

Executive Summary

Public Health Foundation of Columbia County

The local public health plan for Columbia County and its updates can be found at www.oregon.gov. It is also available directly from The Public Health Foundation of Columbia County (“Foundation”) by request at (503) 397-4651. Public Health Foundation was actively engaged in the Community Health Assessment and Community Health Improvement Plan for the Columbia Pacific Coordinated Care Organization. The requirements for a local public health annual plan are in statutes ORS 431.375-431.385 and ORS 431.416. The applicable administrative rules can be found in OAR Chapter 333, Division 14. ORS 431.375 defines policy for local public health services. Policy states that the public health system in Oregon is to provide basic public health services that counties can provide or contract responsibility or relinquish these services to the state, and that all public funds utilized for public health services must be approved by the local public health authority. Columbia County is contracted with the Foundation and the Foundation provides the essential Public Health services.

The Minimum Standards for Local Health Departments document states “In the state of Oregon, responsibility for public health protection is shared between the Oregon Health Authority (OHA) Public Health Division and the local public health authorities. Local and state agencies perform different tasks. They have unique but complimentary roles and they rely on one another to make the public health system work effectively.” The community relies upon the partnership between the state and local government as well as the partnerships at the federal level.

Most of the public health funding in Columbia County is federal: public health emergency preparedness, WIC (Women, Infant, and Children nutrition program), maternal child health services provided through Title V and X funds, water systems’ dollars provided through Environmental Protection Agency, and federal dollars reimbursed for services delivered. These programs are tightly defined by contracts and program assurances from the State of Oregon.

State general funds are linked to the provision of communicable disease and epidemiology standards and are funded by a per capita formula. A registered nurse provides home visit services to ages 0-8 years, School-based Health Center dollars (SBHC) support SBHCs in St. Helens, Rainier, Vernonia, and planning in Clatskanie. Tobacco tax dollars support tobacco education and community planning for healthy living. Private grants fund other projects such as SBHC planning in Scappoose.

Local revenues are provided by Columbia County as defined in Oregon statute to support housing public health services and costs of administration. Funding is generated by the provision of services through fee-for-service reimbursement and donations.

With healthcare reform, the Foundation is striving to provide primary care services at a caliber that is recognized as innovative and satisfactory of the national and state reformation. This design includes primary care homes and coordinated care organizations with the goal of keeping Oregonians healthy.



Columbia Pacific CCO

Columbia County

Community Health Assessment 2014

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INTRODUCTION AND OVERVIEW

The health of the public is the responsibility of everyone, not just our local public health agencies. Hospitals, clinics, behavioral health agencies, community based organizations, early learning councils and school-based health centers should build population health capacity together.

Columbia Pacific Coordinated Care Organization (CPCCO), as part of the CCO transformation plan, seeks to bring together stakeholders from diverse sectors to establish a common agenda, shared metrics, a structured process and a jointly-funded infrastructure for the purpose of creating a shared system of health.

As part of the process of bringing together stakeholders and health data to inform transformation plan activities, CPCCO conducted a community health needs assessment in its service area—Clatsop, Columbia, and Tillamook counties and the Reedsport area of Douglas County—with the goal of gathering community perceptions of health, health care needs and health equity.

CPCCO's four Community Advisory Councils (CACs) participated in and gave oversight to the needs assessment process, including supporting the development of a meta-analysis of existing clinical and community epidemiological health data. An emphasis was placed on reviewing local assessments already conducted in behavioral health, public health, hospital community benefit reporting and other assessments from agencies or community-based organizations that help address socioeconomic issues such as community vitality, employment and food insecurity.

Health disparity issues in rural areas include, but are not limited to: geographic separation; high patient ratio per number of providers to Medicaid clients; paucity of resources; health care provider mix and difficulty coordinating care between hospitals, clinics, behavioral health agencies and social service safety net providers.

To address these disparities, CPCCO seeks to create a Community Health Improvement Plan that aligns to and is coordinated with other required community assessments when appropriate, such as public health department accreditation plans, hospital community benefit plans, the CPCCO Clinical Advisory Panel's clinical transformation priorities and community behavioral health agencies bi-annual improvement plans.

The goal of the CPCCO Community Health Improvement Plan is to use the data on community perceptions of health and health care needs from the community health survey that was conducted in the fall of 2013, along with existing epidemiological data to address the social determinants which lead to poor community health outcomes. The long-term goal is to create opportunities for shared ownership of the health of the community between the CCO, hospitals, public health agencies, behavioral health agencies and other local stakeholders,

including natural supports. This collaboration offers the opportunity to mobilize and leverage resources to achieve measurable and sustainable improvements in health status and quality of life for the region as a whole.

The community health needs assessment and the resulting community health improvement plan incorporate all findings, stories, priorities and strategies for addressing gaps that result in health disparities and health inequity in the communities served by CPCCO.

Description of needs assessment process:

CPCCO has four local CACs and a regional CAC. The charge of the local and regional CACs is to oversee and support the community health needs assessments and a regional community health improvement plan for CPCCO.

The purpose of the regional health needs assessment is to identify the largest challenges CPCCO members face in being healthy and to understand the types of collaborative programs or activities that CPCCO and its partners can undertake to positively impact the health of all members. A guiding principle of the regional health needs assessment process recognizes current perceptions of health equity within the CPCCO service area and works to create a culturally-specific definition of health and a community-specific definition of, and standards for, cultural competence.

To create the regional health needs assessment, CPCCO augmented secondary state and national epidemiological data with a six question community survey that asked participants their opinion of the health and health care needs of the community in which they live. Survey participants were community members in the CCO service area including, but not limited to, CPCCO members. CAC members and CPCCO staff collaborated to disseminate and collect surveys in locations within the community that were thought to be the best opportunities for gathering community voice. Surveys were available in a variety of locations from health clinics to high school health classes. There were 1,190 surveys completed in the region. Additionally, community meetings were held to discuss community health data and to gain feedback on the perception of health and health care needs reported at the local level.

Epidemiological data was used to identify health challenges at a county level. This data and the community survey results that identified local perceptions of health concerns and service needs combined to form a complete community health needs assessment.

The data from the community health needs assessment was disseminated to local CACs. A data analyst presented state, county and local survey results to the CACs and highlighted the top drivers of health concerns. The health concerns were compared to the local community's perceptions of health and health care needs results and similarities between the epidemiological data and community concerns were discussed.

The CACs went through a group decision making process to identify three health priorities (along with sub-categories) at the local level. Each of these local health priorities was recommended to the regional CAC. The regional CAC was given these recommendations and the meta-analysis of data for each county and for the region as a whole. With this information, the regional CAC went through a similar group decision making process as the local CACs to identify regional health priorities.

Using the data from the four local community health needs assessments and after reviewing the local CAC recommendations, the regional CAC chose three health indicators/disparities to address at the regional level.

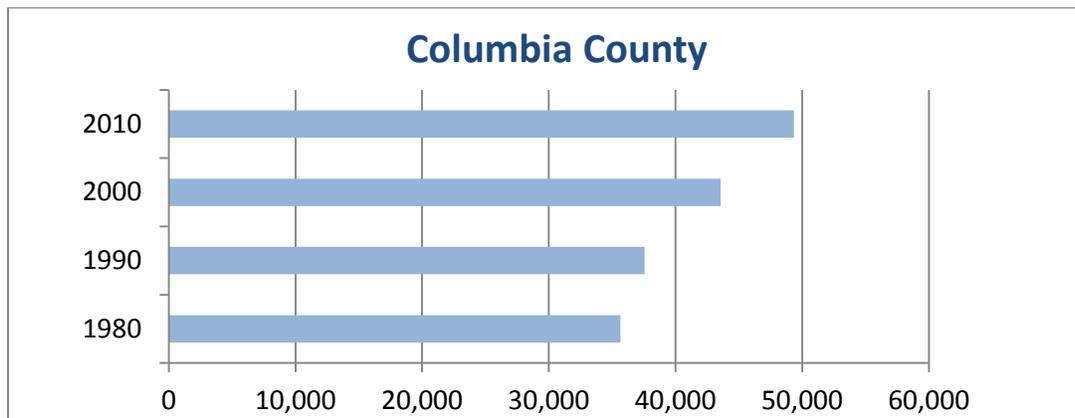
The three health priorities are: **mental health**, **obesity** and **substance abuse**. Goals and strategies discussed related to each recommended health priority are: *crisis management* and *suicide prevention* as strategies to improve mental health; *nutrition* and *food access* as strategies to decrease obesity; *alcohol abuse in transition-age youth* and *tobacco use by pregnant women* as strategies to reduce substance abuse; and *promotion of health and wellness* as foundational to all goals and strategies, including “upstream” prevention practices.

