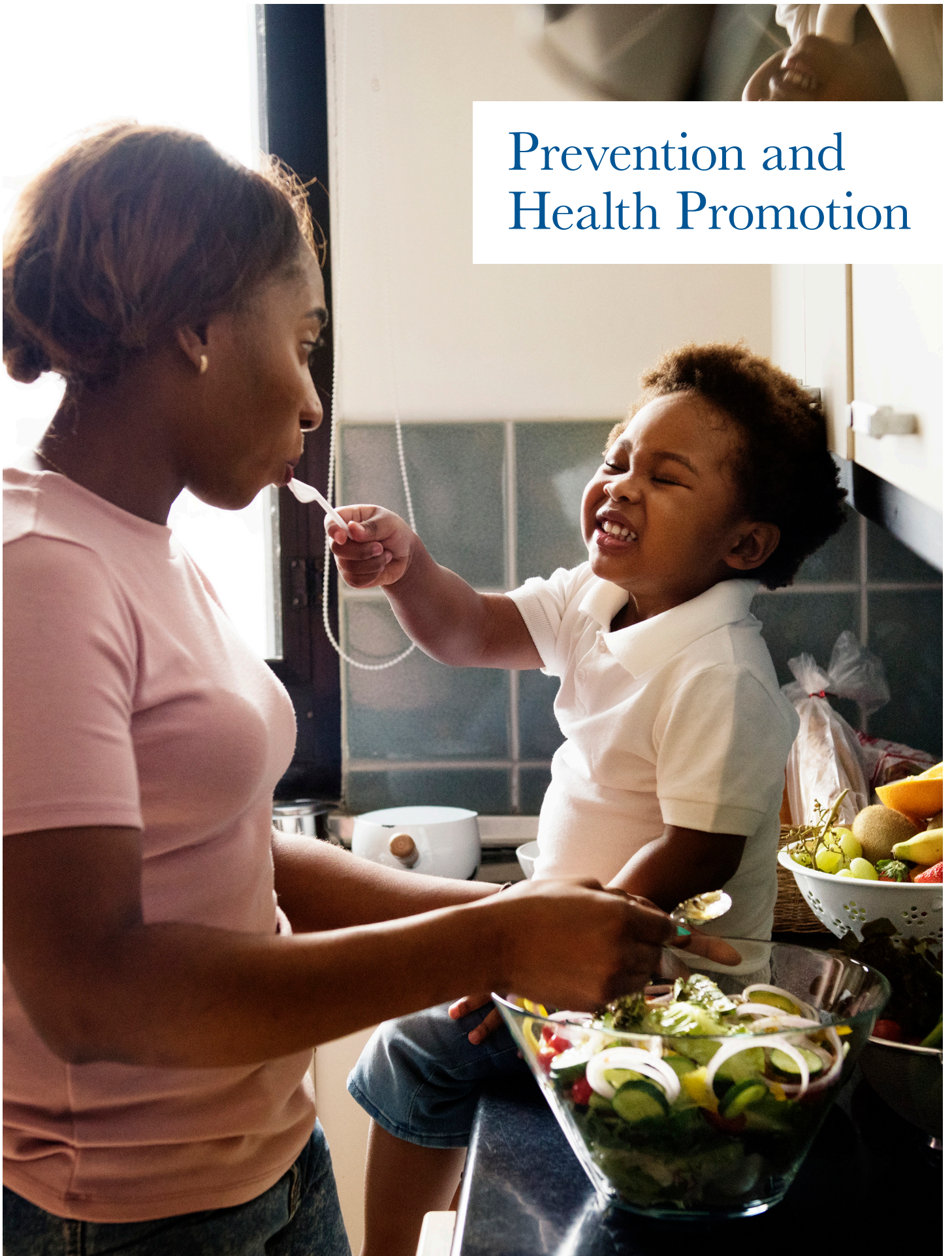


# Prevention and Health Promotion



# Prevention and Health Promotion

One out of every six comments received from community members was related to prevention and health promotion, an area that encompasses policies and programs that provide access to well-being for everyone. The most-commonly cited concerns were related to behavioral health (both mental health and addictions); healthy eating; physical activity; and health education, particularly for children and older adults. People in Oregon recognize that prevention is more effective and less expensive than treating a chronic disease. In addition, community members expressed a need for prevention efforts that promote holistic well-being. Among people living with chronic disease, many said they need tools to help them manage their health.

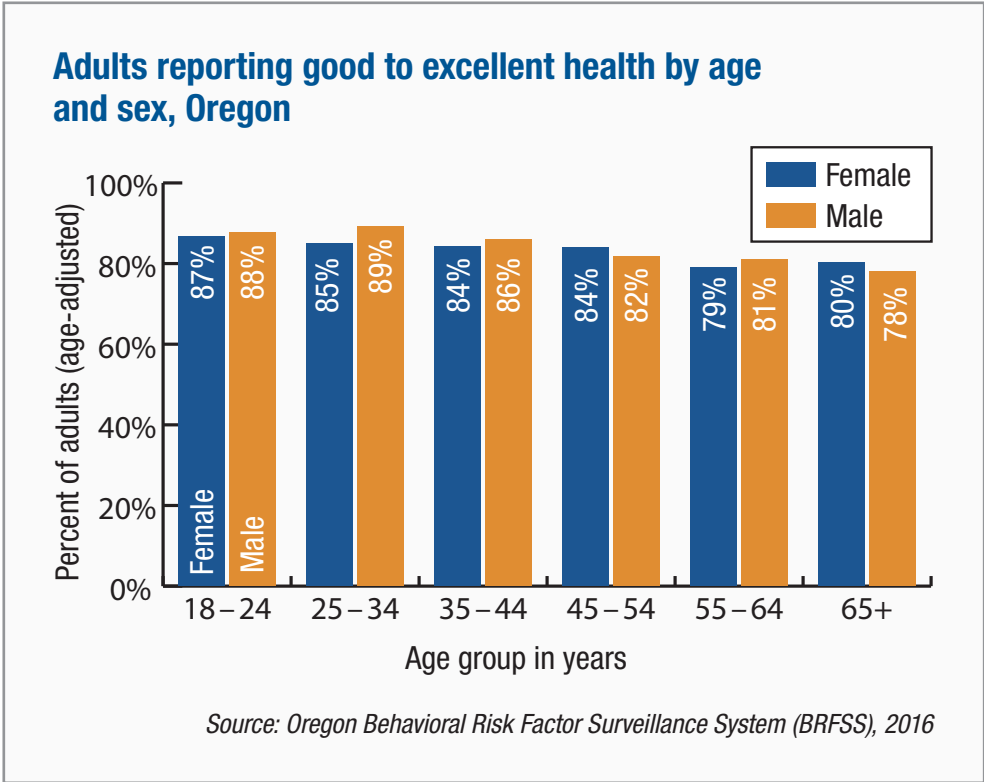
**My community needs...**

**“ Access to the  
necessary means to prevent  
health problems before  
they start.”**

– SHA Community Participant

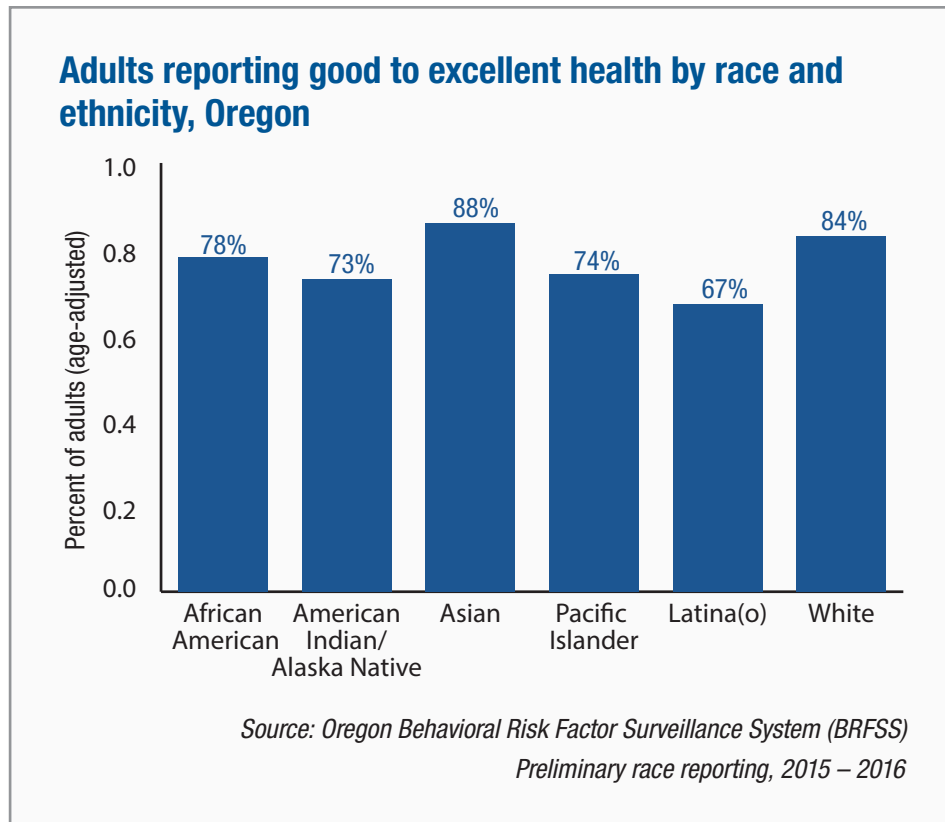
# Overall Health

Self-reported health is an important indicator of overall population health. From 2000 through 2016, more than 80% of Oregon adults reported being in good or excellent health.

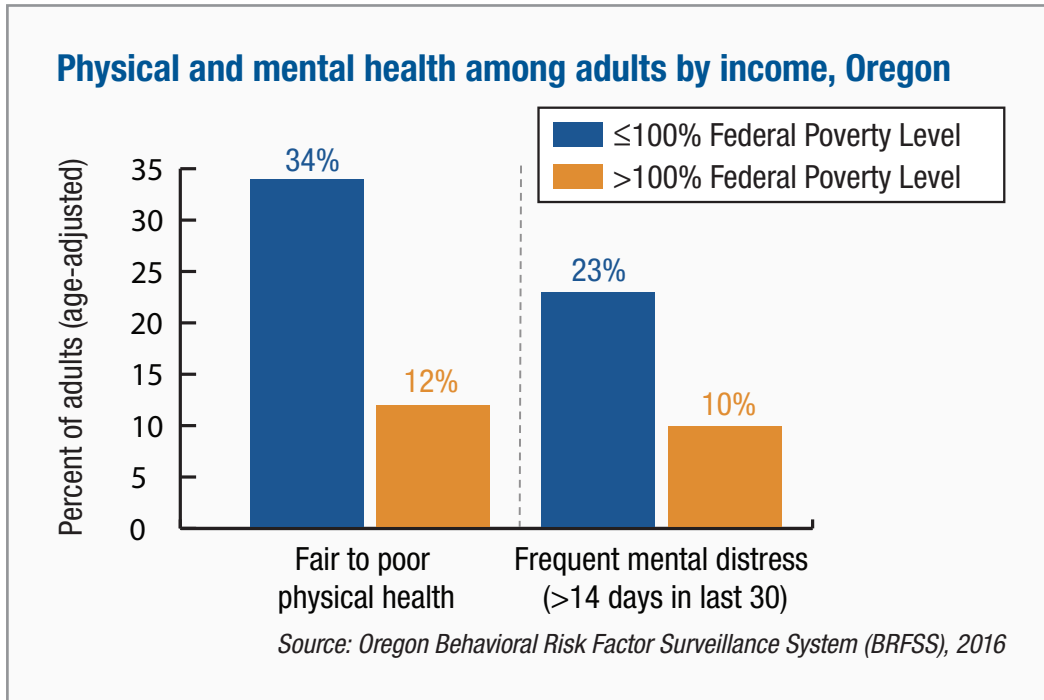


## Disparities in Overall Health

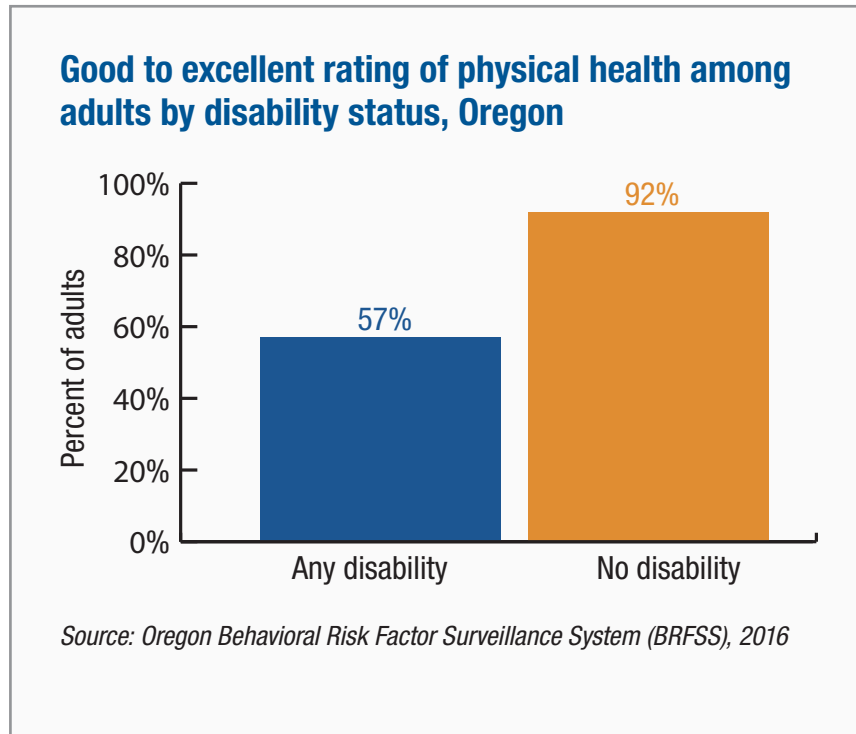
For adults who identify as African American, American Indian and Alaska Native, or Latina(o), the percentage who report good to excellent health is considerably lower than for those identifying as non-Latina(o) white or Asian and Pacific Islander.



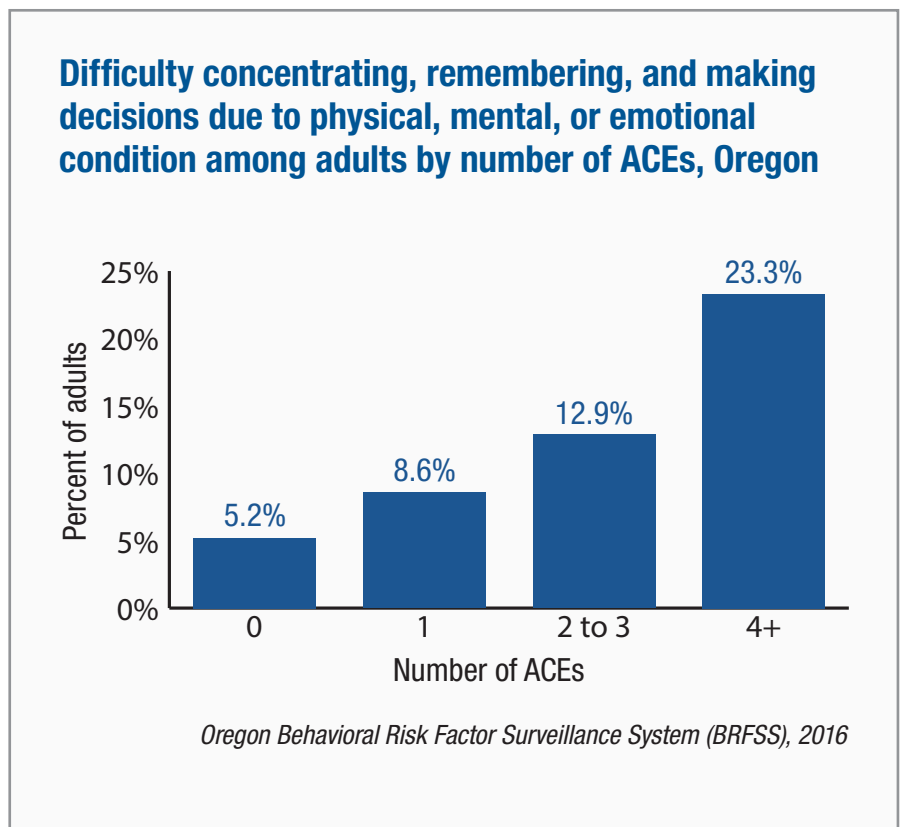
Adults living at or below the federal poverty level are less likely to report good to excellent physical health. In addition, they are more than twice as likely to report frequent mental distress.



Adults living with a disability rate their physical health as lower than those with no disability.



People who have experienced four or more adverse childhood experiences (ACEs) are 4.5 times more likely to have difficulty concentrating, remembering, and making decisions due to their physical, mental or emotional condition, compared to those who experienced no ACEs.



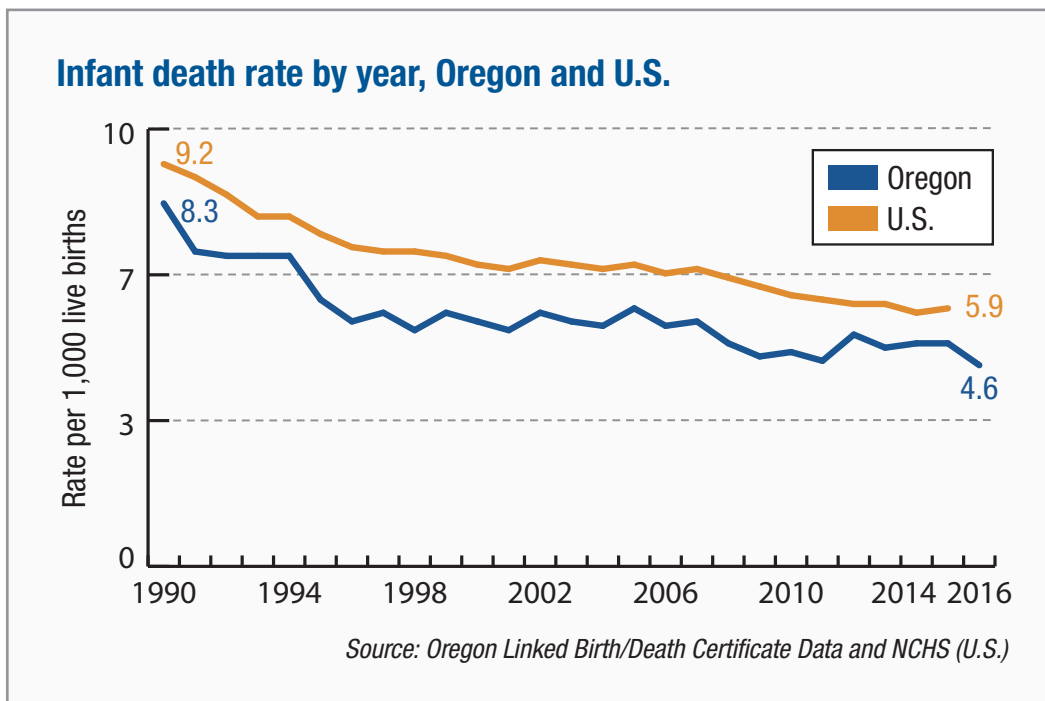
# Maternal, Child, and Adolescent Health

Although the majority of community members agreed that Oregon is a good place to raise a child, Oregon ranks below average in child well-being. According to the 2017 Kids Count Data Book produced by the Annie E. Casey Foundation, Oregon ranks 31st out of 50 states across four domains of child well-being.\*

“ I think we should focus on children at this point. Parents need to be able to get parenting education so that our next generation is safe, happy, healthy, and educated. ”

– SHA Community Participant

Infant mortality (the death of an infant during the child’s first year) in the United States has dramatically declined over the past 60 years. This decline is largely due to medical advances and hospital care provided to premature infants. Nationally, the leading causes of infant death are birth defects, prematurity/low birth weight, maternal complications of pregnancy, sudden unexplained infant death syndrome (SUIDS), and injuries. Oregon’s infant death rate has been lower than the U.S. rate for more than 25 years, but racial and ethnic disparities persist.



\* <http://www.aecf.org/m/resourcedoc/aecf-2017kidscountdatabook.pdf>

Maternal depression (depression during pregnancy or after the baby's birth) adversely affects women, their infants, children, and families. Children of depressed mothers are at risk for health, developmental, emotional, behavioral, and learning problems that can last for many years. In Oregon, more than one in four new mothers (29.9%) report symptoms of depression either during pregnancy or after the birth of their babies.

