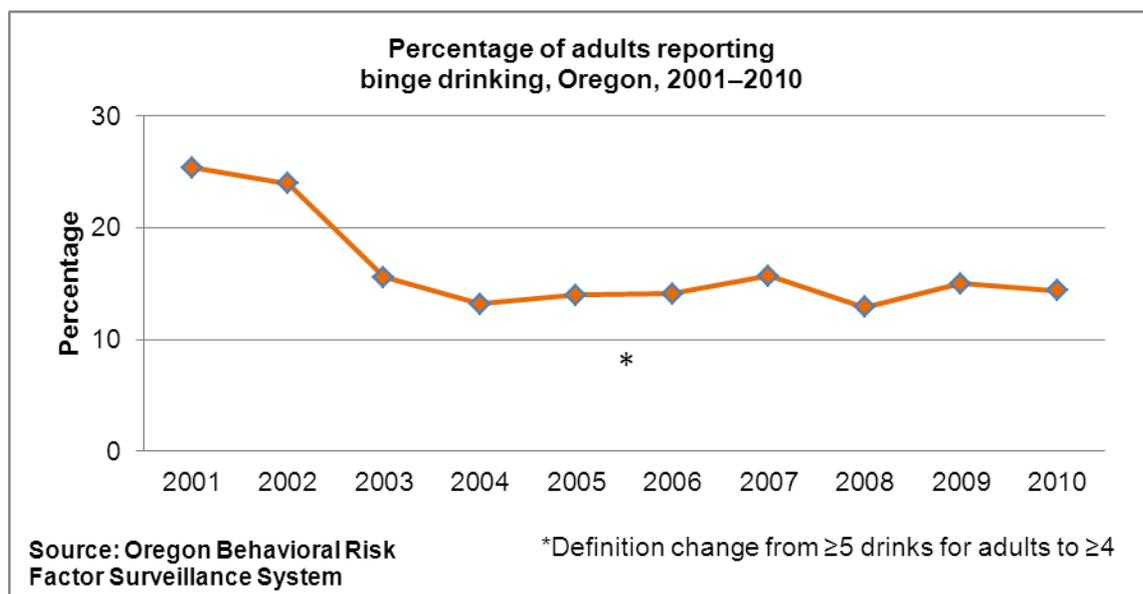
Alcohol use

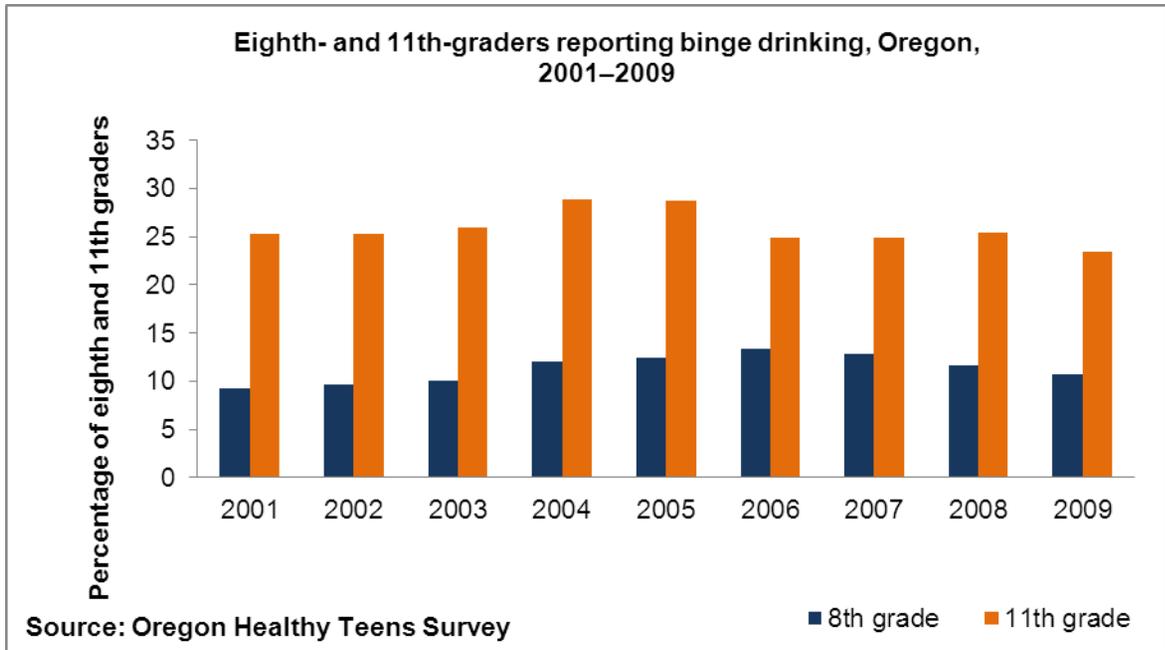
Age of first use of alcohol and alcohol dependency are closely related. Supporting youth to delay first use could yield immediate and long-term health benefits. Research shows that approximately four in 10 youth who first used alcohol by age 14 were diagnosed with alcohol dependency at some time in their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

