pollywog
Prepared parents. Healthy families.

Parent Newsletter
June 2021

Mental Health Matters!

According to mentalhealth.gov, "Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood."

Mental health problems are common but with help people can get better and many recover completely.

Recognizing signs of stress and mental health challenges in your child

Signs of stress and mental health challenges are not the same for every child or teen, but the American Academy of Pediatrics lists these common signs:

Infants, toddlers and young children may show backward progress in skills and developmental milestones. They may also have increased problems with:

- Being more fussy or irritable than usual
- Changes in sleep habits and nightmares
- Changes in appetite, weight or eating or elimination patterns or elimination patterns. New stomach aches
- Seeming more clingy, withdrawn, or hesitant to explore
- Frequent or intense tantrums
- Bedwetting after they're potty trained
- Being more demanding while seemingly unable to feel satisfied
- Conflict and aggression or themes like illness or death during play

Older children and adolescents may show signs of distress with symptoms such as:

- Changes in mood, such as ongoing irritability, feelings of hopelessness or rage, and frequent conflicts with friends and family
- Changes in behavior, such as stepping back from personal relationships
- A loss of interest in usual activities
- A hard time falling or staying asleep, or starting to sleep all the time
- Changes in appetite, weight or eating patterns, such as never being hungry or eating all the time
- Problems with memory, thinking, or concentration
- Less interest and effort in schoolwork
- Changes in appearance, such as lack of basic personal hygiene
- An increase in risky or reckless behaviors, such as using drugs or alcohol
- Thinking or talking about death or suicide

Where can you go for help righ now?

If someone in your family is in crisis here are some ways to get immediate help

Lincoln County Mental Health Crisis Line: 1-866-266-0288
Linn County Mental Health Crisis Line: 1-800-304-7468
Benton County Mental Health Crisis Line: 1-888-232-7192
National Suicide Prevention Line: 1-800-273-8255
Center Against Rape and Domestic Violence (CARDV): 1-800-754-0110
24/7 Confidential Crisis Counseling Text Line: Text OREGON to 741741
Veteran Crisis Line: 1-800-273-8255 or text at 838255

Need some parenting support?

One-on-one parenting support for Linn-Benton-Lincoln County parents is available. Parenting can be challenging! But it's better with support! The Parenting Success Network is working in collaboration with Coach4Parents.com to offer FREE sessions to help families who want Parenting Coaching through phone or video.

Click here to schedule a free session

Pregnancy & Postpartum concerns?

Did you know that pregnancy and postpartum mental health disorders are common, treatable medical conditions? One in five women will experience distressing emotional reactions during pregnancy and the first year after childbirth. These emotional conditions also affect fathers and those who have adopted or suffered perinatal loss.

WellMama Linn-Benton is a Reproductive Mental Health and Emotional Support Services volunteer group serving Linn and Benton counties in Oregon. They provide free phone and email support to pregnant and postpartum mothers and their families.

How to support mental health in babies and children?

Positive adult-child relationships support your child's mental health. Vroom is here to complement parent-child relationships, to ensure that when parents and children have time to interact – whether it's in the middle of chores, preparing for bedtime, or riding the bus – they are maximizing the amount of brain building that is taking place. Vroom makes it easy to nurture your child's growing mind with parenting tips and age-specific activities that make the most of these precious years.

Sign up for Vroom Tips by texting CHILD to 48258, visiting vroom.org or downloading the Vroom app. Vroom messages are available in English and Spanish.

vroom
Brain building moments

Pollywog Facebook

Pollywog Website

Pollywog YouTube

Pollywog Family
6500 Pacific Blvd. SW, LM-132
Albany, OR 97321
541-917-4884

Delilah's First Road Trip

June 7, 2021, Hailey Cain

While most of my family lives down in Southern California, the majority of my husband Joshua's family lives about 7 hours away in Idaho. I'm nowhere near ready to make the long drive down to California with Delilah, but we did feel like she had been doing well enough in the car to make the trip to Idaho. When the opportunity arose, we decided to go for it. I was incredibly nervous about the drive. I couldn't decide when would be the best time for us to leave, to make the car ride go smoothly. Even on our good days, Delilah still isn't a big fan of being in the car seat.

For the drive there we decided to leave just before Delilah's nap, hoping that it would help if she could sleep for a good portion of the drive. Normally I'm the type of person who packs almost a week ahead for trips, but I was kind of a mess for this one. We had been in the process of moving stuff around the house so it felt like all of my stuff and Delilah's was scattered everywhere. With everything a mess, I ended up packing a little bit for each of us here and there, but I felt like I was forgetting everything. I was still packing while Joshua was starting to load stuff into the car. At least my disorganization kept us super busy in the morning before we left, so Delilah was nice and tired when we finally hit the road around 2:30 pm. Our idea to time the drive with her nap was starting out successfully because we gave her a little milk and she fell right to sleep.

I'm not sure how long her nap actually was, but I know she slept a good while. We were well past The Dalles heading east by the time she woke up, and luckily, she was in a good mood. I had a snack ready for her when she woke up, which made her very happy. After her snack, she played with the dogs (who did amazing on the drive by the way), and a few of her toys but as we rolled into evening time she started

Pollywog Update

#51

pollywog
Prepared parents. Healthy families.

Looking for a Second Pollywog Blogger

Pollywog is seeking parenting bloggers to write original posts for our Parent Voice section. Parent Voice content must be thought-provoking and engaging to parents and families with children ages 0-5 years old. We expect the blogger to be able to generate their own topics for blogs as well as accept direction regarding content. Posts can be about the blogger's personal parenting experiences and opinions, and can also include researched information where appropriate.

As the Parent Voice blogger, you will submit posts of 800-1000 words (approximately) and accompanying photos every two weeks. The Parent Voice blogger should have excellent writing skills and be able to write in a way that encourages Pollywog families to continue the conversation either online or elsewhere. Photography skills are also important so that posts are visually interesting. We may ask you to sign up for parenting classes and/or workshops so that you can write about them in your posts. And we also expect you to be living and raising children in Linn, Benton, or Lincoln Counties and be aware of community events and parenting resources.

This position is as an "independent contractor" and not an employee of Linn-Benton Community College or the Parenting Education Department. We pay $50/per blog, and will set-up a bi-weekly schedule of when the blogs and photos need to be submitted for posting to the Pollywog website. We are looking for someone to start immediately.

If you are interested in applying for this position, please submit a cover letter, resume, and a blog sample to leanne.trask@linnbenton.edu.

What's Happening

- The next Pollywog Partner Meetng is scheduled for Thursday, June 10, from 9-10:30am. This will be a remote meeting, using the Zoom platform. Meeting log-in information will be available on the Early Learning Hub website, and we will also be sending out a Google meeting invitation.
- Currently there are 1,659 individuals in the Pollywog database, as well as 19 prenatal and 36 parenting education classes, 6 courses taught in Spanish, and 178 referrals have been sent through Pollywog. All prenatal and parenting education classes are still being held remotely, through at least Summer term.

Family Connects Visits Begin in Linn, Benton and Lincoln Counties

As Early Adopters, we have been waiting for this moment for nearly a year, and it is finally here!! On May 1, Family Connects Home Visiting Nurses will officially begin making home visits to families with newborn babies in our region.

If you have clients who are expecting, or wish to know more about this free, universally offered service, please contact Pollywog at (541) 917-4884 or enroll on our website at www.pollywogfamily.org for more information and assistance.

New Pollywog Assistant

We are pleased to announce that we have a new Pollywog Assistant! Please welcome Samantha "Sam" Rounsavell. Sam has been a long-time employee of the LBL-ESD, and we are excited to have her working with us. Please welcome her to our community!

Pollywog Partner Update

Below is a list of all of the Pollywog Partners, by county, who are trained and ready to receive referrals through the Pollywog database:

Linn County:
Linn County Home Visiting Nurses
Kidco Head Start
Samaritan Albany General Hospital
Samaritan Lebanon Community Hospital
Obria Medical Clinic
Family Tree Relief Nursery
DHS (Albany & Lebanon) - no incoming referrals
Family Connections
WIC
Old Mill Center / Healthy Families

Benton County:
Old Mill Center / Healthy Families
Old Mill Center / Preschool & Counseling
Good Samaritan Regional Medical Ctr.
DHS (Corvallis) - no incoming referrals
Community Doulas
Benton County Health Department

Lincoln County:
Samaritan Pacific Communities Hospital
Samaritan Health Center - Newport
The Olalla Center
Lincoln County Home Visiting Nurses
DHS (Newport) - no incoming referrals
CSC (Newport)

More will be coming soon!

Contact Us

LeAnne Trask
Pollywog Coordinator
(541) 917-4949
leanne.trask@linnbenton.edu

Connie Adams
Pollywog Community Alignment Specialist
(541) 917-4948
connie.adams@linnbenton.edu

Website:
httsp://pollywogfamily.org/

Facebook:
https://www.facebook.com/PollywogFamily/

Prenatal classes are still happening virtually and we have class dates through the end of the year so can help new parents look at class options.
Parent-child classes in the fall will mostly be virtual with the exception of the Albany and Corvallis cooperative preschools, which DO currently have openings.
Families looking for in-person preschool or school age activities this summer should give us a call for more information about options available.There has been funding to promote in-person academic or social activities for kids, especially elementary aged so many programs are free or low cost.

--

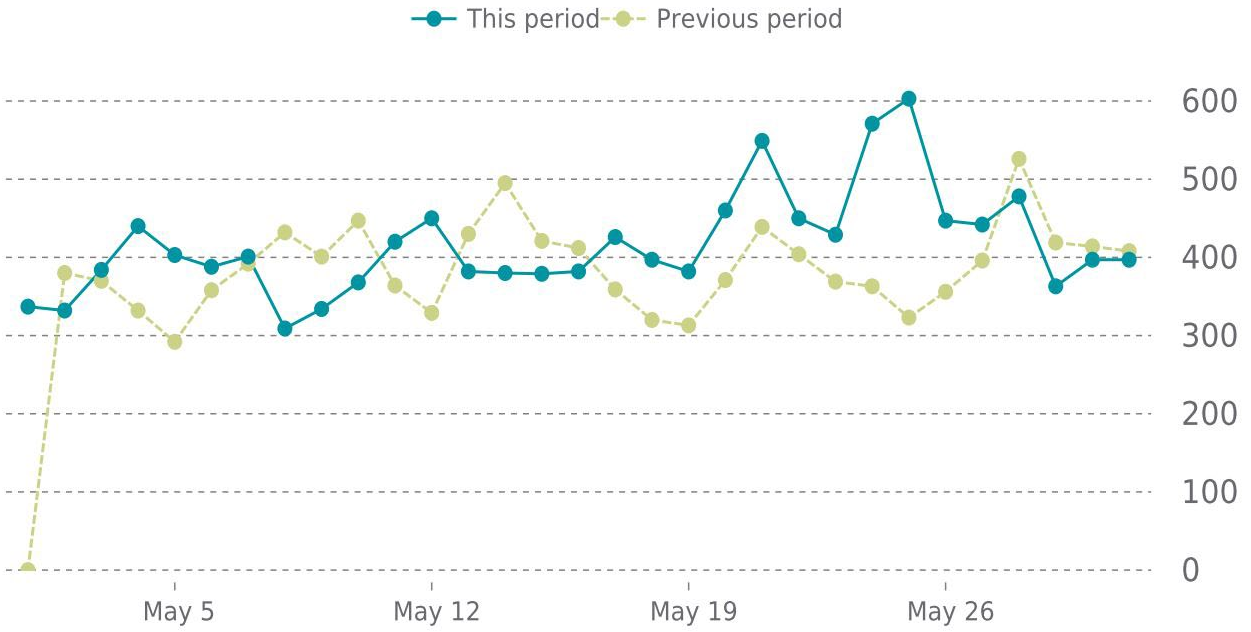
Sheri Branigan
Pollywog and Family Connections
Linn Benton Community College
541-917-4884
www.pollywogfamily.org