COLUMBIA COUNTY: PEOPLE AND PLACE

Population overview

Columbia County, established in 1854, covers 688 square miles of which 657 square miles is land and 32 square miles is water. As of 2013, Columbia County's total population is 49,402. It is estimated that there are 75.1 persons per square mile. (U.S. Census Bureau, 2014).

Year	1980	1990	2000	2010	2014
Columbia County	35,646	37,557	43,560	49,351	49,402



(U.S. Census Bureau, 2014)

Columbia County is bordered on the north and east by the Columbia River, on the south by Multnomah County and Washington County, and on the west by Clatsop County. The southern county line is approximately 30 minutes from Portland, the largest metropolitan area in Oregon. The western county line is approximately 30 minutes from the Pacific coast. (About Columbia County, 2014).

The majority of Columbia County's major population centers are on the flat bottomlands next to the Columbia River. Much of Columbia County would be considered urban rural (greater than 10 miles to a community of at least 50,000) as opposed to isolated rural (greater than 100 miles to a community of at least 3,000), given that most of Columbia County communities are located near an urban area of greater than 10 miles. (Crandall, 2005).

There are seven incorporated cities in Columbia County: Clatskanie (1,729), Columbia City (1,940), Prescott (55), Rainier (1,889), Scappoose (6,658), St. Helens (12,910) and Vernonia (2,142). About 45 percent (22,355) of the county's population lives outside of incorporated cities. Most of Columbia County's recent population increase has been concentrated in the southern portion of the county, such as Scappoose, where commuting distances to the core

Portland job market are shortest and in the unincorporated parts of the county. The only major interior community is Vernonia, located in the southwest portion of the county. (Knoder, 2014).

Demographics

The age distribution of Columbia County's population is similar to Oregon as a whole. One difference is that Columbia County has relatively fewer young adults than does the state. In Columbia County, 50.2 percent of residents are female and 49.8 percent are male. The average age of Columbia County residents is 40.8 with 23 percent of county residents being below 18 years of age and 15 percent who are age 65 and older (Portland State University Population Research Center, 2013).

In Columbia County, 23 percent of residents are under the age of 18, compared to 22.3 percent statewide. Mothers younger than age 18 were responsible for 2.2 percent of births. Additionally, 55 newborns per 1,000 births were low-birth weight infants, lower than the state rate of 63 newborns per 1,000 births. Columbia County has an infant mortality rate of 7.6 per 1,000, higher rate than the state rate of 4.8 per 1,000. In 2010, 4.2 percent of mothers received inadequate prenatal care, lower overall Oregon rate where 5.5 percent of mothers received inadequate prenatal care. (OHA Health Statistics Unit, 2013).

Immigration and growing diversity

The Columbia County population has grown by 14 percent since 2000. It is estimated that between 2015 and 2020 there will be a 1.21 percent increase in population for the county. The largest minority group is Hispanic (4.2 percent). In the last decade, Oregon's Hispanic population increased by 64 percent, more than five times the non-Hispanic population increase. The largest non-Hispanic minorities in Columbia County are Asian (1.1 percent), American Indian or Alaska Native (1.4 percent) and Black or African-American (0.3 percent). Additionally, 3.4 percent of the population report two or more races. In Columbia County, 4.8 percent of the population reports speaking a language other than English and 3.4 percent of the population reports being born outside of the United States. (U.S. Census Bureau, 2014).

Total population	One race	White alone	Black or African-American alone	American Indian & Alaskan Native alone	Asian alone	Native Hawaiian & other Pacific Islander alone	Some other race alone
49,327	47,868	45,565	144	686	555	89	829
100%	97.0%	92.4%	0.3%	1.4%	1.1%	0.2%	1.7%

Total population	Two or more races	White and Black or African-American	White and American Indian & Alaska Native	White and Asian	Black or African-American and American

					Indian & Alaska Native
49,327	1,459	198	788	346	0
100%	3.0%	0.4%	1.6%	0.7%	0.0%

Total population	Total Minority Population	Hispanic of Latino (of any race)	White alone, not Hispanic or Latino
49,327	4,897	2,078	44,430
100%	9.9%	4.2%	90.1%

(U.S. Census Bureau, 2014)

In Oregon, an estimated three percent of adults identify as lesbian, gay, bisexual or transgender (LGBT), while seven percent of 11th-grade youth identify as lesbian, gay, bisexual or are not sure of their sexual identity. No population-based data exists for gender minorities in Columbia County.

Environmental hazards

The average daily measure of fine particulate matter in micrograms per cubic meter in Columbia County is 10.5 compared to 9.1 in Oregon. The national benchmark is 8.8 for fine particulate matter. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers.

The percentage of population exposed to water exceeding a violation limit during the past year in Columbia County is six percent compared to three percent in Oregon overall. Health based violations related to clean water include: maximum contaminant level, maximum residual disinfectant level and treatment technique violations. (Oregon Department of Environmental Quality, 2010)

Waste management

Columbia County continues to haul its solid waste out of the county to the Riverbed landfill in Yamhill County. In February 2006, Columbia County's Land Development Services completed construction on the new Columbia County Transfer and Recycling Center. The 6.32-acre facility includes a 12,500 square foot tipping floor, a household hazardous waste intake facility; a maintenance and truck wash bay and dual scales for both inbound and outbound traffic. This facility is owned by the Columbia County and operated by a contract with Waste Management of Oregon. Additionally, there is a transfer and recycling center in Vernonia.

Each incorporated city in Columbia County manages the public utilities within the city limits. A waste management company serves those outside of the incorporated cities on septic tanks.

OPPORTUNITIES FOR HEALTH

The overall health of Columbia County residents is close to the average for Oregon residents overall. Columbia County ranks 19th of 33 ranked Oregon counties in the Robert Wood Johnson Foundation's County Health Rankings. (Robert Wood Johnson Foundation, 2014). The life expectancy of Columbia County residents compared to Oregon residents is slightly shorter at birth for men (76.6 vs. 77.2 years) and equal at birth for women (81.7 vs. 81.6 years). At every age, the difference between an individual's life expectancy in Columbia County and Oregon overall is less than one year, regardless of gender. (OHA Health Statistics Unit, 2013).

Education and employment

From 2007 to 2011, 88.4 percent of Columbia County residents over the age of 25 reported graduating from high school, roughly equal to Oregon residents overall. Over that same period, Columbia County residents are less likely, however, to have attained a bachelor's degree or higher. In the County, 16.4 percent of residents have a bachelor's degree or higher, compared to 29.3 percent of state residents. (U.S. Census Bureau, 2014). In Columbia County, 65 percent of youth graduate high school in four years, slightly less than the 69 percent of Oregon youth overall. (Robert Wood Johnson Foundation, 2014).

Unemployment rates have decreased in Columbia County from 9.1 percent in December 2012 to 7.5 percent in December 2013. The most common industries of employment for residents who work within the county are: government, trade, transportation, utilities and manufacturing. Of the estimated 20,322 working residents of Columbia County in 2010, about 73 percent (14,789) had their primary jobs outside the county. Most of these worked in another Oregon county, mainly in the Portland area, but 1,089 primary jobs were outside the state in adjacent Cowlitz County, Washington. There has been a 1.9 percent increase in employed adults in nonfarm positions going from 9,900 employed to 9,960 from December 2012 to December 2013. (U.S. Census Bureau, 2014).

Income, poverty and economic challenges

The average annual income in the nonfarm employment industry is \$32,984 and the overall median household income in Columbia County is \$50,707 compared to \$46,535 in Oregon statewide. The Gini Coefficient, a measure of income inequality where a value of 0 would reflect perfectly equal distribution of income and 100 would indicate the most extreme income inequality, is 39 in Columbia County. Oregon overall has a Gini Coefficient of 45. (U.S. Census Bureau, 2014). In 2010, 15.8 percent of Oregonians of all ages live in poverty. The proportion of children in Oregon living in poverty was even higher at 21.6 percent. In Columbia County 17 percent of children and 13.8 percent of adults are living in poverty.

