Oregon Public Health Division

Strategic Plan

2012 – 2017

Oregon Health Authority

Letter from the Oregon Public Health Director and State Health Officer

What determines how healthy people are? Research suggests that only about 10 percent of your health status is determined by health care you receive. While genetics plays a substantial role, our lifestyle choices and the physical and social environments that influence those choices is a much more powerful determinant, accounting for about two-thirds of health outcome. Public health focuses its work on those environments, aiming to make is easier for people to be healthy.

Oregon's public health agency was founded in 1903 when infectious disease outbreaks — smallpox, bubonic plague and tuberculosis — prompted the Legislature to create a State Board of Health, public health laboratory, vital statistics registry and county boards of health. Since then, Oregon Public Health has provided leadership and support to the state as it has faced a wide range of public health challenges.

Public health has made a significant impact on health outcomes, attesting to the power of its approaches. Since 1900, roughly two-thirds of the improvement in life expectancy can be attributed to public health interventions. Although tobacco remains the leading cause of preventable death and disability in Oregon as everywhere in the United States, we have made substantial progress in reducing people's exposure to secondhand smoke and decreasing the rates at which youth start smoking. Certain infectious diseases, such as tuberculosis and diphtheria, that were once major drivers of ill health, are now comparatively rare in Oregon. But the potential for resurgence of these killers is real, unless public health continues to monitor their occurrence and respond appropriately.

Public health needs to aggressively address the more challenging and less visible challenges that have begun to plague us in the last few decades. Suicide kills more Oregonians each year than motor vehicle crashes, and in fact rates have increased about 10 percent over the last decade, despite the fact that almost 20 percent of Americans now take antidepressant medication. Family violence substantially contributes to many of the most burdensome health outcomes, in terms of both human and financial costs.

And new threats also arrive, by definition, unpredictably. Whether it's SARS, HIV, the H1N1 influenza pandemic, the health effects of climate change, or the Fukushima nuclear accident in Japan, public health plays a key role in protecting Oregonians from the health consequences of outbreaks and disasters. The public health system has to be able to recognize the occurrence of a health problem, characterize it and describe its drivers, and mount an effective response that will give the public information they need to protect themselves and also address the cause of the health threat when that is possible.

Letter from the Oregon Public Health Director and State Health Officer

Continued...

Today, the greatest challenges facing Oregonians are not rare illnesses, but the increasing impact of chronic disease and injuries. More than 85 cents on every dollar spent on health care is spent on the treatment of chronic diseases. Without increasing investment in preventing the major drivers of health care costs, such as tobacco-related illnesses, obesity and suicide, we will not have a sustainable business model for our health care system.

Why bother with a strategic plan? The drivers of the major health threats Oregonians face are complex, controversial and multi-faceted. We must focus, or we will be unable to effectively address our challenges. This strategic plan lays out a concrete vision to achieve sustained and measurable improvements in population health in Oregon over the next three to five years. This plan is fully in sync with the creation of Coordinated Care Organizations, the Governor's 10-Year Plan for Oregon, and a focus on improving educational outcome. The plan also builds on the strengths of Public Health in the areas of epidemiology, maternal and child health, and environmental health. It blends these strengths with the opportunities to work with partners in the areas of transportation, health care, education, housing, and the private sector to implement community and clinical interventions.

The public health system cannot do its work alone. It needs the participation of a wide range of partners to be successful. I hope that you will join Oregon Public Health and do your part to implement this plan and help us achieve lifelong health for all Oregonians.

Mel Kohn, MD, MPH
Public Health Director and State Health Officer
Public Health Division
Oregon Health Authority

Public Health Leadership

Melvin A. Kohn, MD, MPH
Public Health Director and State Health Officer

Jean C. O'Connor, JD, DrPH
Deputy State Public Health Director

Katrina Hedberg, MD, MPH
State Epidemiologist and Chief Science Officer

Gail Shibley, JD
Administrator, Center for Health Protection
Senior Advisor for Environmental Health

Michael R. Skeels, PhD, MPH
Acting Administrator, Center for Public Health Practice
Administrator, State Public Health Laboratory

Bruce Gutelius, MD, MPH
Acting Administrator, Center for Prevention and Health Promotion
Deputy State Epidemiologist

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Introduction

Although the United States spends more than any other industrialized country in the world on health care, it ranks among the worst for health outcomes. This is because less than 10 percent of a person's overall health can be attributed to health care; most of what enables people to become or stay healthy is the social and physical environment in which they live. This means no amount of health care alone can ensure good health: preventing injuries and disease, and promoting "a state of complete physical, mental, and social well-being," is essential to achieving better health.

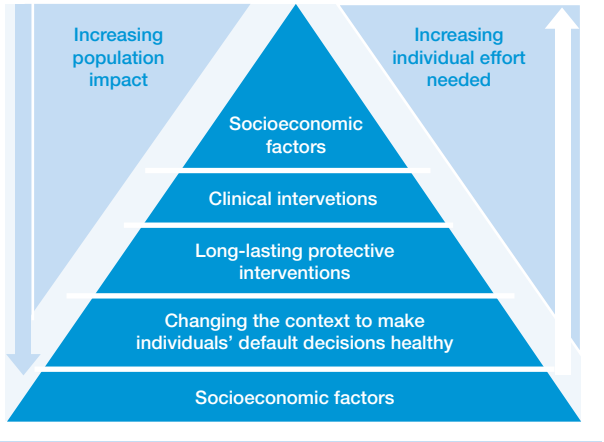
Primary prevention — this approach to preventing poor health before it happens and promoting good health — involves more than just telling people how to be healthy. It includes changing the environments in which they live, learn, work, and play so that the physical environment is a healthy one and so that the social environment enables people to make healthy choices.

For example, a healthy physical environment for a middle-school child could include clean drinking water, a route to school with crosswalks, a school free from lead paint, and a home without allergens that trigger asthma. A healthy social environment for that same child would include a helmet law that made it the norm for her to wear her bike helmet while riding to school, choices for lunch at school that align with nutrition guidelines, school policies that prevent her from being exposed to food marketing when making those lunch choices, a safe place to play after school, a medical home that screens her for tobacco use, obesity and sexual activity, and a family that eats dinner together.

Investing in preventing the causes of poor health and promoting and protecting good health pays.

According to the U.S. Centers for Disease Control and Prevention, some of the greatest return on investments in public health in the past decade include: immunization; tobacco control; folic acid fortification of foods; eliminating lead-based products in the environment; and, preparedness for pandemic influenza. Each of these interventions has saved society billions of dollars. And, each one has permanently changed the context and norms of the physical or social environment, which is the most effective way to reach the largest number of people (Figure 1).

The health impact pyramid



[1]*Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.*

Oregon's public health system

Oregon's public health system works every day to prevent disease and injury and promote and protect health. This work is carried out through a collaborative system of federal, state and local agencies, private organizations and communities and diverse partners working together to protect and promote the health of Oregonians.

Public Health Division

As the state's primary locus for public health leadership, the Public Health Division ensures Oregon's public health system carries out the three core functions of public health, as defined by the Institute of Medicine — 1) assessment of the public's health through data collection and investigations of diseases and injuries; 2) development of policies and programs that support improved health outcomes; and 3) assurance that those programs and policies are being implemented.

To carry out these functions, the Public Health Division is comprised of three Centers overseen by an Office of the State Public Health Director. The Office of the State Public Health Director provides public health policy and direction to the public health programs within the Division, and ensures that the disparate programs within and outside the Division create an effective and coherent public health system for the state. The Center for Health Protection provides a consistent, strong approach to protecting health. Programs in this Center touch every hospital, drinking water system, and restaurant in Oregon. The Center for Prevention and Health Promotion houses community-oriented prevention and clinical prevention services, working with community partners, health care providers, and Coordinated Care Organizations.

The Center for Public Health Practice houses programs that work with local public health authorities, particularly related to communicable disease control. .

Two broad and long-standing areas of public health practice — maternal and child health and environmental health — are woven throughout this structure, which took effect July 1, 2012. This structure enables the Public Health Division to achieve its vision, mission and goals while supporting the broader efforts of health care transformation and creates a structure that can support emerging areas of importance, such as human exposures to toxins.

Oregon Health Authority

Oregon's Public Health Division (PHD) is housed within the Oregon Health Authority (OHA), which is the organizational home for most of the state government's health care programs, including Medical Assistance Programs (i.e., the Oregon Health Plan), Healthy Kids, Pharmacy Services, and Addictions and Mental Health Programs.

OHA is the organization at the forefront of lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians. OHA's vision is a healthy Oregon and its mission is *helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care*. OHA is working to fundamentally improve how health care is delivered and paid for, but because poor health is only partially due to lack of medical care, OHA will also be working to reduce health disparities and to broaden the state's focus on prevention.

County health departments and health districts

A strong partnership between the Public Health Division and Oregon's 34 county health departments and health districts is critical to the effectiveness of the public health system. The Public Health Division operates some statewide programs directly, while others are delivered through county health departments and health districts, which have the statutory authority to protect the public's health in their jurisdictions. For those public health services delivered by county health departments and health districts, the Division provides partial funding, technical support and oversight. .

Rationale for the strategy

The foundations of the modern public health system in Oregon were laid when infectious disease outbreaks — smallpox, bubonic plague and tuberculosis — prompted the Legislature to create a State Board of Health, public health laboratory, a vital statistics registry and county boards of health. Since then, the Public Health Division has provided leadership and support to the state as it has faced a wide range of health issues. New and old risks are a constant threat to the public's health in Oregon, including SARS, West Nile virus, pandemic flu, whooping cough, tuberculosis, global climate change, and E. coli. These risks increase the need for disease surveillance, public education and preparedness.

However, today, the greatest challenges facing Oregonians are not rare illnesses, but the increasing impact of chronic disease and injuries. More than 85 cents on every dollar spent on health care is spent on the treatment of chronic diseases, a system of care we can no longer afford. Improvements in life expectancy and health experienced in the last decade have stalled and tobacco, obesity, and suicide are the three leading causes of death in Oregon. And, injury is the number one leading cause of death for children and young adults.

The emergence of the Coordinated Care Organizations, the Governor's 10-Year Plan for Oregon, and a focus on education outcomes provide a window of opportunity to focus the work the Public Health Division to achieve sustainable and measurable improvements in population health in Oregon.

This public health strategy lays out a vision to embrace these opportunities to achieve lifelong health for all Oregonians by preventing the leading causes of injury, disease and death, and by promoting and protecting good health. The plan builds on the strengths of the Division in the areas of epidemiology, maternal and child health, and environmental health. It blends these strengths with the opportunities to work with emerging partners in the areas of transportation, health care, education, housing, and the private sector to implement community and clinical interventions that we know will work to make Oregon one of the healthiest states in the nation and a global leader in lower costs, better care, and better health.

Public Health Division's Vision, Mission and Values

Vision

Lifelong health for all people in Oregon.

In everything done by its programs and staff, the Public Health Division aims to achieve lifelong health for all people in Oregon. The Division has adopted the World Health Organization's definition of health — "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Lifelong health means from birth to death, and all the stages in between, including maternal and fetal health before, during and after pregnancy. All people in Oregon means all people inside the borders of the state, whether residents of the state or not and regardless of race, age, sex, ethnicity, national origin, sexual orientation, or familial status.

Mission

Promoting health and preventing the leading causes of death, disease and injury in Oregon.

In alignment with the Institute of Medicine's definition of public health, the Division seeks in all that it does not only to eliminate the causes of death, disease, and injury in Oregon, but also to promote systems and social and physical environments that "create the conditions that allow all people to be healthy." By promoting the conditions that give all people opportunities to control and improve their health and by seeking to reduce differences among populations in current health status, PHD supports the achievement of health equity as it is defined in the Ottowa Charter.

Values

The Public Health Division is committed to ensuring the Oregon Health Authority core values are demonstrated in its work.

Health equity

- Eliminating health disparities and working to attain the highest level of health for all people;
- Ensuring the quality, affordability and accessibility of health services for all Oregonians;
- Engaging underrepresented populations in the public health system through culturally specific and culturally competent approaches;
- Integrating social justice, social determinants of health, vulnerable populations, diversity and community;
- Protecting all individuals and communities in Oregon against the spread of disease, injuries and environmental hazards.

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[3] Institute of Medicine. The Future of Public Health. Washington, DC: The National Academies Press; 1988:19.