ANALYTICS

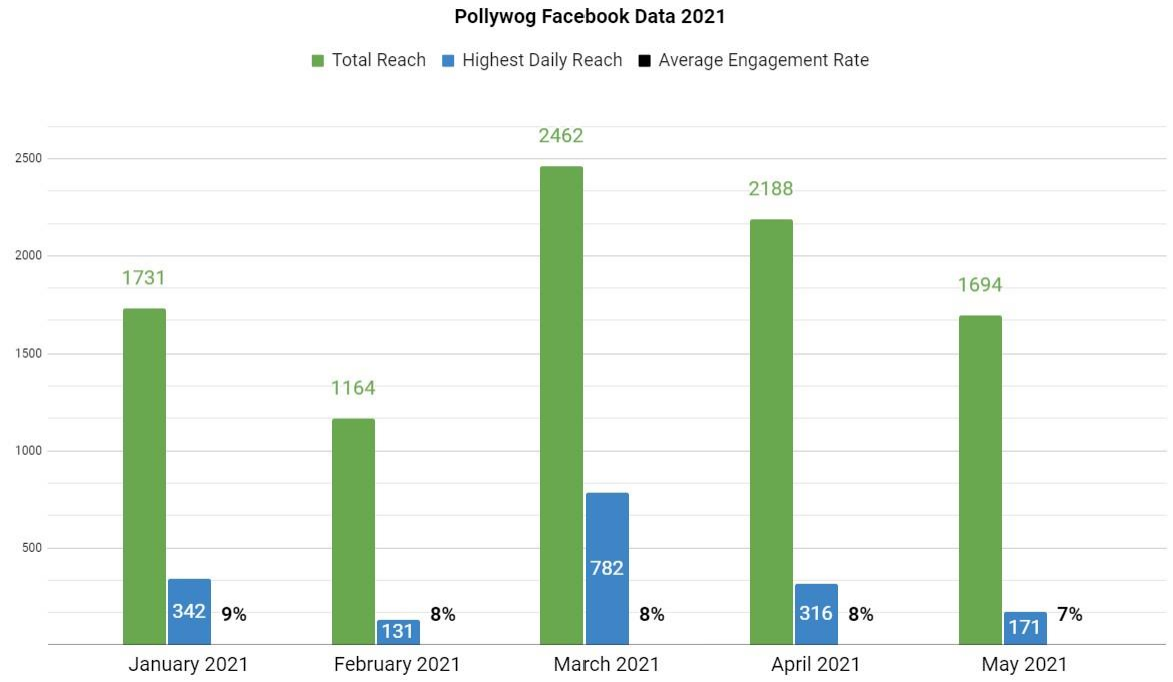
Traffic up by: **10.7%**

2021-04-30 to 2021-05-31

SESSIONS



Pollywog Facebook Data



In May, the post with the highest reach was our blogger ad on 5/10/2021 with 343 people reached and 22 engagements. Our next most popular posts were Hailey's blog on 5/24 about changes babies bring with 98 people reached, and the Fall Live & Learn class post with 93 people reached. Posts that are shared reach many more people. Please like and share our posts!

Most recent campaign performance

Completed Campaign • Jun 1

Pollywog Parent Newsletter June 2021

610 Recipients

Replicate Campaign

Open Rate	42%	Clicks Per Unique Open	258
Click Rate	4%	Total Clicks	26
Successful Deliveries	608	Orders	0
Total Opens	365	Average Order Revenue	$0.00
		Total Revenue	$0.00

Our June Newsletter, was titled Mental Health Matters. We discussed the signs of stress and mental health challenges for children. A list of crisis numbers was also listed. We were informed after publication by DHS of another crisis line/agency in Lincoln County, My Sisters' Place, that provides services similar to CARDV which only serves Linn and Benton county. The newsletter also included

information about the free parent coaching through PSN, postpartum support through Well Mama and a mention of Vroom. The newsletter reached 610 people through email, with an open rate of 42%. The Facebook post about the newsletter reached 61 people and have 10 post engagements. The Spanish translation of the newsletter will be available soon

For the July newsletter the topic we are considering is Purposeful Parenting Month with tips on how to be a more purposeful parent – be engaged, make room for play, set nutrition goals, etc. And information on the importance of reading to children and how to connect with local library Summer Reading programs.

39 (86,576)
Signups

1,092 (22,882,978)
Program Messages

11 (6,530,512)
Community Messages

8 (34,026)
Stops

Last 24 h
0
Signups

Last 24 h
9
Program Messages

Last 24 h
31
Community Messages

Last 24 h
0
Stops

Total Kids
50 (101,344)

Avg Kids Age
3.2 (4.5)

Completion rate
84.8%

Zip Code provided
97.4%

Program Msg CTR
7.9%

Community Msg CTR
209.1%

Retention
83.0%

30 days Survey Completed
15.2%

6 month Survey Completed
0%

Avg Enrolled Days (Active)
108.1

Avg Enrolled Days (STOPs)
73.0

National Msg CTR
3.1%

Find out more about what resources are available in your community:

pollywog

Prepared parents. Healthy families.

VISIT US at www.pollywogfamily.org
CALL 541.917.4884
EMAIL info@pollywogfamily.org

www.familyconnectsoregon.org

Oregon Health Authority

Family Connects Oregon
800 NE Oregon Street
Portland, OR 97232

FAMILY CONNECTS OREGON

Connecting every child to a healthy future

WELCOME to FAMILY CONNECTS OREGON!

Residents of Oregon are being offered a free, in-home visit by a nurse through a new program, Family Connects Oregon.

Family Connects Oregon supports parents like you by bringing health care providers, community resources and families together. Our mission is to connect you with resources that nurture your whole family and support your child's health and wellbeing.

It's about planting seeds for the future.
Together, we're growing healthy babies and making a more prosperous Oregon.

Babies don't come with **an instruction manual. Family Connects Oregon** can help!

What can FAMILY CONNECTS OREGON do for you?

Having a new baby affects many areas of a family's life. Family Connects Oregon nurses are trained to answer all kinds of questions and are knowledgeable about the wealth of resources in our community. Here are a few examples of how Family Connects Oregon nurses can address your family's needs:

- Parent and baby health check
- Breast or bottle feeding help
- Finding help or ways to cope when feeling depressed
- Understanding childcare options
- Back-to-work support
- Help with bathing, diapering & swaddling
- Safe sleep information
- What to do if your baby cries a lot
- Financial resources
- Playgroups & parent support groups
- Family planning advice
- Healthy home connections

WHAT YOU CAN EXPECT

THREE WEEKS
Visits are scheduled around 3 weeks after your baby's birth

NO COST TO FAMILIES
As an eligible caregiver you will not be charged

REGISTERED NURSE
Visits are made by highly-trained nurses

FOR ALL
Helping all families, regardless of income or background

Family Connects is a COMMUNITY-WIDE effort

Raising a healthy child takes a community, and there are many local organizations you may choose to connect with, such as:

Health Navigators
Early Childhood Education
Tribal communities
Faith groups
Relief Nurseries
Parenting Education Workshops
Support Groups

Research shows that when families participate in Family Connects Oregon, mothers feel less anxious, they learn about quality childcare options available to them, and their babies need less emergency care at hospitals. This all adds up to an enormous, positive impact on the community.

Regions offering services soon

Central Oregon

Clatsop County

Eastern Oregon

Four Rivers (Gilliam, Hood River, Sherman, Wasco, Wheeler Counties)

Linn, Benton, and Lincoln Counties

Marion and Polk Counties

Washington County

2 WEEKS READY

Emergency Preparedness in Oregon's Child Care & Afterschool Programs

April 2021

OregonASK
Afterschool & Summer for Kids Network

2 WEEKS READY

Prepared by OregonASK Expanded Learning Partnership, with support from the Early Learning Division and the Willamette Education Service District

---

INTRODUCTION

Children are particularly vulnerable during disasters, and as human-caused emergencies and natural disasters occur more and more frequently, the safety and security of children is more important than ever. Many children and youth spend large swaths of time in child care facilities and afterschool programs, yet there has been little research on whether child care and afterschool providers are adequately prepared for emergency situations. A first of its kind study on emergency preparedness in child care centers concluded that more work is needed to understand and support emergency readiness in child care settings, and a study of Michigan's licensed child care directors found that their state lacked mandated child care guidelines for disasters, and that a substantial proportion of the state's child care programs were missing critical components of disaster planning.

Child care licensing rules in Oregon require, to a modest extent and in compliance with Child Care Development Development Fund (CCDF) rules, that providers demonstrate emergency plans for their programs and participate in health and safety training that includes emergency preparedness. But these modest regulations acknowledge only what providers are supposed to do, and cannot reveal whether providers are — in actuality — adequately prepared to manage disaster situations. The *2 Weeks Ready* Campaign was created to fill that void. Launched in 2019 by the Office of Child Care, OregonASK Expanded Learning Partnership, and the Willamette Education Service District, the *2 Weeks Ready* Campaign strove to better understand how prepared Oregon's child care and afterschool providers are for emergencies, and to support increased emergency readiness within the child care field. The two-year statewide campaign aimed to investigate how prepared Oregon's Child Care Resource & Referral (CCR&R) providers, community organizations, child care providers, and afterschool and summer learning programs are for a natural or man-made disaster.

The *2 Weeks Ready* campaign included two primary goals: first, to gauge how prepared (or not prepared) afterschool and child care providers are for emergencies, to identify barriers providers face to being better prepared, and to propose recommendations for addressing those barriers. Second, the campaign aimed to raise awareness among child care providers, afterschool programs, and related organizations about the importance of adequate emergency management. In particular, the project focused on "the big one," an anticipated large earthquake predicted to strike off the coast of Oregon and Washington with the potential to catastrophically disrupt transportation and infrastructure, and isolate communities for weeks or months on end. Because of this anticipated disaster, the Oregon Office of Emergency Management suggests that residents across the state be prepared, at all times, to support themselves for at least 2 weeks (hence the name for the *2 Weeks Ready* Campaign). While "the big one" carries special weight, the *2 Weeks Ready* campaign also highlighted the need to be prepared for any and all types of emergencies, including wildfire, violence, snow storms, and tsunamis, among others.

The campaign launched in Fall 2019, but quickly faced an unexpected curveball worthy of a Hollywood film. Just as campaign activities were ramping up in early Spring 2020, the COVID-19 pandemic struck worldwide and forced the campaign to pivot to immediate disaster response. Instead of spotlighting general emergency preparedness for theoretical situations, the campaign (and indeed, all of Oregon's child care community) was forced to focus on emergency response and recovery in reality. This shift had benefits and drawbacks. On the one hand, campaign activities narrowed to focus primarily on the specific response to a particular emergency (COVID-19), rather than on preparation for emergencies in general. On the other hand, the unusual timing of the project offered a unique view into real-life emergency response procedures, because we are able to examine experiences that are actual, not predictive. In addition, the COVID-19 pandemic brought the reality and urgency of emergency preparedness into sharper focus for many providers and stakeholders, and highlighted gaps in emergency planning and response procedures. The pandemic also prompted focus group conversations to shift from in-person to virtual, greatly expanding accessibility and enabling distant and rural providers to participate more easily.