In Oregon, more than half of Hispanic/Latino adults below 200 percent Federal Poverty Level are uninsured compared to approximately one in three White and other racial minority adults.

More than one in four African-American and one in three Hispanic/Latino adults of working age surveyed in Oregon had been uninsured for one year or more. African-American, American Indian/Alaska Native and Hispanic/Latino adults are more likely to experience gaps in insurance coverage in the previous year than White adults are. The same is true for Hispanic/Latino children when compared to White children. Overall, uninsurance estimates show higher uninsurance rates for African-American and Hispanic/Latino adults when compared to Whites. (Office for Oregon Health Policy and Research, 2012). Insurance and/or uninsurance data related to race or culture was unavailable for Columbia County specifically.

Housing and home ownership

In Columbia County between 2008 and 2012, there were 19,060 households with an average of 2.57 persons per household. Of those households, 28.6 percent were headed by single parents, lower than the state average of 30.4 percent. The home-ownership rate in Columbia County is 75.5 percent. There are 16 low-income housing sites, of which four are designated residential housing for individuals who have severe and persistent mental health conditions. (U.S. Census Bureau, 2014).

In 2010, Columbia County conducted a one-night homeless count and identified 342 individuals to be homeless, with 30 of the 342 individuals counted meeting the federal definition of chronic homelessness. For the 342 homeless individuals, 217 reported not having access to supportive community services that could potentially eliminate their lack of housing. (Oregon Housing & Community Services, 2010).

Outdoor and indoor environments

Columbia County has developed a full-service parks system that relies on the Columbia River and its many tributaries.

Additionally, there are six interior parks that offer a variety of options from camping to bird-watching. The rate of recreational facilities per 100,000 people is 14. (Seven recreational facilities total). (Robert Wood Johnson Foundation, 2014).



Access to medical care

Between 2010 and 2012, an estimated 12.8 percent of Columbia County residents were uninsured. This represents 5.7 percent of children, 18.2 percent of adults under 64 and one percent of adults over 65. The uninsured rates the same within the margin of error between men and women. Over the same period, the rate for white residents was 12.4 percent and for Hispanic or Latino residents was 18.3 percent. (U.S. Census Bureau, 2014). Based on data from the Behavior Risk Factor Surveillance System, an estimated 15 percent of Columbia County residents did not go to the doctor due to cost in the past year, compared to 14 percent of Oregon residents. (Robert Wood Johnson Foundation, 2014). In 2014, the number of Columbia County residents receiving Medicaid health benefits is 9,717.

In Oregon, the reported payer mix of insurance is six percent self-pay, 37 percent having private insurance, 42 percent Medicare insurance and 15 percent Medicaid insurance. Of the closest hospitals in Oregon to Columbia County, Legacy Emmanuel has a payer mix of nine percent self-pay, 40 percent commercial, 21 percent Medicare and 30 percent Medicaid. Legacy Good Samaritan has a payer mix of five percent self-pay, 36 percent commercial, 48 percent Medicare and 10 percent Medicaid. (Office for Oregon Health Policy and Research, 2013).

The closest hospitals for Columbia County residents are Legacy Emmanuel and Legacy Good Samaritan in Portland; Peace Health and St. John Medical Center in Washington; and Columbia Memorial Hospital in Astoria. Hospitalization discharges are a common measure of hospital utilization overall, in Oregon all hospitals have experienced declining admissions and discharges since a peak in 2008. The average length of stay in the hospital has not changed much over time and has been around 3.2 days for the last five years. Oregon's statewide average length of stay is well below the national average of 4.8 days.

Related to hospitalizations, the top billing codes for Oregon are: normal newborn, vaginal delivery without complicating diagnoses, major joint replacement or reattachment of lower extremity without MCC, psychosis, cesarean section, septicemia or severe sepsis, neonate with other significant problems, esophagitis, gastroenteritis, cesarean section with complications, vaginal delivery with complicating diagnoses. (Office of Health Analytics, 2013).

DISEASE AND INJURY

Leading causes of death in Columbia County

The leading cause of death in Columbia County between 2008 and 2012 was cancer, at a rate of 206.0 per 100,000, close to the Oregon rate of 199.8 per 100,000. In 2012, the most common types were cancer of the bronchus and lung at a rate of 44.3 per 100,000 and of the breast at a rate of 18.1 per 100,000.

The second-leading cause of death over the same period was heart disease at a rate of 167.5 per 100,000, higher than the Oregon rate of 157.3 per 100,000. Ischemic heart disease, in particular, accounted for half of all fatal cases of heart disease. The rate of death due to stroke was 42.2 per 100,000.

The third-leading cause of death in Columbia County over the same period was chronic lower respiratory diseases at a rate of 51.5 per 100,000. The fourth-leading cause was unintentional injuries at a rate of 44.6 per 100,000. Overall, there were higher death rates related to heart disease and slightly higher rates of smoking and heavy binge drinking in females in Columbia County compared to Oregon overall. (OHA Health Statistics Unit, 2013).

Disability

Disability is defined as a limitation in any way in any activities because of physical, mental or emotional problems and having any health problem that requires use of special equipment, such as a cane, a wheelchair, a special bed or a special telephone. More than 800,000 Oregon adults age 18 and older have a disability. This is almost one-third (28.8 percent) of the adult population of Oregon. Columbia County is slightly lower than the state average with a disability rate of 26.8 percent. However, in Columbia County more than a third of adults 45 years and older report disabilities. (Office on Disability and Health, 2013).

Chronic diseases and conditions

Chronic diseases such as heart disease, stroke, cancer and diabetes are among the most prevalent, costly and preventable of all health problems. A significant portion of the population suffers from chronic conditions in Columbia County. The most prevalent chronic conditions in Columbia County are: arthritis, 21.9 percent compared to 25.4 percent in Oregon; asthma, 11.3 percent compared to 9.9 percent in Oregon; and heart attack, 2.5 percent compared to 3.3 percent in Oregon. (The Public Health Foundation of Columbia County, 2013).

	Arthritis	Asthma	Heart Attack
Columbia County	21.9%	11.3%	2.5%
Oregon	25.4%	9.9%	3.3%

(The Public Health Foundation of Columbia County, 2013)

Obesity

Obesity is a major issue across the country with major consequences to health. Obesity-related conditions include some of the leading causes of preventable death: heart disease, stroke and type two diabetes (Centers for Disease Control and Prevention, 2014). In Columbia County, 28 percent of adults are obese, higher than Oregon overall (26 percent). The diabetes rate in Columbia County is nine percent, slightly higher than the overall Oregon rate of eight percent.

Year	2010	2011	2012	2013	2014
Obesity rate (%)	30	31	28	28	28
Diabetes rate (%)	–	8	9	9	10

(Robert Wood Johnson Foundation, 2014)

Additionally, 38 percent of adults do not get the CDC recommended amount of daily physical activity. The percentage of adults who met CDC recommendations for physical activity in Oregon was 55.8 percent and in Columbia County were 49.6 percent. The physical inactivity rate, or the rate of adults who report no leisure time physical activity, in Columbia County is 19 percent, comparable to the Oregon rate of 18 percent. (Robert Wood Johnson Foundation, 2014).

In Columbia County, 16.0 percent of eighth-grade students are obese, compared to 10.7 percent of eighth-grade students in Oregon. Despite this, 43.5 percent of eighth-grade students and 30.8 percent of 11th-grade students in Columbia County reported that they were physically active at least 60 minutes per day during the past week, compared to 32.2 percent of eighth-grade students and 30.8 percent of 11th-grade students in Oregon overall. (OHA Program Design and Evaluation Services, 2013). The CDC recommends that children and youth should be physically active at least 60 minutes per day, including aerobic muscle strengthening and bone strengthening activities.