Breast milk is the most complete form of nutrition for infants, with well-documented benefits for their health, growth, immunity, and development. Breastfeeding rates in Oregon are higher than in the nation as a whole. In 2014, 80.4% of Oregon mothers breastfed their infants at eight weeks after delivery (compared to 64.8% nationally), and 68.2% were still breastfeeding at six months postpartum (compared to 51.8% nationally).\*

Schools often provide the best opportunity for health education and skill-building for healthy decision-making. The positive youth development (PYD) framework measures the physical, psychological, and social strengths that contribute to a young person's healthy development. Higher PYD levels are strongly associated with behaviors that promote physical and emotional health, as well as academic achievement. PYD levels among 8th and 11th graders in Oregon have remained relatively stable since 2006 when the measure was first reported, with a decline between 2013 and 2017. Just over half of students are meeting the PYD benchmark (56% of 8th graders and 57.7% of 11th graders). Latina(o) youth have the lowest level of PYD among 8th graders.

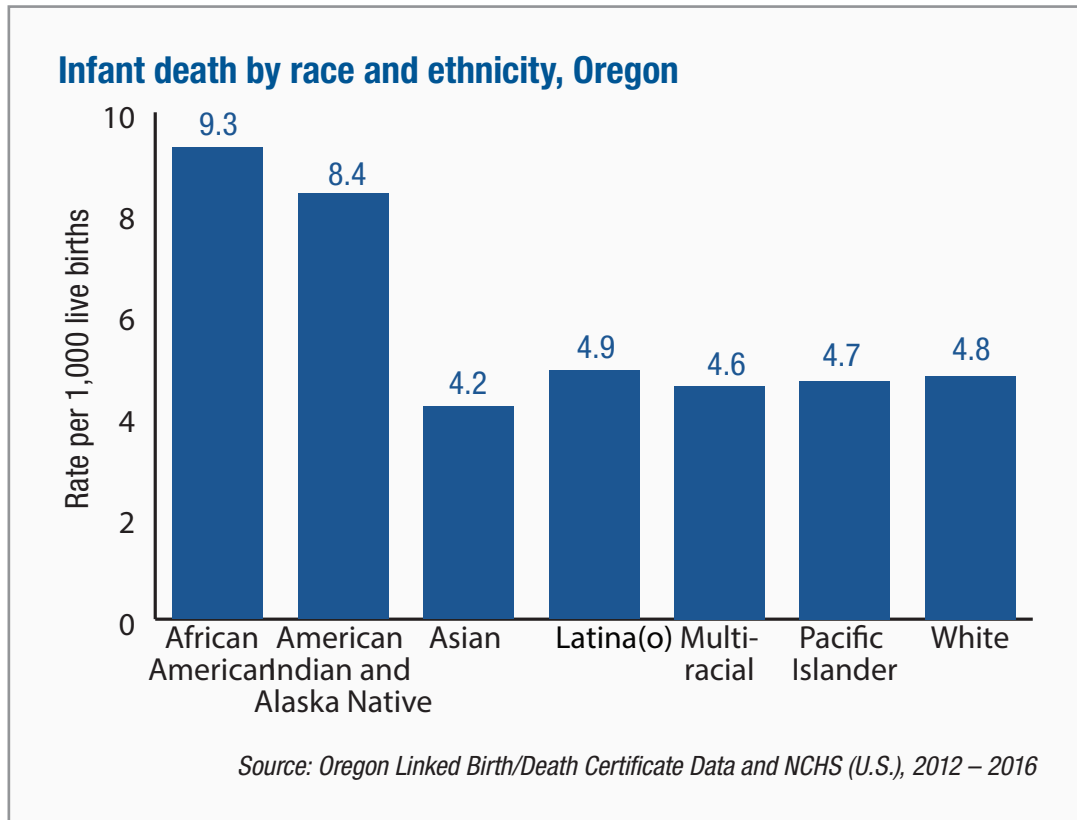
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\* Breastfeeding Among U.S. Children Born 2002 – 2013, CDC National Immunization Survey



## Disparities in Maternal, Child, and Adolescent Health

On average from 2012 to 2016, infant death rates in Oregon were highest among African Americans (9.3 per 1,000 live births) and American Indians and Alaskan Natives (8.4 per 1,000 live births) as compared to Whites (4.8 per 1,000 live births).



## Sexual Health

Ensuring young people have accurate information to make thoughtful choices about their sexual health is important to overall well-being. Within K-12 school settings, Oregon's Human Sexuality Education Law requires that youth have information about healthy relationships, consent, communication, pregnancy, and STI prevention, as well as resources for support when they need them. Although Oregon boasts one of

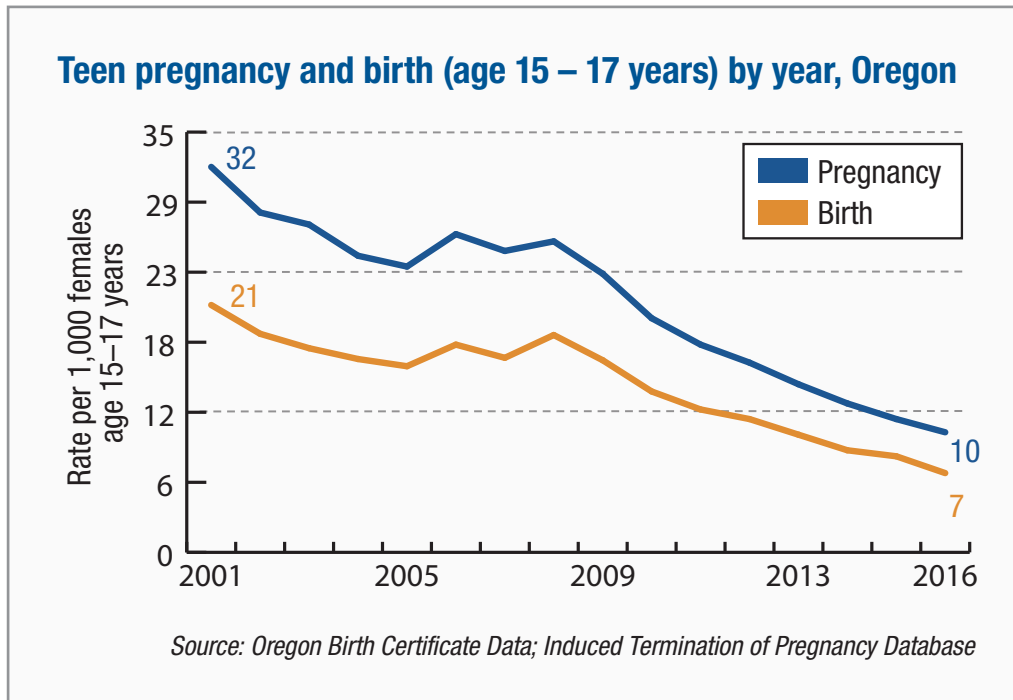
My community needs...

“ Better health education on sex ed, gender, and relationships.”

– SHA Community Participant

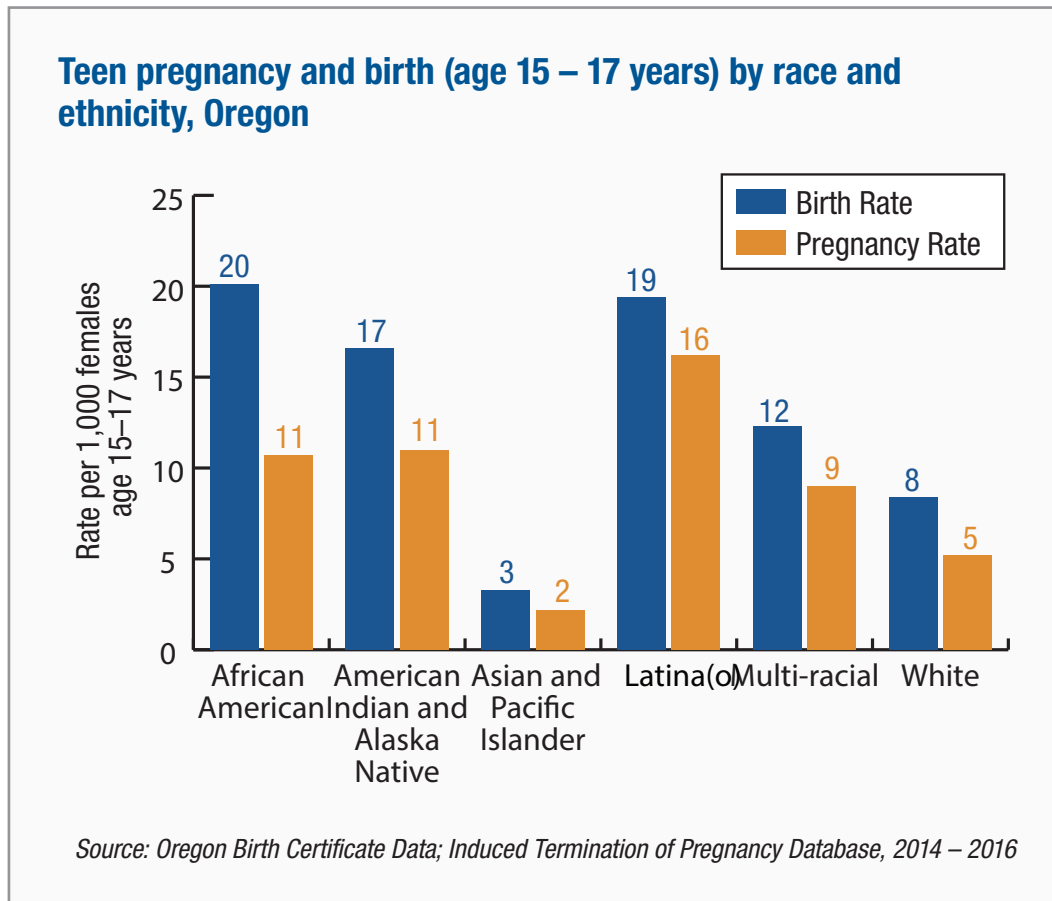
the most comprehensive sex-education curriculums in the country, some community members who participated in the SHA process felt that this curriculum wasn't being followed in their local schools and that education around sexual health was lacking.

In Oregon, sexual activity among 8th and 11th graders is on the decline. The teen pregnancy rate among females 15 to 17 years continues to fall, from 32.1 per 1,000 teens in 2001 to 10.0 per 1,000 in 2016. From 2010 to 2016, Benton County had the lowest teen birth rate (4.5 per 1,000), while Malheur County had the highest (23.1 per 1,000). Disparities in sexual health persist among youth of color, LGB youth, youth with disabilities, and youth in rural areas.



## Disparities in Sexual Health

In Oregon, the highest rates of teen pregnancy are among African American, American Indian and Alaska Native, and Latina teens.



# Nutrition and Physical Activity

People in Oregon appreciate affordable, safe, and easily accessible opportunities for physical activity and outdoor recreation. People in Oregon are very active, ranking third in the country for physical activity.\* Overall, most Oregon adults (88%) report adequate access to places where they can be physically active; however, large disparities are visible across the state, from just 7% reporting adequate access in Sherman County to 99% in Multnomah County.†

Although many of us can access opportunity for exercise, many SHA participants said that it's difficult to afford healthy foods. Others identified a need for health education to improve nutrition, such as community-based programs about preparing nutritious foods. Participants frequently pointed to community gardens and farmers markets as nutrition-related assets in their areas. Despite this, only 20% of adults report eating the recommended five servings of fruit and vegetables every day, a number that has remained stubbornly low for several years.

“Healthy eating, exercise, running or walking 20 minutes a day, hiking, and outdoor activities.”

– SHA community participant

“A tax on high sugar drinks.”

– SHA community participant

“Have some type of fitness activities or facilitates that are usable at hours adaptable by young and old.”

– SHA Community Participant

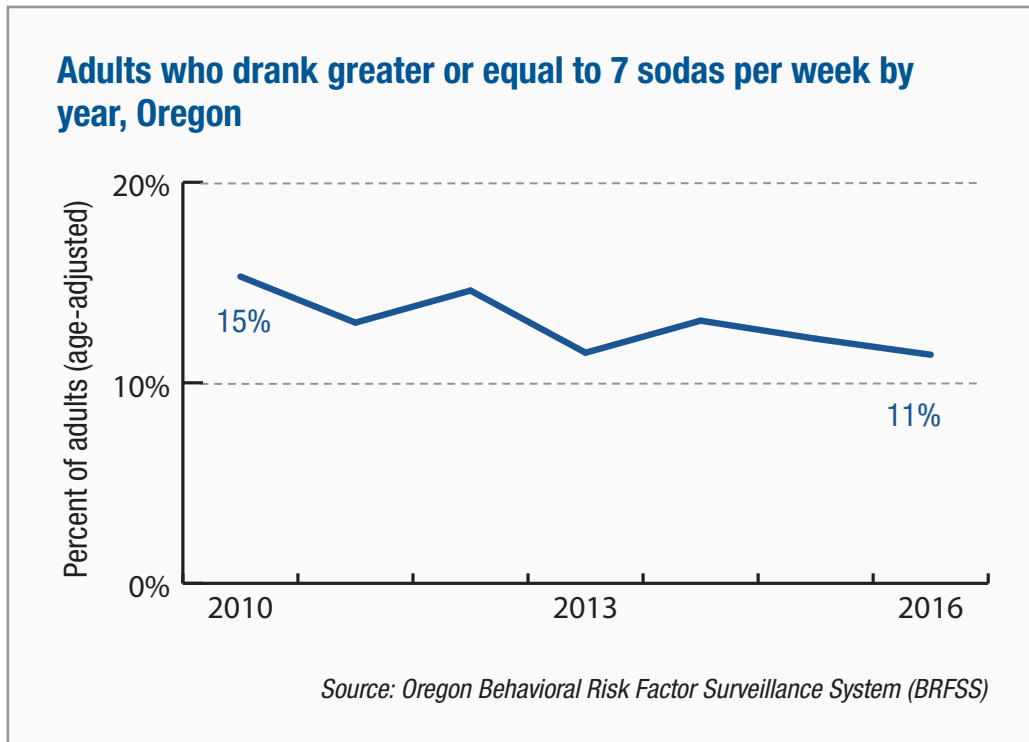
“Our community is rural and very poor. We need more investment in a community center, pool, and places for kids to recreate after school. Easy and affordable access to exercise facilities that are in good shape, affordable fresh foods like fruits and vegetables, and more access to food boxes for working families.”

– SHA Community Participant

\* <https://www.americashealthrankings.org/learn/reports/2017-annual-report>

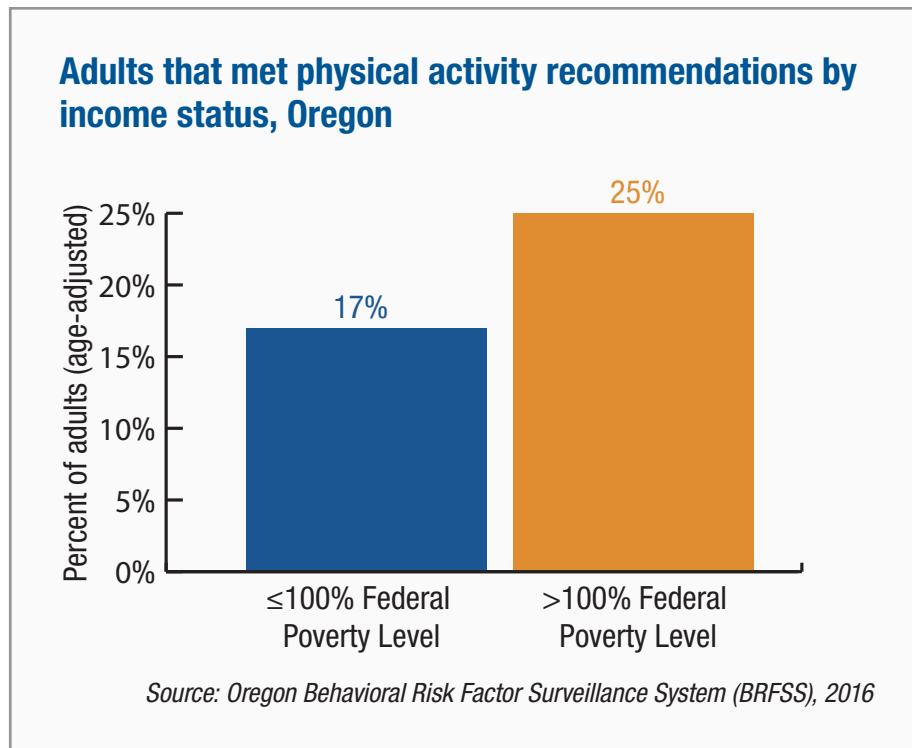
† County Health Rankings

In addition, about one in nine Oregon adults consume seven or more sodas per week, although this percentage has declined since 2010.

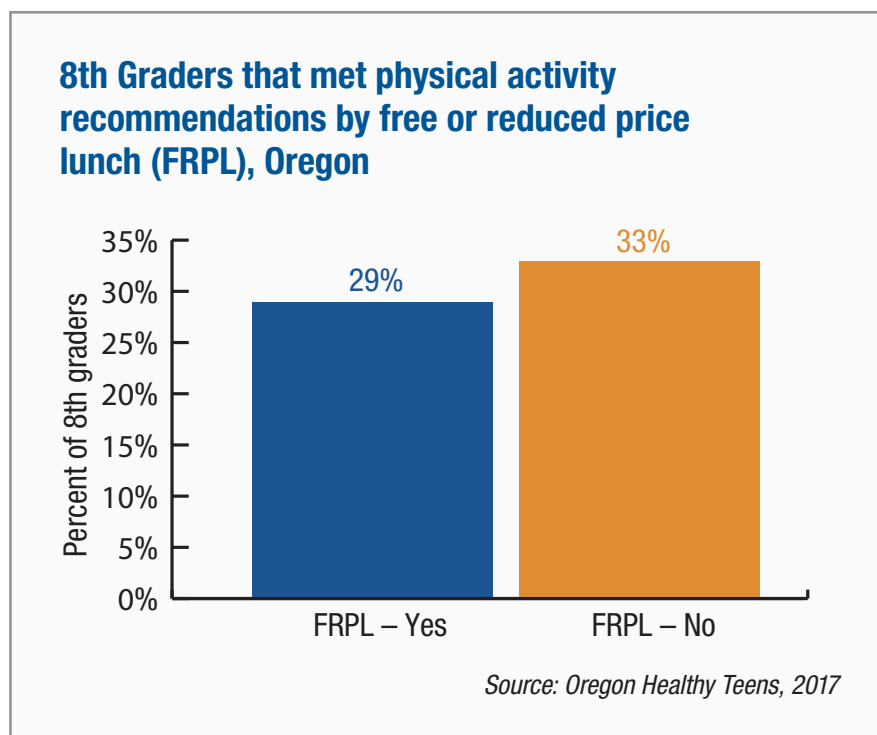


## Disparities related to nutrition and physical activity

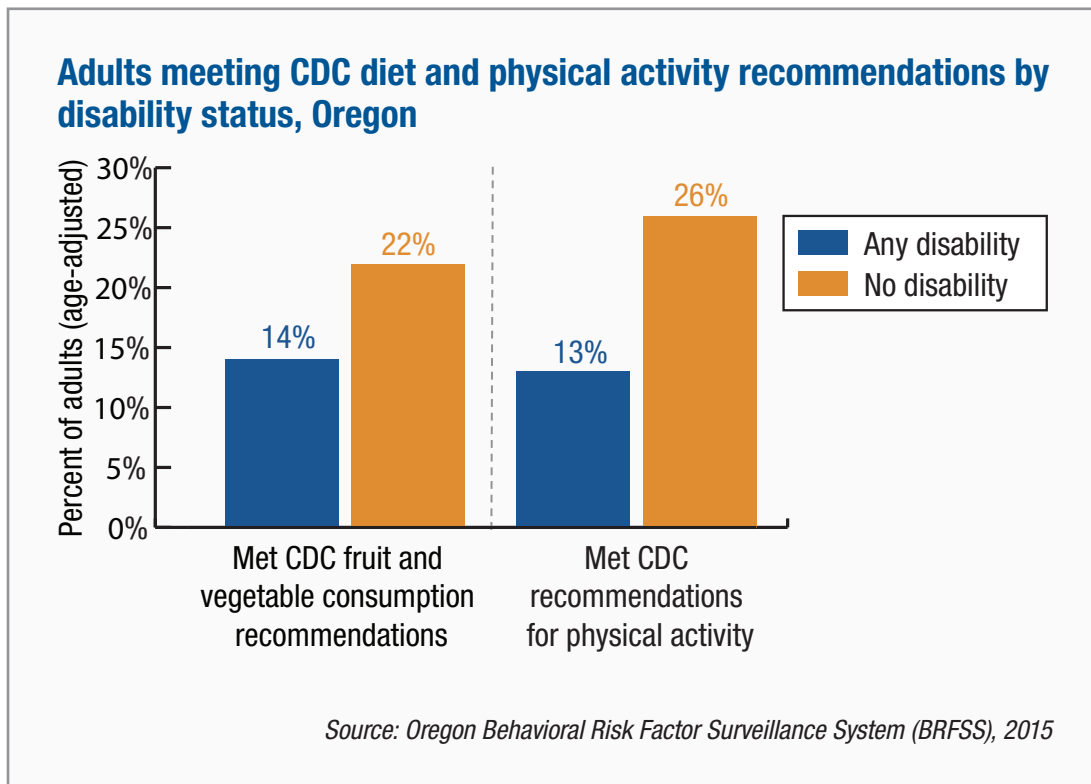
Adults with higher income are more likely to meet physical activity recommendations.