[4] World Health Organization. The Ottawa Charter for Health Promotion. Adopted on 21 November 1986.

Integrity

- Working honestly and ethically in our obligation to fulfill our public health mission;
- Ensuring responsible stewardship of public health resources.

Leadership

- Building agency-wide and community-wide opportunities for collaboration;
- Fulfilling an innovative vision of public health service;
- Championing public health expertise and best practices;
- Creating opportunities for individual development and leadership;
- Adhering to public health principles and standards.

Partnership

- Working with stakeholders and communities to protect and promote the health of all Oregonians;
- Seeking, listening to and respecting internal and external ideas and opinions;
- Optimizing resources and leadership;
- Achieving public health goals in collaboration with our partners;
- Exploring and defining the roles and responsibilities of public health staff and partners.

Service excellence

- Understanding and responding to Oregon's public health needs and the people we serve;
- Pursuing our commitment to innovation and science-based best practices;
- Fostering a culture of continuous quality improvement.

Strategic Challenges and Opportunities for Public Health

The challenges before public health in Oregon, as in states across much of the country, are profound. These include shifting demographics and causes of disease, the rising burden of chronic diseases, funding challenges, and changes in the health care system. Never before has Oregon faced such significant risks to its budget for health and at the same time had such profound opportunities to improve health and lower costs through the prevention of the leading causes of death, disease, and injury in the state. These challenges and opportunities are described in more detail below.

Challenges

Shifting demographics and causes of disease

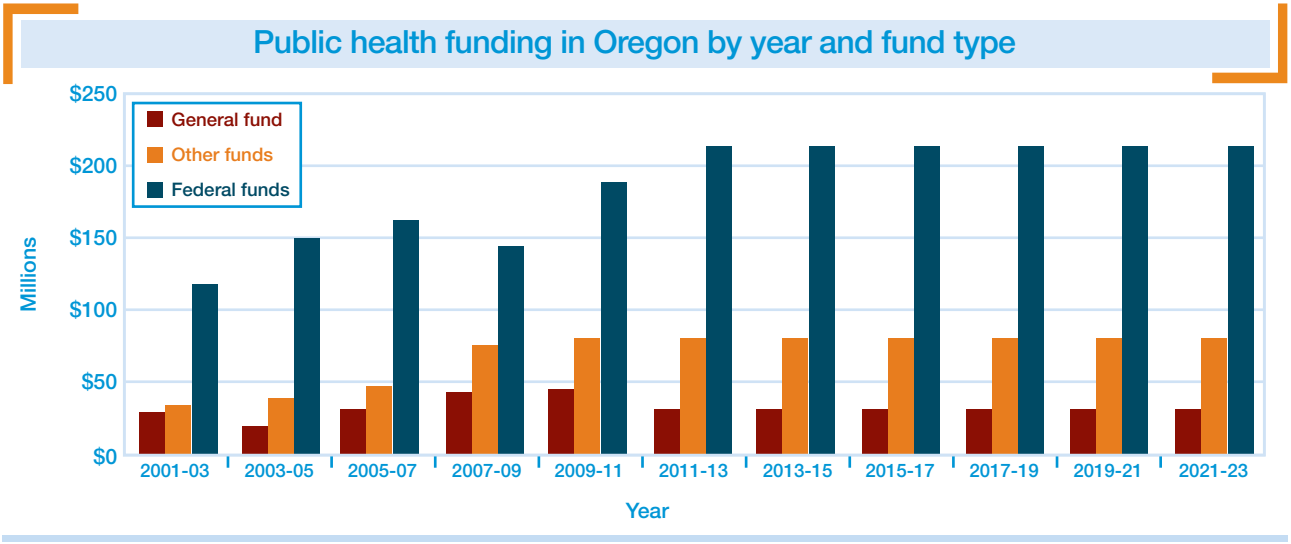
Oregon is a state of 3.8 million people. Our population grew by 12 percent between 2000 and 2010 (the national average for the same period was 9.7 percent). Oregon has an aging and increasingly diverse population. In 2010, approximately 14 percent of its population was over 65 years; by 2020, this is projected to increase to 20 percent. In 1990, Oregon's population was 90 percent white non-Hispanic, and in 2010 it was less than 80 percent. In 2010, 11.7 percent of the population was Hispanic, 3.7 percent Asian; 1.8 percent African American; 1.4 percent American Indian; and 3.8 percent more than one race.

In the early 20th century, public health was primarily focused on control of infectious diseases. In the last several decades, the causes of morbidity and mortality have shifted. Oregon, like other states, has witnessed a rise in the burden of chronic disease and injuries. While tobacco use in Oregon is low compared to other states, tobacco use remains a leading cause of illness and the leading cause of preventable death in Oregon. Oregon has dramatically high rates of obesity in all age groups; for example, more than 60 percent of adult Oregonians are overweight or obese. Cancer and heart disease rates, which are largely influenced by tobacco use and the prevalence of obesity/overweight, are two leading causes of premature death. Diabetes continues to affect more and more Oregonians. And, injury is the single leading cause of death in people under the age of 40, accounting for more than 23 percent of the years of potential life lost. Of note, suicide kills more people in Oregon than motor vehicle crashes.

State and federal fiscal pressures

The economic downturn has affected the public health system's ability to provide services and fund programs to support Oregonians in being healthy. As the graph below displays, currently less than 10 percent of the Public Health Division's budget comes from the state General Fund. Funding for public health services is heavily dependent on federal money. So, in a very real way the budget decisions made in Washington, D.C., affect the health of Oregonians.

[5] *Oregon Health Authority Public Health Division. Oregon State Health Profile. Portland, OR: Oregon Health Authority Public Health Division; 2012.*



Generally federal funding is directly tied to specific health issues and projects, making it difficult to provide core public health functions and address broad or multifaceted issues. Flexible funding streams are urgently needed to adequately address the health needs of our population and ensure that basic public health services are provided consistently, efficiently and equitably.

Stresses on the local public health system

Research shows that for each 10 percent increase in community-level public health spending, there are significant decreases in infant deaths (6.9 percent decrease), deaths from cardiovascular disease (3.2 percent decrease), deaths from diabetes (1.4 percent decrease), and deaths from cancer (1.1 percent decrease). And for every $1 invested in community-based prevention, the return is more than $5.

In Oregon, some key public health activities and programs are directly administered by the Public Health Division while others are delivered at the local level. The commissioners of each of the 36 counties serve as the local boards of health. To carry out this function, the counties maintain county health departments or health districts. Currently each county maintains a health department, except one group of three counties, which has formed a three-county health district, for a total of 34 county health departments or health districts in Oregon. County health departments and health districts are required by statute and rule to deliver a minimal set of services, and many provide additional programs for their communities. These agencies receive some state support, as well as bill for clinical services, receive grants and county general funds.

In the early part of 2012, four of the 34 local public health departments contacted the state regarding their fiscal solvency, raising the possibility that one or more local governments may not be able to support the delivery of local public health services in the future. This complex network of services is further tested by dramatic capacity variations across local public health departments, with a recent assessment of local public health capacity, using national standards, dem-

[6] *Mays GP, Smith SA. Evidence links increases in public health spending to declines in preventable deaths. Health Aff. 2011;30(8):1585-93.*

[7] *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities. Trust for America's Health, 2008.*

onstrating only 57 percent of the needed elements for a fully functioning local public health system. And, as health reform is implemented and there is a lesser need for safety net services in some populations, it is unclear if this change will increase or decrease the ability of local public health to deliver the minimum required services in Oregon and perform the three nationally recognized core functions of public health—assessment, assurance, and policy development.

Significant natural disaster or disease outbreak

Compared with many other states, Oregon has relatively few natural disasters or disease outbreaks. The state has routine but significant events, such as floods, wildfires, and outbreaks of diseases such as meningitis. However, Oregon does face several major threats that will be potentially catastrophic or highly disruptive, when they occur. These include a Cascadia Subduction Zone earthquake; a tsunami from an earthquake originating anywhere in the Pacific Rim; suburban wildfires, particularly in Central Oregon; a volcanic event, such as the eruption of Mt. Saint Helens; or a terrorism or bioterrorism incident. Due to its rural location in the western U.S., Oregon also has occasional outbreaks of rare but dangerous diseases, such as plague. With a major shipping port and international air traffic connecting Oregon to Asia, Australia and Europe, and with significant traffic from Mexico and Canada moving along the I-5 corridor, Oregon is also not immune from global and national threats such as pandemic H1N1 influenza.

Opportunities

10-year plan for Oregon

In August 2011, Governor Kitzhaber created the 10-Year Plan for Oregon initiative. PHD is actively engaged in the 10 year planning process in several outcome areas. The Healthy People objective for the state seeks to ensure that Oregonians are healthy and have the best possible quality of life at all ages. Health is also an important prerequisite for educational success. The Division supports the education outcome by ensuring that babies are born healthy and grow up ready to learn, and that adolescent health is supported and teen pregnancy is avoided so that kids stay in school. PHD programs also work closely with Oregon's natural resource agencies to help control zoonotic diseases and environmental human health risks.

Health care transformation in Oregon

In the last four years, the United States has seen unprecedented investment in prevention and wellness activities as part of federal health reform. This movement is also reflected in Oregon's pioneering health reform efforts. Governor John Kitzhaber played a key role in the creation of the Oregon Health Plan in the 1980s and health reform, embodied in Coordinated Care Organizations (CCOs), is one of his top two priorities. CCOs for Medicaid clients will operate under a global budget, be community-driven, and be held accountable for health outcomes. Eleven CCOs have been selected, and will begin serving 70 percent of the Medicaid population in August 2012. Public health is uniquely positioned to support prevention, particularly at the community level, as a tool to "bend the cost curve."

As costs for the health care system skyrocket, public health is a cost-effective means to promote health, improve care and lower costs by preventing the leading causes of death, disease and injury in Oregon.

[8] *McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Affairs. 2002;21(2):78-93.*

Today, medical care accounts for only about 10 percent of our health status, while lifestyle, behavior, environmental and social factors account for about 65 percent. The rest is hereditary.

Every successful public health program helps with key outcome measures in the 10-Year Plan including decreasing the tobacco use rate; improving health status; reducing per capita cost and chronic disease cost reduction; decreasing obesity among children and adults; shifting resources toward the prevention of chronic disease; and, ensuring access to sufficient, affordable, and nutritious food.

National public health accreditation

In September 2011, the Public Health Accreditation Board officially launched national public health accreditation. Accreditation provides public health departments an opportunity to measure their performance under a set of standards. As previously mentioned, Oregon's public health agencies are operating under drastically reduced capacity. While challenges exist around successfully completing the accreditation process, this new endeavor allows us to demonstrate the value of public health and prevention to Oregon's citizens and decision makers.

New emerging partners

As the health system, government, demographics, and leading causes of death and disease are changing, existing partners like county health departments and health districts, schools, the Oregon Master of Public Health degree program, and health care providers remain essential to the work of the Division. New partners are also emerging. These include the Oregon Education Investment Board, Oregon's first school of public health at Oregon State University, Coordinated Care Organizations, and the private sector. Identifying and building on emerging partnerships to lead across sectors and leverage the abilities of other organizations is critical to PHD's achievement of its vision.

Statewide Leadership and Implementation

Statewide leadership is essential to achieving the vision of lifelong health for all people in Oregon. Public Health Division leadership will ensure the focus on the strategic priorities in this strategy, help to align existing programs and policies, and catalyze coordinated action among partners. Full achievement of the goals and progress on the priority areas in this plan can only be achieved through partnership with local health departments, health care providers, education, the private sector, transportation, and many other organizations.

State-level leadership

The Public Health Division provides coordination and leadership at the state level essential to a common approach to promoting health and preventing the leading causes of death, disease and injury in Oregon. It provides guidance and funding to local public health and environmental health authorities, provides direct services to some stakeholder groups and areas of the state, supports state elected officials in decision making concerning health issues, and collaborates with other state agencies around how they can work together and independently to promote health.

Engage partners

The Division will ensure the ongoing engagement of current partners to better understand public health problems in Oregon, to identify solutions, and to work together to implement those solutions. A wide range of partners at the federal, state, local, and tribal levels are needed, and particularly partners across sectors such as education, housing, and transportation. PHD will work actively to foster new partnerships to carry out the goals in this strategy.