Alcohol use during pregnancy increases the risk of fetal alcohol spectrum disorder (FASD), the leading preventable cause of mental retardation. In Oregon, 51.7% of new mothers reported drinking alcohol before they knew they were pregnant and 8.7% consumed alcoholic beverages during their last trimester (Oregon Pregnancy Risk Assessment and Monitoring System, 2007). Pregnant women are advised to abstain from any alcohol use.

Binge drinking

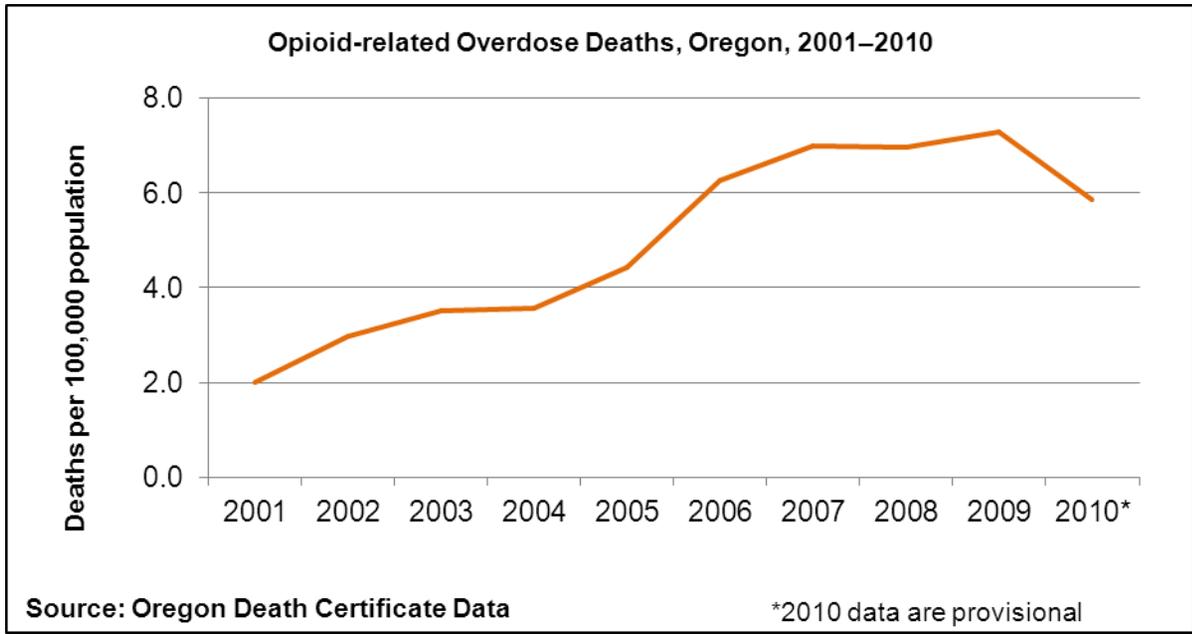
Binge drinking is a significant risk factor for injury, violence and chronic substance abuse. During 2010, 14.4% of adults reported binge drinking on at least one occasion during the past 30 days. Self-reported binge drinking declined from 2001 to 2004 but has not changed much since that time (see line chart below). Males, in general, report binge drinking more frequently than women. Male binge drinking peaks (29.5%) in the 25–34-year age group; female binge drinking peaks (18.1%) in the 18–24-year age group. Among youth in 2009, 10.7% of Oregon eighth-graders and 23.4% of Oregon 11th-graders reported binge drinking in the past 30 days (see bar chart below). Levels of binge drinking were similar among boys and girls (Oregon State Health Profile, 2012).