Children and teens who receive free or reduced price lunch (FRPL) at school are less likely to meet physical activity recommendations.



Adults with disabilities also eat fewer fruits and vegetables and get less physical activity than those without disabilities.



# Behavioral Health

Behavioral health, including mental health and addictions, is a priority concern for people in Oregon. A 2017 Pain in the Nation\* report illustrated the epidemic of drug overdoses, alcohol, and suicide, ranking Oregon the 10th highest in the country for related deaths. Without significant improvements and investments in prevention-related policy and programs, deaths related to drugs, alcohol, and suicide could increase by 35% by 2025.

## Mental Health

Oregon has the highest prevalence of mental illness among youth and adults in the nation. According to the 2017 State of Mental Health in America report, Oregon ranked 49th out of 51 states (including D.C.) in mental health outcomes (down from 40th in 2011).† An estimated 1 in every 5 adults is coping with a mental health condition. Mental health disorders are increasing among adolescents as well. In 2017, 30% of 8th graders and 32% of 11th graders reported being in a depressed mood for two weeks out of the past year. School-based mental health programs are an excellent opportunity to address this problem.

**My community needs...**

**“ We need to look at  
better mental health and  
more access to the care  
we need. ”**

– SHA Community Participant

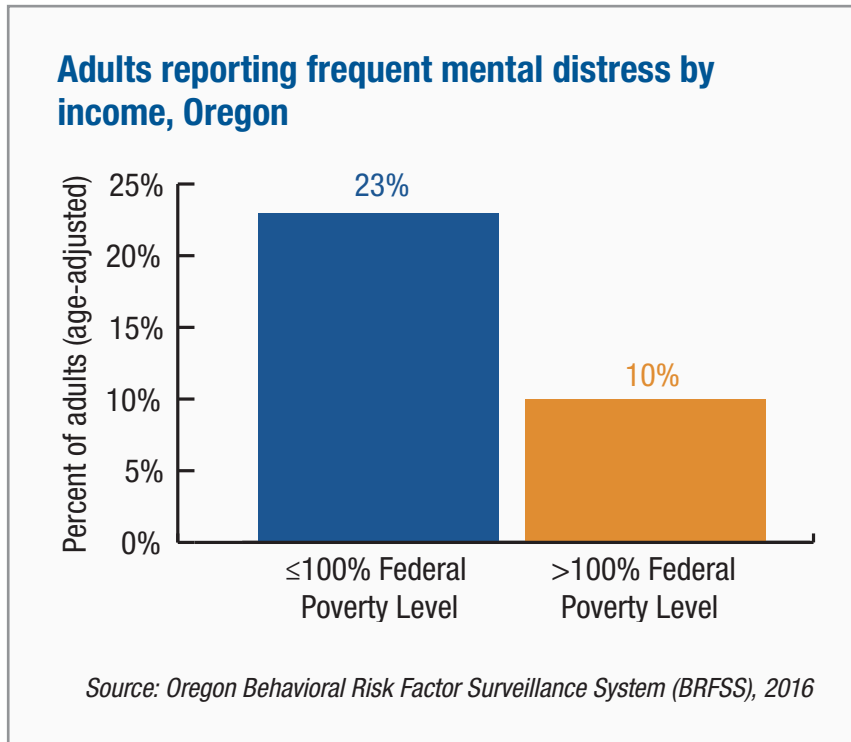
\* [healthyamericans.org/assets/files/TFAH-2017-PainNationRpt-FINAL.pdf](http://healthyamericans.org/assets/files/TFAH-2017-PainNationRpt-FINAL.pdf)

† <http://www.mentalhealthamerica.net/issues/mental-health-america-printed-reports>

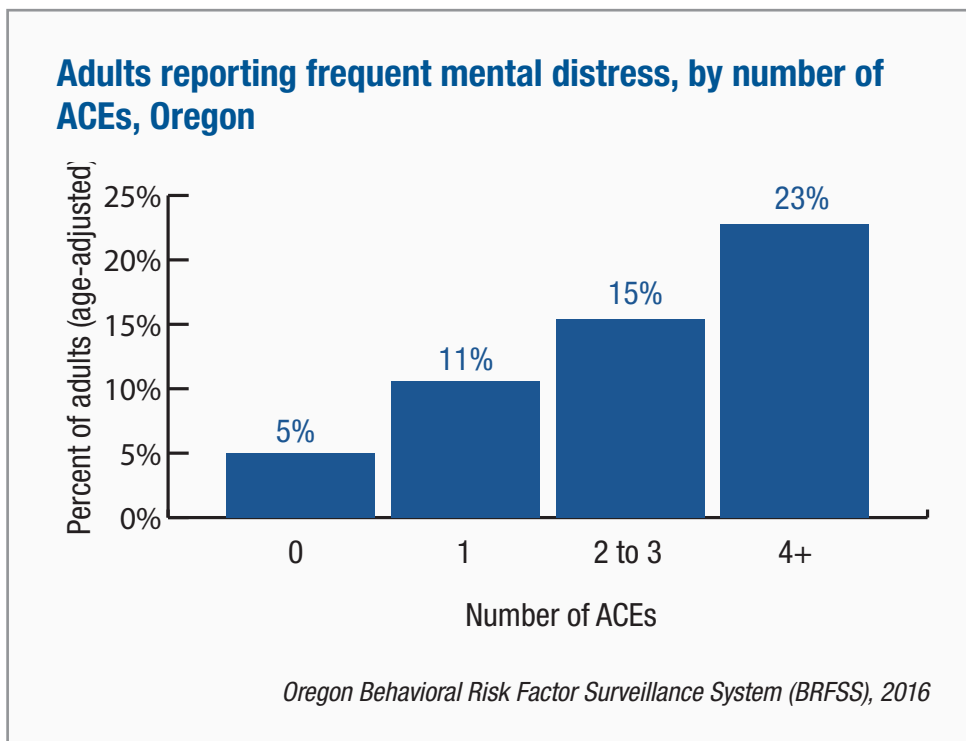


## Disparities Related to Mental Health

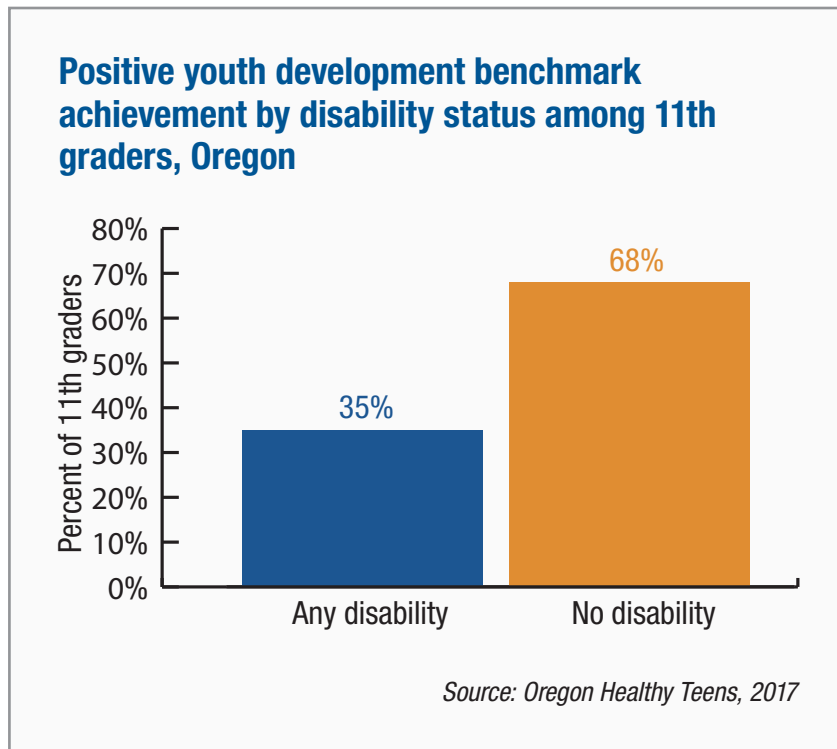
Adults living with low income report more frequent mental distress.



Adults who have experienced four or more ACEs are 4.6 times more likely to have frequent mental distress.

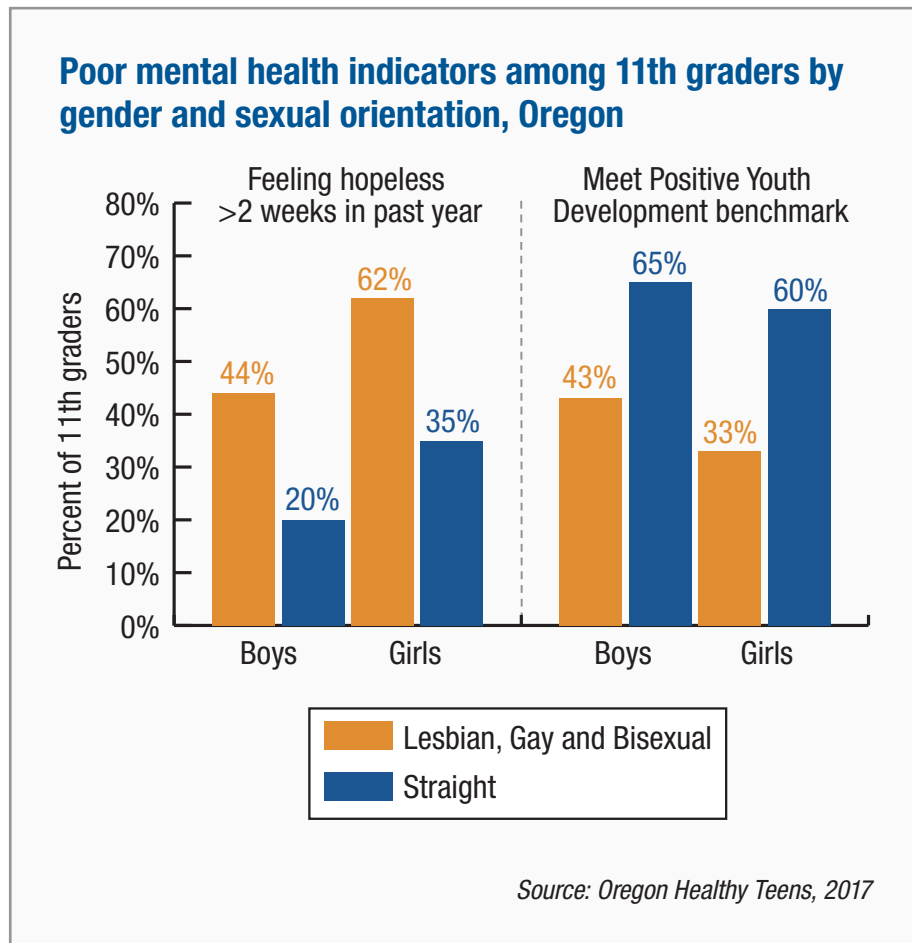


Positive youth development (PYD)\* is a significant protective factor for emotional well-being among youth. Youth without a disability are more likely to meet the benchmark for PYD.



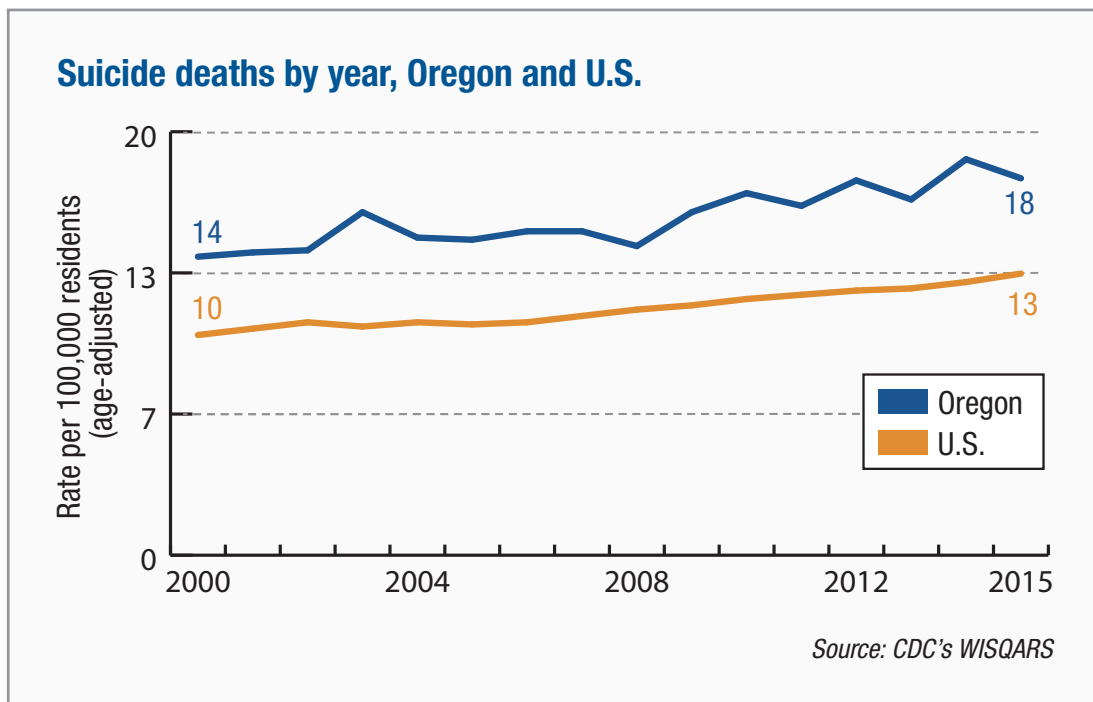
\* The PYD benchmark is a composite measure of physical, mental and emotional health status, and protective individual and environmental factors.

Gay and bisexual youth are at higher risk for a number of indicators of poor mental health.



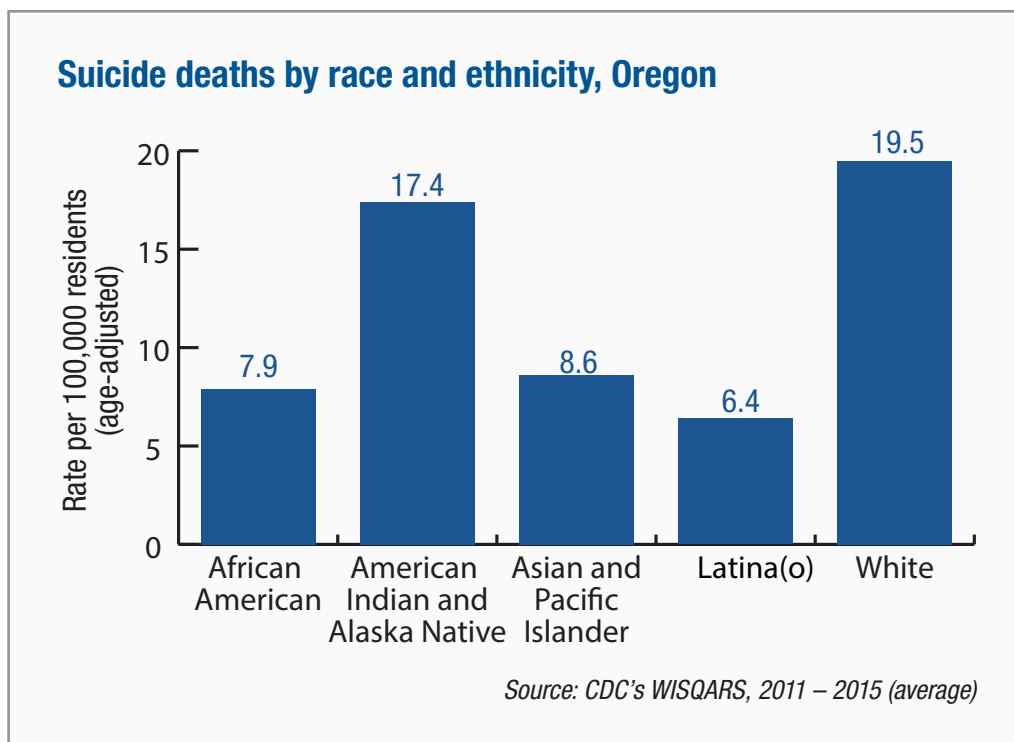
## Suicide

Suicide is an important cause of early death in Oregon, and suicide rates in Oregon have been consistently higher than national rates for the past 30 years. Suicide rates in Oregon and the United States have been increasing over the past decade. In 2015, 762 people in Oregon died by suicide (17.8 per 100,000 residents). People who attempt suicide, when it's not fatal, can suffer lasting health problems that may include brain damage, organ failure, depression, and other mental health problems.

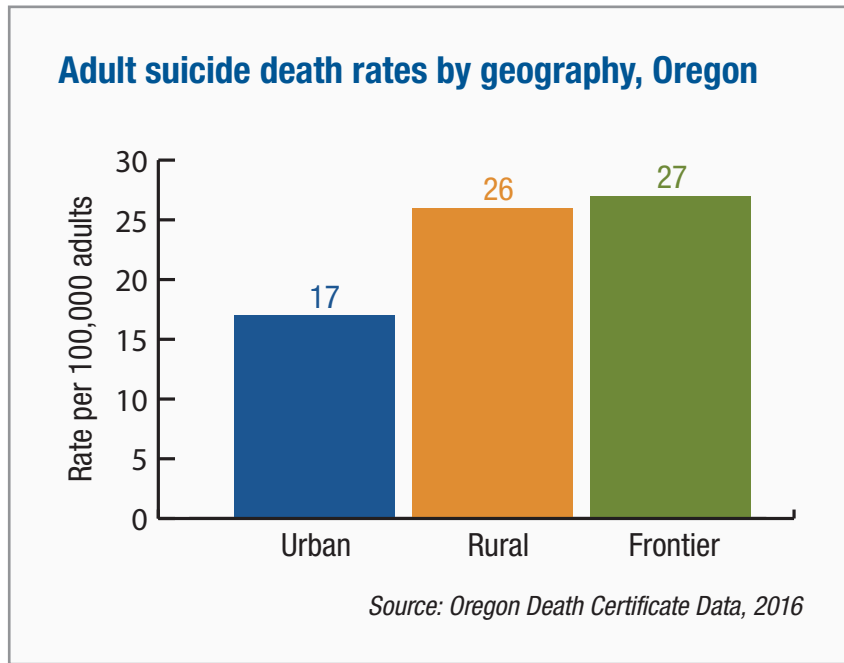


## Disparities in Suicide

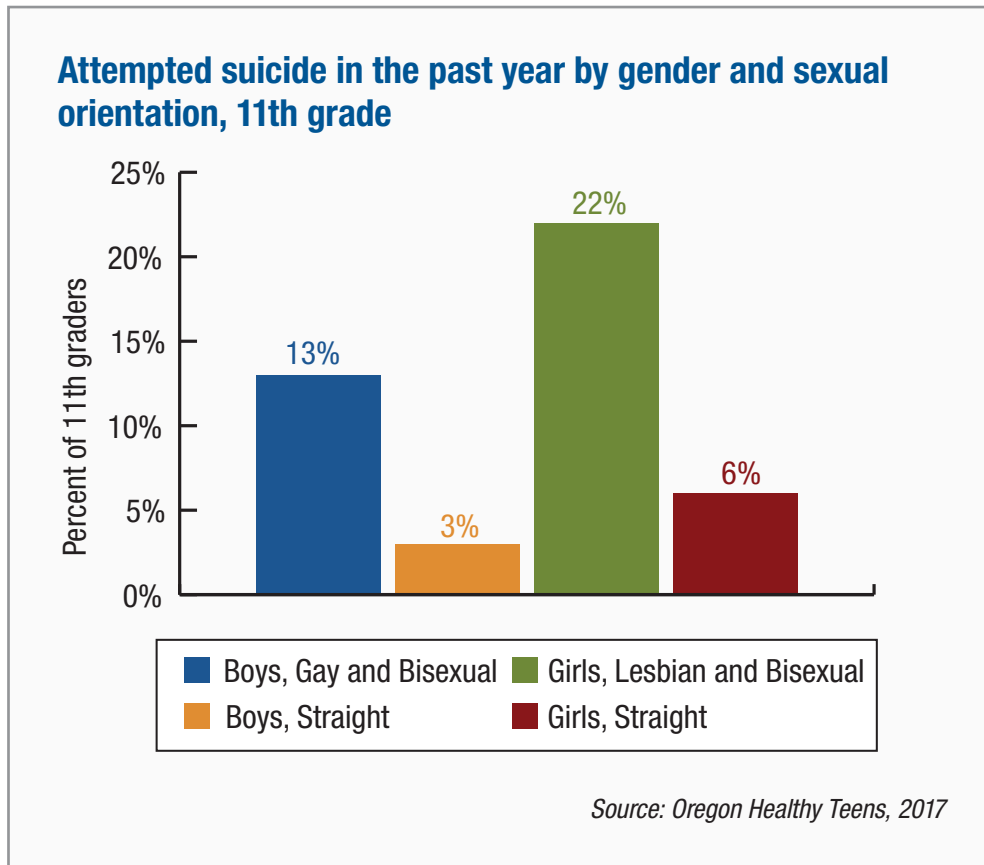
Suicide deaths are disproportionately high among white men and Indians and Alaska Natives.