The following pages of this report summarize the *2 Weeks Ready* campaign and its findings. While the goal of the project was two-fold — to both raise awareness and assess preparedness — this report focuses primarily on the latter. The sections below discuss project methods, findings from conversations with child care and afterschool providers, and recommendations for strategies to improve emergency preparedness within the child care and afterschool field.

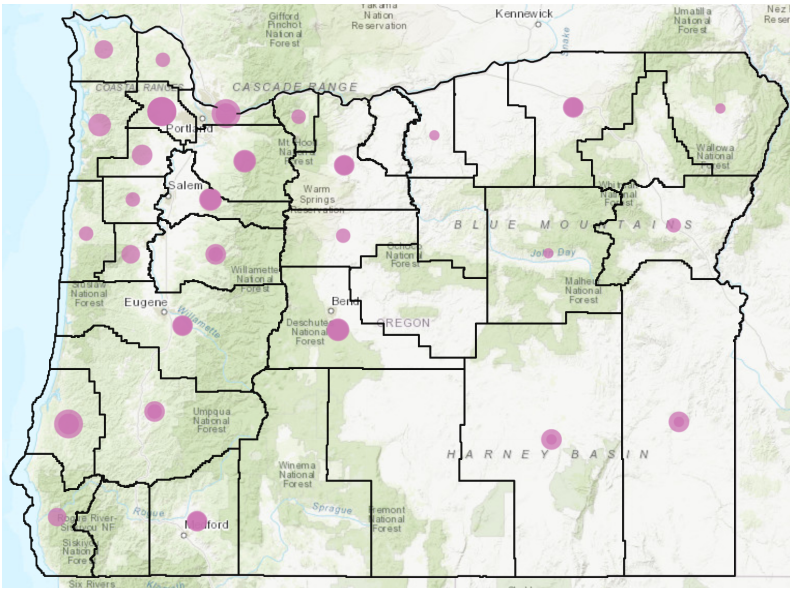
METHODS

The *2 Weeks Ready* campaign unfolded in two phases. In the first phase, OregonASK project managers created a 2-year work plan, developed a campaign framework, and identified a variety of resources to assist child care and afterschool providers in creating emergency preparedness plans. These resources are compiled in a toolkit, and include curriculum for young children, needs assessments and checklists for providers, sample forms, manuals, planning guides, Oregon rules and regulations, and videos and brochures (from the Oregon Office of Emergency Management).

The second phase consisted of structured conversations with CCR&Rs, child care and afterschool providers, community organizations, and other stakeholders. These structured conversations, or focus groups, had two main goals: 1) To present toolkit resources and raise awareness among providers about the need for emergency preparedness; and 2) To gather feedback from providers about their current preparedness level, barriers they face, and what supports they need to be better prepared for emergencies in the future. OregonASK project managers hosted 15 virtual focus groups between April and September 2020. Each focus group was co-hosted by a regional CCR&R, who also helped promote the event to their local

providers and communities. The focus groups included an overview of the *2 Weeks Ready* campaign and the resource toolkit, as well as small group discussion about emergency preparedness efforts (existing provider protocols, barriers/challenges, local agencies and resources, etc.). Original protocols were adapted in consideration of the COVID-19 pandemic, which lent an urgency to campaign efforts, increased interest and participation, and provided context for the discussion. Participants were able to not only reflect on the challenges and successes of the current pandemic response, but were also well placed to evaluate what their emergency procedures should look like in the future.

The 15 virtual focus groups were attended by 204 participants from 28 counties, representing 113 child care and afterschool providers, school districts and ESDs, CCR&Rs, government agencies, and community-based organizations. The map to the right shows focus group participants by county, where the size of the dot represents the number of focus group participants per county (larger dots represent more participants).



One focus group was held in Spanish, the rest were conducted in English. Each focus group was recorded, and recordings were reviewed and coded by OregonASK staff using qualitative and mixed methods research software (Dedoose).

The bulk of the findings in this report are based on focus group conversations. Qualitative data, however, has been supplemented with quantitative data from a survey of CCR&R and Early Learning Hub (ELH) directors. The survey asked directors to reflect on their role in emergency preparedness and to describe what emergency-related resources (if any) they have made available to providers in their region. The survey was distributed between November 2020 and February 2021, and basic statistical analysis was applied to survey data. In addition, relevant sections of the state's current CCDF plan (due for submission in July 2021 and implementation in October) was reviewed to ensure findings and recommendations are contextualized within current regulations.

Finally, as noted above, the *2 Weeks Ready* campaign and focus groups took place during the COVID-19 pandemic. Naturally, pandemic-related topics emerged as primary themes in focus groups, and often dominated conversations that took place early in the pandemic. The Federal Emergency Management Agency's (FEMA) framework for conceptualizing emergency

management, described below, will help frame the findings sections of this report, and will enable us to situate conversations specific to COVID-19 within the larger emergency management landscape.

Broadly speaking, FEMA conceptualizes emergency management as a four-phase cycle that includes mitigation, preparedness, response, and recovery. Mitigation and preparedness represent the stages before an emergency, and ideally comprise activities that serve to reduce or eliminate the impact of emergency situations (mitigation), or seek to develop planned responses to cope with emergency situations that cannot be totally mitigated (preparedness). The response phase represents the time immediately following an emergency where emergency plans are implemented, and the recovery period represents the longer-term period after an emergency where essential services are restored and damage repaired. Taken together, these phases represent the full cycle of disaster planning and response, and illustrate that emergency management is an ongoing, ever-present process that should be constantly and consistently engaged with.

These phases are helpful for framing conversations about, and approaches to, emergency management, but each phase is not wholly distinct from the others, and activities tend to overlap between phases. Nonetheless, they are particularly helpful to our discussion here because they help contextualize comments and findings from focus group participants. When focus groups first began, conversations centered around general mitigation and preparedness strategies, especially in the context of large earthquakes. But when the pandemic struck, conversations shifted to focus specifically on response and recovery to COVID-19. This shift had benefits and drawbacks. On the one hand, some focus group conversations narrowed to fixate primarily on the response to a particular emergency (COVID-19), rather than on preparation for emergencies in general (because many providers naturally found it difficult, if not impossible, to consider and plan for undefined future emergencies while still experiencing hardship and trauma from a current one). On the other hand, the unusual timing of the project offers a unique view into emergency response procedures for child care providers, because we are able to examine experiences that are actual, not predictive. In addition, the COVID-19 pandemic brought the reality and urgency of emergency preparedness into sharper focus for many participants, and highlighted gaps in emergency planning and response procedures. The phases of emergency management will be referenced throughout the discussions that follow, as we distinguish between comments that are specific to the COVID-19 response and recovery, and comments and findings that are more applicable to emergency mitigation and preparedness as a whole.

FINDINGS

The *Two Weeks Ready* campaign asked the question: Are child care and afterschool providers adequately prepared for emergencies? Why or why not? And if not, what supports and systems would enable providers to be better prepared? To answer these questions, we discuss findings from focus groups and survey results in the sections below.

Focus group participants surfaced a wide range of topics on emergency preparedness, from communication challenges with families to emergency backpack kits and evacuation procedures to considerations for trauma-informed policies and procedures. The majority of these topics can be consolidated into three main themes: Communication Systems, Procedures & Protocols, and Resources & Community Support. These three themes emerged prominently in both conversations about existing practices and in discussions of barriers and challenges. Thus, the sections below are structured around these themes; successes, challenges, and sub-themes are explored within each section.

There is some overlap between these three themes, and these overlaps are noted where relevant. For the purposes of the report, however, each theme is defined as follows: Communication Systems will refer to systems of communication between providers and families, and between state agencies and providers; Procedures & Protocols will refer to protocols that define and guide behavior during and after an emergency; and Resources & Community Support will refer to physical resources, systems of support, and community relationships.

COMMUNICATION SYSTEMS

Strengths in Communication

When asked to consider their emergency preparedness protocols, focus group participants frequently mentioned communication practices with families. By and large, many providers felt well-prepared to successfully communicate with families during an emergency. Many have established protocols (like parent contact lists, group texting apps, or phone trees) that they are able to implement during emergencies, like snow storms or wildfires.

> *"We have authorization forms which have parent information [on them]: work, cell phone, home number, whatever. When we had the wildfires, I just called each parent individually and told them what was going on and they responded quickly and came and got their kids."*

> *"I'm thinking about our mini-emergencies throughout the snow season, and sometimes afterschool programs are cancelled at the last minute and we already have kids, and the district decides to close them off and then, you know, it's kind of a*

mini emergency where we have these kids but the buses are going to have to stop. In that time, we do call families one by one."

During the COVID-19 pandemic, providers found success in flexible and individualized communication strategies with families. In-person communication, phone calls, texting, emails, website updates, and social media were all mentioned frequently, and some programs reported using communication apps like Classroom Dojo, or pre-established group texts that can reach all families at once. Phone calls and texting were preferred for time-sensitive communication (especially during the immediate response phase), while emails, websites, or family nights were preferred for more general communication about plans, procedures, and rules (often during the preparedness phase of emergency management).

> *"It was a lot of individualization for our families. You know, some of them are definitely more email people, some are more texting. We were trying to call people, and a lot of times, you know, of course you can't get a hold of them, but if you text them they answer immediately. So we really just did a variety of methods, just because we knew everybody was in a different stage. And we have our website, making sure it's updated and things like that. You know, really I think it was just having a lot of options on hand and using whatever works best."*

For many providers, plans made in advance to communicate with families translated well to the pandemic response and recovery periods, but some providers still expressed concerns. In particular, providers articulated two primary concerns about communicating with families either before or during an emergency: First, conveying accurate information to families in ways that ensure the family understood and processed the information (such as reunification plans or COVID-19 procedures); and Second, simply getting a hold of families.

Some providers reported that it is difficult to ensure that families understand emergency protocols, because families can be uninterested or unconcerned with emergency preparedness information.

> *"The biggest struggle for me is the communication with parents. They are not taking anything very seriously. When I try discussing evacuation plans, they're like, oh okay, yeah, yeah ,yeah. Or new regulations...[they are] like nope, thank you... They're busy. They're young. Communication is a big thing and I try to explain it everyday."*

> *"[We] have designated meeting spots and communicate all this stuff with parents, but parents don't really pay attention to that, they kind of skim over it."*

Other providers reported having trouble simply reaching parents through traditional communication methods, sometimes because families lack access to the internet and phones, and other times because of language barriers.

> *"The biggest hurdle we had was recognizing that many of our families don't have cell or internet service. They are still on landlines, so [we had to] figure out ways to communicate with them."*

> *"One kid never got picked up, and [we are] calling and calling and nobody's answering. What do you do in that case?"*

> *"What would we do to get a hold of families, you know. Many of our families don't speak English or Spanish. All our staff are bilingual, but for those that don't speak either of those languages, how do we communicate with them if cell phones aren't working or if we can't get a hold of relatives or something like that."*

Some providers also noted concerns about communication during a large scale emergency where phone lines, cell services, or texting capabilities can be disrupted. One provider noted that during the pandemic, it was possible for providers to contact AT&T and get first responder phones that are prioritized during emergencies.

It is not particularly surprising the communication with families is a primary concern for providers, or that many providers and afterschool programs have good communication systems already in place. Even during non-emergency times, providers communicate with families on a regular basis about schedules, tuition, events, etc. In addition, our survey of CCR&R and ELH directors found that when providing emergency preparedness resources to providers, 64% indicated that they provide resources on communication with families (the most common topic aside from public health protocols).