Opioid-related overdose

Unintentional opioid-related overdose is one of the leading causes of injury mortality in Oregon, and has increased three- to four-fold during the past decade (from 69 total deaths during 2001 to 225 during 2010). The numbers of Oregonians killed in motor vehicle crashes has declined substantially during the past decade, but the numbers dying from opioid overdoses have been steadily increasing (see chart below). Efforts targeted at patients who use opioids as well as clinicians who prescribe them are needed to address this emerging public health problem.



Untreated mental illnesses cost the United States at least \$105 billion in lost productivity annually, including 35 million lost workdays each year, according to Harvard University Medical School research. In 2010 alone, 678 Oregonians died by suicide; the estimate of total lifetime cost of suicidal deaths was nearly \$680 million. Annual health care expenditures associated with fetal alcohol spectrum disorder total \$78 million (Oregon Department of Human Services, 2009).

Health Priority #4: Prevent and Reduce Substance Abuse and Mental Illness

Health outcomes	Prevent and reduce morbidity and mortality related to mental illness and alcohol and other drugs
Health equity focus	Ensure that systems and strategies are prioritized to address specific populations (e.g. racial and ethnic minority groups, pregnant women, people with mental illness, low income people, veterans, and adolescents ages 10-24) and reduce health disparities.
Measurable Objectives	<p>Reduce:</p> <ul style="list-style-type: none"> ● Rate of death from suicide: 18 per 100,000 (2007-2011 Death Certificate Data) ● Rate of death from alcohol-induced disease: 16 per 100,000 (2007-2011 Death Certificate Data) ● Rate of drug-induced death: 18 per 100,000 (2007-2011 Death Certificate Data) ● Youth depression: 24% 8th grade, 29% 11th grade (2012 Oregon Student Wellness Survey) ● Underage drinking: 24% 8th grade, 38% 11th grade (2012 Oregon Student Wellness Survey) ● Adult binge drinking: 11% females 18+, 20% males 18+ (2006-2009 Oregon Behavioral Risk Factor Surveillance System) ● Youth use of marijuana: 11% 8th grade, 28% 11th grade (2012 Oregon Student Wellness Survey) ● Youth prescription drug abuse: 6% 8th grade, 10% 11th grade (2012 Oregon Student Wellness Survey) ● Youth and Adult prescription pain reliever abuse: 9% 12-17 years old, 17% 18-25 years old, 5% 26 or older (2008-2010 National Survey on Drug Use and Health) <p>*All of the above information is found in the Lane County Epidemiological Data on Alcohol, Drugs and Mental Health 2000 to 2012 (Oregon Health Authority)</p>

Health Priority #4: Prevent and Reduce Substance abuse and Mental Illness			
Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
<p>Strategy 1: Increase public, educator and healthcare provider awareness and education of substance abuse and mental health, including:</p> <ul style="list-style-type: none"> • Risk and protective factors; • Mental health promotion strategies • Adverse Childhood Experiences; • Stigma reduction; and • Positive social norms 	<ul style="list-style-type: none"> • Number of trainings, awareness campaigns, and presentations related to substance abuse, suicide, and mental health • Percent of Lane County youth that recall hearing, reading, or watching an advertisement about prevention of substance abuse • Number of Lane County schools implementing evidence-based curricula specific to substance abuse and mental health 	<ul style="list-style-type: none"> • Increase the number of substance abuse, suicide and mental health educational and awareness activities <p>Baseline: Assessment needed—to be completed by December 2013</p> <ul style="list-style-type: none"> • Increase the percent of Lane County youth in 6th and 8th grade that recall hearing, reading or watching an advertisement about prevention of substance abuse <p>Baseline: 48% 6th grade, 59% 8th grade (2012 Oregon Student Wellness Survey)</p>	CHIP leadership team