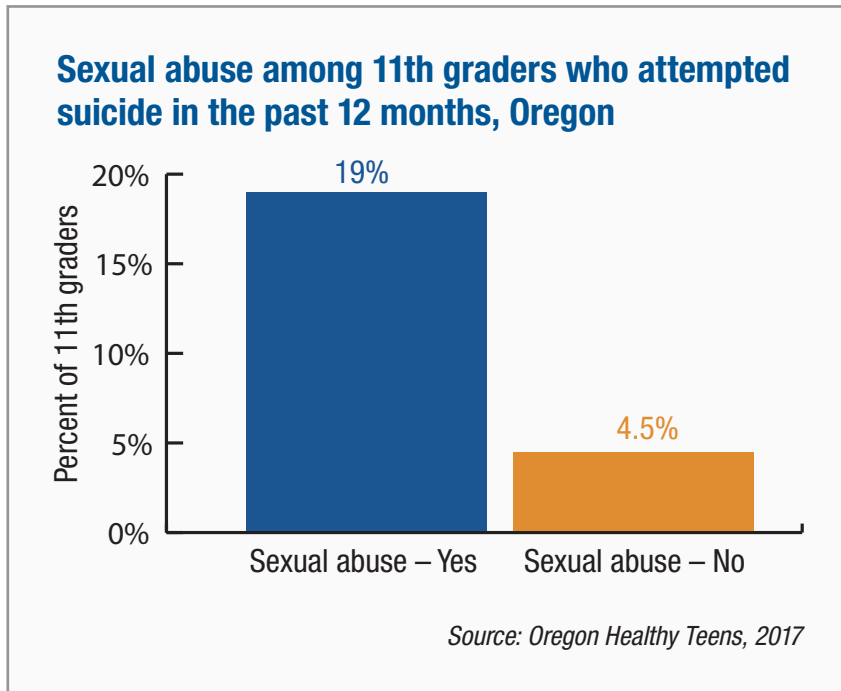
Suicide rates are highest in frontier and rural areas.



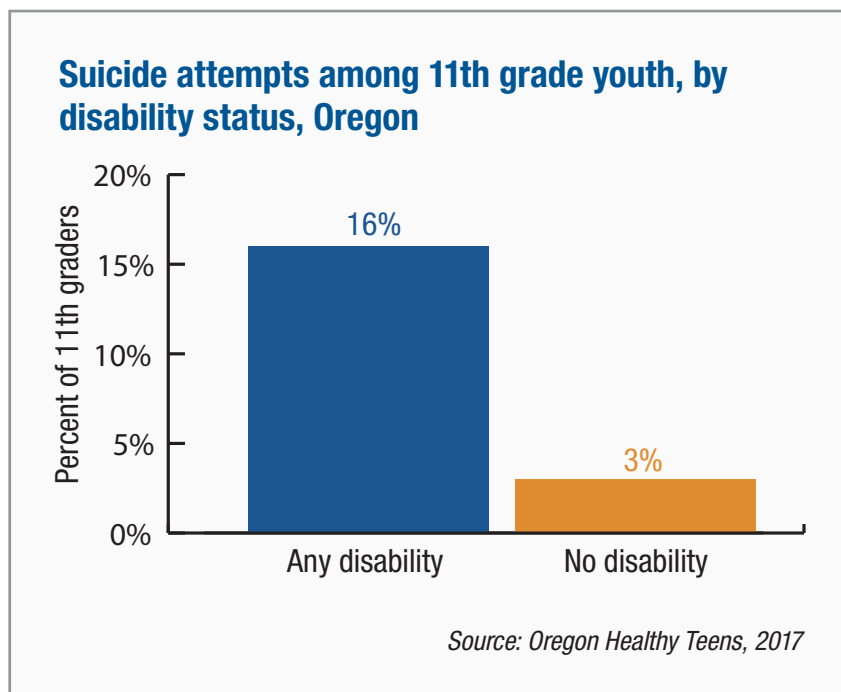
Gay and bisexual youth are more likely to have attempted suicide in the past year.



Youth who have experienced physical or sexual abuse in the past 12 months are more likely to attempt suicide.



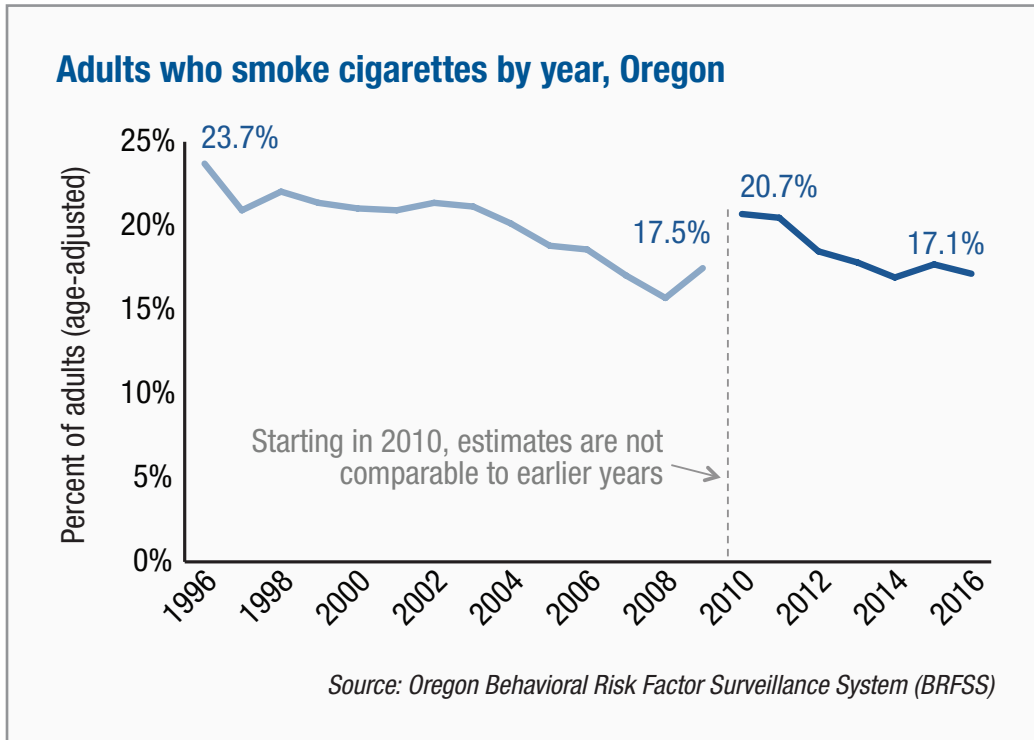
Youth with disabilities are more likely to attempt suicide.



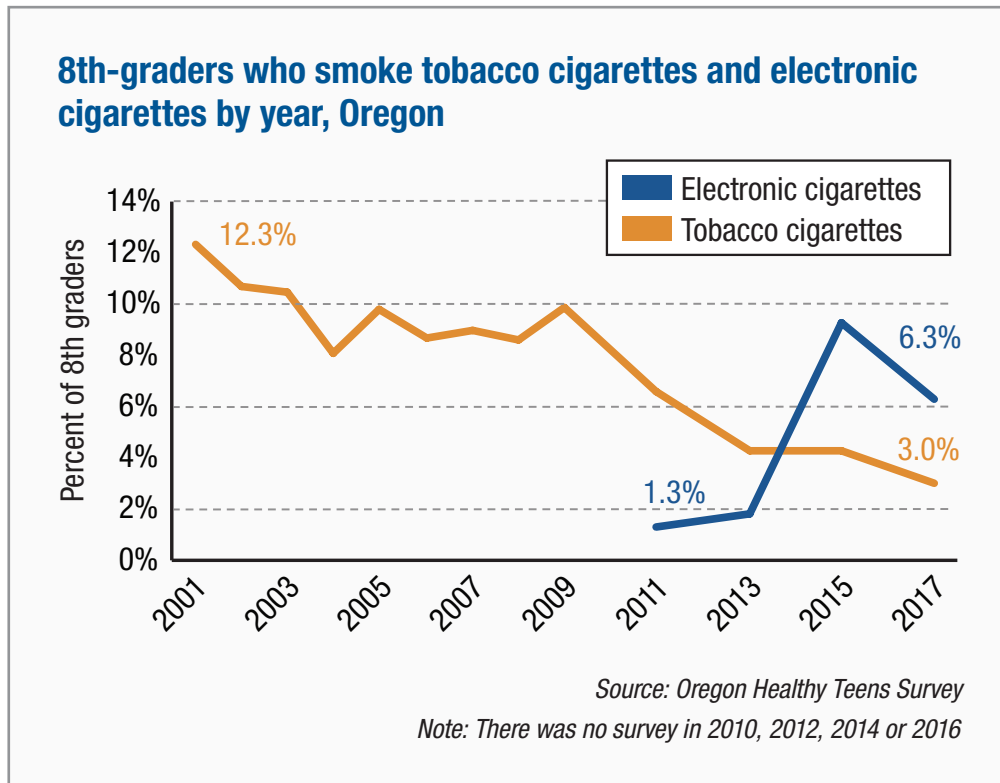


## Tobacco, Alcohol and Other Drugs

Tobacco use remains the number one contributor to preventable death in Oregon, killing more than 7,500 people in Oregon every year. Secondhand smoke causes an additional 650 deaths every year. The consequences of tobacco use fall hardest on lower-income people and certain racial and ethnic groups.

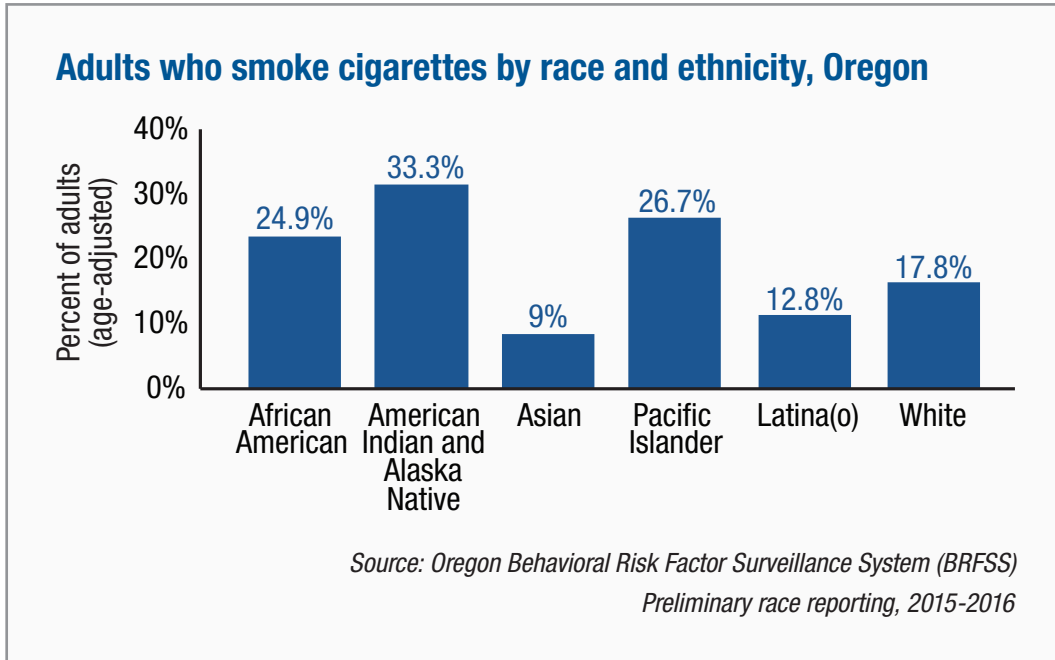


We can potentially lessen the health consequences of tobacco use in Oregon by changing our environment and policies. For example, many people who participated in SHA community meetings asked for more enforcement of laws related to tobacco use and tobacco sales to minors.

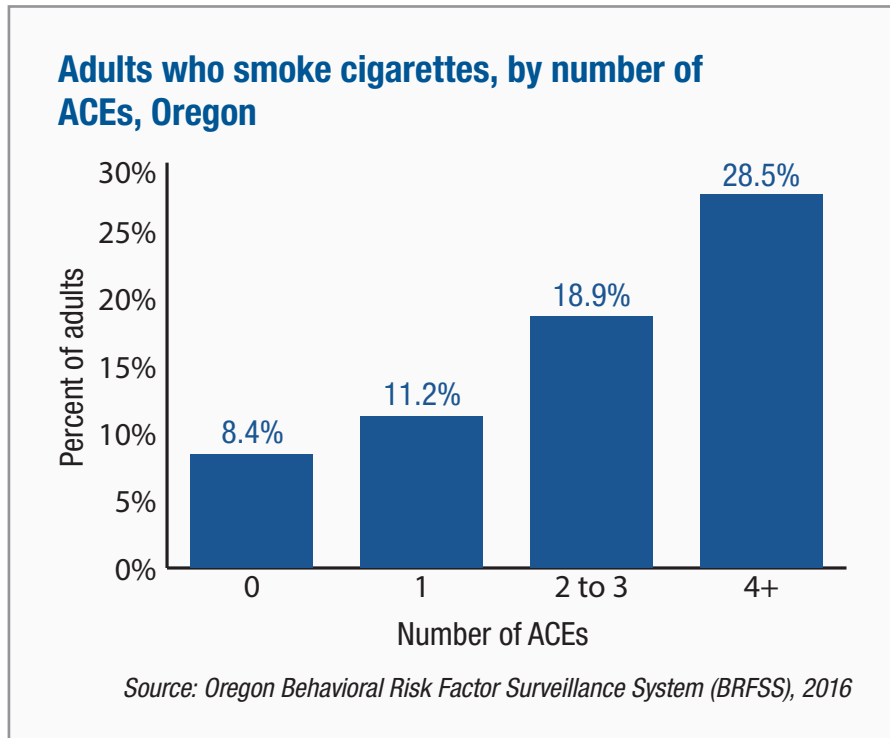


## Disparities Related to Tobacco

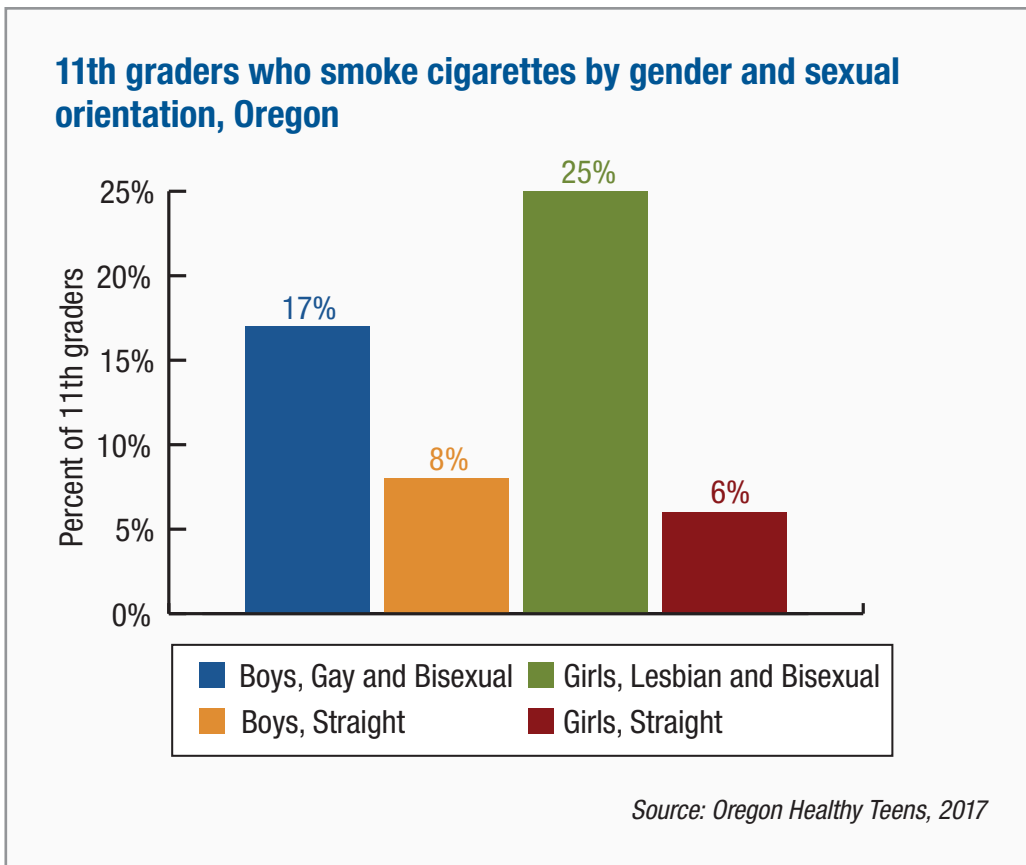
Cigarette use is higher among African Americans, American Indians and Alaska Natives, Latina(o)s and Pacific Islanders.



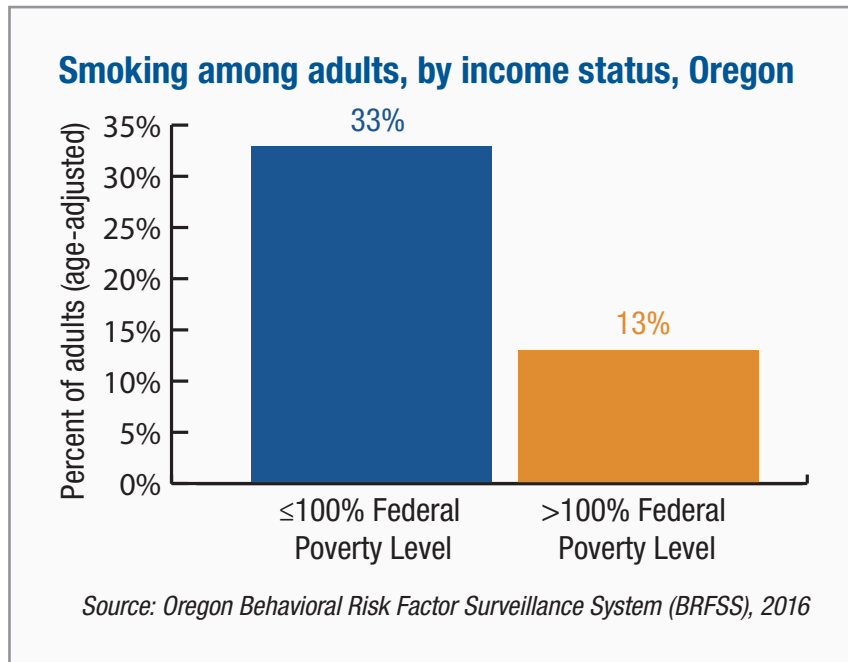
People who have experienced four or more ACEs are 3.4 times more likely to be a smoker.