Innovation

The science that informs our understanding of the leading causes of disease, injury, and death is constantly evolving. The Public Health Division will continuously seek to innovate in its work, and to contribute to the evidence base for public health interventions, particularly in the priority areas. Where innovations are made by others inside or outside the state, the Division will provide statewide leadership in identifying and communicating about these developments, and by incorporating new approaches and science into its programs and policies.

Implementation and accountability

The Public Health Division will align its policies and programs with the priorities identified in this strategy. PHD will identify specific, measurable actions and timelines, and will determine accountability for meeting those timelines within and across Public Health Division programs. Within each priority area, the Division will identify champions and key partners, and work with those partners to assess the trajectory of priority areas, report progress, and document successes and lessons learned. By setting targets, and then measuring the

trajectory to achieve public health goals, leaders and policy makers can prioritize and allocate resources, anticipate improvement opportunities or changes needed to support goals, and better communicate and engage stakeholders and communities.

Assess shifts and trends in health outcomes

The public's health is in a constant state of change, as is the population itself. The Public Health Division will continuously measure the health status of the population of Oregon and the resources and systems that affect health through a statewide health assessment. The Division will also continuously monitor the policy, social, and physical environments that affect health.

Maintaining the Strategic Plan

Oregon's Public Health Strategic Plan is intended to serve as a living document. The Public Health Division will use all of the feedback loops of stakeholder engagement, partnerships, policy and program alignment efforts, and through the health assessment process to continuously refine and evolve this document.

Partnerships and Stakeholders

The engagement of stakeholders and the development of partnerships are essential to achieving the vision of lifelong health for all people in Oregon. This vision can only be achieved through the collective impact of a wide range of organizations and stakeholders, across multiple sectors.

Stakeholders

The stakeholders in public health programs are diverse. The Public Health Division maintains more than 120 programs serving more than 100 different identifiable stakeholder groups, including restaurants, hospitals, emergency medical technicians, drinking water system operators, persons with HIV, persons with chronic diseases, local health departments, elected officials, counties, business, people who drink water in the state of Oregon, schools, and health care providers, and many more. (See the Customer and Stakeholder Appendix for a full list of stakeholders and customers.) Fundamentally, however, PHD's work is focused on a single and critical stakeholder group — the people who live or visit Oregon.

Boards and committees

Individual stakeholder groups are represented on numerous boards and committees that provide input and advice to Public Health Division programs. Collectively, these stakeholders are represented on the Governor-appointed Public Health Advisory Board, which serves as a sounding board for the PHD Director and senior leadership. The Conference of Local Health Officials provides PHD with an important connection to the perspectives of local public health authorities.

Partnerships

Many things affect the health of people and achieving collective impact through partnerships is essential to the work of the Division. Key partners that support all aspects of the mission and vision of the Public Health Division include:

- Association of State and Territorial Health Officials;
- Centers for Disease Control and Prevention;
- Coordinated Care Organizations;
- Federally Recognized Tribes in Oregon;
- Northwest Portland Area Indian Health Board;
- Northwest Health Foundation;
- Oregon's Local Public Health Authorities (Conference of Local Health Officials)
- Oregon's Health Equity Coalitions;
- Public Health Alignment Workgroup Member Organizations.

These partners help PHD to set goals, share information, deliver programs, achieve health outcomes, and ensure funding and policies that support lifelong health for all

Oregonians. These partners help PHD to connect to all of the major geographic areas within the state and with major sub-groups within the state. These partners also connect PHD to the national level and connected with other states. PHD also has other partners that help it carry out its work in specific program and priority areas, and these partners are listed in subsequent sections of this document.

Public Health Goals

In order to move toward the vision of lifelong health for all people in Oregon over the next five years, the Public Health Division has established two goals. The first goal is focused on the health of the public. The second goal is focused on improving the public health system, which includes local public health authorities, health care providers, and new emerging partners. Achieving either goal would be a tremendous success for Oregon. Achieving both goals together will create a self-sustaining cycle of improvement in the health of the people of Oregon.

1. Making Oregon one of the healthiest states in the nation

   According to America's Health Rankings, Oregon ranked as the 15th healthiest state overall in 2011. The Public Health Division aims to make Oregon one of the top 10 healthiest states in the U.S. by 2017. To achieve this goal, Oregon must address the three leading causes of death in the state: tobacco use, obesity and overweight, and suicide. Oregon must also reduce heart disease and stroke, which results from tobacco use and obesity, and increase the ability to survive those conditions. And, Oregon must reduce family violence (child and intimate partner abuse), which along with causing immediate injury and psychological harm, is associated with the development of many chronic diseases later in life. Increasing Oregon communities' resilience to emergencies of all kinds also will help to make Oregon one of the healthiest states.

2. Making Oregon's public health system into a national model of excellence

   To fully achieve its vision of lifelong health for all people, Oregon's public health system must transform itself into a national model of excellence. A system that is a model of excellence will work with emerging health care partners, such as Coordinated Care Organizations (CCO), in new ways; ensure health in all policies; partner with the private sector and other agencies to perform health impact assessments; and maintain disease investigation and data collection capabilities that ensure an accurate picture of the health of the public in Oregon. Public health accreditation, which recognizes health departments that perform all of the core functions, is one mechanism Oregon will use to ensure the system conforms to national standards.

   The subsequent sections of this document lay out the priority areas of focus that will help PHD to achieve these two goals. Each priority area has a set of five-year targets designed to improve health outcomes, and strategies to support the achievement of targets.

[9] *America's Health Rankings Website. http://www.americashealthrankings.org/OR. Accessed 29 Aug, 2012.*

Strategic Priorities

The Public Health Division has established 11 priority areas. Key facts, background about evidence-based interventions, measurable changes in health outcomes, strategies for achieving those outcomes, and key partners are listed below for each priority area.

These priority areas support the goals, which in turn support the mission and vision of PHD and the Oregon Health Authority (see following figure). Each priority area was selected because it represents a unique opportunity to significantly influence the health status of the population, it is an area where there is a significant opportunity to make real progress over the next five years, and its relationship with the other priority areas. These areas are, in essence, potentially winnable battles.

Public Health Division programs and issues not identified as priorities in this document remain important, and will not stop simply because they are not identified as priorities. Although not listed here, nearly every program area in PHD contributes in some way to the priority areas.

Priority: Preventing tobacco use

Tobacco use remains the number one cause of preventable death in Oregon and nationally. Tobacco use kills about 7,000 Oregonians each year, and 800 additional deaths are caused by secondhand smoke. Oregon's public health system has made powerful inroads into addressing the harm caused by tobacco, but much remains to be done.

Key facts

In 2009 in Oregon:

- 18 percent of adults smoked cigarettes.
- 15 percent of 11th-graders smoked cigarettes.
- 10 percent of eighth-graders smoked cigarettes.
- 4 percent of adults used smokeless tobacco.
- 12 percent of 11th-grade boys used smokeless tobacco.

Tobacco use costs Oregon more than $2.4 billion in direct medical expenditures and indirect costs due to premature death. 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 per pack to society of $13.97.

Almost every chronic disease is either caused, or made worse, by tobacco. Chronic diseases account for approximately $0.85 of every $1.00 spent on health care costs. For Oregon to achieve success with health system transformation and the Triple Aim of better health and better health care at lower cost, Oregon must reduce tobacco use and exposure to secondhand smoke.

Approaches that work

We know what works to prevent people from starting to use tobacco, to protect others from second-hand smoke, and to help people quit. The World Health Organization's MPOWER Framework represents a comprehensive approach to tobacco control:

- **M**onitor tobacco use and prevention policies.
- **P**rotect people from exposure to secondhand smoke.
- **O**ffer help to quit tobacco.
- **W**arn about the dangers of tobacco.
- **E**nforce bans on tobacco advertising, promotion and sponsorship.
- **R**aise the price of tobacco.

Current Public Health programs and policies

The Public Health Division's Tobacco Prevention and Education Program (TPEP) is a comprehensive tobacco control program, working with county health departments and other partners to keep kids from starting to use tobacco and help tobacco users quit. TPEP pursues systemic changes that make tobacco use harder and quitting easier, and implements education campaigns warning Oregonians about the dangers of tobacco use and exposure to secondhand smoke. TPEP operates the Oregon Tobacco Quit Line to assist tobacco users who want to quit. Public health programs at the county and state level screen clients for tobacco use when receiving services, and assess and educate pregnant women who smoke. In addition, TPEP collects and analyzes data on tobacco use and exposure to secondhand smoke in order to improve programs and better target outreach and assistance.

[10] *Robert Wood Johnson Foundation. Making the Case for Ongoing Care, 2010. Available from: http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf.*

However, there is much more to do. Given the current limited funding for tobacco control, data on tobacco use among sub-populations are only collected and analyzed approximately every five years. Tobacco warning messages are aired only periodically. In most years, only about 7,000 tobacco users receive services from the Oregon Tobacco Quit Line, representing 1.2 percent of the smokers in the state.

Key documents

- Centers for Disease Control and Prevention's Best Practices for Comprehensive Tobacco Control Programs, October 2007.
- National Prevention Strategy: America's Plan for Better Health and Wellness.
- Oregon Tobacco Facts and Laws. The Community Preventive Services Task Force, The Guide to Community Preventive Services on Reducing Tobacco Use and Secondhand Smoke Exposure.
- The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. 2007.
- Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General, 2012.

Strategies for change

1. Increase the price of tobacco products, with a portion dedicated to a comprehensive tobacco control program.
2. Increase the number of environments where we live, work, learn, and play where tobacco use is prohibited.
3. Reduce tobacco use initiation through hard-hitting, evidence-based, counter tobacco advertising campaigns including broadcast, print, point of sale, and social media.
4. Collect and analyze data on the prevalence of tobacco use across the population and among sub-populations and monitor state and local policies for tobacco control.

Key partners

- American Cancer Society
- American Heart Association
- American Stroke Association
- American Diabetes Association
- American Lung Association of Oregon
- Americans for Nonsmokers' Rights
- Campaign for Tobacco-Free Kids
- Coordinated Care Organizations
- Healthy Communities Coalitions
- Tobacco Prevention and Education Coalitions

Five-year targets

- Reduce adult smoking prevalence to 15 percent or less, resulting in 148,000 fewer adult smokers and a cumulative savings of $2.2 billion in future health costs.
- Eleventh grade smoking prevalence will be reduced to 7.5 percent or less. Eighth grade smoking prevalence will be reduced to 5 percent or less.
- Fewer than 22 packs of cigarettes per capita will be sold in Oregon each year.
- Tobacco use will be prohibited at all state- and county-owned campuses, all residential treatment facilities for people receiving mental health or addictions

treatment, all CCO campuses, all state and county parks and all public housing facilities in Oregon.

- The average price of a pack of cigarettes in Oregon will be at least $7 and there will be corresponding percentage increases for other tobacco products.
- A sustainable, evidence-based tobacco prevention and education program will be supported through a combination of Tobacco Master Settlement Agreement (TMSA funds and tobacco taxes.
- Oregonians on Medicaid who use tobacco will have access to evidence-based help to quit and will be encouraged by health providers and their CCOs to quit using tobacco.
- At least 5 percent of Oregon's tobacco users will register for help with the Oregon Tobacco Quit Line.

Priority: Decreasing obesity /overweight

Obesity is the number two cause of preventable death in Oregon and nationally, 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 eighth-graders and 55 percent for 11th-graders. Since 1990, Oregon's adult obesity rate has increased 121 percent. Preventing obesity among Oregonians 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 they face a lifetime of health consequences.

Key facts

In Oregon in 2009:

1. 60 percent of adult Oregonians were overweight or obese:
   - 26 percent of adults met recommendations for fruit and vegetable consumption;
   - 57 percent of adults met minimum recommendations for physical activity;
   - 73 percent of adults with a history of heart attack were overweight or obese.
2. 27 percent of eighth-graders were overweight or obese:
   - 21 percent of eighth-graders drank seven or more soft drinks a week;
   - 27 percent of eighth-graders played video games, computer games or used the Internet for non-schoolwork for three or more hours in an average school day.
3. 24 percent of 11th-graders were overweight or obese:
   - 19 percent of 11th-graders drank seven or more soft drinks a week;
   - 12 percent of 11th-graders 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 than those of people who are not obese.