Health Priority #4: Prevent and Reduce Substance abuse and Mental Illness			
Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		<ul style="list-style-type: none"> • Increase the number of schools implementing substance abuse and mental health curricula <p>Baseline: Assessment needed—to be completed by December 2013</p>	
Strategy 2: Support the adoption and implementation of mental health- friendly workplace environments to promote mental health and reduce substance abuse.	<ul style="list-style-type: none"> • Number of Lane County employers who complete an assessment of their practices and policies related to mental health • Number of Lane County employers with stress management and other mental health friendly workplace policies 	<ul style="list-style-type: none"> • Increase the number of Lane County employers that implement stress management and other mental health-friendly policies • Baseline: Assessment needed—to completed by June 2014 	CHIP Leadership Team (Public Health, PeaceHealth, Trillium, United Way), healthcare and social service providers, local employers
Strategy 3: Implement policies to reduce access to lethal means of self-harm (firearms, poisons, prescription medications, alcohol and drugs)	<ul style="list-style-type: none"> • Number of healthcare and mental health providers counseling on access to lethal means 	<ul style="list-style-type: none"> • Increase the number of healthcare and mental health providers counseling on access to 	CHIP Leadership Team (Public Health, PeaceHealth, Trillium, United Way), healthcare and social service providers

Health Priority #4: Prevent and Reduce Substance abuse and Mental Illness

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		lethal means. Baseline: Assessment needed	
Strategy 4: Implement policies that reduce the retail and social availability of alcohol and other drugs	<ul style="list-style-type: none"> • Number of alcohol retailers in compliance with not selling to minors • Conduct feasibility studies on <ol style="list-style-type: none"> 1. Social host liability laws in municipalities within Lane County, 2. Increasing the local beer/wine tax, 3. Local alcohol outlet density/saturation policies in Lane County municipalities 4. Prescription drop boxes, 5. Prescription medication tracking 	Assessments completed by July of 2016	CHIP leadership team
Strategy 5: Support healthcare	<ul style="list-style-type: none"> • Number of healthcare and 	<ul style="list-style-type: none"> • Increase the number of 	CHIP Leadership Team (Public

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

Health Priority #5: Improve Access to Care	
Health outcomes	Improved health outcomes for people living with chronic conditions
Measurable Objectives	<ul style="list-style-type: none"> • Increase number of people with health insurance • Increase number of people with a primary care medical home • Increase number of people participating in chronic disease self-management programs • Increase immunization rates • Increase access to health care for rural residents • Reduce incidence of dental cavities • Improve connectivity for physical, behavioral and oral health care • Expand health care workforce

Health Priority #5: Improve Access to Care

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
<p>Strategy 1: Increase the number of people enrolled in a health insurance plan</p>	<ul style="list-style-type: none"> • Percentage of Lane County residents with health insurance • Percentage of eligible people enrolled in Medicaid 	<ul style="list-style-type: none"> • Target for percentage of residents with health insurance: To be determined by Access to Health Care committee Baseline: 23% • Target for percentage of eligible people enrolled in Medicaid: To be determined by Access to Health Care committee Baseline: assessment needed 	<p>CHIP Leadership Team, Access to Care Advisory Group</p>
<p>Strategy 2: Increase the number of people with a medical home</p>	<ul style="list-style-type: none"> • Percentage of Lane County Residents with a medical home 	<ul style="list-style-type: none"> • Target: TBD by Access to Health Care committee • Baseline: Assessment needed 	<p>CHIP Leadership Team, Access to Care Advisory Group</p>