KEY TAKEAWAY

Many providers are confident in their ability to communicate with families about emergency preparedness, but successful communication often requires significant time and effort. Some providers still experience challenges in reaching families or conveying important information in ways that ensure families understand and process the information.

Barriers in Communication

Many focus group participants voiced concerns about communication processes from state level agencies, like the Early Learning Division (ELD), Office of Child Care (OCC), and the Oregon Health Authority (OHA). The vast majority of these comments were specific to the response and recovery phases of the COVID-19 pandemic. While many of these concerns are specific to communication about pandemic rules and regulations, they do offer valuable, real-world insight into how communication from state agencies played out during a large-scale, long-term emergency.

Common themes from focus group participants included confusion over different messaging from different agencies (particularly ELD and OHA), feeling overwhelmed initially at the volume of information, and eventually feeling abandoned by a lack of communication about rules and regulations.

> *"One of the things that has been extremely confusing has been the mixed messaging that [providers are] getting from a variety of different places. Here's the Early Learning Division procedure if you have a staff member or child who is ill, but the health department is saying something different and another organization is saying something different. The mixed message is very confusing. So that's something we really need to address…clear messages, especially for child care providers."*

> *"It's hard to keep track of…new legislation or new protocols or new things that are continuously rolling out from the state level, or the ELD, or the federal level, just getting all this information with a lot of technical language…has been really difficult to keep up with."*

> *"There was so much stuff coming out it was overwhelming, but now, it's going on two, three weeks of nothing."*

> *"I haven't heard from my certifier for a month, and that's a little disheartening."*

> *"Looking at Oregon and Washington mandates and looking at CDC [guidelines] when we reopened, trying to see what their recommendations were to follow and then looking at the child care rules and things coming down from the State …[it] can be very confusing for people."*

Providers also conveyed disappointment about the timing of communication from state agencies to child care and afterschool providers, and communicated concerns about the overall communication system between state agencies and providers. One participant noted

that child care licensing staff have not gone through emergency preparedness training themselves, and were not fully prepared to support providers during a long-term emergency.

> *"The state does not have any kind of communication system set up with licensed providers, let alone those who are unlicensed. Even within the county, there are a lot of people who fall through the cracks in providing care that are not licensed and they are not on anybody's radar."*

> *"Kind of disappointing. Like, hello, aren't we important enough to know, instead of being always the last ones to know, especially when we're running the emergency child care. That was some of the things I found, they want[ed] us to run [child care for] essential workers, but it always seemed like we got the rules last."*

> *"The lack of communication has more come with the fact that the state just can't keep up with everything. I've just kind of experienced that early learning in general is always the last to know."*

Taken together, these comments suggest a somewhat disjointed communication system between the Early Learning Division, providers, and other state agencies involved in emergency response (such as OHA or State Office of Emergency Management). Undoubtedly, the COVID-19 pandemic was an evolving situation with constantly changing rules and regulations as scientists and epidemiologists understood more about transmission of the disease. Despite some level of unavoidable confusion, however, the comments presented here illustrate that the Early Learning Division was not wholly able to mitigate or minimize the confusion, and suggest that our state level agencies were unprepared to manage communication with providers during a large-scale emergency.

Oregon's lack of a strong communication system between state agencies and providers during an emergency is an area of concern, but it is also not uncommon or unexpected. A brief on federal emergency management by the Congressional Research Service notes that from the federal level down, "emergency management in the United States is highly decentralized and contextual in nature: activities often involve multiple jurisdictions as well as a vast number of agencies, nongovernmental organizations, and private sector entities." Decentralized management can result in disconnected systems, redundant efforts, and conflicting information released from different agencies or jurisdictions. Oregon's own Early Learning Emergency Preparedness and Response Plan acknowledges that good communication during a disaster is the exception rather than the rule, and notes that systems to support emergency communication to Oregon's child care providers still need to be built.

As we saw above, providers initially felt overwhelmed at the volume of information flowing from the ELD and OHA. But after an initial flood of information, these agencies went practically

silent for weeks on end, leaving providers feeling abandoned and confused. Finding the "goldilocks" of communication (not too much and not too little) is a problem that is not unique to Oregon nor unique to the child care field. In response to the COVID-19 pandemic, the World Health Organization (WHO) coined the term "infodemic" to describe when too much information is available, including false or misleading information. This excess of information can create confusion and undermine trust in agencies and public health authorities. WHO emphasizes that having access to the right information, at the right time, in the right format, is critical during an emergency.

It is not surprising that there are symptoms of decentralized communication in Oregon's pandemic response, and these symptoms ultimately left child care providers confused and overwhelmed. Some focus group participants identified CCR&Rs and ELHs as a potential conduit for information from state-level agencies to child care and afterschool providers in their communities, although that role is not defined within Oregon's CCDF plan. Oregon's draft CCDF plan for 2022-24 outlines specific roles for the CCR&R system (p.190), including recruitment of providers, provision of professional development and quality improvement opportunities, maintenance of accurate provider information on 211info, and provision of parent information and referral services, among other services. The CCR&R system is specifically tasked with implementing goals and strategies mandated by the ELD (such as strategies identified in Raise Up Oregon), but the CCDF plan does not specify that the CCR&R system should serve as a communication liaison between state agencies and providers. Unsurprisingly, our survey found that most CCR&R and ELHs do not self-identify as a conduit for information from state-level agencies to providers in their communities. The survey included an open-ended question asking respondents to identify what they see as their role in ensuring that child care providers are adequately prepared for emergencies. 29% of respondents representing CCR&Rs included communication practices in their response, and 29% also included connections to agencies and systems. Of respondents representing ELHs, 33% included communication practices in their response, while 11% included connection to agencies and systems.

KEY TAKEAWAY

Feedback from focus group respondents suggest that emergency communication between state agencies and providers is disjointed and decentralized, and ultimately that the Early Learning Division and the Office of Child Care were unprepared to manage communication with providers during a large-scale emergency (the COVID-19 pandemic).

PROCEDURES & PROTOCOLS

Broadly speaking, emergency procedures could encompass nearly all types of emergency preparedness and response protocols, from communication procedures to evacuation procedures to supply and storage procedures. For our purposes here, however, we distinguish emergency procedures from communication systems (discussed in the previous section), and from emergency preparedness resources (discussed in the following section, which will refer to physical resources, systems of support, and community relationships). In this section, the term procedures will relate primarily to protocols that define and guide behavior during and after an emergency.

Strengths in Procedures & Protocols

According to focus group participants, there are many emergency procedures that child care and afterschool providers have adopted and implemented successfully. The emergency procedures mentioned most frequently by participants included evacuation protocols, regular practicing of fire and earthquake drills, and the inclusion of written emergency procedures in handbooks for staff and families, particularly protocols for relatively small-scale emergencies.

Of these common procedures, evacuation protocols were easily the most frequently mentioned. Typical evacuation protocols included having defined evacuation routes, reunification locations, parent contact information, and evacuation backpacks or kits for youth.

> *"For the most part, we have the backpacks…for emergency preparedness…with Head Start they require [the backpacks], so we have one up over a lot of people. [Head Start] has a really good document that is really helpful."*

> *"At our preschool, we encourage parents to bring a tsunami bag for their child at the beginning of each year. They include water, clothes, glow sticks, a picture of their family, and food. We collect each pack and keep it by our backdoor. In case of a tsunami situation, we would be able to grab the packs and emergency information as we leave for the community gather site."*

> *"We have a rendezvous place that the kids are well versed in, and then we have expedited head counts and roll call procedures for the staff. Like schools, we have our green cards and our red cards and things like that, and our site phone."*

Many focus group participants also reported conducting drills on a regular basis. Typically, these drills focus on the immediate response to a discrete emergency, such as a building fire, earthquake, or active shooter. While helpful, drills do have limitations, and some participants noted that real-life situations can vary from those practiced. One provider also noted the

need to approach drills with a trauma-informed lens, especially when working with very young children.

> *"Each classroom has a disaster kit and they do all the drills."*

> *"[She] had great procedures in place….but the actual real life [situation], like somebody had experienced a real fire…[they asked] where are the pulls for the fire alarm and we hadn't paid attention to where those are. Having staff practice those drills to be prepared [is important], because when it happened then the staff was scared…instead of being that calming presence for the kids."*

> *"As best as we can, we try and practice certain things, especially in the context of our school classroom. But we also recognize the trauma that many of our families have lived, surviving coming from other countries or in their own lived experiences, so we also don't want to induce any undue panic. We want to practice and we want to be smart, but we don't want to scare our three-year olds into thinking something really, really bad is happening right now. Nope, we're just practicing, just like we practice writing our name and we practice riding a bicycle."*

And finally, several providers also mentioned having handbooks (either for staff or families) that addressed emergency preparedness plans, or reported having established procedures for smaller scale emergencies, such as an injured or missing child.

> *"In our area it's called Red Book. We are making sure that we are counting all the children that are in our care at all times. So we have a procedures in place that if something were to happen, if a child were to go missing from a classroom or from the playground, that [we would] announce Red Book, and that's notifying that basically we are going to go into lockdown, so that we're able to locate that child as soon as possible, and we know who would be responsible, like managers, supervisors, whoever, we know who is responsible for looking for that child, and that teachers are [responsible for] staying with the children they already have."*

> *"We also have a handbook that we distribute to parents, indicating in the case of emergency where they are going to locate us, in case we have to move away from the facility."*

According to focus group participants, many child care and afterschool providers appear well prepared for standard, small scale emergencies. This level of preparedness is likely expected of all providers, given that existing child care rules mandate that providers have basic emergency procedures and evacuation plans in place. Oregon's draft CCDF plan, for instance, indicates that all child care providers are required to have an emergency preparedness and response plan that meets the requirements of CCDF rule, including

procedures in the event of evacuations, shelter in place, and lockdown, and accommodations for infants and toddlers, children with disabilities, and children with chronic medical conditions. Providers are also required to practice drills on a regular basis, though the frequency depends on the type of provider (licensed vs, regulated, etc.)

KEY TAKEAWAY

Focus group responses indicate that many providers are prepared for the basic initial response (often evacuation) to a discrete emergency (like a building fire or earthquake), and have established procedures in place for smaller scale emergencies, like a missing child.

Barriers in Procedures & Protocols

Focus group participants noted many concerns related to establishing and maintaining emergency preparedness procedures. By far the most common concern was simply having the time and capacity to adequately develop proper procedures, on top of the demands of everyday jobs. Time and capacity barriers are made more daunting by the sheer amount of effort required to properly prepare for every type of emergency. This was a concern particularly highlighted during the COVID-19 pandemic response; many providers noted that they had procedures in place for earthquakes and wildfires, but had never considered procedures for a pandemic.

> *"Thinking about an emergency, we kind of push off the big earthquake that's been coming..and it's not here right now and I need to prioritize these other things first...Personally, I put the [earthquake] off...then I'm not prepared because I haven't prioritized being prepared over the other work that is always sitting in front of us. I think for me maybe it's a mindshift to being prepared for the emergency is part of the regular work that I need to be doing in a day-to-day space."*

> *"I feel like we did all this preparing and then we ended up with COVID-19 and wildfires....Can we ever be prepared for anything because we don't know anything?"*

> *"We talked about everything from school violence to natural disasters...The pandemic was not ever discussed. The closest we ever got was having side conversations about how in other states sometimes schools are closed down when the flu is really bad."*

Focus group participants also expressed some confusion over what procedures to develop and how to develop them. Many providers are aware there are resources available, but feel confused when different resources offer conflicting information. This recalls the previous

discussion about the decentralization of emergency management; without a central authority providing a singular set of guidelines, providers are left to sort through large amounts of sometimes conflicting information on their own. Some providers, especially school-age providers, noted that operating in facilitates that they do not own adds more potential for confusion and complexity, and requires additional collaboration.