Food access and nutrition

In Columbia County, 41 percent of the restaurants can be defined as fast-food establishments. (i.e., food that is inexpensive such as hamburgers, tacos, or fried chicken and is prepared and served quickly). The percent of adults who consumed at least five servings of fruits and vegetables per day was 20.7 percent in Columbia County, lower than the overall Oregon rate of 27 percent. The percentage of zip codes in Columbia County with healthy food outlets, including grocery stores with more than four employees, produce stands and farmers markets in 2009 was 63 percent compared to 61 percent in Oregon. (Robert Wood Johnson Foundation, 2014).

In Columbia County, 36 percent of public school children are eligible to receive free or reduced lunches during the school year. (Robert Wood Johnson Foundation, 2014). Columbia County eighth- and 11th-grade students were similar to Oregon overall in eating less than three servings of vegetables a day and in eating in restaurants one to three times in the past seven days.

Notably, fewer 11th-grade students in Columbia County ate breakfast every day than in Oregon overall (35.1 percent to 41.8 percent). Fewer eighth-grade students (15.4 percent to 19.5 percent) and 11th-grade students (8.6 percent versus 10.5 percent) report eating a meal together with their family every day. (OHA Program Design and Evaluation Services, 2013).

Alcohol

In 2008-2010, the estimated number of persons with alcohol abuse or dependence in Columbia County by age category were: 12-17 years (1,710), 18-25 years (5,373) and 26 or older (18,927) with over 50 percent of adults reporting any drinking of alcohol and 13-15 percent of adults who report binge drinking in the past 30 days. Binge drinking is the consumption of five or more drinks by men or four or more drinks by women in about two hours.

Year	2010	2011	2012	2013	2014
Excessive drinking (%)	15	15	15	15	16
Alcohol-induced deaths (per 100,000)	18.5	18.1	14.1	–	–

(Robert Wood Johnson Foundation, 2014; OHA Health Statistics Unit, 2013)

Columbia County youth participating in the 2013 Oregon Healthy Teens Survey were asked if they had used alcohol three to five days in the last 30 days. While eighth-grade respondents were lower than state average, 1.5 percent compared to 2.4 percent, 11th-grade respondents were significantly higher, with 8.2 percent reporting using alcohol three to five days in the last 30 days compared to Oregon, at 6.9 percent.

Year	Grade	2004	2006	2008	2013
Drank alcohol in the past 30 days (%)	8 th	31.3	34.7	26.5	11.9
	11 th	61.6	50.3	42.0	33.5
Binge drinking in the past 30 days (%)	8 th	16.4	12.6	12.1	4.9
	11 th	50.7	27.8	26.7	19.2

(OHA Program Design and Evaluation Services, 2013)

Illegal and prescription drugs

In the last 10 years, there has been a 450 percent increase in the number of deaths from prescription drug overdoses in Oregon. Currently, there are more deaths per year from prescription drug overdose than there are from automobile accidents. Prescription pain relievers are Oregon's fourth most prevalent substance of abuse following alcohol, tobacco and marijuana. In Columbia County, the percent of young adults, aged 18-25, who used prescription pain relievers for non-medical reasons in the past year was 17 percent compared to the state at

15 percent. For Columbia County residents, age 26 and older, the rate was equal to the state at five percent. (Oregon's State Epidemiological Outcomes Workgroup).

Year	2010	2011	2012	2013	2014
Drug-induced deaths (per 100,000)	20.6	14.1	18.1	–	–

(OHA Health Statistics Unit, 2013)

Illicit drug use other than marijuana in Columbia County is similar to the rate of use in Oregon. The use of cocaine, inhalants, hallucinogens, heroin or prescription drugs for 12-17 years was six percent, 18-25 years was 11 percent and 26 and older four percent. Columbia County youth participating in the 2013 Oregon Healthy Teens Survey, were asked about illicit drug use and respondents reported low use of illicit drugs with two exceptions: 3.2 percent of Columbia County 11th-grade students compared to 1.8 percent of state 11th-grade students reported using Ecstasy in the last 30 days and 5.9 percent of 11th-grade students compared to 1.9 of state 11th-grade students reported using some type hallucinogen (LSD) in the last 30 days. In Columbia County, 2.4 percent of eighth-grade students and 4.6 percent of 11th-grade students used prescription drugs without a doctor's order in the past month, compared to two percent of eighth- and 3.7 percent of 11th-grade students in Oregon overall. (OHA Program Design and Evaluation Services, 2013)

Year	Grade	2004	2006	2008	2013
Marijuana use in the past 30 days (%)	8 th	15.7	12.3	8.7	5.9
	11 th	28.8	17.7	17.2	22.6
Prescription use without doctor's orders in the past 30 days (%)	8 th	8.3	6.5	8.5	4.0
	11 th	16.1	4.7	11.0	8.5

(OHA Program Design and Evaluation Services, 2013)

Tobacco

The Centers for Disease Control and Prevention list the top nine actual causes of death in the following order: tobacco use or second-hand smoke, poor diet, alcohol consumption, microbial agents, toxic agents, motor vehicle accidents, firearms, sexual behavior and illicit drug use. Columbia County's public health department has programs that address tobacco prevention and education, WIC, communicable disease, environmental health, immunizations, emergency preparedness and family planning. (The Public Health Foundation of Columbia County, 2013). In Columbia County in 2012, 26.1 percent of all deaths were linked to tobacco (an additional 20.3 percent were undetermined). (OHA Health Statistics Unit, 2013).

Of adults age 18 and over in Oregon, 16.3 percent reported tobacco use. With 6.9 percent using smokeless tobacco and 47.4 percent reporting a smoking quit attempt during the previous year. In Columbia County, 19.2 percent report smoking cigarettes with 7.9 percent using smokeless tobacco and 41.3 percent reporting a smoking quit attempt during the previous year.

Year	2010	2011	2012	2013	2014
Adult smoking rate (%)	23	22	21	20	19
Reported tobacco use in pregnant mothers (%)	21.5	15.8	15	–	–

(Robert Wood Johnson Foundation, 2014; OHA Health Statistics Unit, 2013)

Smoking during pregnancy can have negative health consequences for both the mother and child, increasing the risk of problems with the placenta, of early births, of low birth weights and even of sudden infant death syndrome (SIDS) (Centers for Disease Control and Prevention, 2014). In Columbia County, 15 percent of mothers who reported using tobacco during pregnancy, compared to 10.5 percent in Oregon (OHA Health Statistics Unit, 2013). Notably, in Columbia County, 5.8 percent of 11th-grade students compared to 3.6 percent in the state reported smoking two to five cigarettes per day in the last 30 days. (OHA Program Design and Evaluation Services, 2013).

Year	Grade	2004	2006	2008	2013
Tobacco use in the past 30 days (%)	8 th	13.2	11.6	10.8	4.8
	11 th	34.2	20.1	20.0	15.5

(OHA Program Design and Evaluation Services, 2013)

Mental health

Columbia County’s mental health agency provides treatment for addiction and mental health agencies offer suicide prevention services, give mental health first aid trainings and have an early assessment and support alliance. Columbia County’s mental health agency reports a good working relationship with adult and adolescent corrections and the justice system. They are involved with three drug courts, adolescent, adult, and dependency. They work closely with child welfare, housing, and employment services. (Columbia Community Mental Health, 2013). The local National Alliance for the Mentally Ill (NAMI) pays for local law enforcement staff to attend trainings in crisis intervention. NAMI also supports a local drop in center for community members who have long-term mental health conditions.

Year	Grade	2008	2013
Had emotional or mental health care needs that were not met in the past year (%)	8 th	13.1	15.8
	11 th	15.4	22.9

Have fair or poor emotional and mental health (%)	8 th	13.9	13.1
	11 th	21.1	23.8

(OHA Program Design and Evaluation Services, 2013)

Suicide

Suicide is the act of intentionally causing death or intending to cause death by an individual. In 2010, the age-adjusted suicide rate among Oregonians of 17.1 per 100,000 was 41 percent higher than the national average. Additionally the rate of suicide among Oregonians has been increasing since 2000. (Oregon Violent Death Reporting System, 2010) Suicide is one of Oregon’s most persistent, yet largely preventable, public health problems. Suicide is the second -leading cause of death among Oregonians ages 15-34 and the eighth-leading cause of death among all Oregonians.