Health Priority #5: Improve Access to Care			
Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
Strategy 3: Increase access to disease self-management programs	<ul style="list-style-type: none"> • Sustainable local program infrastructure with sufficient capacity to meet need • Systematic referrals of appropriate patients to self-management programs 	<ul style="list-style-type: none"> • Number and breadth of disease self-management programs available Baseline: Assessment needed • Number of Lane County residents with one or more chronic conditions participating in a self-management program • Baseline: Assessment needed 	CHIP Leadership Team, Access to Care Advisory Group
Strategy 4: Increase immunization rates	<ul style="list-style-type: none"> • Support statewide legislation to increase barriers to parents opting out of immunizations for their children • Support statewide efforts to remove legislative preemption that prohibits requiring any adult 	<ul style="list-style-type: none"> • Increase the percentage of immunized children in Lane County Baseline: 94% of children in pre-school children's facilities; 94% in Kindergarten & 1st grade; 95% in 7th grade 	CHIP Leadership Team, Access to Care Advisory Group

Health Priority #5: Improve Access to Care

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
	immunizations that are not required in federal legislation (ORS 416.133)	<ul style="list-style-type: none"> • Increase percentage of people classified as Health Care Workers (by CDC definition) that receive CDC recommended vaccinations (influenza, MMR, Varicella, Tetanus/Diphtheria and Meningococcal) <p>Baseline: Assessment needed</p>	
<p>Strategy 5: Improve access to health care for rural Lane County residents</p>	<ul style="list-style-type: none"> • Percentage of rural Lane County residents that have access to health care 	<ul style="list-style-type: none"> • Increase access to affordable transportation options <p>Baseline: Assessment needed</p> <ul style="list-style-type: none"> • Expand telehealth, virtual visits and home monitoring initiatives <p>Baseline: Assessment</p>	<p>CHIP Leadership Team, Access to Care Advisory Group</p>

Health Priority #5: Improve Access to Care

Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		needed	
<p>Strategy 6: Improve oral health</p>	<ul style="list-style-type: none"> Percentage of children and adults with tooth decay, untreated decay and rampant decay 	<ul style="list-style-type: none"> Increase access to fluoride treatment Baseline: Assessment needed Increase access to dental care Baseline: Assessment needed Explore political feasibility of water fluoridation in Lane County and local cities Baseline: assessment needed Decrease number of dental-related emergency room visits Baseline: Assessment 	<p>CHIP Leadership Team, Access to Care Advisory Group</p>

Health Priority #5: Improve Access to Care

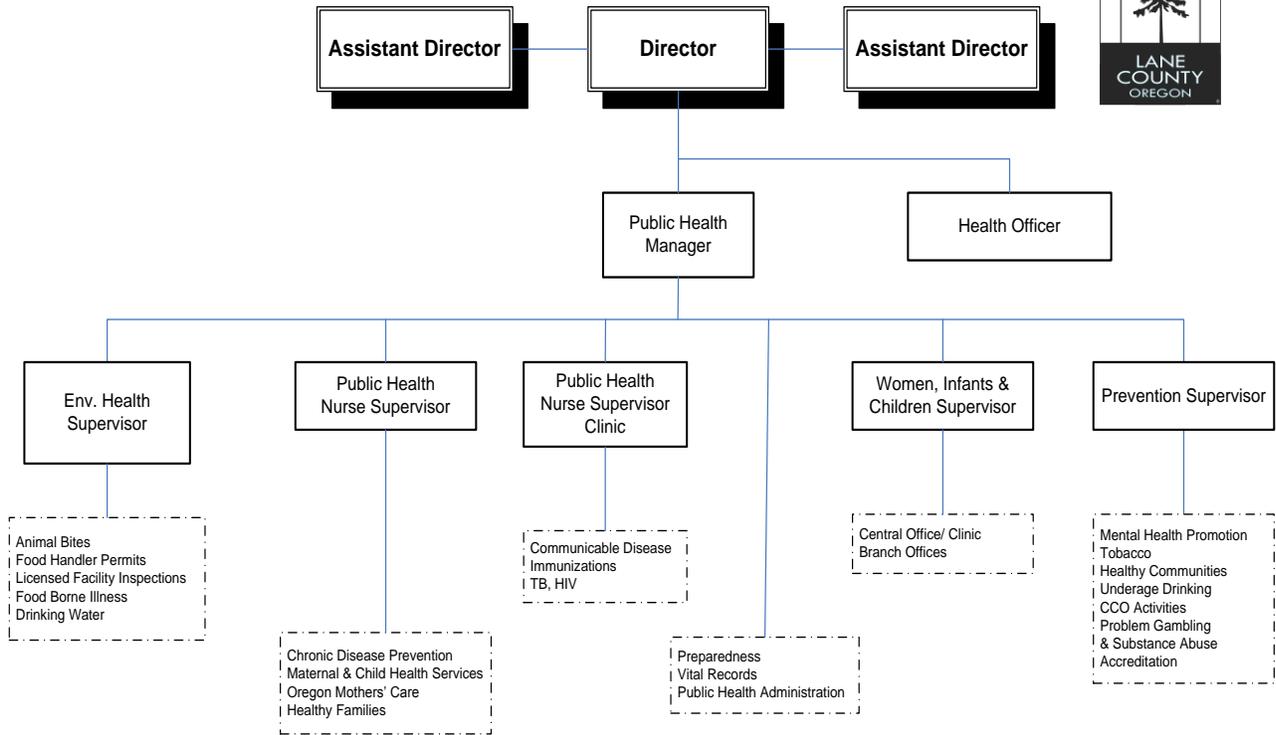
Improvement Strategies	Performance Measure	Target by July 2016	Responsible Parties
		needed	
<p>Strategy 7: Improve patient connectivity with physical, mental and behavioral health services</p>	<p>TBD by Access to Care Advisory Group</p>	<p>TBD by Access to Care Advisory Group</p>	<p>CHIP Leadership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