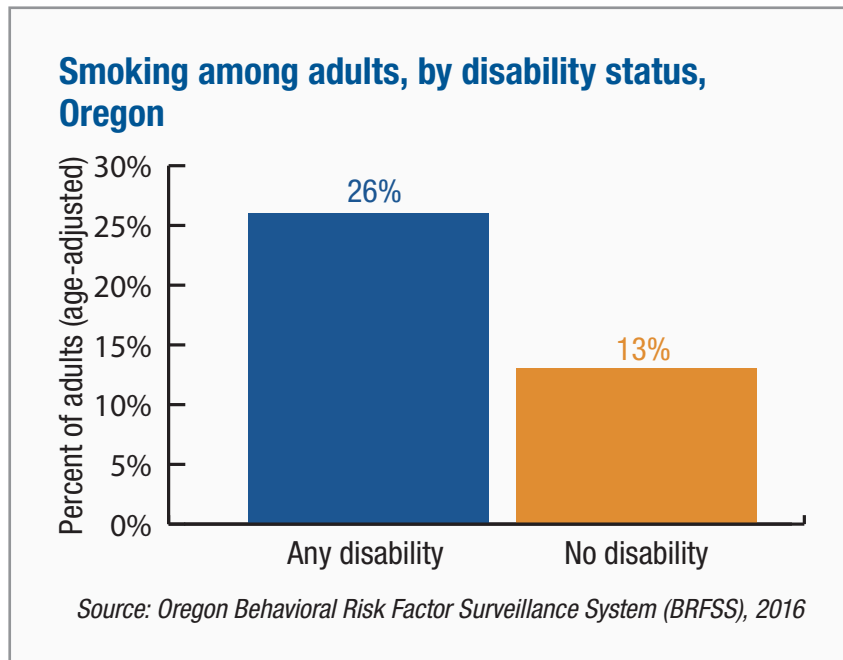
Gay and bisexual youth are more likely to smoke than their straight peers.



Cigarette use is almost twice as high among adults of low socioeconomic status compared to the general population.



Adults with disabilities are more likely to smoke.



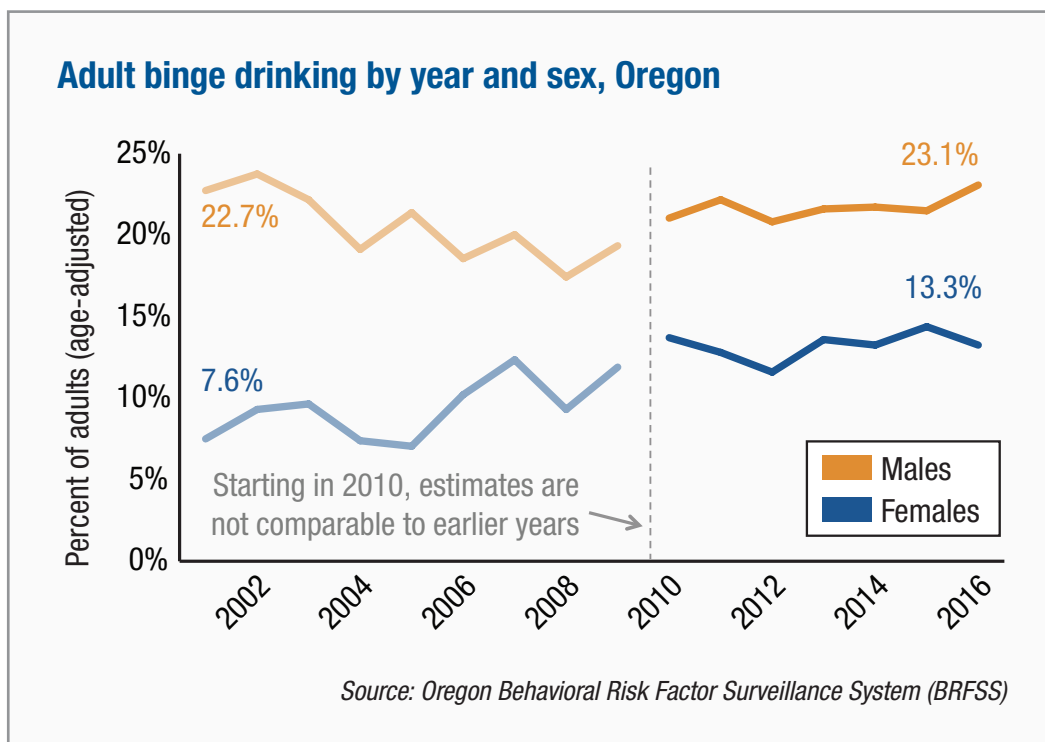
## Alcohol

Oregon ranks third highest in the country for deaths related to alcohol.\* Excessive alcohol use can increase a person's risk of developing serious health problems such as brain and liver damage, heart disease, cancer, fetal damage in pregnant women, and early death. It is a risk factor for injuries, violence, unintended pregnancy, and motor vehicle crashes. In 2015, 1,933 people in Oregon (43 per 100,000 population) died from alcohol-related causes, including chronic diseases, acute poisoning, injury, and perinatal causes. This represents a 38% increase in the overall rate of alcohol-related deaths since 2001. Binge drinking† and heavy drinking‡ among Oregon adults are of particular concern.

My community needs...

“ Fewer dispensaries, liquor stores, and smoke shops, especially within view of school and children. Restrictions on advertising marijuana, alcohol, and tobacco.”

– SHA Community Participant



\* [healthyamericans.org/assets/files/TFAH-2017-PainNationRpt-FINAL.pdf](http://healthyamericans.org/assets/files/TFAH-2017-PainNationRpt-FINAL.pdf)

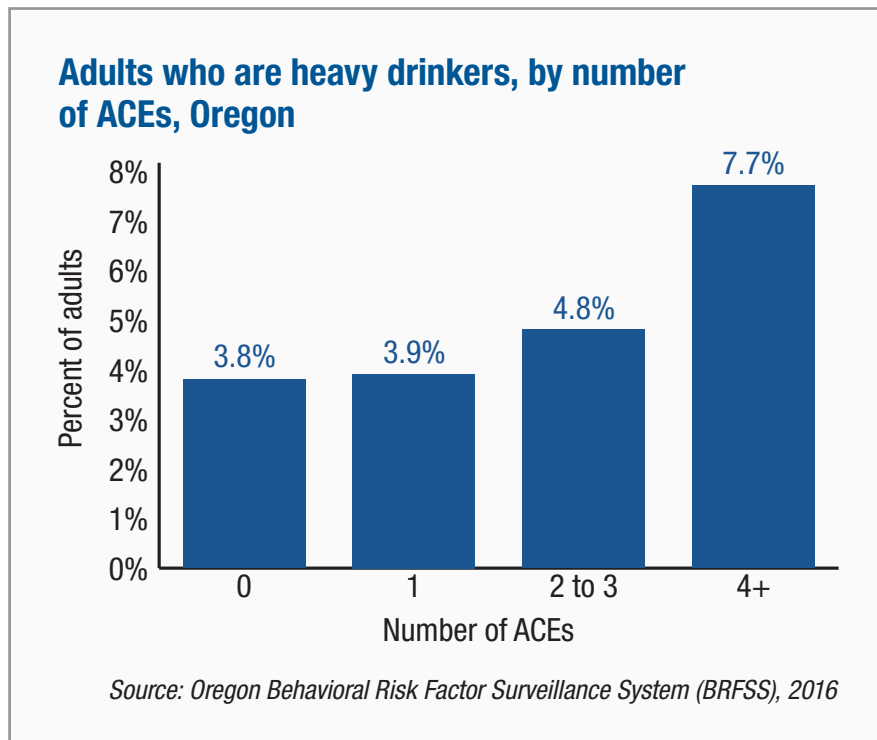
† Defined as drinking four or more drinks for women, and five or more drinks for men, on at least one occasion in the past 30 days.

‡ Defined as 15 drinks or more per week for men or eight drinks or more per week for women.

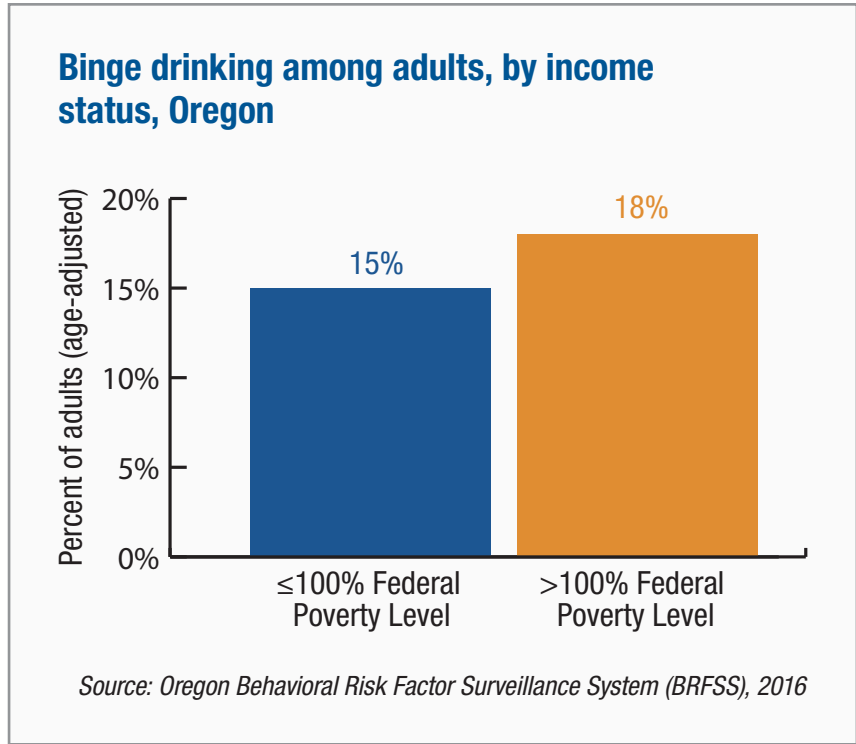
- In 2016, 17% of adults reported binge drinking on at least one occasion within the last month. Adult males report binge drinking more frequently than women.
- In 2017, 14% of 11th graders reported binge drinking on at least one occasion within the last month.
- Rates of adult binge or heavy drinking differ across the state, ranging from 11% in Jefferson County to around 26% in Grant County.

## Alcohol-related Disparities

People with four or more ACEs are twice as likely to be heavy drinkers.

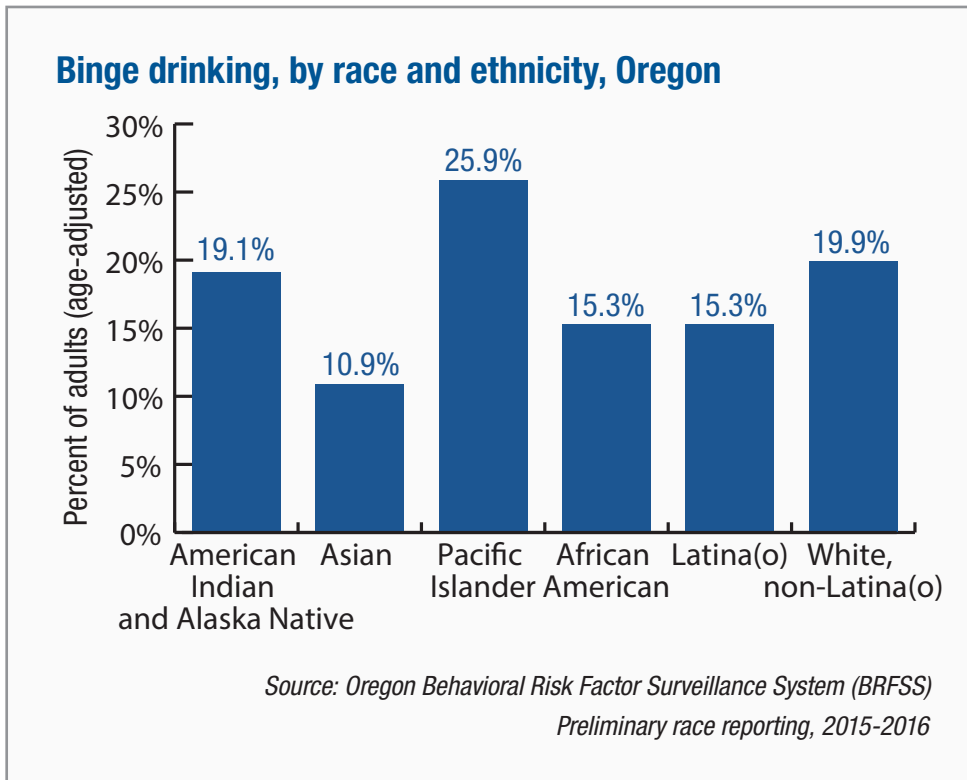


While people with lower income are more likely to smoke, they're less likely to binge drink.



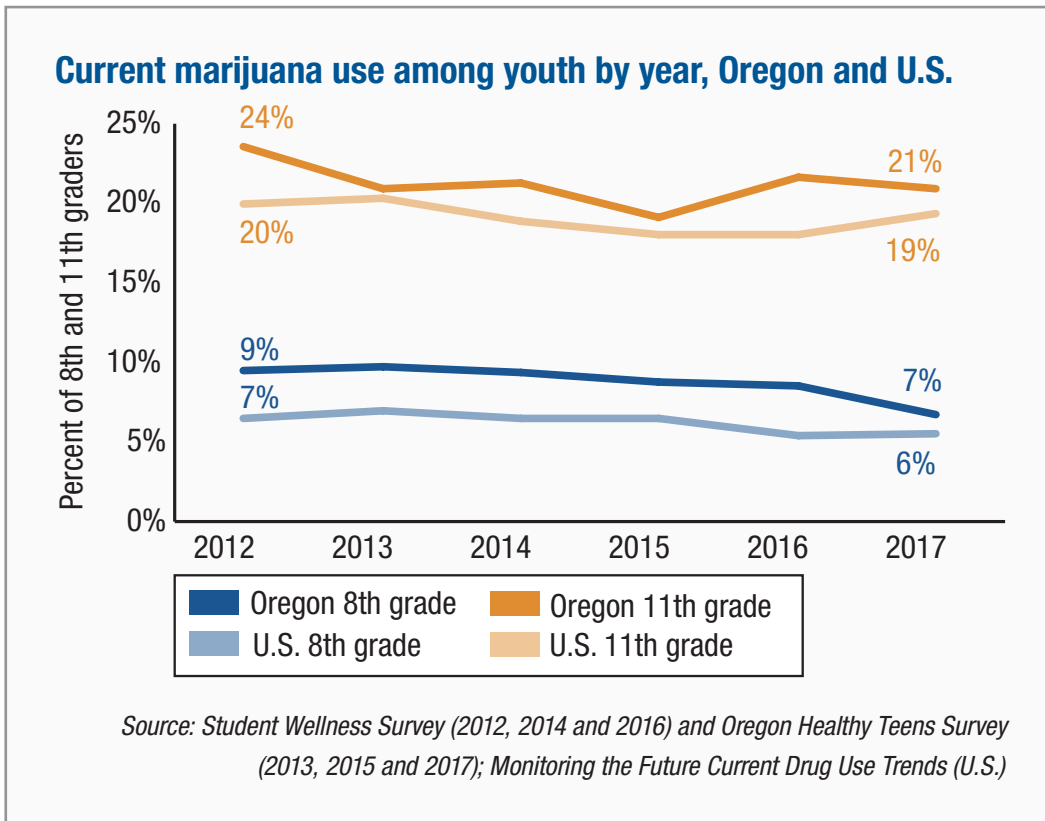


American Indians and Alaska Natives, Pacific Islanders, and Whites have the highest prevalence of binge drinking.



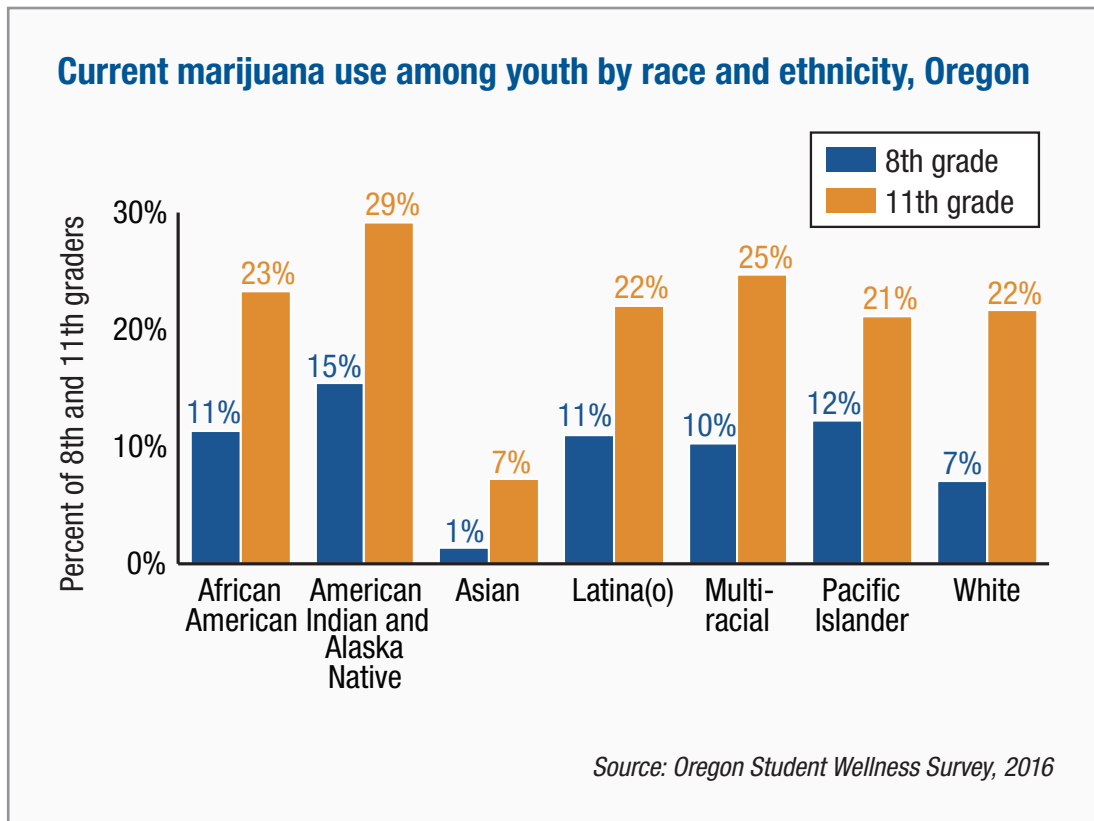
# Marijuana

Marijuana use among Oregon youth and adults has exceeded national rates for the past decade. Marijuana use is consistently higher for younger adults compared to older adults.



## Disparities in Marijuana Use

American Indian and Alaska Native youth have the highest rates of marijuana use, while Asian youth have the lowest rates.



## Prescription and Illicit Drugs

The abuse of substances, both prescribed and controlled, has devastating effects on families and communities across Oregon.

Use of prescription pain relievers has driven a sharp increase in opioid misuse and related deaths since 1999. Opioids include prescription drugs as well as non-prescription drugs such as heroin. Opioid-related overdose deaths in Oregon increased steadily from 2000 to a peak in 2011. Fortunately, these deaths have been declining since 2011.

Methamphetamine is also a top concern, as the number of related deaths is comparable to deaths from opioids. According to Oregon's Criminal Justice Commission, 80% of convictions for possession of a controlled substance in 2016 were specific to possession of methamphetamine.\* Methamphetamine made up the largest portion of drug arrests that year as well: 15,308, compared to 4,990 for heroin.†

### My community needs...

“ Better control of drug distribution, rehab places for those trying to kick addictions.”

– SHA community participant

“ A serious, long-lasting, and impactful investment in all-substances addiction prevention and treatment.”