Approaches that work

To reduce obesity, Oregon must take a comprehensive approach. The same framework for addressing tobacco use also applies to obesity and overweight:

- **Monitor** obesity, obesity-related diseases and healthy eating and active living policies.
- **Promote** healthy eating and active living.
- **Protect** people from unhealthful foods and beverages, and unsafe places for physical activities..
- **Offer** support for people to manage their weight.
- **Warn** about the dangers of sugary beverages and other unhealthful foods.
- **Enforce** laws that enable healthy eating and active living.
- **Raise** the price of unhealthful foods, and lower the price of healthful foods.

Current Public Health programs and policies

The Public Health Division currently does not have funding to support a comprehensive obesity prevention and education program. However, by leveraging existing programs, obesity prevention approaches are included in various PHD goals including, but not limited to, WIC services, Healthy Communities funding for counties and tribes, the Healthy School Initiative, and Health Impact Assessments. In addition, PHD collects and analyzes data on obesity, obesity-related diseases and risk factors. Data are used to improve programs and prioritize areas of focus.

Key documents

- Keeping Oregonians Healthy: Preventing Chronic Diseases by Reducing Tobacco Use, Improving Diet, and Promoting Physical Activity and Preventive Screenings.
- Oregon Overweight, Obesity, Physical Activity and Nutrition Facts.
- Oregon SB 931: Task Force for a Comprehensive Obesity Prevention Initiative: Policy Recommendations (2007).
- Promoting Physical Activity and Healthy Eating among Oregon's Children: A Report to the Oregon Health Policy Commission.
- National Prevention Strategy: America's Plan for Better Health and Wellness.
- Strategic Plan to Slow the Rate of Diabetes in Oregon: A Report to the 2009 Oregon Legislature from the HB 3486 Advisory Committee.
- The Guide to Community Preventive Services.

Strategies for change

- Establish a comprehensive obesity prevention and education program.
- Increase the price of sugary beverages with a portion dedicated to a comprehensive obesity prevention and education program.
- Collect and analyze data on the prevalence of obesity and obesity-related diseases and risk factors across the population and among sub-populations and monitor state and local policies for obesity prevention, healthy eating and active living.
- Collaborate with childcare, schools, worksites, health systems, and state and local governments to adopt and implement standards for nutrition (including breastfeeding and restrictions on sugary beverages and unhealthful foods), physical activity and screen time.
- Collaborate with other state agencies to ensure obesity prevention and education approaches that work are integrated into statewide initiatives, including health system and education transformation, and transportation and planning priorities.
- Support birthing hospitals seeking Baby Friendly certification.
- Warn of the dangers of sugary beverages through hard-hitting, evidence-based, advertising campaigns including broadcast, print, point of sale, and social media.
- Increase state and local capacity to effectively enforce laws that promote healthy eating and active living and restrict unhealthful foods and beverages.

Key partners

- American Cancer Society
- American Heart Association
- American Stroke Association
- American Diabetes Association
- Coordinated Care Organizations
- Healthy Communities Coalitions
- Nutrition Council of Oregon
- Oregon Academy of Nutrition and Dietetics
- Oregon Department of Education
- Oregon Department of Transportation
- Oregon Public Health Institute
- Upstream Public Health
- Northwest Health Foundation

Five-year targets (2017)

- Increase the percentage of adults who meet CDC-recommended physical activity guidelines to 75 percent.
- Adult obesity prevalence will be 30 percent or less.
- Eleventh grade obesity prevalence will be 10 percent or less, and eighth grade obesity prevalence will be 11 percent or less.
- Greater than 84 percent of babies born in Oregon will have a birth weight in the normal range.
- Greater than 50 percent of women will have a healthy pregnancy weight.
- All government employers offer weight management and chronic disease self-management programs as a covered benefit to employees and dependents.
- Increase the percentage of eighth-graders who consume five or more fruits and vegetables a day to 30 percent.
- Reduce food insecurity to less than 20 percent in households with children.
- All state agencies, county governments, CCOs, hospitals, childcare facilities, and schools implement standards for nutrition (including breastfeeding) and physical activity to benefit employees, clients, students and patients.
- All birthing hospitals in Oregon will be certified as Baby Friendly.

Priority: Reducing suicide

Suicide is a much more common problem than most people realize. It is among the top 10 causes of death for Oregonians. Oregon has more deaths from suicide each year than from motor vehicle crashes. A person's risk of suicide increases with age, and the highest rates in Oregon occur among men above age 65. Rates among middle-aged women have been increasing the fastest in recent years. Suicide rates vary among different racial and ethnic groups, and are highest among whites and Native Americans. The strongest predictor of dying by suicide is having attempted suicide in the past. Because of this high risk level, and because even failed suicide attempts are associated with significant suffering and injury, attempters are also an important group of focus for suicide prevention efforts.

Key facts

- Each year in Oregon there are more than 600 deaths by suicide and more than 1,800 hospitalizations for suicide attempts. Nearly two people die every day by suicide in Oregon.
- In 2010, 7 percent of eighth-graders and 0.5 percent of adults reported having made a suicide attempt in the past year.
- In 2010, 14 percent of eighth-graders and 4 percent of adults ages 18 and older report having had serious thoughts of suicide during the past year.
- The rate of suicide among Oregonians has been increasing since 2000, and is higher than national rates.
- One in four suicides in Oregon occurs among veterans.

Approaches that work

Individual mental health treatment alone will not address the problem of suicide. Over the last few decades the number of adults in the United States taking antidepressant medication has increased dramatically. Today, almost one in five adults takes these medications. Over this same period, however, rates of suicide have continued to increase.

Instead, concerted focus on the social and environmental forces that contribute to suicide are needed. Social connectedness is an important potentially modifiable influencer of the individual factors contributing to suicide. The Adverse Childhood Experiences Study[11] has also found that almost two-thirds of suicide attempts could be attributed to having had several adverse experiences as a child. Adverse childhood experiences included in this study were: psychological, physical, or sexual abuse; violence against mother; and living with household members who were substance abusers, mentally ill or suicidal, or had ever been in the correctional system. These findings suggest that prevention of childhood exposure to these experiences, or interventions that minimize the impact of these exposures could have a dramatic impact on the incidence of suicide.

The U.S. Surgeon General and the Action Alliance for Suicide Prevention have identified the following four priorities to prevent and reduce suicide:

1. Integrate suicide prevention into health care reform;
2. Transform health care systems to reduce suicide;
3. Change the public conversation about suicide and suicide prevention;

[11] *Adverse Childhood Experiences Study Website, http://www.cdc.gov/ace/index.htm. Accessed September 17, 2012.*

4. Increase the quality, timeliness, and usefulness of surveillance data regarding suicidal populations.

Current Public Health programs and policies

The Public Health Division conducts surveillance on suicide and suicide attempts statewide, analyzes and disseminates data to the public, policy makers, and the media. The Division also maintains a listserv to inform members about data reports, training opportunities, research, education, available resources, grants, conferences, and other relevant information. In addition to a network of 21 school-based health centers, PHD maintains a group of 100 suicide intervention skills trainers who provide training and information in their communities. Culturally appropriate interventions are assured through engagement with the tribes and Latino communities. Nineteen Oregon counties have a prevention strategy that includes school-based programs, intervention skills, public education, emergency room intervention, and coalition building.

Key documents

- Suicide trends and risk factors: Oregon Five Year Retrospective.
- Oregon Youth Suicide Prevention Plan.
- Oregon Older Adult Suicide Prevention Plan.
- Oregon Injury Prevention Plan.
- The National Strategy for Suicide Prevention.

Strategies for change

1. Prevent the risk factors associated with suicide.
    - Work with the Early Learning Council to expand and enhance home visiting programs throughout the state.
    - Partner with schools to implement a coordinated and comprehensive school health approach that supports the social, emotional and behavioral health of students.
    - Promote adoption of evidence-based suicide prevention in community and health care settings.
    - Integrate suicide prevention into PHD's Healthy Communities program, with particular focus on worksite wellness efforts, and help market worksite wellness with business leaders.
    - Integrate suicide prevention into state-sponsored services delivered to older adults.
    - Expand "gatekeeper" training to other groups who interact with those who may be at high risk for suicide.
2. Improve the quality of care for people at risk of suicide
    - Increase the number of emergency departments educating families and caregivers of a person with suicidal ideation or attempts about the need to restrict the means to commit suicide (e.g., securing firearms, prescription drugs, and alcohol) in the home.
    - Include robust suicide prevention in Oregon's early psychosis intervention programs and take those programs to scale across the state.
3. Expand and enhance suicide-related data, including attempts, and surveillance to include all age groups
    - Plan, write and disseminate regular surveillance reports on suicide to

policy makers, health care providers and the general public.

- Collect better data. Work with the State Medical Examiner to improve data collection on suicide deaths to better inform prevention efforts.

Key partners

- Coordinated Care Organizations
- Healthy Communities Coalitions
- Hospital emergency departments
- Local public health and addictions and mental health services authorities
- Local school districts

Five-year targets

- Zero suicides;
- Increase to 50 percent the number of schools integrating evidence-based practices that support the social, emotional and behavioral health of students;
- Reduce the percentage of eighth-grade youth who report unmet mental health needs to less than 10 percent;
- Reach 100 percent of high-risk children with home visiting programs;
- Ensure 100 percent of Healthy Communities Coalitions have integrated suicide prevention into their work.

Priority: Heart disease and stroke

Cardiovascular disease, including heart disease and stroke, is the leading cause of death in Oregon and nationally largely due to the leading risk factors of tobacco use and obesity. Survivors of heart attack and stroke experience disability and decreased quality of life. Fortunately, cardiovascular diseases are among the most preventable conditions. The leading modifiable risk factors for heart disease and stroke are high blood pressure; high cholesterol; cigarette smoking or secondhand smoke exposure; diabetes; diet; physical inactivity and overweight and obesity.

Key facts

In 2009 in Oregon:

- 26 percent of all Oregon deaths were caused by heart disease and stroke.
- 4 percent of Oregon adults (an estimated 117,000 people) reported ever having a heart attack in their lifetimes, and 3 percent (an estimated 88,000 people) reported ever having a stroke.
- 25 percent of adults reported having high blood pressure.
- 31 percent of adults reported having high cholesterol.
- 8 percent of adults reported having diabetes.
- 60 percent of adults were overweight or obese.
- 27 percent of eighth-graders were overweight or obese.
- 24 percent of 11th-graders were overweight or obese.
- 18 percent of adults smoked cigarettes.
- 11 percent of adults had high blood pressure, high cholesterol and were overweight or obese.
- 77 percent of adults had at least one of the primary risk factors for heart disease and stroke (i.e., high blood pressure, high cholesterol, overweight or obese, or current cigarette smoking).

Heart disease and stroke are among the most widespread and costly health problems in Oregon. In 2011, there were 5,990 hospitalizations due to heart attack and 8,743 hospitalizations due to stroke in Oregon. The average cost of a heart attack hospitalization was $43,964 and the average cost of a stroke hospitalization was $30,479. In 2011, heart attack and stroke accounted for more than $540 million in health care expenditures in Oregon.

Approaches that work

Creating heart-healthy environments can help reduce the burden of heart disease and stroke. This comprehensive, community-based framework for the prevention of heart disease and stroke is known as the ABCS:

- Aspirin: Increase low-dose aspirin therapy according to recognized prevention guidelines.
- Blood pressure: Prevent and control high blood pressure; reduce sodium intake.
- Cholesterol: Prevent and control high blood cholesterol; reduce artificial trans fats intake.
- Smoking: Reduce smoking and tobacco use; eliminate exposure to secondhand smoke; prevent youth initiation; increase access to cessation resources for adults and youth.

Current Public Health programs and policies

The Public Health Division's Heart Disease and Stroke Prevention (HDSP) Program works in an integrated fashion with other chronic disease programs, including Healthy Communities, Living Well with Chronic Conditions, Tobacco Prevention and Education Program, WISEWOMAN, Wellness@Work, sodium reduction, emergency response, and health system transformation. Across PHD, heart disease and stroke prevention initiatives aim for systemic changes that promote the ABCS. The Division collects and analyzes available data on heart disease, stroke, and related risk factors, and uses these data to focus interventions.

Key documents

- Institute of Medicine Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension.
- Institute of Medicine Strategies to Reduce Sodium Intake in the United States.
- National Prevention Strategy.
- The Community Preventive Services Task Force, Guide to Community Preventive Services.
- The U.S. Preventive Services Task Force, Guide to Clinical Preventive Services.