CONCLUSION

This plan outlines strategies for our community to work together to improve the health of Lane County residents. Lane County's Healthy Future is a living document. While the priorities are clear, the methods for addressing each of them will evolve over time. The community health assessment and community health improvement plan leadership team and the community recognize this collective effort as a powerful means to improve critical health indicators. Across the state of Oregon and Lane County, diverse stakeholders are working together to better understand and outline ways to achieve health equity and to support lifelong health.

As the numbers of those engaged in this effort grow, we envision a future where everyone in Lane County is empowered to improve the lifelong health of all people in Lane County.

**Health & Human Services
Public Health**



Public Health Department Structure
Last Update: 01/2014

**REQUIRED REPRODUCTIVE HEALTH ANNUAL PLAN
FY 2015
July 1, 2014 to June 30, 2015**

As a condition of Title X funding, sub-recipient agencies are required to submit an annual plan to the OHA Reproductive Health (RH) Program, as well as a projected budget for the time period of the plan. In order to increase the relevance of the process, we have developed a new required format which more accurately reflects the services – both direct and indirect – that lead to better health outcomes.

The following goals (also located in the drop-down menu of the annual plan form) are derived from OPA Priorities and cover the areas of Clinical Services, Counseling Services, Program Outreach and Health Systems Transformation.

- A.** Assure that delivery of quality family planning and related preventive health services is in accordance with Title X Program requirements and nationally recognized standards of care.
- B.** Assure that delivery of reproductive health services to adolescents is in accordance with Title X Program requirements and nationally recognized standards of care (where they exist).
- C.** Direct services to address reproductive health disparities among your community's high priority and underserved populations.
- D.** Identify strategies for addressing the provision of health care reform and for adapting the delivery of reproductive health services to a changing health care environment.

To complete your annual plan, please choose a minimum of two goals, and then choose one corresponding objectives for each goal from the objectives drop-down list. It is also acceptable to choose two or more objectives for one goal. The objectives reflect National Standards of Care, where available, and best practices. Describe the activities you will conduct to achieve your benchmark and explain how you plan to evaluate your outcomes.

Additional information to help with this process, including suggested activities and program data, can be found at:
http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Documents/TitleX/annual_plan_supporting_information.pdf The new data reports provided here reflect your agency's work in many of these areas during the past fiscal year. The RH program suggests that you review your county's current status for each objective and make your decision based on the needs or issues for your agency.