> *"I think that part of the concern we have as providers as we try to develop safety plans is that there is a lot of really great information, but like [she] said, the information can be conflicting and so it makes it difficult to make a plan and feel confident [that] the direction you're heading in is the appropriate direction. When you get in the emergency situation, you're going to hope [that you] do the best you can given the situation, but it's difficult….with all the conflicting information."*

> *"We don't necessarily own or control the facilities so there are other people's emergency plans and things we need to be considerate of."*

On top of being time intensive and confusing to develop, emergency procedures have endless potential for detail and nuance, and focus group participants articulated many specific concerns. One particular issue noted by several participants was the accessibility of written procedures and parent contact information; if important information is stored on computer software, it may be impossible to access during an emergency.

> *"Contact information, all the registration is in the cloud…We need to print that and put it in the binder, or laminate it. And then kids need to have pictures of their parents in their little backpacks so if something happens…they won't be able to describe their parents so they can show emergency workers, if need be, these are my parents. Thinking through all these procedures."*

Another specific issue voiced by several participants concerned emergency procedures for youth with health conditions or medications, especially medications that require special storage.

> *"One of the conversations we've had on emergency preparedness is with children who need life sustaining medication. [She] has two diabetic sons and my boyfriend's daughter is diabetic and they need insulin. If the power goes out, and the medicine needs to be refrigerated, is one of the discussions we've had. We've talked to Red Cross about it and we've gone to other emergency trainings and there is really no advice on what to do if you need insulin or where to store insulin."*

Another prevalent theme was the need for social emotional supports and trauma-informed care. It is evident in focus group conversations that the COVID-19 response phase was mentally, physically, and emotionally challenging for many providers. Focus group

participants noted the need for a trauma-informed lens, and emphasized that emergency procedures and systems must acknowledge the mental and emotional realities of experiencing trauma for staff (and for children and families, as well), and build in safeguards that ensure adults can mitigate their stress in order to manage the emergency situation without jeopardizing the safety of children. One key element is ensuring that child care and afterschool staff have personal emergency preparedness plans in place, so that they can care for the youth in their program without worrying about their own families (to the extent possible). Another key element is adequate staff training, which is discussed in the next section.

> *"I was completely overwhelmed. With all the stuff and all the rules they were asking me to do, and the communications to get out, and it was almost like 3 or 4 zoom meetings a day. At one point I had to just unplug because it was so much."*

> *"It's so, so important to make sure that your staff can manage their anxiety when something is happening because they are also taking care of children, or you're trying to respond to other staff, and so being able to do that without completely shutting down and freaking everyone else out is so important."*

> *"In terms of planning, how can we put structures in place that are going to help people of all developmental stages manage their grief, their upset, the things that didn't go well while they were separated from their friends, from their teachers, from the people that bring them hope and bring them help. So what comes up for me is a lot of social emotional learning skills and trauma informed care practices."*

> *"If we would have had some kind of plan that was a little bit better. Of course nobody knew that this was going to happen. But if we had a plan for A, B, and C, [we could have directed parents about what to do first]. But it was just so scattered and unprepared, and they're very scared."*

> *"To watch other people and to suddenly be worried about my neighbors and my friends. Do my coworkers have enough food? What am I going to do? How am I going to help, without jeopardizing what I can do for my own family."*

KEY TAKEAWAY

Preparing adequately for emergencies requires significant time and capacity, which can be a heavy lift for already busy child care and afterschool providers. Barriers to developing comprehensive, thoughtful procedures and protocols are particularly exacerbated by the

overwhelming variety of potential emergency situations (both big and small), and the decentralized nature of resources and support.

RESOURCES & COMMUNITY SUPPORT

Strengths in Resources & Community Support

There are emergency preparedness resources available to child care and afterschool providers from a variety of agencies and community organizations, including CCR&Rs, ELHs, County Emergency Preparedness Coordinators and Managers, FEMA, Red Cross, local Community Emergency Response Teams (CERT), and first responders (fire, law enforcement, etc.). Some focus group participants mentioned making use of these resources in their programs, mostly with success (although one provider noted a negative experience). Representatives from some of these organizations attended focus groups to share about their available resources.

> *"Reaching out to what resources are out there that you can tap into and knowing that.....FEMA and Red Cross...have programs to help schools and people who don't have budgets."*

> *"We are here to do presentations, and we are more than willing to come out and not only talk with staff, but with families and your children. ...[Many counties] have a Preparedness Coordinator..so do not hesitate to use us as a resource to help you....And not only presentations, but we can come and sit down and help you go through your planning. Did you develop a plan and you need an expert to come and look at it and see if it's feasible? Did you miss anything? We're able to provide that resource as well... We are here to support you. [We are] a resource."*

> *"I know as a CCR&R, since the whole COVID thing...we have been looking for resources on how to support providers. We have been looking for resources for them to get masks and hand sanitizer, and all of those kinds of things."*

> *"We actually partnered with a local city. We partnered with Hillsboro and started taking their CERT classes, which is the Community Emergency Response Team. In Portland, it's called NET, Neighborhood Emergency Team. They do a lot of trainings for any city member that wants to be a volunteer for it. They teach you a little bit more advanced [topics], like treating trauma...and triage....That has been a real beneficial resource...If anyone hasn't looked into the local emergency response team, you can get a lot of resources."*

> *"We contacted a fire marshall or a police officer this last year…and I got the impression…that the guy was being straightforward, [saying] 'we're going to have the big earthquake,'…and scaring parents to the point that it was so quiet in the room that you could hear a pin drop, because they were so intimidated by this guy talking about all these natural disasters. And I was [thinking] 'you're not supposed to scare the families.' …I could feel the coldness in the room from the guy."*

Community partnerships were a commonly mentioned emergency preparedness resource, and many focus group participants reported having community partnerships with organizations not specific to emergency response, most often schools. Other providers mentioned having partnerships with businesses, families, and churches.

> *"This last year we reached out to our school programs and we were able to use some of the resources they had at the school district to allow us….to access those [resources] in a time of emergency."*

> *"We do have a small community school with the Albertson's that is right next door, so that's a plus."*

> *"[It's] not really an expectation beyond typical child care licensing. We have our first aid kits and things like that. I know some school districts in their classrooms, which are the spaces that we utilize, will have some emergency kits. I know Portland Public Schools have freeze dried food and…[space blankets]. If the school district has those…and we happen to be in that space, we do have access to those."*

Tangible resources were also a common topic, and focus group participants frequently mentioned having emergency supplies on hand, most commonly first aid supplies and stored food and water.

> *"We purchased emergency backpacks from the American Red Cross that have a fire blanket, water bottles, granola bars…We have those throughout our facility and in all our busses and actually all of our full time staff were given one to keep in their personal cars."*

> *"One way we tackled the food [issue]…was we already have to provide snacks and bottled water. So we've just made sure we always have a week or more of snack supplies on hand. So if you can just double your weekly snack, you now have rations, if you needed it."*

> *"We have put together bins of baby formula, diapers, first aid, water, non-perishables."*

> *"We have always kept an emergency supply of food and things like that in the centers."*

> *"[We have] important paperwork packed and transportable. Medical kits, a diaper kit, food kit , and places to go in case of emergency."*

Some focus group participants also mentioned that they provide emergency preparedness resources to families, such as parent handbooks or family nights. During the response phase of the COVID-19 pandemic, many providers were able to provide resources to their families and communities, such as food services or home learning kits.

> *"We were working on engaging our families. We had two or three nights where we had families come into the school and do family plans for emergencies and those sort of things."*

> *"We're doing Youtube videos, which are wild and so far out of my comfort zone. And we're doing Zoom calls with kiddos and connecting families to other families via a Zoom call…We're also in the process of putting together some home learning kits. Paper, tape, glue, things families may not have at home."*

> *"That was really, really tricky, because with this COVID thing, the food program has really changed how things work. The school district didn't think they would be able to provide services to us, [but] the superintendent figured out a way for us to do that. Basically, our parents had to sign a waiver saying that our program would in no way be reimbursed for any type of food services period…So we're able to get breakfasts and lunches for our children, and we provide snacks ourselves."*

Within Oregon's child care landscape, CCR&Rs and ELHs serve as a primary resource for providers. The role of CCR&Rs, in particular, is outlined in Oregon's draft CCDF plan for 2022-2024 (p.190), and includes recruitment of providers, provision of professional development and quality improvement opportunities, maintenance of accurate provider information on 211info, and provision of parent information and referral services, among other services. Our survey of CCR&R and ELH directors demonstrated that emergency resources are included, to some extent, within the resources and training they offer to providers. 64% of CCR&R and ELH directors, for instance, reported providing emergency preparedness training either annually or on an ongoing basis, and 52% indicated that they provide up-to-date emergency preparedness materials on their websites. Another 52% reported that they offer coaching or mentoring on emergency preparedness, and 82% indicated that they offer connections to local resources. When asked what topic areas are included in the emergency preparedness support and resources they offer, survey respondents reported that the most common topics included protocols for public health events, communication with families, protocols for specific natural disaster events, and access to food.

An open-ended question on the survey asked directors what they see as their role in ensuring that child care providers are adequately prepared for emergencies. Responses were coded by theme, and the results are presented below. Overall, CCR&R's see their role primarily as providing connections to resources and offering training and professional development. ELHs reported their role primarily as providing connections to resources.

What do you see as your role in ensuring that child care providers are adequately prepared for emergencies?				
	CCR&R		ELH	
Training and PD	11	79%	2	22%
Connection to resources	14	100%	7	78%
Technical assistance	2	14%	1	11%
Connection to agencies/systems	4	29%	3	33%
Provide supplies	2	14%	0	0%
Advocacy	2	14%	1	11%
Communication	4	29%	1	11%
Communication with families	0	0%	1	11%
n=	14		9	

KEY TAKEAWAY

Resources are available to child care and afterschool providers from various community organizations and agencies, including CCR&Rs and ELHs, and many providers make use of these resources to some extent. Providers are also likely to have food and water and first aid supplies on hand. Providers also serve as a resource to families, particularly during the COVID-19 pandemic.

Barriers in Resources & Community Support

Easily the most common concern voiced by focus group participants was the expense associated with being emergency prepared. In the preparation and mitigation phases, the biggest barrier cited by participants was the cost of purchasing tangible resources, such as first aid kits, emergency kits, and food and water reserves. Providers frequently noted that these are not one-time expenses; many supplies, especially food and water, expire and need

to be replaced on a regular basis. Storage space can be another barrier, particularly for school-age programs that are more likely to operate in spaces they do not own. And while the cost of supplies can be formidable, the finances of emergency preparedness extend beyond buying supplies in the preparation phase. The COVID-19 pandemic demonstrated that during response and recovery phases, providers also need strategies for how to stay fiscally afloat during a long-term disaster, particularly when services have to close or families cannot afford to pay.

