Promote Enhanced Physical Health Across Communities
Regional Health Improvement Plan Workgroup

Join Zoom Meeting
https://zoom.us/j/188624791

Join by phone:
+1 669 900 6833
Meeting ID: 188 624 791

September 22, 2020. 8:00-9:30am

Aim/Goal

Equitably and measurably support all Central Oregonians to prevent disease by improving health behaviors and reducing risk factors that contribute to premature death and diminish quality of life.

Future State Metrics

1. Decrease asthma, cancer, cardiovascular disease, and diabetes rates
2. Decrease obesity rates in adults
3. Increase fruit/vegetable consumption and physical activity in youth
4. Decrease risk factors for cardio-pulmonary and/or preventable disease
5. Decrease sexually transmitted infections
6. Increase individuals receiving both an annual wellness visit and preventative dental visit

AGENDA

8:00-8:10 Welcome & Land Acknowledgement
8:10-9:25 Strategic Direction
9:25-9:30 Next Steps
## Promote Enhanced Physical Health Across Communities

### Regional Health Improvement Plan Workgroup

### Future State Metrics – Full Detail

1. **By December 2023, decrease chronic disease rates by 10% in each County, age-adjusted:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Crook County</th>
<th>Deschutes County</th>
<th>Jefferson County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma (%)</td>
<td>7.4</td>
<td>8.2</td>
<td>12.9</td>
</tr>
<tr>
<td>Cancer (%)</td>
<td>7.0</td>
<td>6.4</td>
<td>4.9</td>
</tr>
<tr>
<td>Cardiovascular Disease (%)</td>
<td>8.7</td>
<td>4.3</td>
<td>5.1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>9.5</td>
<td>5.3</td>
<td>18.3</td>
</tr>
</tbody>
</table>

2. **A.) By December 2023, reduce adult obesity rates in Central Oregon Region by 7% in each county:**

<table>
<thead>
<tr>
<th>County</th>
<th>Crook County</th>
<th>Deschutes County</th>
<th>Jefferson County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Obesity</td>
<td>29.3%</td>
<td>19.9%</td>
<td>39.2%</td>
</tr>
</tbody>
</table>

2. **B.) By December 2023, increase the percentage of Central Oregon youth who meet the physical activity and fruit/vegetable consumption goals by 10 percentage points in each county to:**

#### 8th Grade Rates

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Crook County</th>
<th>Deschutes County</th>
<th>Jefferson County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of students reporting 60 minutes or more of physical activity in the last 7 days.</td>
<td>47%</td>
<td>38%</td>
<td>32%</td>
</tr>
<tr>
<td>Index of 6 fruit and vegetable consumption questions, what percentage of youth are getting at least 5 servings of fruit or vegetables per day.</td>
<td>38%</td>
<td>33%</td>
<td>41%</td>
</tr>
</tbody>
</table>

#### 11th Grade Rates

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Crook County</th>
<th>Deschutes County</th>
<th>Jefferson County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of students reporting 60 minutes or more of physical activity in the last 7 days.</td>
<td>39%</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>Index of 6 fruit and vegetable consumption questions, what percentage of youth are getting at least 5 servings of fruit or vegetables per day.</td>
<td>31%</td>
<td>26%</td>
<td>25%</td>
</tr>
</tbody>
</table>
31. By December 2023, decrease risk factors that contribute to Cardio-Pulmonary Disease and/or Preventable Disease by 7% in each county:

<table>
<thead>
<tr>
<th></th>
<th>Crook County</th>
<th>Deschutes County</th>
<th>Jefferson County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-adjusted % of adults who currently smoke</td>
<td>24.5%</td>
<td>16.1%</td>
<td>11.9%</td>
</tr>
<tr>
<td>The age-adjusted rate of persons hospitalized for stroke per 100k</td>
<td>196.0</td>
<td>190.0</td>
<td>319.0</td>
</tr>
<tr>
<td>The age-adjusted rate of persons hospitalized for diabetes per 100k</td>
<td>86.0</td>
<td>59.5</td>
<td>128.5</td>
</tr>
</tbody>
</table>