Our intention is to evaluate your progress by periodically reviewing your agency data when objectives are measurable. For objectives that are not data driven, we will request periodic progress updates

NOTE: We will not be asking for your progress report for FY2014 until after June 30, 2014. You may want to take the opportunity to look at your current plan and evaluate your own progress as you determine your new goals.

If you have any questions, please contact Connie Clark @ (541) 386-3199 x 200 or Linda McCaulley @ (971) 673-0362.

**REQUIRED REPRODUCTIVE HEALTH ANNUAL PLAN
FY 2015
July 1, 2014 to June 30, 2015**

Goal # 1 Choose an item.			
Objective	Current Status	Activities	Evaluation timeframe
A1. By June 30, 2015, Chlamydia testing on all sexually active women < 25 yrs of age will INCREASE by 10 %	24.3 %	1. Review current recommendations and screening guidelines with providers and support staff. 2. Specifically review current documentation of our statistics and review documentation process with staff.	1. 3/14 staff meeting for providers and at a meeting for support staff (date undecided at this point). 2. Review Ahler’s data for improvement in 6 months.
Goal # 2 Choose an item.			
Objective	Current Status	Activities	Evaluation timeframe
B3. By June 30, 2015, increase by 5 % and 10 % respectively, the proportion of ESTABLISHED ADOLESCENT (18 yrs and under) clients who receive STD/HIV prevention and relationship safety counseling at least once a year	78.8% 27.3 %	1. Review and encourage use of State for “Know Your Risk For STDs” 2. Utilize “Bright Futures” and State information for relationship safety counseling. 3. Evaluate current documentation process. 4. Work with pediatric teams on documentation of Reproductive Health visits and counseling using the client visit record.	1. Begin work with pediatric teams ASAP. For improving documentation and counseling at Reproductive Health visits. 2. Review Ahler’s data for statistical improvement in 6 months.



REQUIRED REPRODUCTIVE HEALTH ANNUAL PLAN
FY 2015
July 1, 2014 to June 30, 2015

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FY 2014 - 2015 Oregon WIC Nutrition Education Plan Form

County/Agency: Lane County

Person Completing Form: Katey Bosworth, MA, RD

Date: 11/20/2013

Phone Number: (541) 682-4202

Email Address: katey.BOSWORTH@co.lane.or.us

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by December 1, 2013
Sara Sloan, 971-673-0043

Goal : Oregon WIC staff will provide ongoing nutrition education related to Family Meals and Baby Behaviors utilizing quality participant centered services.

Objective 1: WIC agencies will assure participants are offered and receive consistent nutrition education messages on the topics of Family Meals and Baby Behaviors.

Activity 1: During plan period, each agency will develop and implement a plan for incorporating Family Meals messages into ongoing nutrition education for WIC families in order to emphasize the physical emotional and social benefits of sharing meals with others.

Note: Additional information and resources for promoting Family Meals will be provided by the State WIC Office.

Implementation Plan and Timeline:

In addition to the ongoing Family Mealtime class offered at our local agency (LA), Lane County will also implement a plan for consistently and regularly sharing messages about the importance of Family Meals. Our LA will utilize State provided information and resources as they become available to help develop ongoing nutrition education related to Family Meals.

Activity 2:

During plan period, each agency will develop and implement a plan for incorporating Baby Behavior messages and the interpretation of infant cues into ongoing nutrition education in order assist WIC families with breastfeeding support and appropriate infant feeding practices.

Note: Additional information and resources for promoting Baby Behaviors will be provided by the State WIC Office.

Implementation Plan and Timeline:

Lane County WIC will develop and implement a plan for consistently and regularly sharing messages about understanding Baby Behaviors and interpreting Baby Cues with appropriate WIC participants. Lane County will utilize State provided information and resources as they become available to help develop ongoing nutrition education related to Baby Behavior and Cues.

Objective 2: During plan period, each agency will assure staff continue to receive appropriate training to provide quality nutrition and breastfeeding education.

Activity 1: Complete and return Attachment A by December 1, 2013. This attachment identifies your agency training supervisor(s), projected staff in-services dates and topics for FY 2014-2015.