Strategies for change

In addition to the work to address tobacco and obesity and overweight, which will also reduce the incidence of heart disease and stroke, PHD will seek to:

1. Promote the adoption and implementation of evidence-based nutrition standards in all publicly funded educational, work, and health care environments (e.g., state agencies, county governments, hospitals, childcare facilities, and schools).
2. Reduce sodium and artificial trans fats in the Oregon food supply.
3. Strengthen statewide coordinated systems of care for stroke and cardiac emergency patients.
4. Establish mechanisms to monitor emergency cardiac and stroke care and outcomes in Oregon.
5. Improve access to recommended clinical screenings and services for all Oregonians, including:
    - Assessment and monitoring of all patients in Patient-Centered Primary Care Homes for body mass index, tobacco use status, aspirin use, and blood pressure and cholesterol control;
    - Chronic disease self-management programs that maximize health outcomes and reduce avoidable health care costs related to cardiovascular disease and risk factors;
    - Free risk factor screening and referral to lifestyle intervention programs for uninsured or underinsured women and men between the ages of 40 and 64.

Key partners

- American Heart and Stroke Association
- American Lung Association of Oregon
- Campaign for Tobacco-Free Kids
- Coordinated Care Organizations
- Emergency Medical Services providers and organizations

- Healthy Communities Coalitions
- Tobacco Prevention and Education Coalition
- Acumentra Health
- Living Well Network
- Oregon State University Food Innovation Center
- Oregon Department of Education

Five-year targets*

- Reduce the rate of heart attack hospitalization among Oregon adults aged 74 or younger to 135/100,000.
- Achieve nutrition policies in 100 percent of state and county worksites and childcare facilities.
- Five Oregon bread manufacturers will reduce sodium in bread products.

** All tobacco and obesity targets are applicable to heart disease and stroke.*

Priority: Community resilience to emergencies

Public health emergencies can include natural, biological, chemical, radiological, and nuclear incidents. Since 2005, public health agencies across the nation have responded to emergencies including anthrax, SARS, pandemic influenza and radiation from the 2011 Japan tsunami. Community resilience is the sustained ability of communities to withstand and recover from adversity. Resilient communities include healthy individuals, families, and communities with access to health care, both physical and psychological, and with the knowledge and resources to know what to do to care for themselves and others in both routine and emergency situations. Community resilience to emergencies ensures the ability of the public health system, the behavioral health system, the health care community, and individuals to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those in which scale, timing, or unpredictability threatens to overwhelm routine capabilities.

Key facts

Since 1955 there have been 43 declarations made in support of county, tribal or statewide emergency, fire management assistance, or major disasters in Oregon. These declarations range from: fires, wildfires, severe storms, flooding, winter storms, earthquakes, mudslides/landslides, coastal storms, drought, tornado, and tsunami.

Before, during, and after an incident, communities may have needs in one or more of the following areas: communication, medical care, maintaining independence, supervision, and transportation. In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Act (i.e., children, senior citizens, and pregnant women), individuals who may need additional response assistance include those who have disabilities, live in institutionalized settings, are from diverse cultures, have limited English proficiency or are non-English speaking, are transportation disadvantaged, have chronic medical disorders, and have pharmacological dependency. The Public Health Division is particularly concerned with the ability of communities to meet the needs of these high-risk populations and the ability of communities affected by an emergency to demonstrate resilience.

Approaches that work

The National Health Security Strategy sets out a vision for community resilience, built on a foundation of healthy individuals, families, and communities with access to health care and with the knowledge and resources to take care of themselves during emergencies. Ensuring healthy communities with policies and programs that promote overall health and social cohesion is critical to establishing and ensuring community resilience. The national whole of community approach to preparedness and response is essential to meeting the needs of vulnerable populations before, during and after an emergency.

Current Public Health programs and policies

In Oregon, current community resilience efforts include:

- Robust laboratory testing that enables public health to investigate and respond to threats in a more timely way.
- 24-7 responsiveness of the public health system so that when someone

calls the health department during an emergency there is someone to answer and provide help.

- Communications hardware, software and training to provide accurate and timely information to the public.
- The ability to use the incident command structure so public health can quickly and effectively communicate with partners in other agencies and use the state and local emergency management systems.
- The capacity to monitor health care system capacity and needs so that lifesaving resources in short supply during an emergency can be targeted to where they are needed most.
- Funding local public health authorities to maintain public health emergency response capabilities.
- Recruitment of medical volunteers for the State Emergency Registry of Volunteers in Oregon.

Key documents

- Center for Disease Control and Prevention Office of Public Health Preparedness and Response Strategic Plan.
- Oregon Public Health Division's Emergency Operations Base Plan.
- Oregon's Health Security, Preparedness and Response 2011 Strategic Plan.
- National Health Security Strategy.
- Presidential Policy Directive 8.

Strategies for change

1. Foster informed, empowered individuals and communities prepared for emergencies.
2. Sustain the workforce needed to respond to public health emergencies.
3. Promote the whole of community approach to preparedness, response, and recovery.
4. Ensure integrated, scalable health care delivery systems, including mental health systems.
5. Ensure timely, culturally appropriate, and effective risk communications, particularly with vulnerable populations.
6. Support community efforts to enhance individual preparedness and social cohesion through the use of social networking tools, informational and educational campaigns and incentives.

Key partners

- Oregon State Hospital
- Oregon Association of Hospitals and Health Systems
- Oregon Emergency Management
- Oregon Department of Human Services
- Oregon Department of Transportation
- Oregon Drinking Water System Operators
- Oregon National Guard
- Oregon Partnership for Disaster Resilience
- Oregon State Police
- Local Emergency Managers
- Local Medical Health and Substance Abuse Authorities
- Local and Regional Planning Commissions and Agencies

Five-year targets

- Implement a plan based on an assessment of public health, medical, and mental/behavioral health services available in the state to enhance community resilience.
- Behavioral health is fully integrated into the Health Security Preparedness and Response (HSPR) program response evidenced by 100 percent participation in all phases of the disaster/emergency cycle.
- Audit the SERV-OR volunteer pool and create at least three behavioral health strike teams.
- Ensure behavioral health representation with every state-deployed strike team during a declared disaster.
- All local public health jurisdictions in Oregon will have the capability to utilize risk communications tools and social marketing to foster community resiliency.

Priority: Preventing family violence

Family violence is both a substantial public health issue in its own right, and a major "upstream" driver for many very costly and debilitating physical and mental health problems. Because of its broad impact, family violence not only adversely affects the health of Oregonians, but also drives the need for many other services delivered through the criminal justice, corrections, education and social service systems. Public health has a unique and potentially powerful role to play in strengthening the work of these other systems: describing the extent of, and risk factors for, family violence through public health surveillance, supporting the development and implementation of policies and programs based on what the data tell us, and evaluating the effects of those policies and programs.

Key facts

The Adverse Childhood Experiences Study (ACES)[12] has demonstrated the far-reaching effects of family violence (as well as other adverse events), including its link with depression, suicide, substance abuse, obesity, heart disease and other ailments later in life.

Family violence affects many Oregonians.

- One in 10 Oregon women (over 85,000 women) age 20-55 report that their current or most recent intimate partner had physically or sexually assaulted them in the preceding five years.
- Although substantial numbers of both men and women experience intimate partner violence, a woman's risk of serious injury or death from intimate partner violence is four to 14 times higher than a man's risk.
- One in three women who have experienced intimate partner violence report that a child witnessed a physical assault, and one in five witnessed a sexual assault in the previous five years. This exposure to violence puts these children at risk for physical, behavioral, and emotional problems.
- In 2010, more than 11,000 children were determined by the Department of Human Services to be victims of child abuse or neglect. On an average day in 2010 almost 9,000 Oregon children spent at least one day in some kind of foster care. Threat of harm to the child (50% of cases) and neglect (31% of cases) were the most commonly identified types of maltreatment confirmed for these children.
- The number of reports of child maltreatment received by the Department of Human Services has almost doubled over the last decade.
- The most common family risk factors identified in confirmed cases of child abuse or neglect were parental drug or alcohol use (44% of cases), intimate partner violence (33% of cases) and parental involvement with law enforcement (27%).
- In 2010, the Department of Human Services investigated almost 6,000 complaints of abuse involving persons above age 65, including allegations of financial exploitation, neglect, abandonment, physical abuse, sexual abuse, and verbal abuse. Of these, almost 1,700 were substantiated. Family members were the most frequent perpetrators of these incidents.

[12] *Adverse Childhood Experiences Study Website, http://www.cdc.gov/ace/index.htm. Accessed September 17, 2012.*

Approaches that work

The term "family violence" encompasses violence involving children, parents, intimate partners and elders. Family violence includes not only physical violence or neglect, but also psychological and sexual violence as well as threats of violence; often the most devastating impacts of family violence are mental health ones.

Violence affecting these groups often co-occur within a family and also share several underlying drivers or risk factors, such as inability to manage anger in nonviolent ways, drug or alcohol use, and the intergenerational transmission of violent behavior patterns. The co-occurrence of violence affecting more than one group within a family and the presence of these common drivers is part of the rationale for grouping family violence together as a priority area for public health action. By focusing on the family, rather than just a specific form of violence, such as child abuse, and by addressing the underlying common drivers for several kinds of violence, public health approaches can efficiently help address this problem.

Another hallmark of the public health approach to family violence is the framing of the problem as one substantially caused (or at least contributed to) by physical and social environments, rather than solely an individual problem or a moral failing. This is analogous to the non-judgmental way public health approaches communicable or chronic diseases.

Public health approaches that work to reduce family violence include:

- Assessing the scope of the problem in a community through data collection and public health surveillance.
- Multi-disciplinary reviews of child deaths and deaths caused by intimate partner violence to uncover the root causes of those deaths, including where existing systems have failed, and to build political will for policy change to address those system failures.
- Changing social norms around healthy communication within intimate relationships, masculinity, and gender roles to reduce sexual violence.
- Promoting effective parenting, through programs such as nurse home visiting.
- Inquiring about family violence during well-child and prenatal care visits to health care providers, and ensuring appropriate follow up.
- Policies and environmental changes that reduce alcohol and substance abuse.

Key documents

- Recommendations to Prevent Sexual Violence.
- Oregon Violence Against Women Prevention Plan.
- Oregon Youth Sexual Health Plan.

Strategies for change

1. Assess gaps in public health surveillance for family violence, and develop and implement a plan to address those gaps.
2. Promote the adoption by Coordinated Care Organizations of evidence-based screening, counseling, referral and care coordination related to family violence.
3. Work with the Early Learning Council to take home visiting programs to scale.
4. Ensure statewide leadership on the issue of family violence:
   - Inventory the multi-agency task forces

and committees already in existence related to family violence, ensure that public health is appropriately participating, and get input from partners on the task forces about plans for surveillance reports;

- Collaborate with the Drug and Alcohol Policy Commission to address the contribution of drug and alcohol use to family violence;
- Create a proposal for a Family Violence Task Force for consideration by Oregon Health Authority leadership and the Governor's Office.

5. Create a prioritized list of policy changes that could reduce family violence, and create a work plan to accomplish the top three.
6. Evaluate the effectiveness of current screening and referral practices during the Women, Infants and Children visit and develop recommendations for improvement; explore other ways that the WIC visit could be used to address family violence.

Key partners

- County health departments
- Coordinated Care Organizations
- Healthy Communities Coalitions
- Oregon Department of Human Services
- Oregon Department of Justice
- Oregon Child and Domestic Violence Fatality Review Teams
- Health care and hospital services and associations

Five-year targets

- Produce annual surveillance reports related to family violence.
- Establish statewide leadership on the issue of family violence.
- Reduce deaths due to family violence (intimate partner violence [IPV], child physical abuse, elder physical abuse).
- Reduce the number of children scoring greater than 2 on the ACES scale.

Priority: Supporting Coordinated Care Organizations (CCOs)

A CCO is a network of health care providers and community organizations who have agreed to work together in their local communities to serve people who receive health care coverage under OHP (Medicaid). CCOs are accountable for the health outcomes of the populations they serve.

PHD can support CCOs in achieving the Triple Aim of better health and better health care at lower cost by assisting CCOs with the development of their community health assessments and community health improvement plans, integrating evidence-based strategies to prevent and manage health problems into their model of care and providing data to assist CCOs in identifying and improving the health of their population. The Public Health Division also can help CCOs meet their Designated State Health Programs Waiver requirements by implementing programs and policies in their communities that support CCO members in achieving optimal health and providing expertise on community health worker programs. Collaboration with local and state public health will help CCOs have the information and expertise needed to be successful in achieving the desired health outcomes among their members and the broader communities they serve.