– SHA community participant

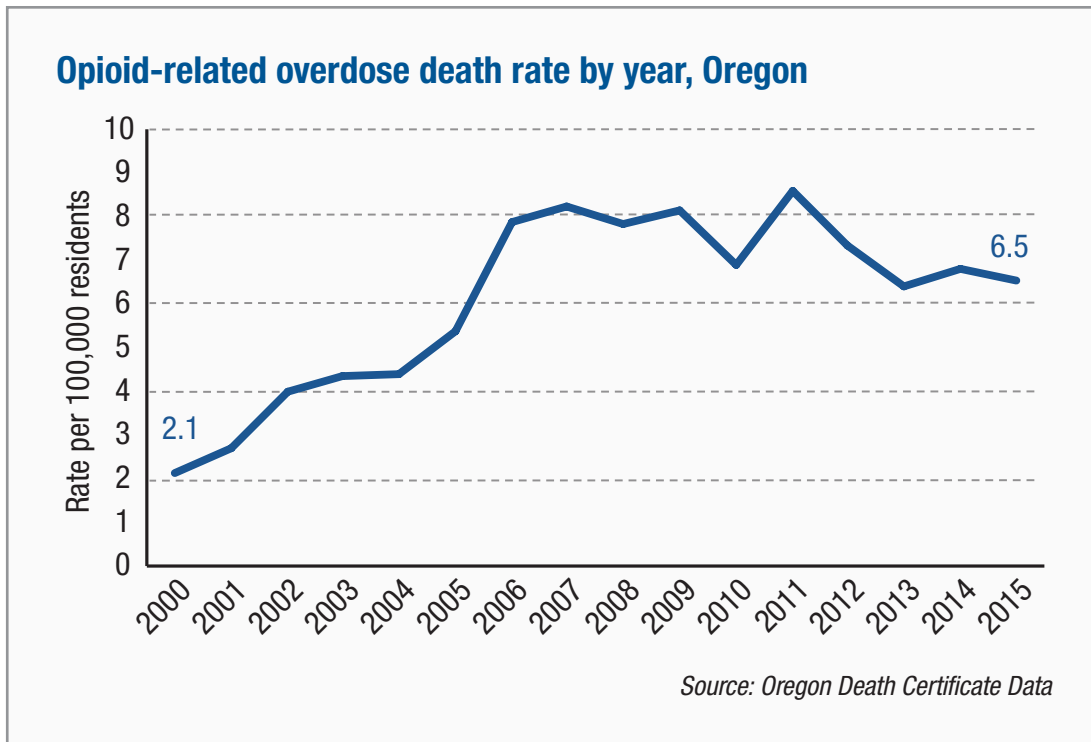
### My community needs...

“ A miracle. Alcohol and drug abuse are rampant.”

– SHA Community Participant

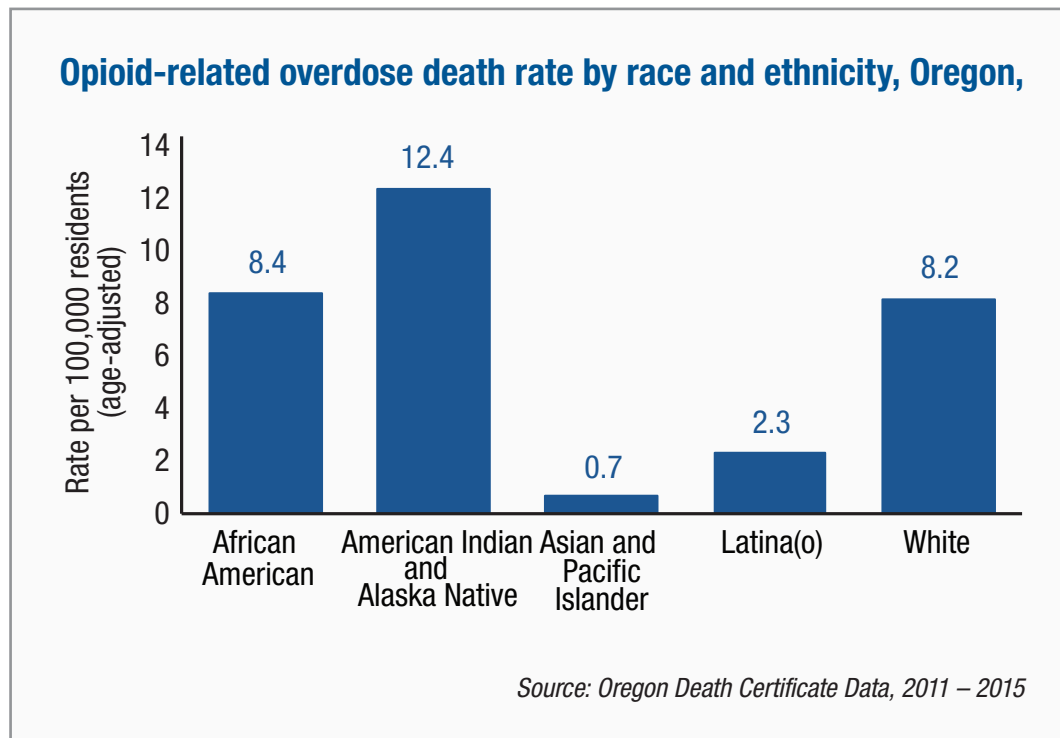
\* <http://www.oregon.gov/cjc/data/Pages/pcs.aspx>

† [http://www.oregonlive.com/pacific-northwest-news/index.ssf/2017/07/meth\\_heroin\\_pose\\_greatest\\_drug.html](http://www.oregonlive.com/pacific-northwest-news/index.ssf/2017/07/meth_heroin_pose_greatest_drug.html)



## Disparities Related to Prescription and Illicit Drugs

The lowest rate of opioid-related overdose deaths occurred among non-Latina(o), Asian and Pacific Islanders.

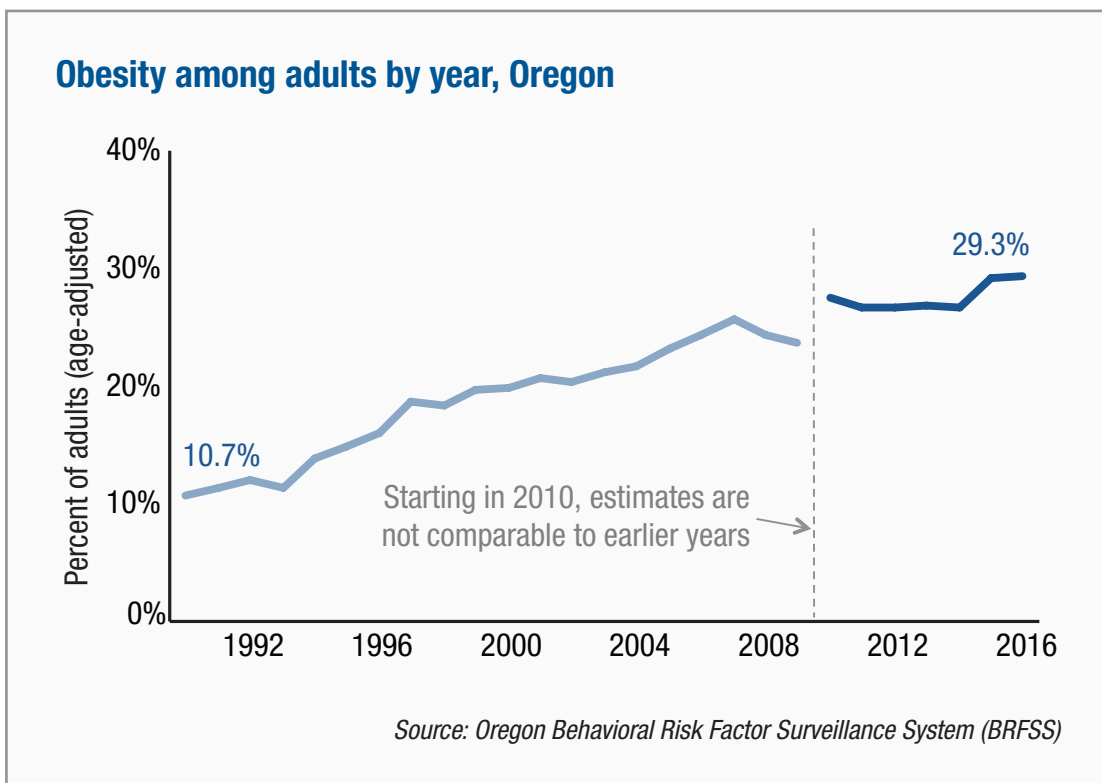


# Chronic Diseases and Conditions

Many people in Oregon are living with a chronic disease, including cancers, cardiovascular diseases, asthma, obesity, and diabetes.

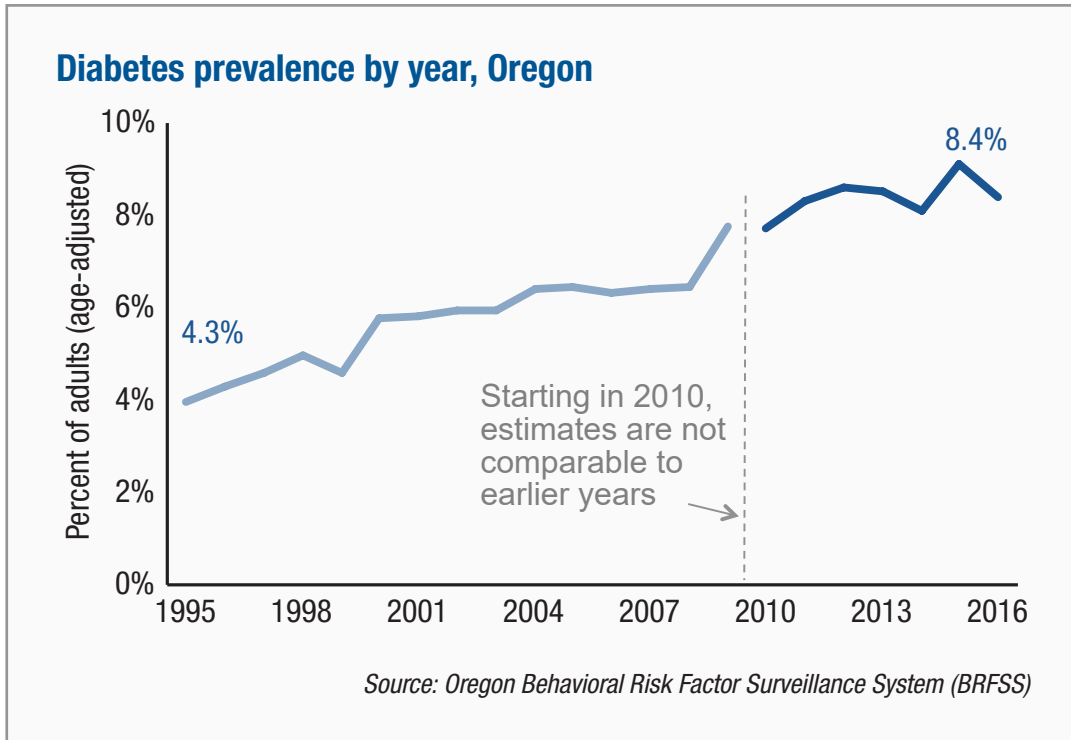
## Obesity

Poor nutrition and lack of physical activity increase risk of obesity, the second-leading contributor to early death in Oregon and responsible for an estimated 6,000 deaths each year. Obesity prevalence among Oregon adults has risen quickly in the past two decades, from 11% in 1990 to 29% in 2016. Obesity is a major risk factor for high blood pressure, high cholesterol, diabetes, heart disease, and cancer. Children with obesity have a greater risk of high blood pressure, high cholesterol, type 2 diabetes, asthma, joint problems, fatty liver disease, gallstones, and gastroesophageal reflux disease (GERD).



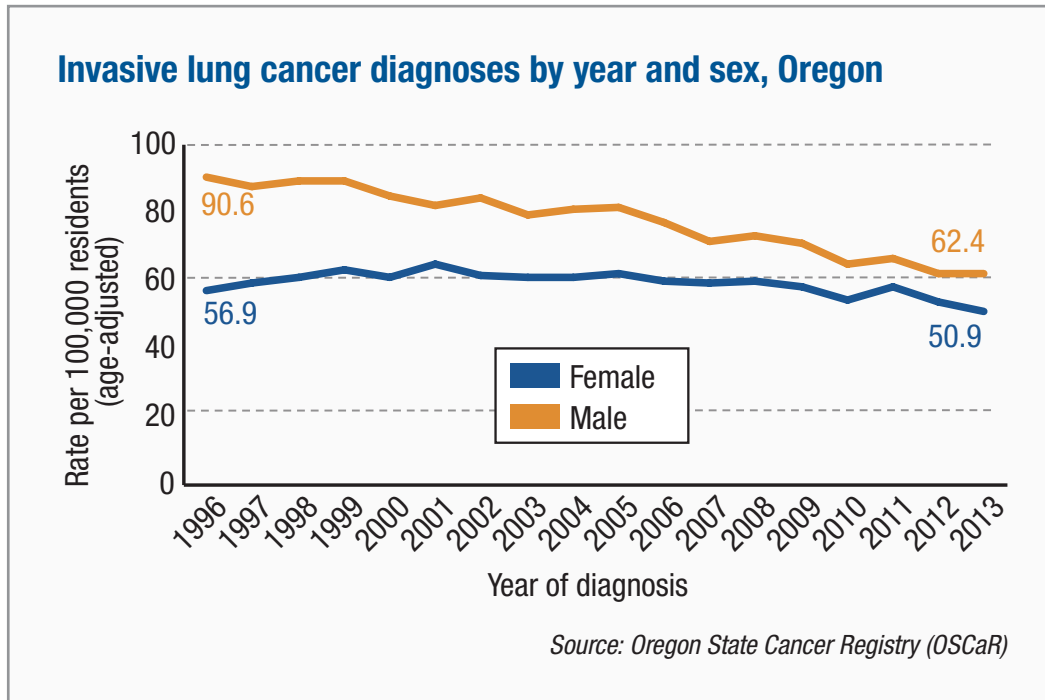
## Diabetes

Diabetes is a chronic disease that occurs when glucose (sugar) levels in the blood are above normal. If not carefully managed, diabetes can cause heart attack, stroke, blindness, and kidney damage. Diabetes can also cause blood vessel and nerve damage so severe that it may result in limb amputation. In 2016, 8% of Oregon adults reported having diabetes, which is twice the percentage that reported having diabetes in 1995. The increase in diabetes prevalence is a national trend that tracks with increasing rates of obesity.



## Lung Cancer

Lung cancer is the leading cause of cancer deaths in Oregon and was the second most commonly reported cancer in 2014.\* Oregon death certificates indicate that nearly four out of five lung cancer deaths are related to tobacco smoking.

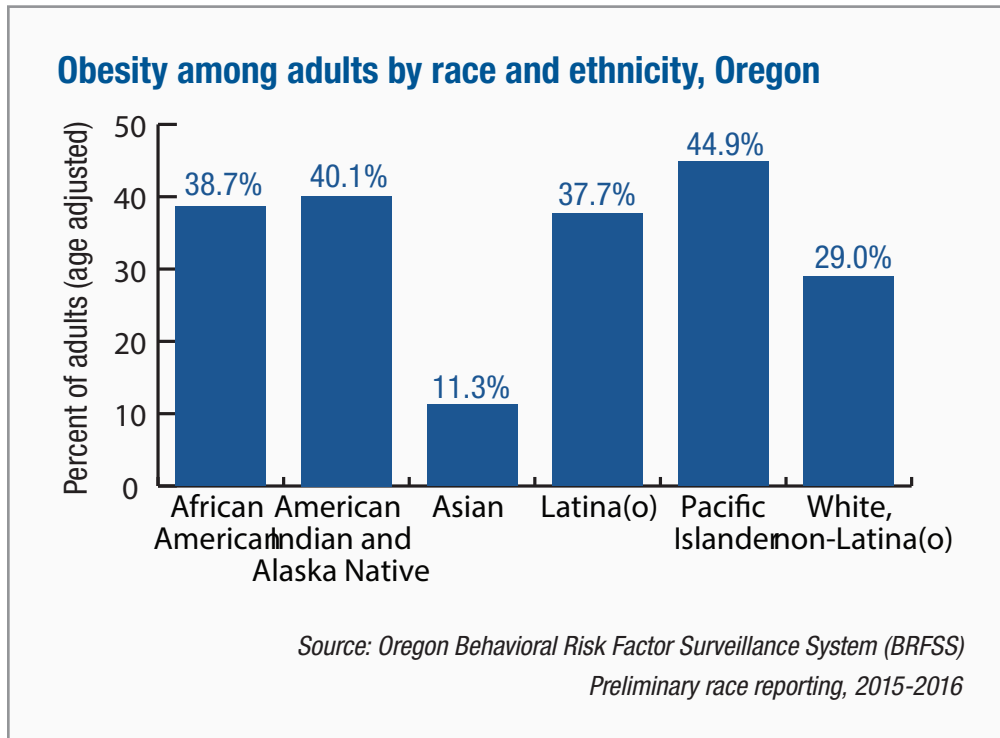


\* Oregon Death certificates 2014; OSCaR web tables.

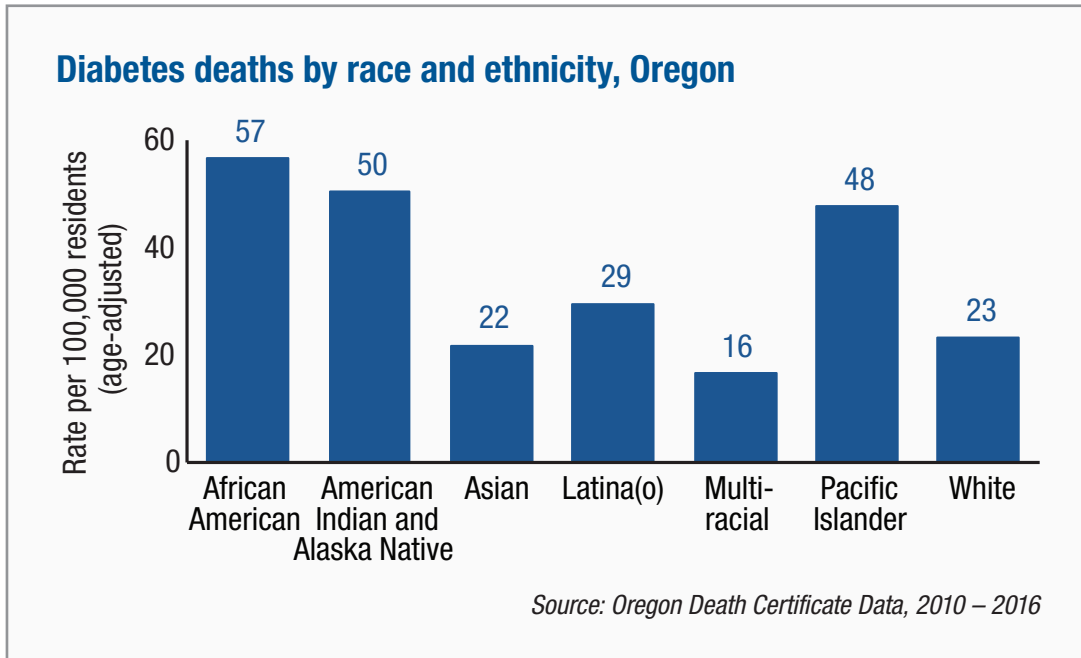


## Disparities in Chronic Diseases and Conditions

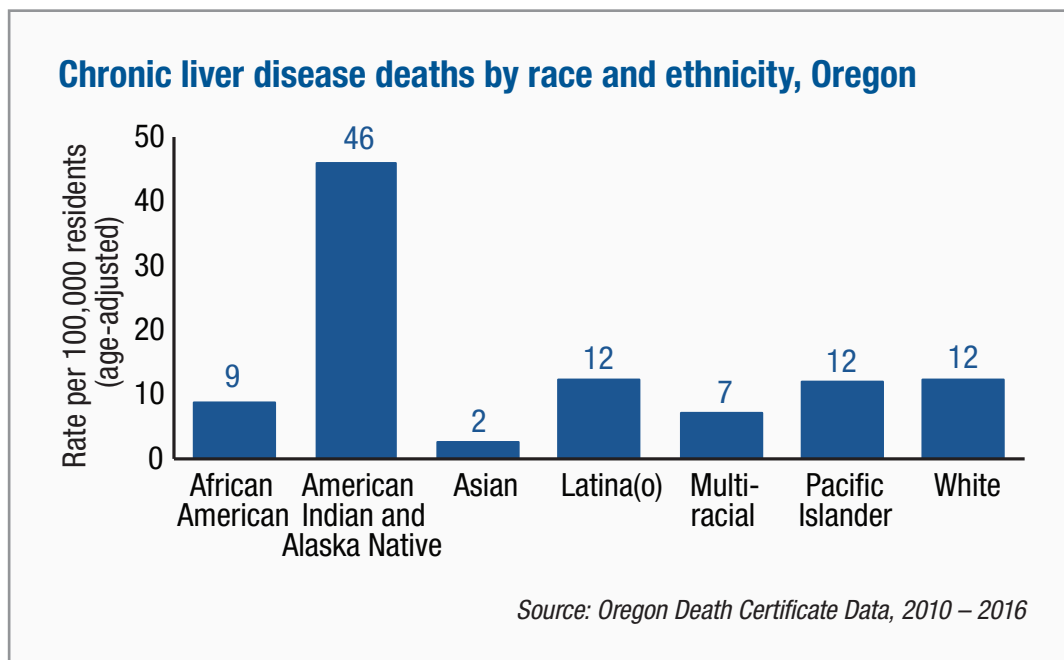
Obesity is highest among African Americans, American Indians and Alaska Natives, Latina(o)s, and Pacific Islanders.