> *"I hope DHS continues [the changes to subsidy rules] after COVID is [over]. Because people are coming in at such a debt. [DHS] talked about [how] it's only during this time that they're doing the [changes]. So I really hope they continue it for a good six months, eight months afterwards to help the providers, because we're going into huge debt just staying open."*

> *"[We are] applying for loans and stuff like that so we can still function and we can still pay our staff."*

> *"Looking for grants and what not. We have a hospital foundation, they're helping us find some money to help forgo the tuitions that parents can't pay. [These are parents] that ended up losing their jobs but still owed me money. We're working to forgo all of those tuitions so they can come back at zero and not have any more debt."*

> *"[I'm from a CCR&R, and] because we're part of an agency, I think one of the things that's been slow is the agency buy-in, and the funding to help buy supplies. But after this I think they really are stepping up now and seeing the need."*

Many focus group participants also reported facing barriers that are distinct from cost challenges. These barriers to accessing resources can take many forms, depending the type of resource and the phase of emergency management. During the COVID-19 response and recovery period, for instance, many providers experienced significant difficulty simply finding tangible resources (usually cleaning supplies and personal protective equipment). In the response and mitigation phases, however, the primary barrier to access was a lack of awareness of available resources, particularly of community resources. In many cases, these comments echoed concerns from previous sections; the scope and variety, as well as the decentralized nature, of available resources can be overwhelming and confusing. Some providers also recognized their lack of connection to local emergency first responders.

> *"We acknowledge that there are probably resources and information out there, and it's just maybe a matter of us digging for it."*

> *"What's already available in Clackamas County and what is missing, and how are those things that are available communicated, not only with child care providers and youth service providers, but also with other nonprofits, other service providers, and community members."*

> *"We realized that a lot of times that our local police heroes are not aware of before and after school programs, so if there is an emergency… they typically call the schools to alert them of what's occurring. They don't alert [afterschool] programs because they don't know that we exist and they don't have our contact information. In terms of communication, it is something that should be addressed as well because they have the first hand information."*

Another significant barrier to access can be language barriers, because most emergency preparedness resources are available only in English.

> *"For non-english speakers, where do you go for information and how readily available is this information?"*

Finally, a major concern for many providers is a lack of training for their staff. First and foremost, staff should be trained on the basics of emergency preparedness, such as ensuring that they are familiar with emergency protocols, know where supplies are located, know evacuation routes, etc. Some focus group participants noted that staff had trouble remembering things they thought they knew during an emergency situation (such as where the fire alarm pulls are during a building fire). Oregon currently requires limited emergency preparedness training for child care providers. Oregon's draft CCDF plan for 2022-24 indicates that all registered providers, certified providers, and regulated subsidy providers must complete the Child Care Health and Safety training prior to becoming licensed (or approved for subsidy), and all staff in child care settings must complete the training prior to having unsupervised access to children. Emergency preparedness and response planning is included as one of nine topics addressed during the approximately 2 hour training.

> *"We've got our emergency backpacks, we've got our phone numbers and everything ready in there. The only thing that I think would be a problem is if we lost communication, and I think that would just be hoping our staff is trained well enough to handle the situation and have their own back-up plans."*

> *"Among staff members, getting appropriately trained and feeling like they know and understand the emergency plans and how to jump into action if they need to."*

> *"Like, knowing that when all the cell phone towers go down and no one's able to use cell phones for calling, text messages will actually go through. A lot of people don't know that…A lot of staff don't have that kind of training. And a lot of private centers*

that you're going to be working with at child care facilities, do not have the budget to do this kind of staff development work."

> *I'm from a CCR&R, and on my end, [one of our priorities] is making sure that webinar trainings continue throughout the next six months. We've been doing way more, of course, because all our face-to-face trainings shut down. [We're trying to help] providers maintain their license. [So], we're really trying hard to continue that. These are state-wide webinars."*

> *"At the Oregon Department of Education, we now realize that training for situations like this is important for those in our programs. It is important that providers and organizations know what is available in these situations from the Oregon Department of Education."*

In addition to being trained and comfortable with emergency protocols and procedures, staff must also be ready to handle the social and emotional, and potentially traumatic, realities of an emergency situation, both for themselves and for the youth in their care. Training for staff should incorporate trauma-informed strategies (for adults and youth), and it also should incorporate personal emergency planning. If staff are personally (for themselves and their families) prepared for an emergency, they are more likely to be calm and stay present during a large-scale emergency.

> *"I come from an organization previously that did a lot of work nationally around emergency preparedness for young children. A lot of what we saw had to do with staff training and lack of staff training around emergency preparedness…..and how to have steps in place for your own families so that you are less likely as soon as you're able to leave your work environment…to worry more about your family at home…"*

> *"It's so, so important to make sure that your staff can manage their anxiety when something is happening because they are also taking care of children, or you're trying to respond to other staff, and so being able to do that without completely shutting down and freaking everyone else out is so important."*

Similar to how personal emergency preparedness planning for staff bleeds into professional planning for providers, the ability of families to access resources can impact providers, as well. This was especially apparent during the response and recovery phases of the COVID-19 pandemic. Many families lacked access to technology (which complicated communication between providers and families or impacted learning from home efforts), or relied on the resources and services normally provided by child care or afterschool programs (such as meals and snacks, infant supplies, etc.). Some focus group participants expressed a desire to have more resources available to families during an emergency.

> *[If this ever happened again], I would love to have… food boxes and links and things like that for my parents at my center, where I can give it to them, and they could use those resources as much as possible when they're down."*

> *"[Some of our families struggle with] just basic things like food, you know, [paying] bills, just those basic things….On our website we put up many resources, but it was very late… It should have been there from the very start, I think."*

> *"What comes up for me…is that any sort of natural disaster or any kind of pandemic crisis like we're in now, makes worse things like child abuse, intimate partner violence, financial hardships."*

> *"…Our program fills that gap in many ways for [families]. They would be able to come into our classroom and talk to somebody, or get a snack. All of those resources that [we were] providing are just gone."*

KEY TAKEAWAY

Access to tangible supplies can be challenging for providers during all stages of emergency management (particularly during the response and recovery phases of long-term emergencies), with cost being the primary barrier. Providers also underutilize existing community and agency resources, and have limited access to training resources for staff.

CONCLUSIONS

The findings in this report demonstrate that Oregon's child care and afterschool providers are prepared for emergencies in certain areas, including communication with families, basic emergency protocols like evacuation, and storage of food, water, and first aid supplies. For many providers, however, these protocols are theoretical plans that remain largely untested during real emergencies (in other words, the plans fall within the preparedness and mitigation phases of emergency management, and have never been implemented in a true emergency response phase). The COVID-19 pandemic demonstrated that the real-life challenges of an emergency can easily exceed even well-laid plans, and it exposed weaknesses within our child care infrastructure. While the child care and afterschool field, as a whole, demonstrated a remarkable ability to adapt quickly to changing circumstances, ultimately our providers and agencies alike were unprepared for a large-scale, long-term disaster. Disjointed communication, decentralized resources, cost and funding barriers, and a

lack of access to staff training were the primary systemic shortcomings articulated by focus group participants.

Nonetheless, there are key elements of emergency management already in place in Oregon's child care system. The ELD has established guidelines for continuation of child care subsidies and services during an emergency, and created provisions for emergency and temporary child care, as outlined in the Early Learning Emergency Preparedness and Response Plan. The plan also presents a thorough summary of the challenges that stand between our current system and one that is wholly prepared for emergencies, although it offers few details or guidance that would help providers become more prepared themselves. CCR&Rs and ELHs offer some emergency-focused training and support to providers, and the ELD maintains an Emergency Preparation and Response webpage with resources available, although the resources are limited and self-guided. The emergency plan templates provided by the ELD (which are required of licensed and regulated providers), for instance, are sparse and offer little guidance and best practices, consisting mostly of empty boxes for providers to fill in.

The findings from this report highlight areas for improvement within Oregon's child care emergency management system. The recommendations below build off of these key findings, and offer actionable recommendations that fit within Oregon's existing framework and resource networks.

RECOMMENDATIONS

Centralized Communication

Feedback from focus group participants suggests that emergency communication between state agencies and providers is disjointed and decentralized. A key recommendation, therefore, is to centralize communication between state agencies and providers and establish roles and responsibilities dedicated to emergency preparedness. (Note: While this recommendation is specific to emergency preparedness, centralized communication in general would benefit the child care field as a whole, beyond just emergency communication). Specific recommendations include:

- Designate a full or part-time position at the ELD that is responsible for overseeing emergency preparedness and emergency communication with child care and afterschool providers.
- Establish a full or part-time position at each CCR&R agency that is responsible for supporting emergency preparedness for both providers and families. Possible responsibilities of the position could include:
    - Serving as a conduit between the ELD and providers during emergency situations, to ensure that communication and directives from ELD reach providers in a timely fashion.

- Ensuring that providers have easy access to up-to-date, high-quality emergency preparedness resources on an annual basis.
- Facilitating communication and collaboration between provider and local emergency services (Red Cross, first responders, local emergency management teams, etc.).
- Providing technical assistance to providers focused on emergency preparedness, as needed.
- Providing emergency preparedness resources to families, or hosting conversations or family nights focused on emergency preparedness.

Quality Supports and Training

Providers would benefit from high-quality resources and training, provided through a central authority, that support emergency preparedness. These supports build upon and expand currently available resources. Current licensing rules require emergency preparedness training only to the extent that is included within the two-hour Introduction to Child Care Health and Safety training. ELD maintains an Emergency Preparation and Response webpage with resources available. Expanded quality support recommendations include:

- A standalone, free-of-charge emergency preparedness training for providers and staff that is consistent state-wide, applicable to Oregon systems, and required of all providers. Training should include real-life examples, tangible resources, and best practices of disaster messaging.
- High-quality supports and resources for providers, that include:
  - Wide-ranging communication supports for all types of stakeholders that address: language use (verbal and written), communication with providers, and communication with families.
  - Resources that support personal preparedness of providers, staff, and families
  - Resource and planning guides differentiated by age (early childhood vs school age)
- Ensuring that OCC licensing staff participate in emergency preparedness training, and incorporate oversight of emergency preparedness planning into licensing requirements and site visits.
- Earmarked funds for regional training systems, in order to support:
  - Translation services and dedicated outreach to populations that don't speak english
  - Connection to state emergency management resources
  - Equity-centered resources and supports

Workgroup Oversight

We suggest convening a short-term workgroup to oversee and support implementation of resources, training, and communication strategies. The workgroup must take into account the language and cultural barriers many Oregon child care providers and families face in accessing accurate and updated information, and ensure all implemented strategies are responsive to these barriers. Potential workgroup responsibilities include:

- Identifying possible rules and protocols that can help solidify roles and responsibilities for providers and families in cases of emergencies.
- Identifying goals for quality supports and training, and recommending qualified experts, agencies, or contractors to develop and implement them.

Funding

In addition to the actions recommended above, we propose several additional areas for increased funding to better support emergency preparedness of child care and afterschool providers, including:

- Funding that encompasses direct support to providers and communities, especially to support communication, training, planning, and partnerships/collaboration with emergency service providers.
- Funding for infrastructure to support long-term system development and implementation (such as funding for CCR&Rs to support a dedicated full or part time emergency preparedness coordinator).

ACKNOWLEDGEMENTS

We would like to thank the *2 Weeks Ready* Workgroup for generously sharing their time and expertise in contribution to this project. Workgroup members convened throughout the project to advise on project activities, assist with planning, and share reflections on the campaign. Their input was an invaluable asset to this project.
Please note: Data analysis and report findings were developed independently of the workgroup, and inclusion on this list does not signify endorsement of the findings in this report.