Key facts

The potential cost savings for Oregon are substantial — CCOs could save more than $3 billion during the next five years — and will ensure that our most vulnerable citizens maintain coverage, while freeing limited resources for other public priorities.

If CCOs are supported in implementing evidence-based population health promotion interventions, the potential savings for Oregon is even greater. The estimated net annual savings after five years for a $10 per person investment in disease prevention programs in Oregon is $193 million.[13] An estimated $35.8 million annually could be saved to the Oregon Health Plan (OHP) through a 5 percent reduction in diabetes and hypertension through the use of primary prevention programs.[14]

Approaches that work

Coordinated Care Organizations can achieve the Triple Aim and meet the requirements of the Designated State Health Programs Waiver through the support of evidence-based public health programs that address the leading causes of death and disability in Oregon, such as tobacco, obesity, suicide, heart disease and stroke, and family violence.

- Tobacco: PHD can work with CCOs to implement policies to limit exposure to tobacco, offer evidence-based tobacco cessation benefits, provide training to health care providers on tobacco use assessment and referral to cessation programs and educate CCO members on the risks of tobacco.
- Obesity: PHD can work with CCOs to offer evidence-based weight management programs, develop nutrition standards in health care settings, provide training to providers on how to track physical activity and body mass index and refer to evidence-based weight management programs and promote breastfeeding.

[13] *Trust for America's Health. Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities. 2008. Available at www.rwjf.org/files/research/3355.32711.tfahissuebrief.pdf.*

[14] *Ormond, BA et al. Potential National and State Medical Care Savings From Primary Disease Prevention. 2011. American Journal of Public Health, 101(1): 157-164.*

- Suicide: PHD can work with CCOs to train providers to screen for depression and refer to appropriate mental health resources and implement programs in communities and schools to reduce the risk of suicide.
- Heart disease and stroke: PHD can work with CCOs to train health care providers on the ABCS, promote evidence-based self-management programs, such as Living Well with Chronic Conditions, and develop community health worker programs.
- Family violence: PHD can work with CCOs to implement Nurse-Family Partnerships and parenting programs, provide training for health care providers on how to screen for family violence and refer to appropriate community resources and strengthen the local domestic violence referral network.

Current Public Health programs and policies

The Public Health Division maintains evidence-based community prevention programs (e.g., tobacco prevention; worksite wellness; policy development coalitions; home visits to asthma patients and pregnant women) that keep people healthy and reduce the need for health care. The Division provides information to the public and health care providers about how to prevent injury and illness and promote population health. The Public Health Division uses its surveillance systems to routinely measure, monitor and provide reports on population health trends. This information is the foundation for formal community health assessments of communities and the state. PHD also has expertise in engaging diverse groups in the community and implementing health promotion strategies that are rooted in the values and practices of diverse communities, including developing and implementing community health worker programs and other culturally competent strategies to improve the health of diverse communities.

Key documents

- Oregon Senate Bill 1580 (2012).
- Oregon's Designated State Health Programs Waiver.
- Oregon Health Improvement Plan.
- Primary Care and Public Health: Exploring Integration for Population Health, Institute of Medicine Report.

Strategies for change

1. Provide technical assistance to Coordinated Care Organizations across the state to ensure they are delivering evidence-based approaches to clinical preventive services and following nationally recognized guidelines.
2. Guide CCOs in addressing health disparities, improving health equity, and engaging communities.
3. Ensure population health data are readily available to help CCOs measure their progress toward achieving better health at lower costs.
4. Work with CCOs and local partners to ensure community-based prevention programs and services for the leading causes of preventable death, disease, and injury in Oregon.
5. Support the reform of payment systems to prioritize reimbursement for clinical services in community settings and non-clinical services that help to reduce the need for "sick care."

6. Enable local public health and CCOs to come together to assess the health and health needs of the population in their communities.

Key partners

- Centers for Medicare and Medicaid Services
- Coordinated Care Organizations
- Local public health authorities
- Federally-Qualified Community Health Centers
- Health care providers and hospitals
- Health Equity Coalitions
- School-based Health Centers
- Upstream Public Health

Five-year targets

- All CCOs will implement evidence-based approaches to tobacco control.
- At least 60 percent of CCOs will realize a reduction in tobacco use among their member population through implementation of evidence-based tobacco cessation benefits and other tobacco prevention initiatives.
- One hundred percent of CCOs will partner with their local public health authority to implement public health programs and policies that yield improved population health.

Priority: Public health accreditation

Public health accreditation has the potential to transform our public health system by ensuring all people in Oregon are served by a health department that can, or partner with other jurisdictions that can, demonstrate the core functions of public health practice. Accreditation was launched nationally in 2011 to improve and protect the health of every community by advancing the quality and performance within public health departments. Public health accreditation is a voluntary process, and recognizes state and local health departments that achieve a set of standards. Health departments must complete three prerequisites before applying: Community Health Assessment; Community Health Improvement Plan; and Agency Strategic Plan. Accreditation allows our communities to know that they are receiving high quality and equitable public health services.

Key facts

National public health accreditation formally launched in September 2011:

- One hundred percent of state and local health departments have completed the Public Health Accreditation Board's (PHAB) accreditation readiness checklist.
- No Oregon public health departments have completed the process. As of Sept. 1, 2012, four local health departments have PHAB approval to apply.
- As of September 2012, none of Oregon's population lives within a region served by an accredited health department.

Approaches that work

- National accountability instruments and processes, e.g., National Public Health Performance Standards Program (NPHPSP), that generate agreement on standards and performance measures.
- Center for Disease Control and Prevention (CDC), National Public Health Improvement Initiative: Dedicated funding to support broad public health capacity building rather than specific program areas.
- Mobilizing for Action through Planning and Partnerships (MAPP) is a community-based strategic planning tool developed through the joint efforts of CDC and National Association of County and City Health Officials (NACCHO) in 2001. This tool considers the entire public health system rather than focusing on the agency.
- Active performance management and quality improvement to achieve health department priorities and improve health outcomes.

Current Public Health programs and policies

In fall 2012, the Public Health Division plans to apply as a state health department for public health accreditation. The Division is also supporting local public health authorities in their readiness for accreditation and providing technical assistance with funding from the CDC's National Public Health Improvement Initiative.

Key documents

- Institute of Medicine The Future of the Public's Health in the 21st Century.
- 10 Essential Public Health Services.
- Public Health Accreditation Board's Standards and Measures, Version 1.0.

Strategies for change

- PHD will pursue and attain accreditation as a state health department.

- Increase the number of local health departments completing at least one prerequisite for public health accreditation.
- Increase the proportion of local health departments submitting their Statement of Intent to apply for accreditation.
- Develop and maintain performance reporting for PHD's implementation progress for the accreditation prerequisites.
- Demonstrated continuous improvement activity within PHD in PHAB-identified areas for improvement.

Key partners

- American Public Health Association
- Local public health authorities
- Oregon Public Health Advisory Board
- Oregon Health Policy Board
- Public Health Accreditation Board
- Northwest Center for Public Health Practice

Five-year targets

- PHD has PHAB approval to begin identifying and submitting documentation for the accreditation site visit by fall 2012.
- PHD is accredited by December 2013.
- Proportion of local health departments with PHAB approval to begin identifying and submitting documentation for accreditation site visits.
- Seventy-five percent of population lives within a region served by an accredited local health department by September 2017.

Priority: Health in All Policies

Health in All Policies (HiAP) is a collaborative approach that emphasizes consideration of the public's health and well-being in policy decisions across all sectors. It provides a lever for governments to address the key determinants of health through a systematic approach.[15] HiAP is based on the recognition that population health is largely determined by living conditions and other societal and economic factors (also known as the social determinants of health) and, therefore, influenced by policies and actions beyond the primary scope of the health care sector.[16] The state's most challenging health problems, including obesity, chronic diseases, and widening health inequities, are driven by such things as the built environment; transportation options; access to food; and educational and economic opportunities. In order to address these complex problems and improve the public's health, it is necessary to ensure that all policies in all sectors promote health.

Key facts

- Health can be significantly positively or negatively impacted by non-health related policies.
- The impacts of environmental policies, for example, on health have been well documented.
- HiAP approaches have been implemented in the European Union and in Australia, and California.
- In 2010, California established an interagency HiAP Task Force via Executive Order.

Approaches that work

- Existing approaches to achieving HiAP convene diverse stakeholders to integrate health considerations into non-health decision-making processes.
- HiAP can use policy evaluation methods to study the potential impact of a policy on health outcomes.
- Health impact assessments (HIAs) also can be used to determine the potential health and health equity impacts of a proposed program and to provide recommendations on how to minimize negative health outcomes and promote positive health outcomes.

Current Public Health programs and policies

The Public Health Division works across programs and with partner agencies, such as the departments of Transportation and Environmental Quality, to educate others about the impact of policy decisions on the lifelong health of all Oregonians. The Division also monitors health status indicators driven by programs outside of the Oregon Health Authority, and participates in a variety of interagency workgroups that function to ensure health in all policies. However, Oregon does not currently have a comprehensive approach to HiAP.

Key documents

Health in All Policies: Prospects and Potentials.

California Executive Order S-04-10.

Strategies for change

PHD aims to implement HiAP by:

1. Building the capacity and capability to conduct public health policy evaluation studies.

[15] *Kickbusch, I., Buckett, K. (Eds.). Implementing Health in All Policies: Adelaide 2010. Rundle Mall, South Australia: Department of Health, Government of South Australia, 2010.*

[16] *World Health Organization. Closing the gap in a generation. Health equity through action on the social determinants of health. Geneva: WHO. 2008.*

2. Analyzing and communicating about the health care cost savings and other economic benefits that could be achieved through an HiAP approach.
3. Developing an interagency community engaged in dialogue and problem solving around health issues.
4. Prioritizing sectors in which to pursue HiAP work and increase representation at the structural level on key committees.

Key partners

Governor's Office

Coordinated Care Organizations

Oregon Department of Education

Oregon Department of Energy

Oregon Department of Transportation

Five-year targets

- An interagency health in all policies task force is established.
- A health impact statement is required for all state agency regulations.
- Education, transportation, agriculture, consumer/business services, and housing agencies have incorporated health into one or more of their policies.

Priority: Health impact assessment

Health impact assessment (HIA) provides decision makers with information about how any policy, program or project may affect the health of people. Conducting an HIA raises awareness about health in other sectors, such as land use, transportation, energy, housing and education. While projects in these sectors can have a profound impact on the health of specific communities and the general population, consideration of health has not been a routine part of decision making. HIA is one tool that public health professionals can use to better integrate health into the programmatic, policy, and funding decisions made within these sectors.

In addition to ensuring that health considerations are incorporated into projects and policies, HIA has several other benefits including:

1. HIA uses a broad definition of health that ensures that social and environmental determinants of health are included in the assessment. This may include factors such as education, housing, transportation, or access to goods and services.
2. HIA has a focus on equity and social justice. These values are central to HIA because they emphasize the distribution of health effects in the population.
3. HIA is multidisciplinary in nature, and requires collaboration with partners in other fields.
4. HIA invites communities to participate in the process. Community members are the experts on local issues, and so involvement is crucial in selecting topics for assessment, prioritizing issues to study, collecting local information, and disseminating results to stakeholders

Key facts

- More than 125 HIAs have been conducted nationwide since 1999.
- Oregon is considered a leader in conducting HIAs, conducting more than 12.
- HIAs can be conducted for energy, transportation, and many other types of projects.
- HIAs can complement, but are different from, Environmental Impact Assessments.
- Oregon encourages, but the law does not require, HIAs to be conducted.
- Oregon has a network of more than 250 professionals who collaborate on HIAs.

Approaches that work

The U.S. Department of Health and Human Services recommends HIA as a planning resource for implementing national public health objectives. The major steps in conducting an HIA include:

- Screening to determine if an HIA is an appropriate tool;
- Scoping the health risks to be assessed;
- Assessing risks and benefits;
- Developing recommendations;
- Reporting;
- Monitoring and evaluating the effects of the HIA findings.