31. By December 2023, decrease 5-year rates and/or 5-year case counts of STIs by 20%:

<table>
<thead>
<tr>
<th></th>
<th>Crook County</th>
<th>Deschutes County</th>
<th>Jefferson County</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 5-year age-adjusted rate of gonorrhea per 100k</td>
<td>52.7</td>
<td>23.5</td>
<td>95.8</td>
</tr>
<tr>
<td>Central Oregon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-year syphilis case count</td>
<td></td>
<td></td>
<td>37</td>
</tr>
<tr>
<td>5-year HIV case count</td>
<td></td>
<td></td>
<td>21</td>
</tr>
</tbody>
</table>

5. By December 2023, increase the percentage of PacificSource (Central Oregon CCO) Medicaid members, at any age, who received both an annual wellness visit by a Primary Care Provider and a preventive dental visit by a member of the Oral Health Care Team by 10 percentage points to:

<table>
<thead>
<tr>
<th></th>
<th>Crook County</th>
<th>Deschutes County</th>
<th>Jefferson County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29.8%</td>
<td>32.75%</td>
<td>31.3%</td>
</tr>
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</table>
Regional Health Improvement Plan (RHIP) Workgroup

Guiding Principles

Shared Focus
We come together to improve the health and well-being of individuals living in various and diverse communities throughout Central Oregon region. We use the Regional Health Improvement Plan (RHIP) as our guide. It is our region’s shared vision of current problems and our aims. As workgroup partners we develop agreed-upon actions to solve the issues and keep the needs of our communities as the main focus.

Shared Metrics
We measure progress, process and outcomes through a shared lens. We use the Regional Health Assessment (RHA), Regional Health Improvement Plan and community dashboard.

Involve Targeted Population
The individuals living in our diverse Central Oregon communities are the center of our work. We make every effort to include people from every part of the region in our workgroups, discussions, processes and decisions.

Collaborate to Solve Complex Issues
Inviting diverse perspectives from throughout the Central Oregon region deepens our shared understanding of complex issues and propels us toward better progress and outcomes. We practice frequent, structured, open communication to build trust, assure shared objectives, and create common motivation. We respect the privacy and sensitivity of information partners share.

Coordinate Collective Efforts
We are made up of diverse partner organizations and individuals with unique strengths, skills, and resources. We coordinate our efforts and use our unique strengths and skills to meet the goals of the RHIP.

Learn and Adapt Together
We embrace shared learning and a growth mindset. We create a space that allows for mistakes, failures, second changes, and a celebration of brave attempts. We adjust and apply our learnings to the complex and changing landscape of health and well-being in Central Oregon.
Promote Enhanced Physical Health Across Communities

Background: Why are we talking about this?

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<tr>
<td><strong>1990s</strong>: Rise in obesity rates</td>
</tr>
<tr>
<td>• Increased sugar consumption</td>
</tr>
<tr>
<td>• Decrease in recess time at school</td>
</tr>
<tr>
<td>• Increasing Aging Population</td>
</tr>
<tr>
<td>• Tech Advancement &amp; Screen Time</td>
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<td>• Vaping / E-cigarettes</td>
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Physical health is influenced by genes and biology, health behaviors, social environment, physical environment, and health services. Enhancing physical health throughout our communities improves quality of life and reduces the burden of healthcare and other costs to personal and public health. Access to healthcare is a challenge for residents in rural areas.

Current Condition: What’s happening right now?

- Current rates of cardiovascular disease: Crook 9.7%, Deschutes 4.8%, Jefferson 5.7%
- Current rates of diabetes: Crook 10.6%, Deschutes 5.9%, Jefferson 20.4%
- Current adult obesity rates: Crook 31.5%, Deschutes 21.4%, Jefferson 42.2%
- Fewer than 30% of 11th graders report 60 minutes or more of physical activity in 7 days
- Fewer than 25% of 11th graders report getting 5 or more servings of fruits and vegetables per day
- Adults who currently smoke: Crook 29.3%, Deschutes 17.3%, Jefferson 12.7%
- Adults reporting high blood pressure: Crook 48.8%, Deschutes 24.8%, Jefferson 16.9%
- New cases of syphilis have been steadily increasing in the entire region since 2012
- Percentage of Medicaid members who receive both annual wellness visit and preventive dental visit: Crook 17.8%, Deschutes 20.75%, Jefferson 19.3%

See RHIP for Full Current State Metrics

Goal Statement: Where do we want to be in 4 years?