Workgroup Members

Brent Balog, Clackamas Workforce Partnership

Colleen Dorfler, OregonASK

Collette Brown, Providence Wee Care Child Development Center

Crys O'Grady, Oregon Department of Education, Early Learning Division

Crystal Persi, Oregon Department of Education

Dave Busby, Fire Emergency Planning Manager City of Corvallis

Debra Reed, NW Regional CCR&R

Eric Cardell, Oregon State University

Jessica Visinsky , Oregon Department of Education, Child Nutrition Programs

Jose Hernandez, Linn Benton Community College

Kaitlin Skreen, Oregon Department of Education, Child Nutrition Programs

Kathleen Silva, Emergency Management Marion County

Kelsey Rittenhouse, Ashland Family YMCA

Laura Hall, Regional Disaster Preparedness Organization

Nancy Patten, Child Care Partners

Nunpa, Antfarm Youth Services

Parker Sczepanik, Lines for Life

Renate Garrison, Emergency Management City of Beaverton

Rhonda McDowall, Fruit and Flower

Roni Pham, Oregon Department of Education, Early Learning Division

Steve Pegram, Emergency Management Columbia County

Special thanks to the hundreds of providers across the state who participated in focus groups, for their input and support in this project.

Robert Wood Johnson Foundation Program
County Health Rankings
2010 - 2021

Counties are ranked based on Health Outcomes, how healthy is a county and Health Factors, what influences the health of a county.

2021

County	Health Outcomes	Health Factors
Benton	1	1
Lincoln	27	26
Linn	18	11

2020

County	Health Outcomes	Health Factors
Benton	2	2
Lincoln	31	26
Linn	11	19

2019

County	Health Outcomes	Health Factors
Benton	2	1
Lincoln	31	29
Linn	18	17

2018

County	Health Outcomes	Health Factors
Benton	2	1
Lincoln	34	29
Linn	20	19

2017

County	Health Outcomes	Health Factors
Benton	3	1
Lincoln	30	26
Linn	19	25

2016

County	Health Outcomes	Health Factors
Benton	3	1
Lincoln	29	24
Linn	22	26

2015

County	Health Outcomes	Health Factors
Benton	3	1
Lincoln	25	30
Linn	17	21

2014

County	Health Outcomes	Health Factors
Benton	1	1
Lincoln	21	24
Linn	22	20

2013

County	Health Outcomes	Health Factors
Benton	2	1
Lincoln	24	23
Linn	23	22

2012

County	Health Outcomes	Health Factors
Benton	1	1
Lincoln	23	25
Linn	24	23

2011

County	Health Outcomes	Health Factors
Benton	1	1
Lincoln	27	25
Linn	28	20

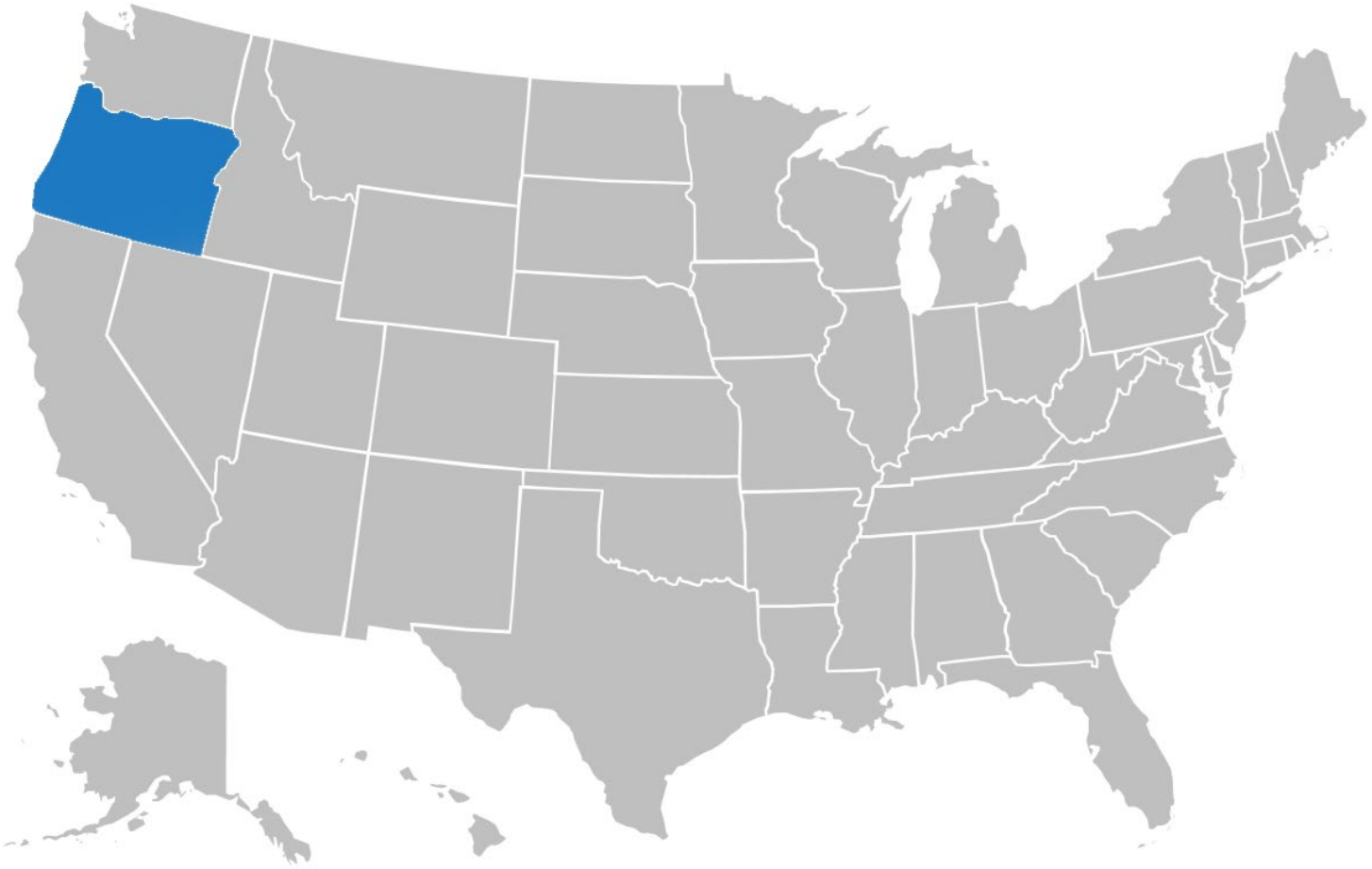
2010

County	Health Outcomes	Health Factors
Benton	1	1
Lincoln	28	25
Linn	26	23

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

Oregon



2021 State Level Data and Ranks

University of Wisconsin Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Support provided by
Robert Wood Johnson Foundation

2021 County Health Rankings for Oregon: Measures and National/State Results

Measure	Description	US	OR	OR Minimum	OR Maximum
HEALTH OUTCOMES					
Premature death*	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	6,900	5,900	3,900	9,800
Poor or fair health	Percentage of adults reporting fair or poor health (age-adjusted).	17%	18%	15%	26%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	3.7	4.7	3.8	5.6
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	4.1	4.8	4.4	5.6
Low birthweight*	Percentage of live births with low birthweight (< 2,500 grams).	8%	7%	5%	11%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	Percentage of adults who are current smokers (age-adjusted).	17%	16%	13%	23%
Adult obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m^2.	30%	29%	22%	40%
Food environment index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	7.8	7.8	4.4	9.1
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity.	23%	17%	14%	28%
Access to exercise opportunities	Percentage of population with adequate access to locations for physical activity.	84%	88%	50%	98%
Excessive drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	19%	19%	17%	24%
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement.	27%	31%	0%	60%
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population.	539.9	464.0	127.6	707.1
Teen births*	Number of births per 1,000 female population ages 15-19.	21	17	4	37
CLINICAL CARE					
Uninsured	Percentage of population under age 65 without health insurance.	10%	8%	6%	12%
Primary care physicians	Ratio of population to primary care physicians.	1,320:1	1,060:1	1,370:0	480:1
Dentists	Ratio of population to dentists.	1,400:1	1,210:1	1,910:0	670:1
Mental health providers	Ratio of population to mental health providers.	380:1	180:1	640:1	100:1
Preventable hospital stays*	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	4,236	2,799	891	4,232
Mammography screening*	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	42%	42%	30%	48%
Flu vaccinations*	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.	48%	44%	16%	55%
SOCIAL & ECONOMIC FACTORS					
High school completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	88%	91%	76%	96%
Some college	Percentage of adults ages 25-44 with some post-secondary education.	66%	70%	43%	85%
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	3.7%	3.7%	2.9%	6.9%
Children in poverty*	Percentage of people under age 18 in poverty.	17%	14%	7%	32%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.9	4.6	3.6	5.7
Children in single-parent households	Percentage of children that live in a household headed by single parent.	26%	21%	13%	33%
Social associations	Number of membership associations per 10,000 population.	9.3	10.2	0.0	29.3
Violent crime	Number of reported violent crime offenses per 100,000 population.	386	249	0	474
Injury deaths*	Number of deaths due to injury per 100,000 population.	72	75	43	142
PHYSICAL ENVIRONMENT					
Air pollution - particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	7.2	6.4	4.8	8.8
Drinking water violations	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	N/A	N/A	No	Yes
Severe housing problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	18%	19%	11%	23%
Driving alone to work*	Percentage of the workforce that drives alone to work.	76%	72%	56%	82%
Long commute - driving alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	37%	30%	10%	58%

* Indicates subgroup data by race and ethnicity is available

2021 County Health Rankings: Disaggregated State-Level Racial/Ethnic Data

Measure	Overall	AIAN	Asian	Black	Hispanic	White
HEALTH OUTCOMES						
Premature death*	5,900	9,500	3,500	8,500	4,000	6,200
Life expectancy	79.9	78.8	85.8	77.1	86	79.5
Premature age-adjusted mortality	300	410	170	440	190	310
Child mortality	40	50	30	60	40	40
Infant mortality	5	5	4	8	5	5
Low birthweight*	7%	7%	8%	10%	7%	6%
HEALTH FACTORS						
HEALTH BEHAVIORS						
Drug overdose deaths	13	24	3	24	6	15
Motor vehicle crash deaths	11	18	4	9	8	12
Teen births*	17	24	5	23	30	13
CLINICAL CARE						
Preventable hospital stays*	2,799	4,155	1,958	5,070	2,738	2,775
Mammography screening*	42%	36%	35%	37%	34%	42%
Flu vaccinations*	44%	41%	45%	34%	35%	45%
SOCIAL & ECONOMIC FACTORS						
Reading scores^	2.9	N/A	3.3	---	2.4	3.1
Math scores[+]	2.8	N/A	3.3	---	2.3	3.0
Children in poverty*[‡]	14%	27%	15%	33%	26%	13%
Median household income	$67,000	$44,300	$78,800	$41,800	$52,500	$64,400
Injury deaths*	75	88	29	66	33	85
Homicides	3	5	2	11	3	3
Suicides	19	21	9	11	8	21
Firearm fatalities	13	14	4	15	5	14
PHYSICAL ENVIRONMENT						
Driving alone to work*	72%	70%	67%	63%	68%	74%

* Ranked measure

^ Data not available for AK, AZ, LA, MD, NM, NY, VT

[+] Data not available for AK, AZ, LA, MD, NY, VT, VA

[‡] Overall county level values of children in poverty are obtained from one-year modeled estimates from the Small Area Income and Poverty Estimates (SAIPE) Program. Because SAIPE does not provide estimates by racial and ethnic groups, data from the 5-year American Community Survey (ACS) was used to quantify children living in poverty by racial and ethnic groups.