Year	2008	2009	2010	2011	2012
Suicide deaths (per 100,000)	14.6	12.4	22.6	20.2	12.1

(OHA Health Statistics Unit, 2013)

In Columbia County, 23.4 percent of eighth-grade students compared to the state at 25.6 percent and 31.4 percent of 11th-grade students compared to the state at 27.0 percent reported that during the last 12 months they felt sad or hopeless for more than two weeks at a level that interfered with their activities of daily living.

Of Columbia County eighth-grade students, 15.5 percent compared to the state at 16.1 percent and 18.9 percent of 11th-grade students compared to the state at 14.5 percent reported considering attempting suicide in the past 12 months and most concerning, 2.6 percent of eighth-grade students in the county compared to the state at 2.6 percent and 2.6 percent of 11th-grade students compared to the state at 1.6 percent reported attempting suicide two to three times in the last 12 months. (OHA Program Design and Evaluation Services, 2013)

Year	Grade	2004	2006	2008	2013
Seriously considered suicide in the past year (%)	eighth	13.9	16.4	18.6	15.5
	11 th	15.7	12.3	9.7	18.9
Suicide attempt in the past year (%)	eighth	8.3	10.2	9.6	6.4
	11 th	5.4	4.2	3.8	7.0

(OHA Program Design and Evaluation Services, 2013)

Injury and violence

In Columbia County the rate of injury per 100,000 was 274.1 in 2010-2011, which is below state average. (Office of Adult Abuse Prevention and Investigations, 2013). Motor vehicle crashes are a leading cause of death in Oregon especially among persons 5-34 years old. A large portion of vehicle fatalities involve alcohol or drugs. The rate of death from motor vehicle crashes per 100,000 populations (all ages) in Columbia County is 21 per 100,000 and is twice the Oregon rate, 10 per 100,000. (Oregon's State Epidemiological Outcomes Workgroup).

Each year, nearly 400 deaths and 8,600 hospitalizations in Oregon are due to falls. Falls are the leading cause of both fatal and nonfatal injuries for those 65 and older, and nearly 60 percent of seniors in Oregon who are hospitalized for falls are discharged into long-term care. Fall hospitalization rates increase drastically as adults age; the rate of fall hospitalization for adults 75 years and older was nearly five times the rate for adults 60-74 years. Between 2002 and 2006, the average cost for fall injury hospitalization among adults 65 years and older in Oregon was \$101 million per year. (OHA Health Statistics Unit, 2013).

Intentional injuries in Columbia County were limited. The violent crime rate is much lower than in Oregon as a whole, at 92 per 100,000 compared to 251 per 100,000 (Robert Wood Johnson Foundation, 2014).

Year	2010	2011	2012	2013	2014
Violent crime rate (per 100,000)	67	96	96	92	92

(Robert Wood Johnson Foundation, 2014)

Abuse among vulnerable adults

In Oregon, there are approximately 500,000 older adults and people with physical disabilities who may be vulnerable. This includes 15,000 adults enrolled in Intellectual and Developmental Disabilities (I/DD) Services, 50,000 adults enrolled in Mental Health Services, and 3,000-4,000 children with I/DD or who reside in a licensed setting that provides therapeutic treatment.

In 2012, I/DD programs received 1,496 allegation of abuse that were investigated of the 758 allegation of abuse were substantiated. In the County, 910 adults were reported as victims of abuse and 544 adults were determined to have been abused. The most common type of abuse for this population was neglect. In 2012 there were 208 adults with I/DD enrolled in services, 42 abuse allegations investigated, 34 abuse allegations substantiated and of these two required involvements with law enforcement.

In 2012, older adult and people with physical disabilities programs received 10,201 allegations of abuse that were investigated. Of these, 2,683 allegations of abuse were substantiated. The most common type of abuse for this population was financial exploitation. In Columbia County 50 allegations of abuse in care facilities were investigated and 12 were substantiated resulting

in action. Additionally, in the county, 163 allegations of abuse were investigated and 17 were substantiated resulting in action. (Office of Adult Abuse Prevention and Investigations, 2013)

Of adults enrolled in mental health services in Oregon in 2012, 604 allegations of abuse were investigated and 214 of the allegations of abuse were substantiated. In the County, 165 adults were determined to have been abused. The most common type of abuse was found to be physical. In Columbia County there are 376 adults enrolled in mental health services and there were five allegations of abuse of which three were substantiated. There was not referral or involvement of law enforcement in the substantiated cases in Columbia County. (Office of Adult Abuse Prevention and Investigations, 2013).

In 2012, of children in Columbia County receiving services through a children’s care provider or who have an I/DD diagnosis and receive residential care through a 24-hour residential program or a proctor care program, there were 226 allegations of abuse were investigated and 72 allegations of abuse were substantiated. Financial and physical abuses were the most common types of abuse of children involved in I/DD programs and/or residential care. In 2011, 17.6 per 1,000 children were reported to be abused, a higher rate than the overall Oregon rate of 13.4 per 1,000. (Children, Adults, and Families Division, 2012).

Infectious diseases

Some communicable diseases can be controlled by vaccinations. In 2012, 62.5 percent of two-year olds in Columbia County had up-to-date immunizations; that is, had four doses of DTaP, three doses of IPV, one dose of MMR, three doses of Hib, three doses of the HepB vaccine and one dose of varicella vaccine. In Oregon overall, 69.5 percent of two-year olds were up-to-date in the same series. Vaccination rates are 7.4 percent lower in Columbia County even on the most basic series of 4:3:1 DTaP, IPV and MMR. (Oregon Immunization Program, 2013)

Disease	Number of cases
AIDS/HIV	1
Campylobacteriosis	7
Chlamydia	129
Cryptosporidiosis	5
<i>E. coli</i>	5
Giardiasis	3
Gonorrhea	6
Hepatitis B (acute)	1
Hepatitis C (chronic)	64
Legionellosis	1
Listeriosis	1
Lyme disease	1
Pertussis	8
Rabies, animal	1

(OHA Acute & Communicable Disease Prevention Section, 2012)

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APPENDIX 1: Health Issue Background Information

Data source Health issue*	CCO Transformation Plan**	County-specific archival data	Evidence-based programs	OHA Incentive Metrics for CCOs	Survey response priorities
<i>Alcohol & illegal drug abuse</i>	X	X	X	X	X
<i>Cancer</i>		X	X		X
<i>Heart disease</i>		X	X		
<i>Mental health conditions</i>	X	X	X	X	
<i>Nutrition</i>			X		X
<i>Obesity</i>		X	X	X	X
<i>Physical activity</i>			X		X
<i>Prescription drug abuse</i>	X	X	X	X	X
<i>Preventative services received</i>	X	X	X	X	X
<i>Stroke</i>			X		
<i>Suicide</i>		X	X		
<i>Tobacco use</i>		X	X	X	
<i>Unintentional injuries</i>		X	X		

CCO Transformation Plan – *some priorities fit multiple categories*

Alcohol & illegal drug abuse

- Performance Improvement Project 1: Best practices in the treatment of chronic pain syndromes with opioids – WITH CAP
- Performance Improvement Project 2: Improving timeliness of prenatal care and behavioral health screening, including screening for substance abuse and clinical depression – WITH CAP
- Transformation Element 1: Creating a Pain Management model that utilizes behavioral health technology
- Transformation Element 8: Improve prenatal and maternal care through consistent behavioral health and addictions screening and developmental screening for children under 36 months

Mental health conditions

- Performance Improvement Project 2: Improving timeliness of prenatal care and behavioral health screening, including screening for substance abuse and clinical depression – WITH CAP
- Transformation Element 1: Developing & implementing a health care delivery model that integrates mental and physical health care – must specifically address the needs of individuals with severe and persistent mental illness
- Transformation Element 8: Improve prenatal and maternal care through consistent behavioral health and addictions screening and developmental screening for children under 36 months

Prescription drug abuse

- Performance Improvement Project 1: Best practices in the treatment of chronic pain syndromes with opioids – WITH CAP
- Transformation Element 1: Creating a Pain Management model that utilizes behavioral health technology
- Transformation Element 8: Improve prenatal and maternal care through consistent behavioral health and addictions screening and developmental screening for children less than 36 months

Preventative services received

- Performance Improvement Project 2: Improving timeliness of prenatal care and behavioral health screening, including screening for substance abuse and clinical depression – WITH CAP
- Transformation Element 2: Continued implementation and development of Patient Centered Primary Care Homes
- Transformation Element 8: Improve prenatal and maternal care through

consistent behavioral health and addictions screening and developmental screening for children under 36 months

County-specific archival data:

note: data source is noted if different than Ari Wagner's presentation for Columbia County which utilized data from the Oregon Health Authority and the Office of Rural Health.