Current Public Health programs and policies

The Public Health Division's Health Impact Assessment initiative focuses on building our collective capacity to evaluate the health effects of projects and policies,

and to provide the information to decision makers. Oregon's Health Impact Assessment program has teamed up with Metro, Oregon Department of Transportation, and the Oregon Department of Energy, among others, to conduct health impact assessments. The Oregon HIA Network is a diverse group of more than 250 professionals from government agencies, nonprofit and advocacy groups, health care organizations, and private sector companies that share a common interest in decision making around health.

Key documents

Improving Health in the United States: The Role of Health Impact Assessment.

Minimum Elements and Practice Standards for Health Impact Assessment.

Strategies for change

1. Establish sustainably funded program for selecting, conducting, and promoting HIA with the public health system
2. Build capacity and capability within PHD and local public health authorities to conduct HIAs.
3. Establish mechanisms to measure and monitor the impacts of HIAs on the health of Oregonians.
4. Demonstrate leadership through HIA policy, proposals, and actions to improve the health of the general population.
5. Increase local city, county, and tribal government capacity to do HIAs.

Key partners

Federally-recognized tribes in Oregon

Local public health authorities

Local and regional planning commissions and agencies

Oregon Climate Change Research Institute

Oregon Department of Transportation

Oregon Department of Energy

Oregon HIA Network

Upstream Public Health

Oregon Public Health Institute

Five-year targets

- Adopt a formal set of HIA practice standards for Oregon.
- Build the capability to do HIA by conducting at least one health impact assessment per year.
- Ensure at least 33 percent of the local public health departments are able to support a health impact assessment.

Priority: Epidemiology and surveillance

Accurate information on the health status of the population is essential for improving the health of Oregonians. Public health gathers information on population health through surveillance and epidemiology. Surveillance involves systematically collecting, analyzing and interpreting data in order to plan, implement and evaluate public health efforts. Epidemiology is the study of patterns of disease. It allows us to track patterns of disease (including leading causes of death, chronic conditions, injuries, and disease outbreaks), identify factors (such as behaviors, demographic characteristics, and socioeconomic status) that raise the risk of illness, take steps to control diseases, and measure how well our control efforts are working.

Having access to high-quality and timely data is critical for effective decision making and prudent use of resources. Oregon needs a strong public health system to achieve better health outcomes at lower costs and to transform health care delivery. Accurate data and information for decision making ensures that the right work is done the right way at the right time. Striving for excellence in state-level data collection and reporting also will help to improve the effective use of data at the local level.

Key facts

- Each year, more than 45,000 babies are born in Oregon; birth certificates on these babies are registered with the state Center for Health Statistics, and data on characteristics of the infants and their mothers are compiled and released in an annual report.
- In 2010, almost 32,000 Oregonians died; information on the majority of these deaths was filed electronically, and data on the decedents were analyzed and reported by demographic characteristics, and leading causes of death.
- Oregon law specifies over 80 diseases, infections, microorganisms, and conditions of public health importance that must be reported to local public health authorities. Electronic laboratory reporting (ELR) is legally mandated for laboratories sending more than 30 records per month to Oregon public health.
- In 2011, 18,950 confirmed and presumptive communicable diseases cases were reported in Oregon. Of these, the majority (>14,000) were caused by sexually transmitted infections, and 1,364 were caused by vaccine preventable diseases, such as pertussis, hepatitis B, and meningococcal disease.
- Each year, >20,000 Oregonians are diagnosed with invasive cancer; these cancers are reported to the Oregon State Cancer Registry, which serves as a source for cancer data in our state, and for researchers looking at causes, prevention and treatment of cancer.
- Through Oregon's Behavior Risk Factor Surveillance System, > 9,000 Oregonians were contacted for telephone interviews about overall health status, risk behaviors, (such as smoking, diet, and physical activity), health outcomes (such as diabetes and obesity), and demographic characteristics.
- Through the Oregon Healthy Teens Survey, more than 3,900 eighth-grade students, and more than 3,700 11th-grade students are interviewed about their health risk behaviors.

- In 2012, Oregon launched its syndromic surveillance system, ESSENCE, which provides real-time data from emergency departments across the state; however, only four of Oregon's 61 hospitals are currently sending data.
- PH is working with the Oregon Health Authority's Office of Health Information Technology to ensure disease reporting through electronic medical records systems in the future.

Approaches that work

Public health surveillance and epidemiology informs strategies to achieve several purposes, in alignment with the Oregon Health Authority's Triple Aim:

Data to improve population health:

- Health outcomes, which include measures of mortality and morbidity;
- Health determinants, which include measures of health behaviors, the physical environment, and social and economic factors;
- Public health policies and services.

Data to improve quality of clinical care, and the individual's experience of care:

- Health care access;
- Quality of health care;
- Health care utilization;
- Health care outcomes.

Data to reduce average costs across Oregon's population:

- Direct health care costs associated with health outcomes;
- Indirect costs associated with health outcomes.

Current Public Health programs and policies

The Public Health Division currently has an array of surveillance systems that collect data on the health status of the population. Together these systems gather information on the population along the lifespan, from prenatal health, to birth, infancy, childhood, adolescence, adulthood, older adulthood and death. Along the lifespan, data are collected on outcomes (such as communicable and chronic diseases, injuries and causes of death), risk behaviors (tobacco use, substance abuse), as well as the social and environmental context for the behaviors and outcomes. The Oregon Center for Health Statistics collects data that cross public health programs, such as vital statistics (birth and death certificates); and the adult and student population-based surveys. Data that are more topic-focused, such as the registries of reportable diseases and conditions, data on the environment and community conditions; and information on laws, policies and regulations are collected by the programs themselves where the content expertise lies. In addition, specific public health programs analyze data collected by outside bodies, such as administrative and medical claims data, and hospital discharge data, to gain insight into public health priority areas.

Key documents

Oregon State Health Profile.

CDC's Vision for Public Health Surveillance in the 21st Century, Blueprint Version 2.0: Updating Public Health Surveillance for the 21st Century.

Oregon Health Authority, Data Needs Assessment.

National Health Security Strategy.

National Strategy for Biosurveillance.

Oregon Selected Reportable Communicable Disease Summary.

CDC Guidelines for Evaluating Surveillance Systems.

Strategies for change

1. Establish epidemiology and surveillance partnerships with Coordinated Care Organizations and clinical practitioners, and related fields – mental health, education, and child welfare.
2. Guide and support local capacity around epidemiology and surveillance.
3. Improve the sustainability of data collection and surveillance by emphasizing systems information technology solutions.
4. Increase informatics capacity to build and maintain public health data systems – internal data, external feeds to PHD, and integrate epidemiology and surveillance with informatics capabilities.
5. Increase the speed at which data are collected and analysis is performed to make the data relevant and timely for use in decision making.
6. Fill gaps in key priority areas to ensure sufficient data for public health decision making.

Key partners

Oregon Conference of Local Health Officials

Association of Public Health Laboratories

Association of Professionals in Infection Control and Epidemiology

Clinical laboratories

Council of State and Territorial Epidemiologists

Electronic medical and laboratory records systems providers

Health care providers and insurers

Oregon state agencies

Oregon Hospital Association

Oregon Health Authority Office of Health Information Technology

Oregon University System

Five-year targets

- Sustained support of current surveillance data systems.
- Ability to access electronic medical records for population health data.
- Address gaps in current population health data, including health information on elementary school aged children, behavioral health conditions, and data on the built environment.
- Encourage all Oregon hospitals to submit data to the ESSENCE syndromic surveillance system.
- All laboratories reporting via ELR will send data according to the current HL7 specifications, and ELR data are routed directly into the Communicable Disease Registry (Orpheus).
- Orpheus will be interoperable with other public health data systems (e.g., ALERT Immunization Information System, HIV Medical Monitoring Project, vital records systems), and with surveillance systems required by CDC.
- Data from public health surveillance systems will be analyzed, interpreted, and reported out in a timely fashion, a minimum of annually.

Cross-Cutting Areas

Most of a person's health is determined by social and economic factors, rather than the health care they receive. This means that public health must work across a variety of sectors to assure the conditions that allow all people to be healthy in all types of settings and in all parts of their lives. In addition to the partners listed in this document, PHD aims to develop collaborations and initiatives with education, transportation, and housing to address the priority areas in this plan.

Each of these sectors represents several of the major social determinants of health. These sectors influence the investment of significant state and federal resources and they have the potential on their own to positively influence health outcomes. Strategies to achieve health outcomes with each sector will be developed through a partnership strategy unique to that sector. Examples of potential strategies are listed below.

Transportation

- Provide health-related expertise and technical assistance to active transportation projects;
- Develop collaborations between local Area Commissions on Transportation and Healthy Community Coalitions;
- Data and tools to predict health outcomes associated with different types of transportation projects;
- Safe routes to school for children;
- Enhance and support the Emergency Medical Services system, particularly in rural areas.

Education

- Reduce the causes of poor health that increase school absenteeism;
- Early screening, identification, and treatment of risk factors for poor health outcomes to enhance children's readiness for kindergarten;
- Healthier school environments that are tobacco-free and provide opportunities for social connectedness, healthy food choices, and recommended levels of physical activity.

Housing

- Increase the availability of tobacco-free housing environments for all people in Oregon, regardless of income or mental health status;
- Healthy homes free from environmental exposures that contribute to school absenteeism and poor health outcomes;
- Stable housing for children and families with one or more health conditions, particularly families that have faced violence or who have mental health risk factors.

Linkages between the Public Health Division's Strategic Plan and Oregon's Healthy Future (State Health Improvement Plan)

The Public Health Division's (PHD) strategic plan and Oregon's Healthy Future, our state health improvement plan, both clearly reflect our communities' concerns and priorities for action. Both plans acknowledge that there is more work to do around our challenges with tobacco and obesity. Activities undertaken in these areas will be clearly aligned in order to maximize success in these complex areas.

Specific strategies aligned between the strategic plan and Oregon's Healthy Future, are:

- Tobacco Strategy 1: Increase the price of tobacco products, with a portion dedicated to a comprehensive tobacco control program.
- Tobacco Strategy 2: Increase the number of environments where we live, work, learn, and play where tobacco use is prohibited.
- Obesity Strategy 2: Increase the price of sugary beverages with a portion dedicated to a comprehensive obesity prevention and education program.
- Obesity Strategy 4: Collaborate with childcare, schools, worksites, health systems, and state and local governments to adopt and implement standards for nutrition (including breastfeeding and restrictions on sugary beverages and unhealthful foods), physical activity and screen time.

Health equity is represented in our strategic plan as a core value and reflected in Oregon's Healthy Future as a key priority. We anticipate a rich partnership between these two bodies of work as initiatives are defined and implemented.

The PHD strategic plan has a strong focus on improving our infrastructure through accreditation, epidemiology and surveillance, health impact assessments and health in all policies in order to ensure we have the right skills at the table to support our state's improvement activities. These skills, tools and resources are critical components for effective support of Oregon's Healthy Future initiatives.

Linkages between the Public Health Division's Strategic Plan and Quality Improvement Plan

The Public Health Division has made a strong investment in Quality Improvement (QI) since 2008. Our staff and programs strive to continually improve our systems and services. Our service excellence core value gives voice to this commitment by focusing on collaborative response, innovation, sharing best practices and fostering a culture of continuous improvement.

PHD has a standardized prioritization process for identifying, planning and resourcing QI activities across the Division. Additionally, many of our programs are running continuous improvement activities. PHD is revising its existing QI plan and prioritization matrix to incorporate alignment with the strategic plan and Oregon's Healthy Future. Priority area strategies being evaluated for inclusion in our QI plan include:

- Community Resilience Strategy: Ensure timely, culturally appropriate, and effective risk communications, particularly with vulnerable populations.
- Accreditation Strategy: Demonstrated continuous improvement activity within the Public Health Division in PHAB-identified areas for improvement.
- Supporting the CCOs Strategy: Ensure population health data are readily available to help CCOs measure their progress toward achieving better health at lower costs.
- Epidemiology and Surveillance Strategy: Improve the sustainability of data collection and surveillance by emphasizing systems information technology solutions.
- Epidemiology and Surveillance Strategy: Increase the speed at which data are collected and analysis is performed to make the data relevant and timely for use in decision making.