N/A indicates data not available for this race/ethnicity.

--- Data not reported due to NCHS suppression rules (A missing value is reported for counties with fewer than 20 deaths or 10 births.)

2021 County Health Rankings: Ranked Measure Sources and Years of Data

	Measure	Weight	Source	Years of Data
HEALTH OUTCOMES				
Length of Life	Premature death*	50%	National Center for Health Statistics - Mortality Files	2017-2019
Quality of Life	Poor or fair health	10%	Behavioral Risk Factor Surveillance System	2018
	Poor physical health days	10%	Behavioral Risk Factor Surveillance System	2018
	Poor mental health days	10%	Behavioral Risk Factor Surveillance System	2018
	Low birthweight*	20%	National Center for Health Statistics - Natality files	2013-2019
HEALTH FACTORS				
HEALTH BEHAVIORS				
Tobacco Use	Adult smoking	10%	Behavioral Risk Factor Surveillance System	2018
Diet and Exercise	Adult obesity	5%	United States Diabetes Surveillance System	2017
	Food environment index	2%	USDA Food Environment Atlas, Map the Meal Gap from Feeding America	2015 & 2018
	Physical inactivity	2%	United States Diabetes Surveillance System	2017
	Access to exercise opportunities	1%	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files	2010 & 2019
Alcohol and Drug Use	Excessive drinking	2.5%	Behavioral Risk Factor Surveillance System	2018
	Alcohol-impaired driving deaths	2.5%	Fatality Analysis Reporting System	2015-2019
Sexual Activity	Sexually transmitted infections	2.5%	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
	Teen births*	2.5%	National Center for Health Statistics - Natality files	2013-2019
CLINICAL CARE				
Access to Care	Uninsured	5%	Small Area Health Insurance Estimates	2018
	Primary care physicians	3%	Area Health Resource File/American Medical Association	2018
	Dentists	1%	Area Health Resource File/National Provider Identification file	2019
	Mental health providers	1%	CMS, National Provider Identification	2020
Quality of Care	Preventable hospital stays*	5%	Mapping Medicare Disparities Tool	2018
	Mammography screening*	2.5%	Mapping Medicare Disparities Tool	2018
	Flu vaccinations*	2.5%	Mapping Medicare Disparities Tool	2018
SOCIAL & ECONOMIC FACTORS				
Education	High school completion	5%	American Community Survey, 5-year estimates	2015-2019
	Some college	5%	American Community Survey, 5-year estimates	2015-2019
Employment	Unemployment	10%	Bureau of Labor Statistics	2019
Income	Children in poverty*	7.5%	Small Area Income and Poverty Estimates	2019
	Income inequality	2.5%	American Community Survey, 5-year estimates	2015-2019
Family and Social Support	Children in single-parent households	2.5%	American Community Survey, 5-year estimates	2015-2019
	Social associations	2.5%	County Business Patterns	2018
Community Safety	Violent crime	2.5%	Uniform Crime Reporting - FBI	2014 & 2016
	Injury deaths*	2.5%	National Center for Health Statistics - Mortality Files	2015-2019
PHYSICAL ENVIRONMENT				
Air and Water Quality	Air pollution - particulate matter	2.5%	Environmental Public Health Tracking Network	2016
	Drinking water violations	2.5%	Safe Drinking Water Information System	2019
Housing and Transit	Severe housing problems	2%	Comprehensive Housing Affordability Strategy (CHAS) data	2013-2017
	Driving alone to work*	2%	American Community Survey, 5-year estimates	2015-2019
	Long commute - driving alone	1%	American Community Survey, 5-year estimates	2015-2019

*Indicates subgroup data by race and ethnicity is available

2021 County Health Rankings: Additional Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Life expectancy*	National Center for Health Statistics - Mortality Files	2017-2019
	Premature age-adjusted mortality*	National Center for Health Statistics - Mortality Files	2017-2019
	Child mortality*	National Center for Health Statistics - Mortality Files	2016-2019
	Infant mortality*	National Center for Health Statistics - Mortality Files	2013-2019
Quality of Life	Frequent physical distress	Behavioral Risk Factor Surveillance System	2018
	Frequent mental distress	Behavioral Risk Factor Surveillance System	2018
	Diabetes prevalence	United States Diabetes Surveillance System	2017
	HIV prevalence	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
HEALTH FACTORS			
HEALTH BEHAVIORS			
Diet and Exercise	Food insecurity	Map the Meal Gap	2018
	Limited access to healthy foods	USDA Food Environment Atlas	2015
Alcohol and Drug Use	Drug overdose deaths*	National Center for Health Statistics - Mortality Files	2017-2019
	Motor vehicle crash deaths*	National Center for Health Statistics - Mortality Files	2013-2019
Other Health Behaviors	Insufficient sleep	Behavioral Risk Factor Surveillance System	2018
CLINICAL CARE			
Access to Care	Uninsured adults	Small Area Health Insurance Estimates	2018
	Uninsured children	Small Area Health Insurance Estimates	2018
	Other primary care providers	CMS, National Provider Identification	2020
SOCIAL & ECONOMIC FACTORS			
Education	High school graduation	EDFacts	2017-2018
	Disconnected youth	American Community Survey, 5-year estimates	2015-2019
	Reading scores*+	Stanford Education Data Archive	2018
	Math scores*+	Stanford Education Data Archive	2018
Income	Median household income*	Small Area Income and Poverty Estimates	2019
	Children eligible for free or reduced price lunch	National Center for Education Statistics	2018-2019
Family and Social Support	Residential segregation - Black/White	American Community Survey, 5-year estimates	2015-2019
	Residential segregation - non-White/White	American Community Survey, 5-year estimates	2015-2019
Community Safety	Homicides*	National Center for Health Statistics - Mortality Files	2013-2019
	Suicides*	National Center for Health Statistics - Mortality Files	2015-2019
	Firearm fatalities*	National Center for Health Statistics - Mortality Files	2015-2019
	Juvenile arrests+	Easy Access to State and County Juvenile Court Case Counts	2018
PHYSICAL ENVIRONMENT			
Housing and Transit	Traffic volume	EJSCREEN: Environmental Justice Screening and Mapping Tool	2019
	Homeownership	American Community Survey, 5-year estimates	2015-2019
	Severe housing cost burden	American Community Survey, 5-year estimates	2015-2019
	Broadband access	American Community Survey, 5-year estimates	2015-2019

*Indicates subgroup data by race and ethnicity is available

+ Not available in all states

See additional contextual demographic information and measures online at **www.countyhealthrankings.org**

2021 County Health Rankings for the 34 Ranked Counties in Oregon

County	Health Outcomes	Health Factors
Baker	26	18
Benton	1	1
Clackamas	4	4
Clatsop	13	8
Columbia	11	16
Coos	24	29
Crook	23	25
Curry	17	24
Deschutes	5	3
Douglas	30	23
Gilliam	NR	NR
Grant	29	22
Harney	25	21
Hood River	3	6
Jackson	15	20
Jefferson	32	33
Josephine	31	28
Klamath	34	32
Lake	33	31
Lane	16	10
Lincoln	27	26
Linn	18	11
Malheur	28	34
Marion	10	19
Morrow	19	27
Multnomah	7	5
Polk	6	7
Sherman	14	13
Tillamook	12	15
Umatilla	21	30
Union	22	14
Wallowa	9	17
Wasco	20	12
Washington	2	2
Wheeler	NR	NR
Yamhill	8	9

For more information on how these ranks are calculated visit **www.countyhealthrankings.org**

Stay Up-To-Date with County Health Rankings & Roadmaps

For the latest updates on Rankings, What Works for Health, Action Learning Guides, and more visit www.countyhealthrankings.org.

You can see what we are featuring on our webinar series, what communities are doing to improve health, and how you can get involved!

Talk to a Team Member:

Have questions about your data? Need help finding an evidence-informed strategy? Looking for more information on how to start taking action? CHR&R team members are available to help you navigate the many resources we have available to support you on your journey to create healthy, equitable communities.

To contact us, please go to www.countyhealthrankings.org/contact-us. We're here to help!

Technical Notes

How are race and ethnicity categories defined?

Race and ethnicity are different forms of identity but are sometimes categorized in non-exclusive ways. Race is a form of identity constructed by our society to give meaning to different groupings of observable physical traits. An individual may identify with more than one race group. Ethnicity is used to group individuals according to shared cultural elements. Racial and ethnic categorizations relate to health because our society sorts groups of individuals based on perceived identities. These categorizations have meaning because of social and political factors, including systems of power such as racism. Examining the variation among racial and ethnic groupings in health factors and outcomes is key to understanding and addressing historical and current context that underlie these differences.

Data sources differ in methods for defining and grouping race and ethnicity categories. To incorporate as much information as possible in our summaries, County Health Rankings & Roadmaps (CHR&R) race/ethnicity categories vary by data source. With a few exceptions, CHR&R adheres to the following nomenclature originally defined by The Office of Management and Budget (OMB):

American Indian & Alaska Native (AIAN): includes people who identify as American Indian or Alaska Native and do not identify as Hispanic.
Asian: includes people who identify as Asian or Pacific Islander and do not identify as Hispanic.
Black: includes people who identify as Black or African American and do not identify as Hispanic.
Hispanic: includes people who identify as Mexican, Puerto Rican, Cuban, Central or South American, other Hispanic, or Hispanic of unknown origin.
White: includes people who identify as White and do not identify as Hispanic.

Note:

- Racial and ethnic categorization masks variation within groups.
- Individuals may identify with multiple races, indicating that none of the offered categories reflect their identity; these individuals are not included in our summaries.
- OMB categories have limitations and have changed over time, reflecting the importance of attending to contemporary racialization as a principle for examining approaches to measurement.
- For some data sources, race categories other than White also include people who identify as Hispanic.

Learn More:
The above definitions apply to all measures using data from the National Center for Health Statistics (see Ranked & Additional Measure Sources and Years of Data tables on pages 4 & 5). For this data source, all race/ethnicity categories are exclusive so that each individual fits into only one category.

Other data sources offer slight nuances of the race/ethnicity categories listed above. The American Community Survey (ACS) only provides an exclusive race and ethnicity category for people who identify as non-Hispanic White. An individual who identifies as Hispanic and as Black would be included in both the Hispanic *and* Black race/ethnicity categories. Another difference with ACS data is the separate race categories for people who identify as Asian and people who identify as Hawaiian & Other Pacific Islander. For measures of Children in Poverty and Driving Alone to Work, CHR&R reports a combined estimate for the Asian & Other Pacific Islander categories, while for Median Household Income we only report the Asian race category.

Measures using data from the Center for Medicare and Medicaid Services (Mammography, Preventable Hospital Stays, Flu Vaccinations) follows the ACS categories with the exception of having a combined Asian/Pacific Islander category. For this data source, race and ethnicity are not self-reported.

The Stanford Education Data Archive used for the Reading and Math Scores measures follow the National Center for Education Statistics (NCES) definitions of Asian or Pacific Islander, American Indian & Alaska Native, non-Hispanic Black, non-Hispanic White, and Hispanic.

How do we rank counties?

To calculate the ranks, we first standardize each of the measures using z-scores. Z-scores allow us to combine multiple measures because the measures are now on the same scale. The ranks are then calculated based on weighted sums of the measure z-scores within each state to create an aggregate z-score. The county with the best aggregate z-score (healthiest) gets a rank of #1 for that state. To see more detailed information on rank calculation please visit our methods in **Explore Health Rankings** on our website: www.countyhealthrankings.org.