Alcohol & illegal drug abuse

- Columbia County has higher rates of binge drinking and heavy drinking by females, compared to the state (13 percent versus 11 percent and nine percent versus six percent, respectively for the years 2006-2009)
- The death rate from drug induced causes was 14.0 per 100,000 and 11 percent of 18-25 year olds used illicit drugs other than marijuana in the past month.¹

Cancer

- The death rate due to cancer in Columbia County is 196.6 per 100,000 in Columbia County, compared to 199.0 in Oregon. It is the leading cause of death.²

Heart disease

- The death rate due to heart disease is 175.0 per 100,000, compared to 163.1 per 100,000 in Oregon.

Mental health conditions

- Columbia County residents report 4.6 poor mental health days in the last month, compared to 3.3 in Oregon.
- There is one mental health provider for every 49,334 residents, compared to one for every 2,193 residents in Oregon.³
- 25 percent of eighth-grade and 27 percent of 11th-grade students have had a depressive episode in the past year. 12 percent of eighth-grade and 10 percent of 11th-grade students exhibit psychosocial distress based on mental health inventory-5.¹

Obesity

- Columbia County adult obesity rate is 27 percent, compared to 24.5 percent in Oregon.

Prescription drug abuse

- 17 percent of individuals aged 18-25 report using prescription pain relievers for

¹ Columbia County's Epidemiological Data on Alcohol, Drugs and Mental Health 2000 to 2012, Oregon Health Authority

² Oregon Vital Statistics County Data 2012; Oregon Health Authority

³ County Health Rankings and Roadmaps; Robert Wood Johnson Foundation

non-medical reasons in the past year, compared to 15 percent in Oregon (and Oregon has the highest rate of nonmedical use of prescription pain relievers in the nation).¹

Preventative services received

- Diabetic screening in Columbia County is 84 percent, compared to 86 percent in Oregon.
- 72.1 percent of two-year-olds have up-to-date immunizations compared to 69 percent in Oregon.

Suicide

- Columbia County suicide rate is 15.2 per 100,000. The national rate is 12.0 per 100,000.

Tobacco use

- Columbia County adult smoking at 20 percent, compared to 17 percent in Oregon.
- 26.1 percent of deaths in Columbia County are linked to tobacco, compared to 21.8 percent statewide.²
- 17.5 percent of infants were born to mothers who reported using tobacco during pregnancy, compared to 10.5 percent in Oregon.²
- 7.2 percent of males use smokeless tobacco, compared to 6.3 percent of males in Oregon.

Unintentional injuries

- the death rate in Columbia County due to unintentional injuries is 49.2 per 100,000, compared to 41.9 in Oregon.

Evidence-based programs – *do programs exist to address the priority?*

Alcohol & illegal drug abuse

- The CDC's Community Guide has task force recommendations on interventions for preventing excessive alcohol consumption.
- There are substance abuse-focused programs certified by OHA's division of Addiction and Mental Health Services (AMH)
- There are programs focusing on both alcohol and drugs in SAMHSA's National Registry of Evidence-based Programs and Practices.

Cancer

- The CDC's Community Guide has evidence-based practices on the prevention of skin cancer and on improving rates of cancer screening.

Heart disease

- The CDC's Community Guide has evidence-based practices on the prevention and control of cardiovascular disease.

Mental health conditions

- The CDC's Community Guide has task force recommendations on home-based, clinic-based, and community-based care and interventions.
- There are programs focusing on mental health in SAMHSA's National Registry of Evidence-based Programs and Practices

Nutrition

- NACCHO has many model and promising practices related to healthy eating and food access.

Obesity

- The CDC's Community Guide has task force recommendations on the prevention and control of obesity focusing in community settings.

Physical activity

- The CDC's Community Guide has task force recommendations on increasing physical activity through behavioral and social approaches, campaigns and informational approaches and environmental and policy approaches.

Prescription drug abuse

- There exist numerous databases of evidence based programs focusing on drug abuse.
- There are substance abuse-focused programs certified by OHA's division of Addiction and Mental Health Services (AMH).
- There are programs focusing on drugs abuse in SAMHSA's National Registry of Evidence-based Programs and Practices.

Preventative services received

- NACCHO has many model and promising practices related to primary care and improved access to care.

Stroke

- The CDC's Community Guide has evidence-based practices on the prevention and control of cardiovascular disease.

Suicide

- The Suicide Prevention Resource Center recognizes over 20 evidence-based suicide-related interventions.

- There are programs focusing on suicide prevention in SAMHSA's National Registry of Evidence-based Programs and Practices.

Tobacco use

- There is numerous programs focusing on secondhand smoke exposure, cessation and preventing initiation in the CDC's Community Guide.
- There are programs focusing on tobacco cessation in SAMHSA's National Registry of Evidence-based Programs and Practices.

Unintentional injuries

- NACCHO have many model and promising practices related to injury prevention. The programs range from preventing dog bites to syringe disposal.

OHA Incentive Metrics for CCOs – *some metrics fit multiple categories*

Alcohol & illegal drug abuse

- Alcohol or other substance misuse (SBIRT)

Cancer

- Colorectal cancer screening (HEDIS)

Heart disease

- Controlling high blood pressure (NQF 0018)

Mental health conditions

- Adolescent well-care visits (NCQA)
- Follow-up after hospitalization for mental illness (NQF 0576)
- Follow-up care for children prescribed ADHD meds (NQF 0108)
- Screening for clinical depression and follow-up plan (NQF 0418)

Obesity

- Diabetes – HbA1c Poor Control (NQF 0059)

Preventative services received

- Adolescent well-care visits (NCQA)
- Ambulatory Care: Outpatient and Emergency Department utilization
- Colorectal cancer screening (HEDIS)
- Developmental screening in the first 36 months of life (NQF 1448)
- Mental and physical health assessment within 60 days for children in DHS custody
- Patient-Centered Primary Care Home enrollment
- PC-01: Elective delivery before 39 weeks (NQF 0469)
- Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)

Stroke

- Controlling high blood pressure (NQF 0018)

Survey response priorities:

Alcohol & illegal drug abuse

- 49.01 percent of respondents said that alcohol and drug addiction was one of the top three health issues in the community. It was the first response of 26.
- 31.19 percent of respondents said that alcohol and drug prevention and treatment were one of the three most important ways to create a healthier community. It was the third response.

Mental health conditions

- 22.28 percent of respondents said that mental illness was one of the top three health issues in the community. It was the sixth-highest ranking response of 26 and within five percentage points of third. An additional 12.13 percent of respondents said that the lack of mental health treatment facilities was one of the top three health issues.

Obesity

- 35.89 percent of respondents said that obesity was one of the top three health issues in the community. It was the second-highest response of 26.
- 24.75 percent of respondents said that diabetes was one of the top three issues. It was the fourth-highest response.

Prescription drug abuse

Note: the survey didn't differentiate between prescriptions and other illicit substances

- 49.01 percent of respondents said that alcohol and drug addiction was one of the top three health issues in the community. It was the highest-ranking response of 26.
- 31.19 percent of respondents said that alcohol and drug prevention and treatment were one of the three most important ways to create a healthier community. It was the third-highest response.

Preventative services received

- 34.90 percent of respondents said that more health education and wellness services were one of the three best ways to improve community access to healthcare. It was the third-highest response of 12 choices. An additional 22.28 percent said that more disease prevention and screening services were one of the three best ways. It was the sixth-highest response.

Tobacco use

- 23.02 percent of respondents said that tobacco use was one of the three most critical health issues in the community. It was the fifth-highest response of 26, and within four percentage points of the third-highest ranking response.