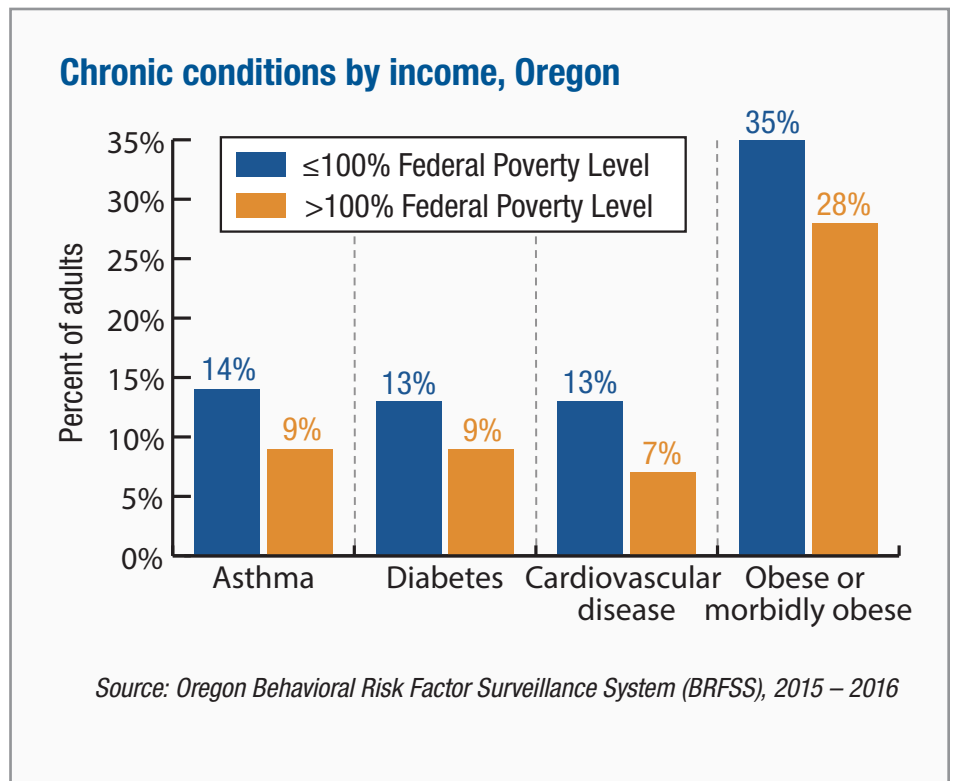
American Indians and Alaska Natives and non-Latina(o) African Americans are more than twice as likely to die from diabetes as non-Latina(o) whites.



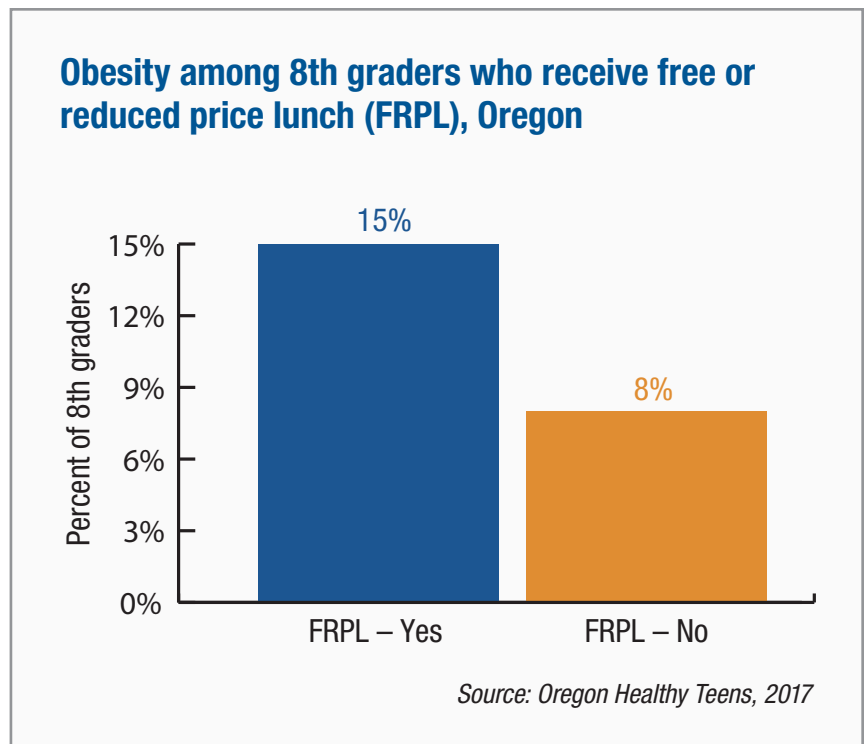
American Indians and Alaska Natives have a much higher death rate from chronic liver disease than any other group.



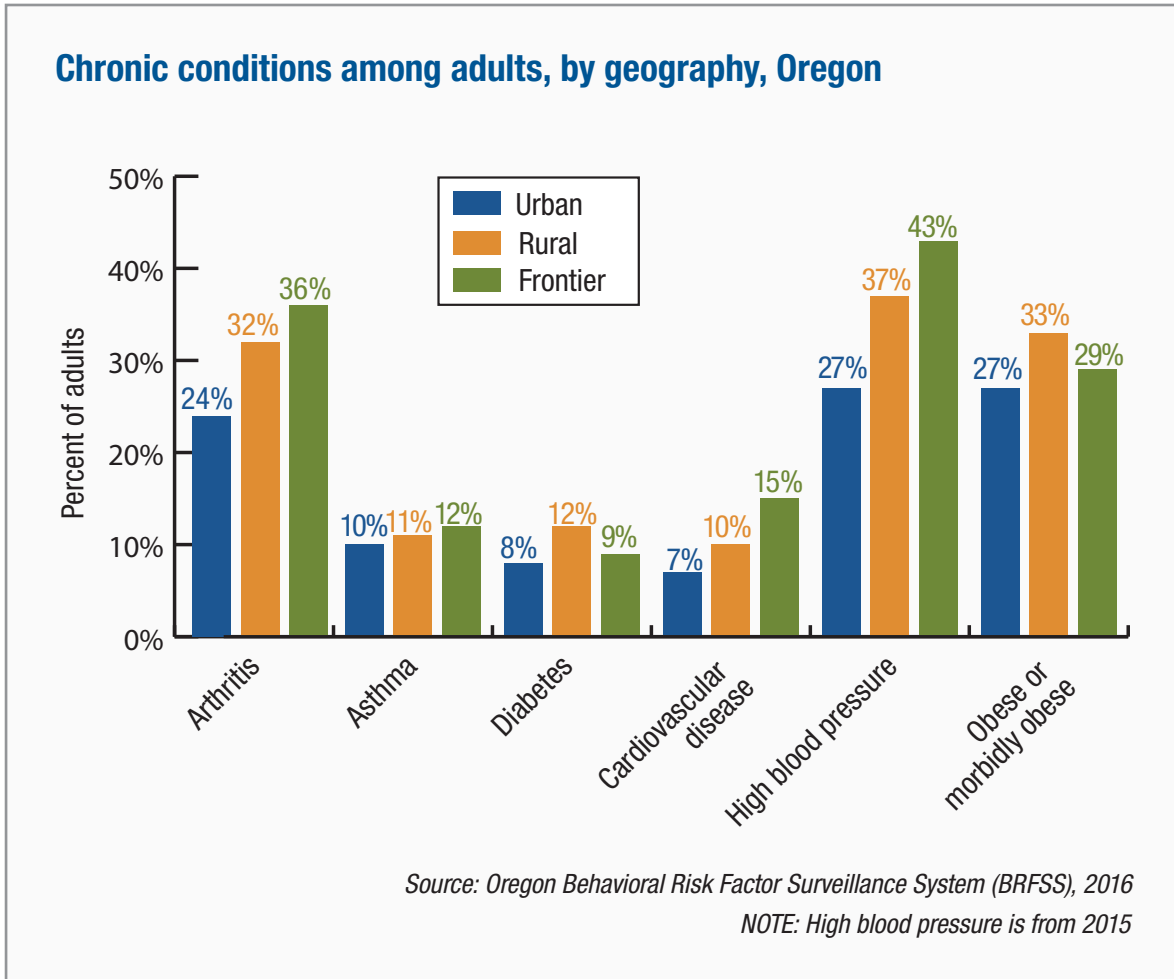
Chronic conditions vary by income. Adults living below the federal poverty level have a higher prevalence of asthma, obesity, diabetes, and cardiovascular disease.



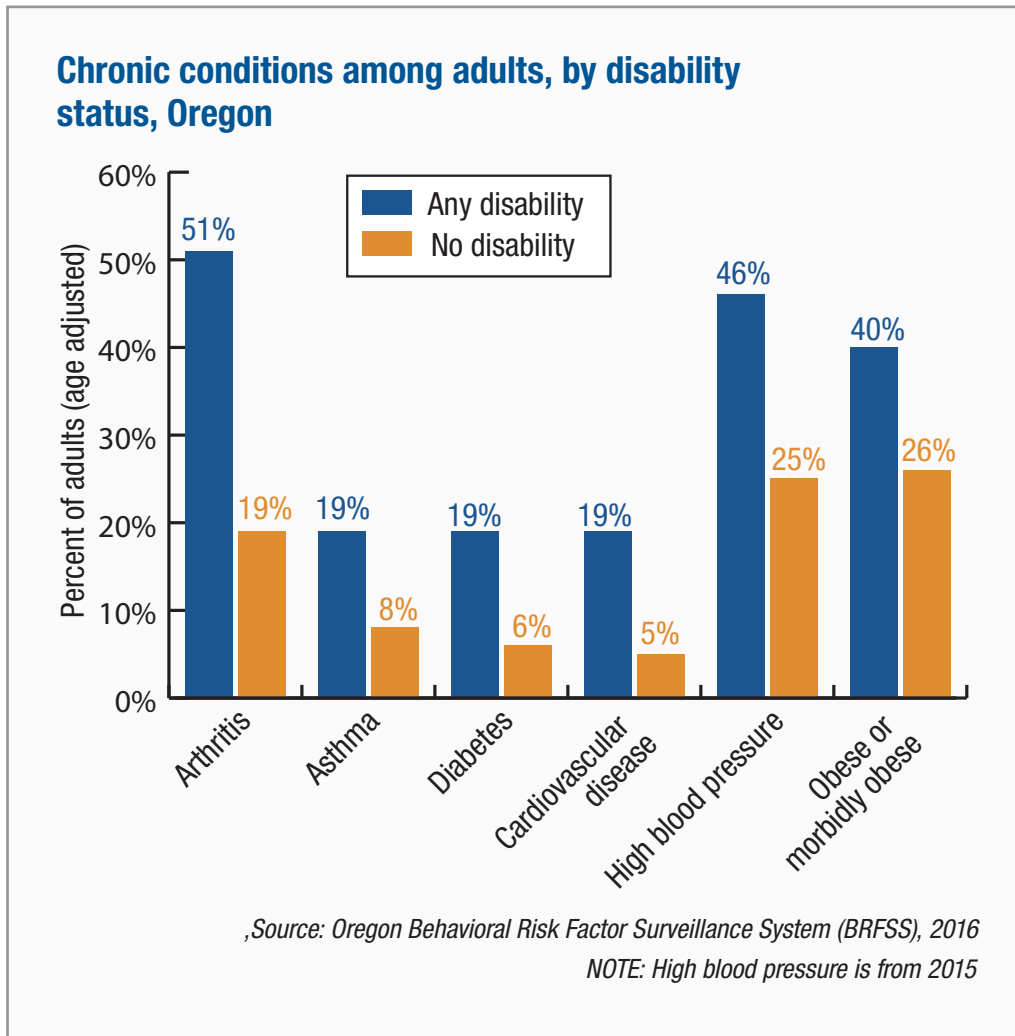
Likewise, children and teens who receive free or reduced price lunch (FRPL) at school are more likely to be obese.



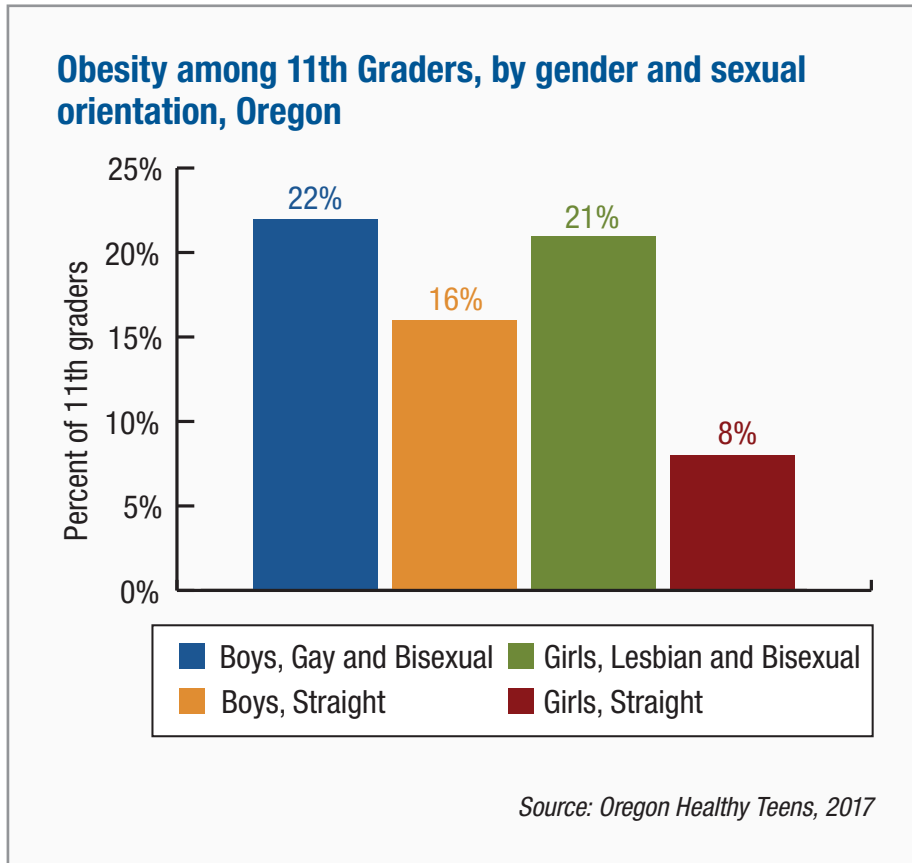
People living in rural and frontier areas have higher rates of chronic conditions compared to people in urban areas.



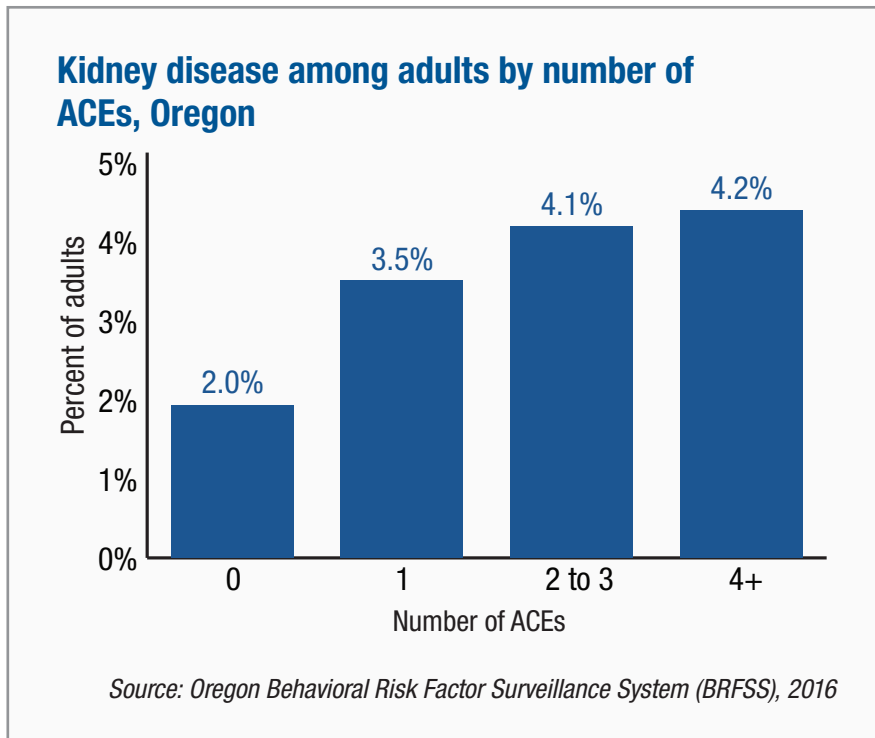
Chronic conditions are more common among people with disabilities.



Gay and bisexual youth are at higher risk for obesity.

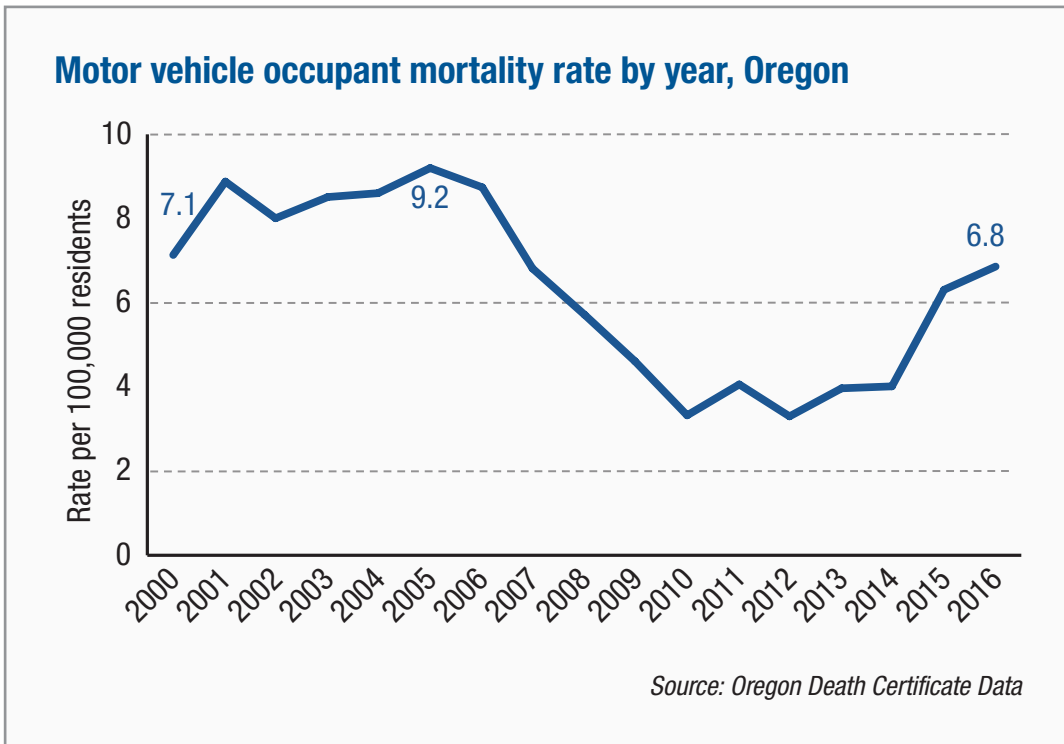


People who have experienced ACEs are more likely to have chronic diseases such as kidney disease.