Appendices

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Karen Bettin, PHD

Christianne Biggs, PHD

Claudia Bingham, PHD

Julie Black, PHD

Katherine Bradley, PHD

Marjorie Bradway, Oregon Department of Transportation

Kathryn Broderick, PHD

David Caress, Acumentra Health

Joe Carlson, PHD

Todd Carpenter, PHD

Candy Cates, PHD

Paul Cieslak, PHD

Daniel Coleman, Portland State University

Rebecca Collett, Washington County

Cristin Corcoran, Cities Readiness Initiative

Emilee Coulter-Thompson, PHD

Morgan Cowling, Coalition of Local Health Officials

Beth Crane, PHD

Curtis Cude, PHD

Cathryn Cushing, PHD

Sonya Czerniak, PHD

Muriel DeLaVergne, Crook County

Lesa Dixon-Gray, PHD

Jessica Duke, PHD

Lorraine Duncan, PHD

Megan Dunford, PHD

Julie Early-Alberts, PHD

Lydia Emer, PHD

Bill Emminger, Benton County

Tom Engle, PHD

Steve Fiala, PHD

Tony Fields, PHD

Michelle Fusak, PHD

Jonathan Gates, Attorney General's Sexual Assault Task Force

Beth Gebstadt, PHD

Matt Gilman, PHD

Karen Girard, PHD

Jennifer Goodrich, American Diabetes Association

Joyce Grant-Worley, PHD

Susan Greathouse, PHD

Mandy Green, PHD

Erin Greenawald, Oregon Department of Justice

Nancy Greenman, Attorney General's Sexual Assault Task Force

Holly Groom, PHD

Heidi Guenin, UpStream Public Health

Anona Gund, PHD

Silas Halloran-Steiner, Yamhill County

Andrea Hamberg, PHD

Brett Hamilton, Tobacco-Free Coalition of Oregon

Karen Hampton, PHD

Jim Hanson, Portland Public Schools

Toby Harris, Washington County

Mike Harryman, PHD

Danna Hastings, PHD

Sybil Hebb, Oregon Law Center

Ruth Helsley, PHD

Tia Henderson, UpStream Public Health

Jere High, PHD

Jill Hollingsworth, Columbia Care

David Howe, PHD

Sarah Humphrey, PHD

JoAnn Jackson, PHD

Sujata Joshi, PHD

Beth Kaye, Oregon Public Health Institute

Karen Kelley, PHD

David Kerschner, US Department of Health and Human Services

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Juventila Liko, PHD

Kim La Croix, PHD

Ellen Larsen, Hood River County

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Luci Longoria, PHD

Mimi Luther, PHD

Tom Machala, Jefferson County

Julie Maher, Multnomah County

Shanie Mason, PHD

Tara McAdoo, Acumentra Health

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Daniel Morris, PHD

Eric Morrisey, Centers for Disease Control and Prevention

Heather Morrow-Alameida, PHD

Carole Moses, PHD

Adrienne Mullock, PHD

Stefani Murray, Centers for Disease Control and Prevention

Annie Neal, Multnomah County

Dyuen Ngo, PHD

Loreen Nichols, Multnomah County

Jody Noon, PHD

Donna Noonan, PHD

Bob Nystrom, PHD

Lisa Millet, PHD

Jean O'Connor, PHD

Kathleen O'Leary, Washington County

Cheryl O'Neill, Oregon Health Authority

Gary Oxman, Multnomah County

Jason Parks, American Cancer Society

Tamara Perkins, NPC Research

Lari Peterson, PHD

Diana Pickett, PHD

Eric Pippert, PHD

Rebecca Pawlak, PHD

Barbara Pizacani, Multnomah County

Cara Railsback, PHD

Bridget Roemmich, PHD

Ken Rosenberg, PHD

Sarah Rosenberg, PHD

Laura Saddler, PHD

Kari Salis, PHD

Carol Sanders, PHD

Erica Sandoval, PHD

Chip Saturn, PHD

Rosemary Schaefer, PHD

Patricia Schoonmaker, PHD

Stacey Schubert, PHD

Dana Selover, PHD

Xun Shen, PHD

Donald Shipley, PHD

Sara Sloan, PHD

Ellen Smit, Oregon State University

Spencer Soderlind, PHD

John Sorenson, PHD

Robin Stanton, PHD

Amy Sullivan

Stephanie Tama-Sweet, American Heart Association

Ann Thomas, PHD

Liz Thorne, PHD

Vanessa Timmons, Oregon Coalition Against Domestic and Sexual Violence

Sarah Tinker, PHD

Pam Triplett, PHD

Lesli Uebel, PHD

Robert Vega, PHD

Kathleen Vidoloff, PHD

Jennifer Vines, Multnomah County

Lissa Vorhees, Lane County Suicide Prevention Steering Committee

Rick Wendtt, PHD

Steve White, Oregon Public Health Institute

Lila Wickham, Multnomah County

Susan Wickstrom, PHD

Cate Wilcox, PHD

Sue Woodbury, PHD

Jennifer Woodward, PHD

Darren Yesser, PHD

Collette Young, PHD

Jennifer Young, PHD

Amy Zlot, PHD

Appendix 2: Strategic Planning Process

In fall 2011, the Public Health Division began a one-year strategic planning process. The process was adapted from a variety of planning methodologies including two well-known strategic planning approaches, Balanced Scorecard and Hoshin. The Division also adapted principles from several other planning processes and tools.

The process consisted of four phases. The first stage, held from October 2011-December 2011, focused on completing a situational analysis and an analysis of the Public Health Division's strengths and opportunities for improvement. This phase focused on identifying the factors and ideas necessary to creating a broad vision for the future. The second stage, from January 2012-March 2012, engaged Public Health Division leadership in a decision-making process to articulate the vision, including finalizing the formal mission and vision statements of the Division, setting goals, and identifying the priority areas of focus for the Public Health Division over the next five years. During Phase 3, from April to July 2012, a variety of stakeholders, including local public health officials, equity coalitions, partner organizations, and other state agencies identified the key strategies and initiatives that would enable the Division to achieve the priorities. A fourth and final phase is to publish the plan for comment and refine the strategies and initiatives with additional input from partners. Each phase is described below.

Phase 1: October 2011 to December 2011

- Survey: Approximately 400 individuals responded to a seven-question survey distributed widely to Public Health Division staff, local health departments and partners.
- Situational Assessment: Plans and documents related to public health in Oregon were gathered and reviewed as input to the plan, including the Oregon Health Policy Board's Action Plan for Health and its chronic disease-focused Health Improvement Plan.
- Retreats: Public Health Division managers and leadership, and local public health department staff, discussed the vision, mission and goals of the Public Health Division and considered strategies to achieve the goals from four perspectives: 1) the stakeholders public health serves; 2) organizational learning and growth opportunities; 3) financial considerations; and 4) internal business processes. These perspectives, commonly used in the Balanced Scorecard strategic planning method, ensure that an organization identifies initiatives that consider different elements of an organization's success.
- Values Work Group: Public Health Division staff interpreted the Oregon Health Authority values of service excellence, leadership, integrity, health equity and partnership in the context of public health.
- Conversations with Stakeholders: During the planning process, many individuals inside and outside state government offered their insights, observations, and thoughts about priorities and the future direction of public health in Oregon.

Phase 2: January 2012 to March 2012

- Vision Work Group: Staff reviewed all of the input on the vision statement,

generated two versions, and made a recommendation to leadership regarding the pros and cons of each option.

- Selection of Priorities: Considering all of the input from the first phase and data regarding the public's health in Oregon, Public Health Division leadership selected the two goals and the 11 priority areas.

Phase 3: April 2012 to July 2012

- Priority Topic Area Planning Sessions: Public Health Division staff, managers, and stakeholders convened to identify targets, strategies, and initiatives associated with each priority area.
- Health Equity Input: Division staff met with the Oregon Equity Coalitions and other partners, as well as the Oregon Health Authority Office of Equity and Inclusion to ensure a health equity perspective was considered in the plan.
- Program Input: Public Health Division program staff and managers further defined goals and targets into measurable outcomes.

Phase 4: August 2012 to October 2012 and beyond

Between August and October 2012, the Public Health Division will release the strategic plan for public comment and refine the document accordingly. Once the final document has been developed, initiatives will go through a prioritization process to support implementation scheduling, resourcing and activity. Progress within initiatives will be measured and reported on a quarterly basis through the Public Health Division's performance management process. Updates to initiatives will be made, as needed, in response to this data. In keeping with the Division's emphasis on continuous quality improvement, this strategic plan is intended to be a living document. It is envisioned that the strategic plan will be updated continuously, and additional versions released at least once a biennium.

Appendix 3: All Stakeholders

"Users" of Health Care

Academia

Advocacy Groups

Alaska

Ambulatory Surgery Centers

American Red Cross

AMH

ASPR/HPP

Association of Food and Drug Officials (AFDO)

Birthing Centers

CAF (2)

California

CDC (5)

CDC (various divisions)

CDRC (2)

Child Care Providers (2)

Childcare Division

Children

Chiropractors

Clients

Clinical Laboratories

Clinics

CMS

Commission on Children and Families

Community-Based Organizations (2)

Community-Based Providers

Community Health Organizations

Community Residents

Conference for Food Protection

Contractors

Correctional Facilities

Corrections

Counties

County Clerks

County Commissioners

County Emergency Managers

County Environment Health

County Environmental Health Staff

County Health Administrators

Dental Hygienists

Dentists

Department of Revenue

DEQ (2)

DHS (3)

Dialysis Facilities

Dining Public

Division of Child Support

Doctors (3)

Early Childhood

Education

Educators

Energy

Environmental Health Consultants

Environmental Health Laboratories

Environmental Laboratories

EPA (2)
Epidemiologists
Faith Based Organizations
Families
Farmers
FBI
FDA
FDA (2)
Federal Agencies
Federal Grantors
Federal Policy and Funding
FEMA
Fire Departments
Fire Marshals
Food Industry
Food Industry Association
Forestry
Funeral Homes
General Public (2)
General Public Needing Vital Records
Governor, The
Governor's Office
Grocery Retailers
Head Start
Head Start Collaboration Office
Health Care Architects
Health Care Designers
Health Care Engineers
Health Care Facilities, Miscellaneous
Health Care Planners
Health Care Providers (2)
Health Care Trade Association
Home Health Care Providers
Hospice Providers
Hospital Administrators
Hospitals (6)
HRSA
Idaho
Industry
In-Home Care Providers
Laboratories
Lactation Consultants
Law Enforcement
Legislators (3)
Licensees
Local Health Departments (7)
Local Public Health Educators
Media
Medicaid
Medical Doctors (MDs)
Medical Examiners
Medical Providers (2)
Mental/Behavioral Health
Midwives
Migrant Health
Moms

National Association of County Health Officials (NACHO)

National Center for Health Statistics (NCHS)

Newborns

Non-Governmental Organizations (NGOs)

NRC

Nurses (2)

Nursing Homes

ODOT

OEPH Administrator

OEPH/ Research and Evaluation Services

OEPH/DWP

OEPH/FPLHSS

OHA Employees

OHSU

ONG – 102nd

OPHA

Oregon Association of Hospitals and Health Systems (OAHHS)

Oregon Board of Dentistry

Oregon Board of Medical Imaging (OBMI)

Oregon Dental Association

Oregon Department of Agriculture

Oregon Department of Education

Oregon Emergency Management

Oregon Families

Oregon Medical Association

Oregon Public Health Association (OPHA)

Oregon State Fire Marshal

Oregon State Hospital

Oregon State Police

Oregon Veterinary Association

Oregonians (All) (2)

Other Public Health Programs

Other State Agencies (2)

Other State Public Health Lab

Other States

Parents (2)

Patients (3)

Patrons of Public Swimming Facilities

People Living with HIV/AIDS

People with Disabilities

PH/Med Volunteers

PHD

PHD Programs

Physicians

Podiatrists

Private Drinking Water Programs

Private Sector Clinics

Private Sector Hospitals

Private Sector Labs

Public Health Emergency Preparedness (PHEP)

Public with Complaints/Reports Regarding Patient Safety

Public with Complaints/Reports Regarding Poor Health Care

Registrants

Researchers

Researchers at Universities

Sanitarians

School Age Children

School-Based Health Clinics

Schools

Social Service Advocates

Special Populations

State Drinking Water Programs

TB Program

Teens

Tourists and Travelers

Tribal Environmental Health

Tribes (2)

Universities (2)

USDA (3)

USPH

Veterinarians (2)

Vital Records Offices

Vulnerable Populations

Washington State

Water Resources

Water Systems Operators

Women

X-ray Machine Technicians

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