APPENDIX 2: Community Survey Results

n=423

1. In the past year, have you or anyone living in your home used health services at any of the following locations?

Doctor's office	Dental	Hospital	Urgent care	Mental Health	Public Health	911	A/D Tx	VA
87%	72%	64%	56%	30%	23%	16%	8%	7%

2. What conditions exist now in your community to help create or foster good health?

Good doctors	Good preventative services	Available recreational facilities	Access to specialists
67%	40%	33%	16%

3. What do you think are the three most important ways to create a healthier community?

Job opportunities and a healthy economy	Good schools	Drug & alcohol prevention /treatment	Better access to health care	Affordable housing	Access to healthy foods	Clean environment
55.7%	34.2%	31.2%	28.5%	26.7%	26.2%	26.0%
Health prevention and wellness services	Sports and recreation facilities	Mental health services	Low crime	Food banks	Tobacco prevention	Racial and cultural acceptance
25.5%	23.3%	20.1%	18.6%	14.9%	9.2%	5.5%

4. What do you think are the three most critical health problems and needs in your community?

Alcohol and drug addiction	Obesity	High cost of care/lack of insurance	Diabetes	Tobacco use	Mental illness	Not enough doctors
49.1%	35.9%	26.7%	24.8%	23.0%	22.3%	14.8%
Cancer	Lack of affordable housing	Poor nutrition/eating habits	Dental problems	High blood pressure	Heart disease	Limited educational opportunities
17.1%	17.1%	17.8%	15.8%	14.6%	14.4%	13.4%
Lack of mental health Tx facilities	Too few exercise facilities	Lack of transportation	Child abuse	Lung/respiratory illnesses	Low access to healthy foods	High crime rates
12.1%	8.9%	8.9%	7.2%	6.9%	6.4%	3.2%
STDs	Suicide	Domestic violence	High cost of MH svcs	HIV/AIDS		
5.2%	4.7%	4.2%	3.2%	1.5%		

5. If you could pick just three things to improve your community's access to health care, what would they be?

Medical appointments after 5 p.m. and weekends	More doctors/health care providers	More health education and wellness providers	Expand the Oregon Health Plan (Medicaid)	More alcohol and drug treatment programs	More disease prevention and wellness services
52.0%	43.8%	34.9%	33.4%	23.5%	22.3%
More mental health services	Transportation assistance to appointments	Alternative health care (acupuncture, naturopathy)	More dentists	More tobacco cessation programs	More culturally sensitive care
19.8%	18.8%	18.6%	16.6%	7.9%	3.7%

6. Think about the most recent time when you or a family member living in your home went without needed health care. What were the reasons why?

Cost too much	Did not have insurance	Waited for the problem to go away	Doctor's office not open when needed	Couldn't get appointment fast enough	Transportation problems
58.4%	40.4%	24.8%	23.8%	20.3%	16.1%
Do not have regular doctor	Afraid of what they might find	Do not know where to get care	Do not like doctors/refused to go	On OHP, but do not have a doctor	Childcare issues
10.6%	8.2%	6.4%	5.9%	3.7%	3.2

Age:

0 – 17	18 – 29	30 – 39	40 – 49	50 – 59	60+
4.7%	20.8%	20.8%	21.5%	19.3%	16.8%

Gender:

Male	Female
28%	72%

Income:

Less than \$5,000	\$5,000 – 15,999	\$16,000 – 25,999	\$26,000 – 40,999	\$41,000 – 70,999	\$71,000 – 99,999	\$100,000 or more
17%	13%	16%	15%	18%	9%	7%

Results add up to less than 100 percent. Some respondents chose not to answer.

Race and ethnicity:

American Indian or Alaska Native	Asian	Black or African-American	Latino or Hispanic	Native Hawaiian or Pacific Islander	White (Caucasian)
2.8%	0.7%	0.2%	3.5%	0.7%	82.0%

Results add up to less than 100 percent. Some respondents chose not to answer. Respondents selected all applicable options.



Columbia Pacific CCO

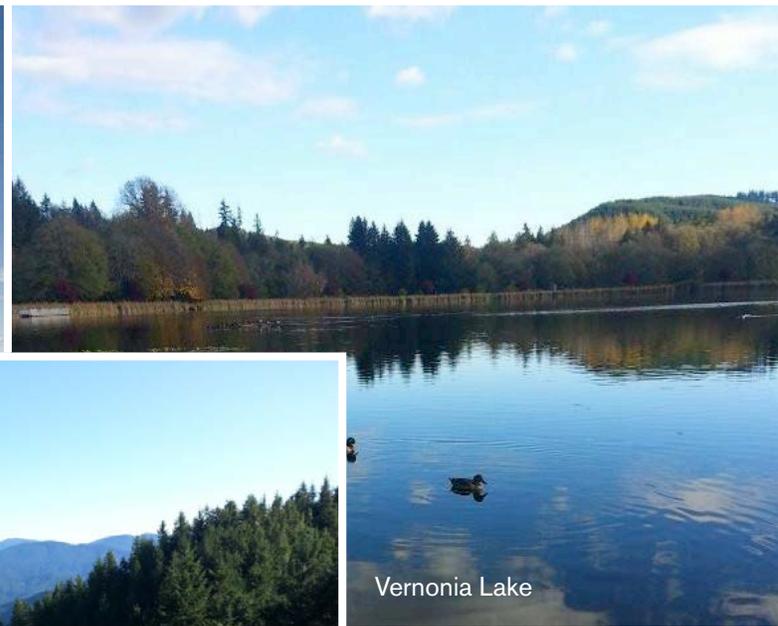
Columbia Pacific Coordinated Care Organization:

Regional Community Health Improvement Plan | 2014

Creating Health Together



Clatskanie



Vernonia Lake



Tillamook State Forest



Dunes Recreation Area



Astoria

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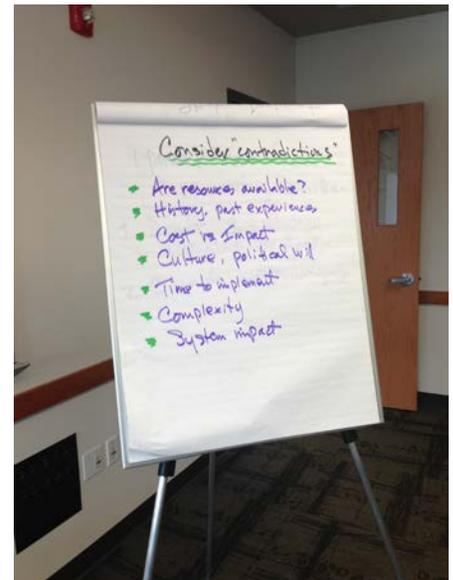
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Acknowledgements

Columbia Pacific Coordinated Care Organization would like to thank the individuals and community partners who generously shared their time and expertise to collaborate on the development and completion of the Community Health Assessments and the work which resulted in the creation of this Community Health Improvement Plan.

Without the support of the local Community Advisory Councils in Clatsop, Columbia and Tillamook Counties, and in the Reedsport area of Douglas County, the Regional Advisory Council, and the Columbia Pacific Board of Directors, the creation this Community Health Improvement Plan would not have been possible.

CPCCO gives special thanks to AmeriCorps® VISTA, Jaclyn Testani, who spent countless hours collecting, assembling and analyzing stories and other data about the factors that influence health and well-being in and across our communities.



Tillamook strategy planning



Reedsport area of the Umpqua River

Introduction

The health of the public is the responsibility of everyone, not just our local public health agencies. Hospitals, clinics, behavioral health agencies, community-based organizations, early learning councils and school-based health centers should build population health capacity together.

Columbia Pacific Coordinated Care Organization (CPCCO), as part of the CCO Transformation Plan, seeks to bring together stakeholders from diverse sectors to establish a common agenda, shared metrics, a structured process and a jointly-funded infrastructure for the purpose of creating a shared system of health.

As part of the process of bringing together stakeholders and health data to inform transformation plan activities, CPCCO conducted a community health needs assessment in its service area—Clatsop, Columbia, and Tillamook counties and the Reedsport area of Douglas County—with the goal of gathering community perceptions of health, health care needs and health equity.

CPCCO's four Community Advisory Councils (CACs) participated in and gave oversight to the needs assessment process, including supporting the development of a meta-analysis of existing clinical and community epidemiological health data. An emphasis was placed on reviewing local assessments already conducted in behavioral health, public health, hospital community benefit reporting and other assessments from agencies or community-based organizations that help address socioeconomic issues such as community vitality, employment and food insecurity.