# Motor Vehicle Crashes

Deaths from motor vehicle crashes are an important cause of early death in Oregon and have been increasing since 2012. In 2016, there were 504 deaths related to a motor vehicle crash. Of these, 280 were drivers or passengers, 50 were motorcyclists, 81 were pedestrians and 9 were bicyclists. Thirty-three percent of driving-related deaths in Oregon involved alcohol. This figure ranges from 0% of motor vehicle-related deaths in Gilliam County to 60% of motor vehicle-related deaths in Sherman and Wallowa counties.\* Some communities are actively working to reduce motor-vehicle-related fatalities such as Portland’s Vision Zero initiative.†

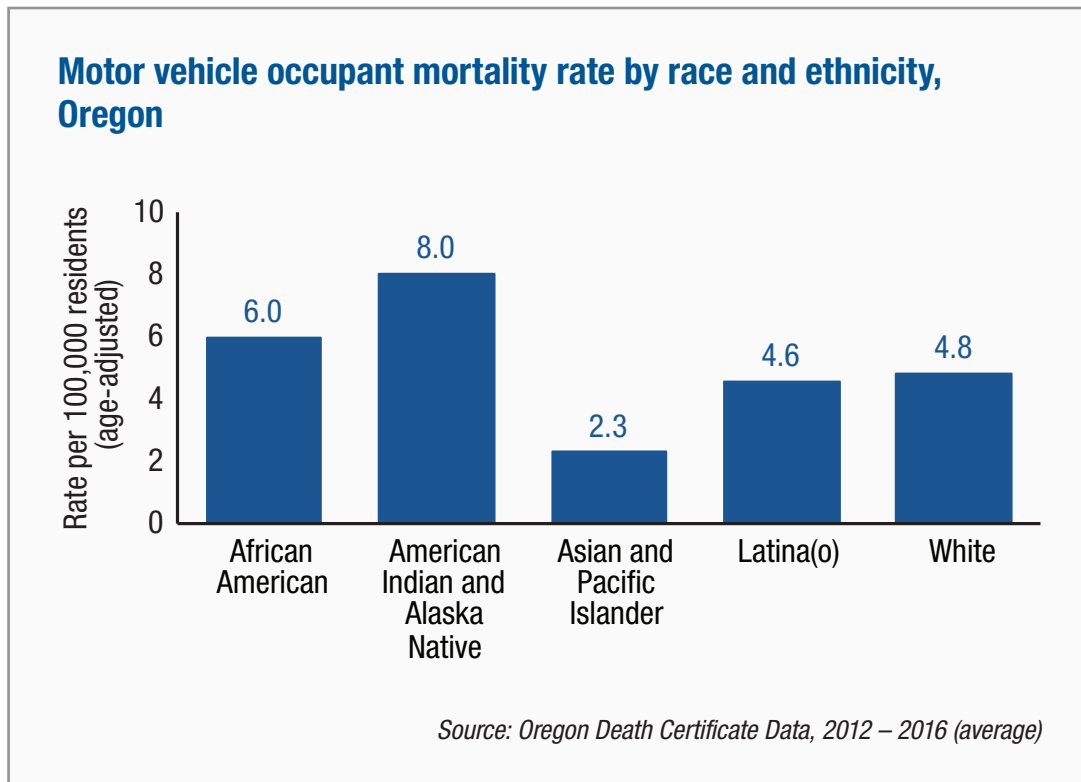


\* County Health Rankings

† <https://www.portlandoregon.gov/transportation/40390>

## Disparities in Motor Vehicle-Related Deaths

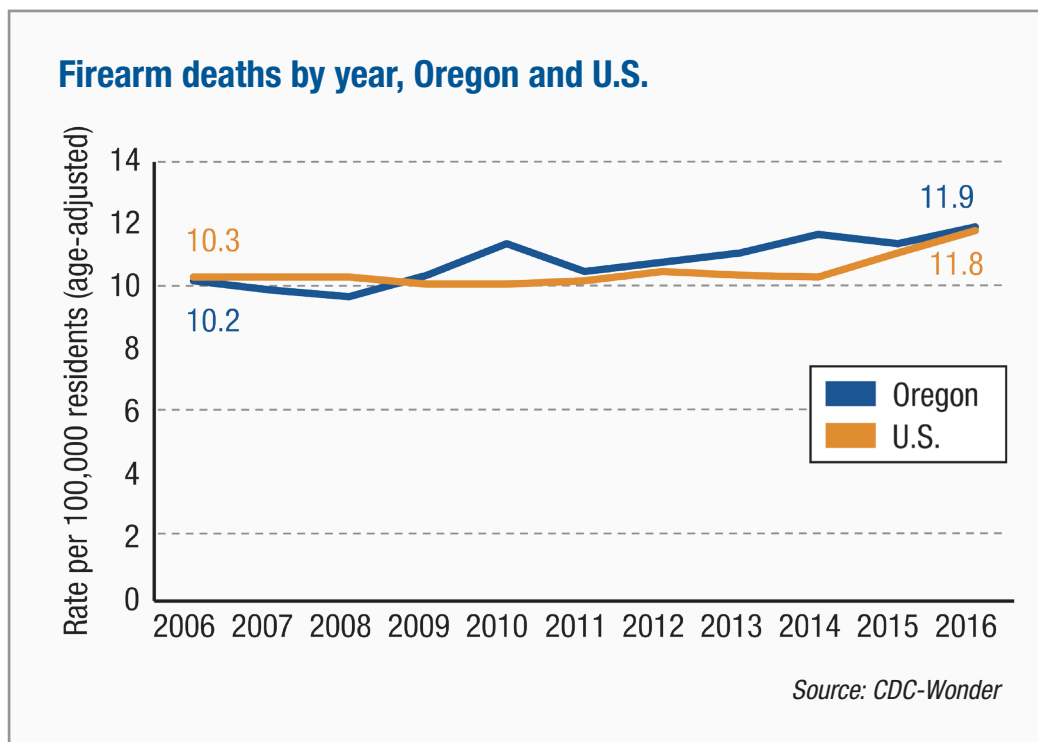
American Indians and Alaskan Natives experience significantly more motor vehicle deaths compared to other racial and ethnic groups.





# Firearms

Gun-related injury and death is a persistent and complex social and public health problem. Prior to 2010, Oregon had a firearm fatality rate comparable to the U.S. rate. Since then, both the number and rate of firearm deaths have increased in our state, putting Oregon ahead of the nation.

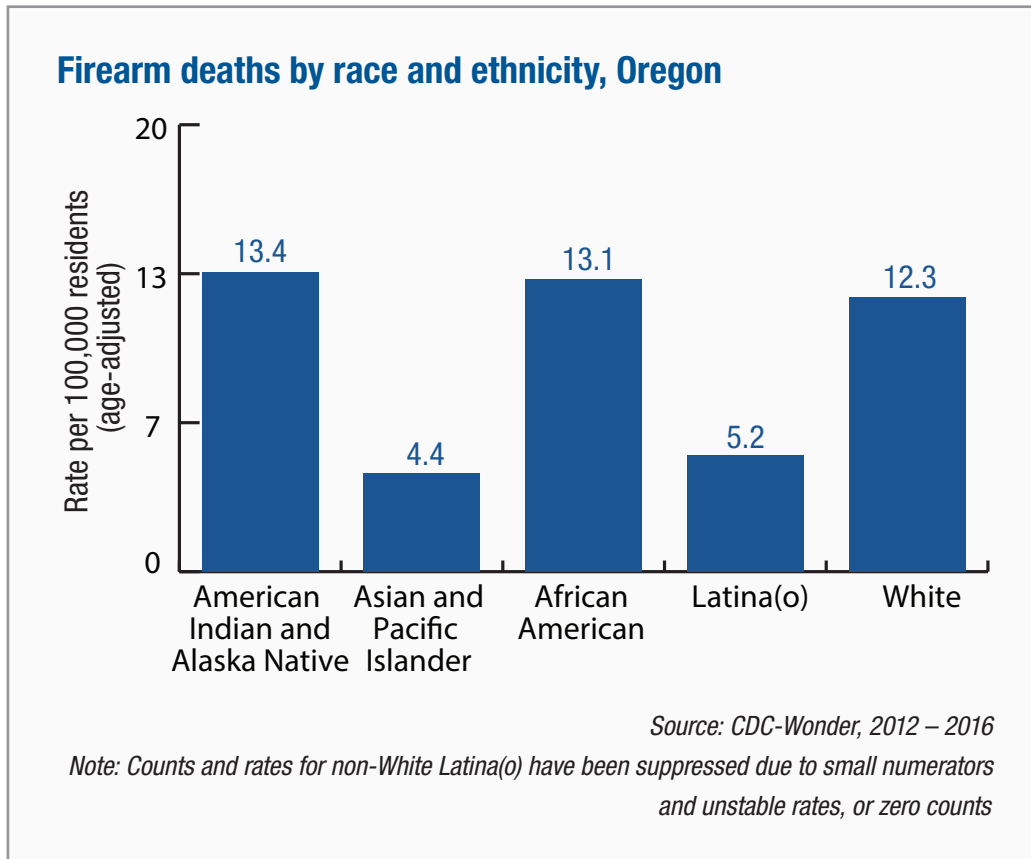


In 2008 – 2009, approximately 400 people in Oregon died from gun violence (10.0 deaths per 100,000 population). In 2014 – 2015, the number increased to 490 firearm deaths (11.5 deaths per 100,000 population). Most deaths from gun violence in Oregon involve one person, most often from a suicide. From 2003 to 2015, 140 gun-related incidents involved multiple deaths. One mass shooting in 2015 resulted in 10 deaths.

Between 2010 and 2015, men in Oregon were nearly six times more likely to die from firearm injury than women. Older white men had the highest risk of suicide death by firearm, and young African Americans had the highest risk of death by firearm homicide.

## Disparities Related to Firearms

American Indians and Alaska Natives, African Americans and non-Latina(o) whites are more likely to die as a result of a firearm.

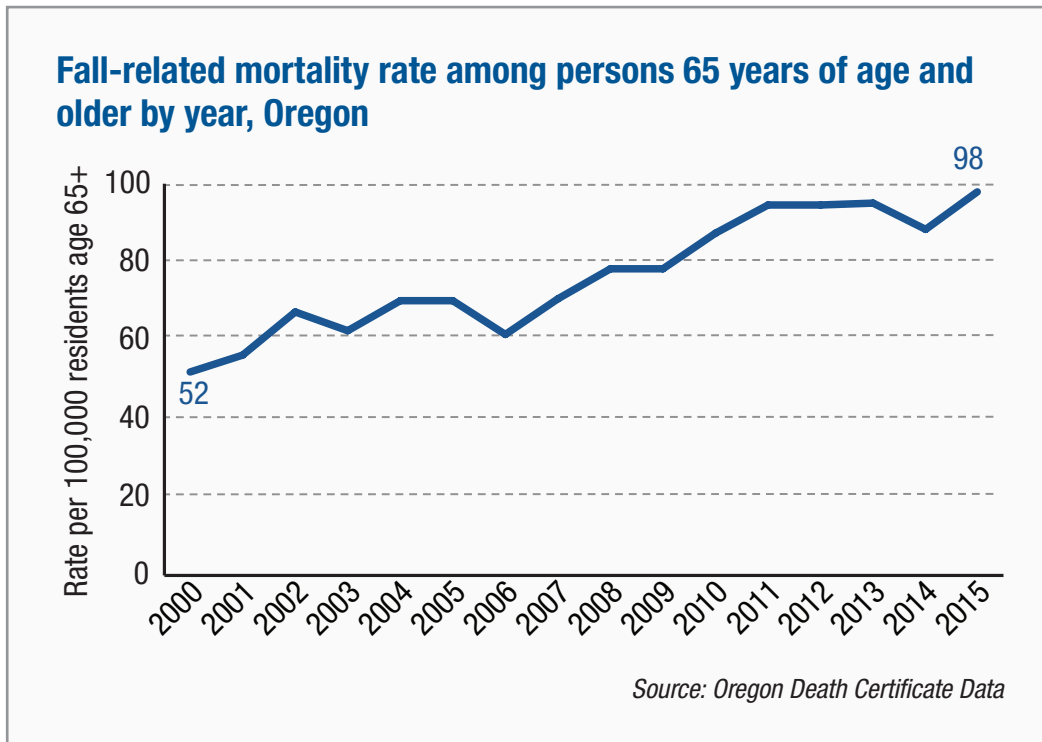


# Older Adults

Oregon’s growing population of older adults are a vital resource. Oregon has a high proportion of seniors living independently in their communities. Aging in place requires adequate resources such as transportation, community-based exercise and social opportunities, food and medicine delivery, and access to health care to manage acute and chronic conditions.

According to the United Health Foundation 2017 America’s Health Rankings Senior Report, Oregon ranks 12th in the country for older adult health.\* Community members and respondents to the SHA survey reinforced these findings; 75% agreed that Oregon is a good place to grow older. However, excessive drinking is more prevalent among older adults here. The state also lags in flu vaccinations and fall prevention among older adults.†

Among older adults, falls are the leading cause of injury-related death. Falls are also the most common cause of nonfatal injuries and hospital admissions for trauma. The death rate from falls among older men and women in Oregon rose from 52 deaths per 100,000 people in 2000, to 98 deaths per 100,000 people in 2015.

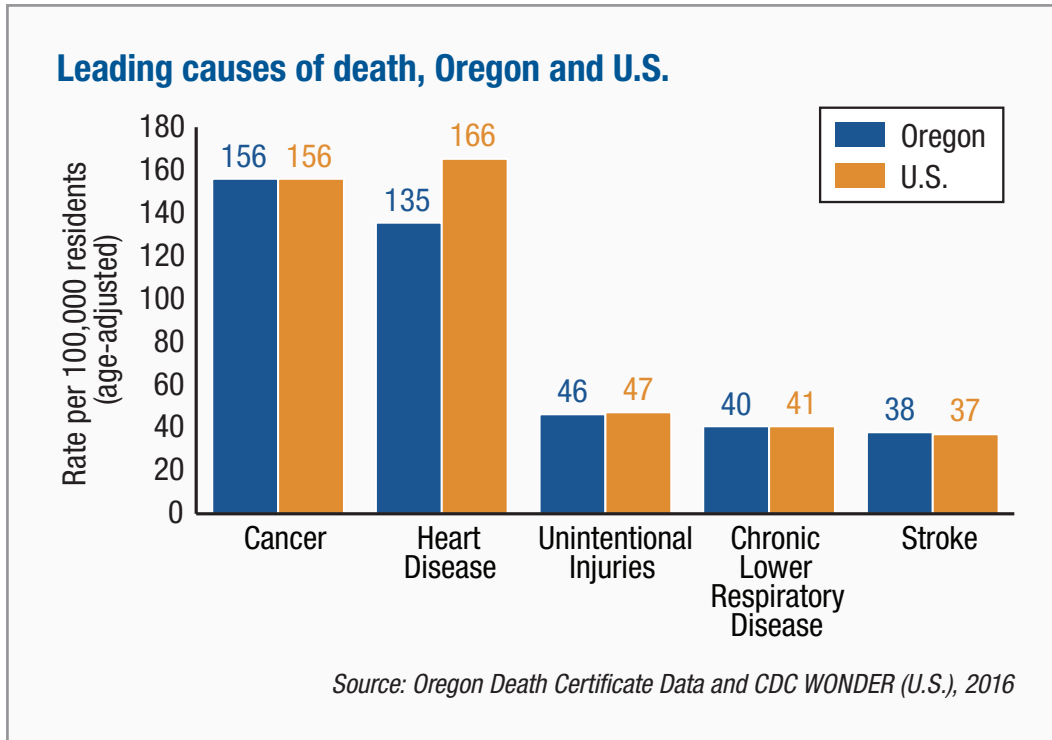


\* [https://assets.americashealthrankings.org/app/uploads/ahr2017\\_seniorreport.pdf](https://assets.americashealthrankings.org/app/uploads/ahr2017_seniorreport.pdf)

† America’s Health Rankings Senior Report, 2017.

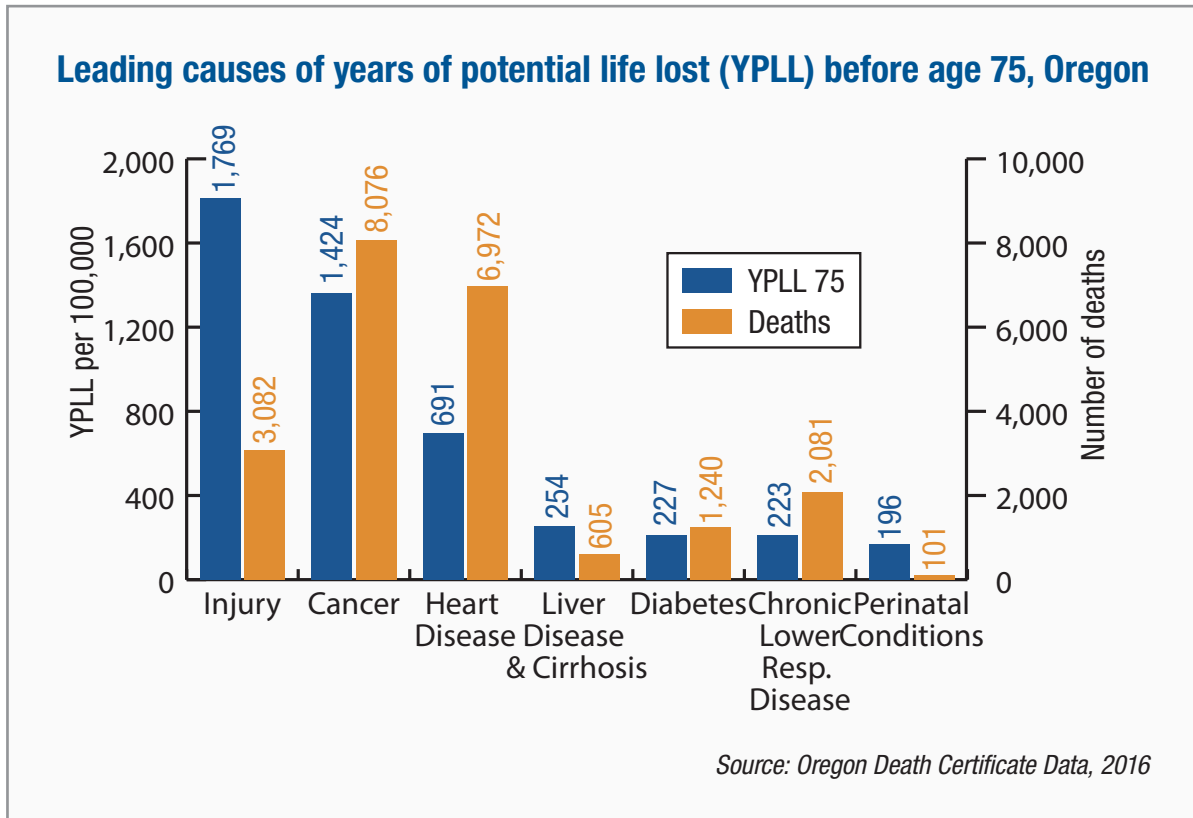
# Causes of Death

The five primary causes of death in Oregon are cancer, heart disease, chronic lower respiratory disease, unintentional injuries, and stroke. Certain racial and ethnic groups face a higher risk of death from heart disease and stroke. Non-Latina(o) African Americans have nearly twice the rate of avoidable deaths from heart disease, stroke, and high blood pressure as non-Latina(o) whites.



## Disparities in Potential Life Lost

One way to calculate the burden of early death is by measuring the number of years between a person's age at death and a standard age at death (e.g., 75 years). This is called estimating the years of potential life lost (YPLL). For example, a person dying at age 21 would result in 54 years of potential life lost, compared to a person dying at age 70, which would result in five years of potential life lost.



In Oregon in 2015, African Americans and American Indians and Alaska Natives had higher YPLL compared to Whites. Asians and Latina(o)s had lower YPLL compared to Whites. African Americans and American Indians and Alaska Natives have the highest YPLL from unintentional injuries, homicides, and diabetes. Whites have the highest YPLL from suicide, and African Americans have the highest YPLL from heart disease.

People living in rural and frontier areas are dying at an earlier age than people living in urban areas, as demonstrated by higher rates of YPLL before age 75.