Aim/Goal
Equitably and measurably support all Central Oregonians to prevent disease by improving health behaviors and reducing risk factors that contribute to premature death and diminish quality of life.

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Analysis: What’s keeping us from getting there?

- Inequitable measurement and approaches to weight and health management
- Rigidity of time, funding/payment, availability of service and receiving service
- Disparate funding and deceptive marketing
- Siloed systems prevent coordination of care
- Power dynamics adversely affect and create an underrepresentation in policy creation
- Trauma without resilience skills negatively impacts health
- Resource inequality exacerbates health disparity
- Individual and collective health beliefs impact health literacy efforts
- Restrictive and inequitable built environment impacts health

Follow-Up: What’s working? What have we learned?

(insert)
| Root Cause Barriers: What is blocking us from moving toward our future state measures? |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Rigidity of time funding/payment, availability of service and receiving service | Individual and collective health beliefs impact health literacy efforts | Restrictive and inequitable built environment impacts health | Resource inequality exacerbates health disparity | Trauma without resilience skills negatively impacts health | Power dynamics adversely affect and create an underrepresentation in policy creation | Insufficient integration of systems prevents coordination of care | Inequitable measurement and approaches to weight and health management | Disparate funding and deceptive marketing |
| Inaccessibility to services | Cultural differences in health practices and health literacy | Physical activity engineered out of our lifestyles | Ability to pay for dental care | School support for gardening and growing fresh fruits and veggies | Dental appointments aren't scheduled | Remove weight stigma and work to create healthy relationships with food | Media - social media exposure, marketing targeting audiences |
| Working time is barrier to PA - only affluent can fit it in | Hours and transportation limit access to early education | Walkability and distance to access stores, parks, etc. | Cost is #1 barrier to sports participation for low income families | Lack of family structure | School-based health center limits on education and prevention | Workflows are not easy for clinics, with scheduling being an obstacle | Focus on obesity rates with an individual can lead to fat shaming and it's not supportive |
| Access / time | Constrained parental engagement | Transportation | Poverty | Shifting political climate shifts priorities | Public perception that eating healthy means it doesn't taste good | |
| | Understanding risk factors for disease | Environmental factors | Insurance coverage | Unstable Family Structure | Food deserts | Stigma silences people |
| | Education | |

Enhanced Physical Health Across Communities
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Strategic Direction:
How do these groups relate to each other? Which ones have similar intent?

[Diagram showing various strategies and programs for enhancing physical health across communities.]

- Coordinate funding
- Expand Double Up Food Bucks
- A centralized Oregon County Services organization
- Reduce financial barriers to physical activity
- Provide sports registration fees
- Partnership between local, state, and federal health programs
- Free summer camps for kids in rural communities
- Movement for every body: eliminating the pay-to-play, focus on the fun of movement
- Cover insurance gaps
- Community Rural Health Programs (not insurance-based)
- Funding pool to cover copay/co-insurance

These are about reducing financial barriers to improve health.

- Discover and coordinate transportation resources (for medical and non-medical needs)
- Inciting OHP signup and providing transportation services
- Build a create and mobilize mobile medical/financial other services
- Food market street, local farmers, etc.

These are about accessing services.

- Destigmatize weight
  - (meas.) Educate providers and insurance (to regard individual health as a whole, not just BMI)
- “Ditch the BMI” training
- Create counter and alternative marketing
- Media campaign for cheap, healthy dinners

These are about changing the message to destigmatize wellness.

- Partner with underserved communities in leadership and decision making
- Work with underserved communities to co-design programs, partnerships, and strategies that promote health equity and inclusion
- Include people with lived experience on boards by providing compensation so they can attend
- Power dynamics, Policy Processes
- Include underserved voices to drive decision making on top strategies for workforce

These are about partnering with underserved communities.

- Advocate for state and local policy
- Provide insurance for all
- Tobacco retail licensing
- Increase the price of sugary drinks
- Use Health Impact Assessments to evaluate plans before construction
- Joint Use Agreements

Advocating for policy change.

[Other strategies and programs related to enhancing physical health across communities.]

- Increase fruit and vegetable consumption and physical activity
- Decrease risk factors for cardio-pulmonary and/or diabetes rates
- Increase individuals receiving both an annual wellness visit and preventative dental visit.