Regional Advisory Council selecting health priorities

Health disparity issues in rural areas include, but are not limited to: geographic separation; high patient ratio per number of providers to Oregon Health Plan members; limited resources; health care provider mix; and difficulty coordinating care between hospitals, clinics, behavioral health agencies and social service safety net providers.

To address these disparities, CPCCO seeks to create a Community Health Improvement Plan that aligns to and is coordinated with other required community assessments when appropriate, such as public

health department accreditation plans, hospital community benefit plans, the CPCCO Clinical Advisory Panel's clinical transformation priorities and community behavioral health agencies bi-annual improvement plans.

The goal of the CPCCO Community Health Improvement Plan is to use the data on community perceptions of health and health care needs from the community health survey that was conducted in Fall 2013, along with existing epidemiological data to address the social determinants which lead to poor community health outcomes. The long-term goal is to create opportunities for shared ownership of the health of the community between the CCO, hospitals, public health agencies, behavioral health agencies and other local stakeholders including natural supports. This collaboration offers the opportunity to mobilize and leverage resources to achieve measurable and sustainable improvements in health status and quality of life for the region as a whole.

The community health needs assessment and the resulting community health improvement plan incorporate all available findings, stories, priorities and strategies for addressing gaps that result in health disparities and health inequity in the communities served by CPCCO.

Description of Needs Assessment Process

CPCCO has four local CACs and a regional CAC. The charge of the local and regional CACs is to oversee and support the community health needs assessments and a regional community health improvement plan for CPCCO.

The purpose of the regional health needs assessment is to identify the largest challenges CPCCO members face in being healthy and to understand the types of collaborative programs or activities that CPCCO and its partners can undertake to positively impact the health of all members. A guiding principle of the regional health needs assessment process recognizes current perceptions of health equity within the CPCCO service area and works to create a culturally-specific definition of health and a community-specific definition of, and standards for, cultural competence.

To create the regional health needs assessment, CPCCO augmented secondary national and state* epidemiological data with a six question community survey that asked participants their opinion of the health and health care needs of the community in which they live. Survey participants were community members in the CPCCO service area including, but not limited to, CPCCO members. CAC members and CPCCO staff collaborated to disseminate and collect surveys in locations within the community that were thought to be the best opportunities for gathering community voice. Surveys were available in a variety of locations from health clinics to high school health classes. There were 1,104 surveys completed in the region.

	Clatsop	Columbia	Tillamook	Reedsport area	Latino
Percent of completed surveys: (n=1104)	15.4 percent	38.3 percent	33.8 percent	12.4 percent	6.9 percent
Percent of total service region population:	31.5 percent	42.0 percent	21.5 percent	5.0 percent	6.4 percent

U.S. Census

Additionally, community meetings were held to discuss community health data and to gain feedback on the perception of health and health care needs reported at the local level.

Epidemiological data was used to identify health challenges at a county level. This data and the community survey results that identified local perceptions of health concerns and service needs combined to form a complete community health needs assessment.

The data from the community health needs assessment was disseminated to local CACs. A data analyst presented state, county, and local survey results to the CACs and highlighted the top drivers of health concerns. The health concerns were compared to the local community's perceptions of health and health care needs. The results and similarities between the epidemiological data and community concerns were discussed by the local and regional CACs.

The CACs went through a group decision-making process to identify three health priorities (along with sub-categories) at the local level. Each of these local health priorities was recommended to the regional CAC. The regional CAC was given these recommendations and the meta-analysis of data for each county and for the region as a whole. With this information, the regional CAC went through a similar group decision making process as the local CACs to identify regional health priorities.

Using the data from the four local community health needs assessments and after reviewing the local CAC recommendations, the regional CAC chose three health indicators/disparities to address at the regional level.

The three health priorities are: **Obesity, Mental Health** and **Substance Abuse**.

Goals and strategies discussed related to each recommended health priority are:

- *Improved nutrition and food access* as strategies to decrease obesity;
- *Crisis management and suicide prevention* as strategies to improve mental health;
- *Decreasing alcohol abuse in transition age youth and tobacco use by pregnant women* as strategies to reduce substance abuse;
- *Promotion of health and wellness* as foundational to all goals and strategies, including "upstream" prevention practices.

Priority Health Issue: Obesity

Situational Analysis: why this is a concern

A. Obesity

Obesity has far-ranging negative effects on health. People who are overweight or obese have an increased risk for developing many different health conditions, including heart disease, diabetes, bone and joint diseases.

More than one-third of the U.S. population is obese – 35 percent of adult women and 33 percent of adult men are obese. Obesity is a chronic disease affecting increasing numbers of children and adolescents, as well as adults. There are many factors that may influence the occurrence of obesity. Along with genetics and metabolism, there is a strong relationship between socioeconomic status and obesity.

Obesity rates in the U.S. have doubled since 1980 among children and have tripled among adolescents. More than one-third of minors are considered overweight or obese. This rises to over two-thirds of American adults. (Centers for Disease Control and Prevention, 2011-2012).

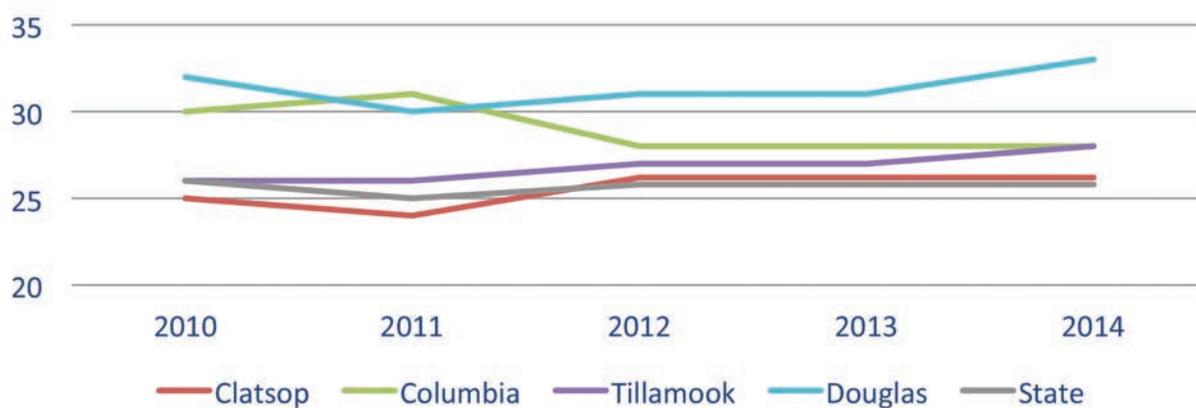
CPCCO's CACs have defined obesity as a community wide issue that stems from causes like poor nutrition and a lack of physical activity. Obesity can have wider implications on an individual's mental, social, spiritual health and well-being. CAC members support the idea that the community should be an environment in which the "healthy choice is the favorable choice." Examples of healthy choices in the community that could potentially improve health outcomes related to obesity are: walking, biking and public transit modes are more convenient than driving for errands; restaurants have healthy portion sizes; fast food venues are not within walking distance of schools; safe routes to schools exist so children develop the habit of walking and of physical activity as part of normal daily activity.

Promoting good nutrition and sustainable food systems have been identified by CPCCO service area communities as a priority for addressing obesity within the service area. Increase public awareness of the linkages between nutrition, the food system and their impact on both the environment and public health was identified as an important component of this work.

Although diabetes is not always connected to obesity, being overweight or obese does increase the risk for individuals to develop diabetes and other chronic conditions. For CPCCO members, diabetes mellitus is one of the top 10 diagnoses and had the most patient encounters in the CPCCO service region in the past year. Diabetes was identified as one of the top health concerns by community members who responded to the CPCCO community survey, conducted in the fall 2013 by CPCCO and its CACs.

Adult obesity rate (percent)					
Year	Clatsop	Columbia	Tillamook	Douglas	State
2010	25	30	26	32	26
2011	24	31	26	30	25
2012	26	28	27	31	26
2013	26	28	27	31	26
2014	26	28	28	33	26

County Health Rankings



Clatsop County

In Clatsop County, the adult obesity rate is 26 percent, equal to the overall Oregon rate of 26 percent (County Health Rankings & Roadmaps, 2014). Also in Clatsop County, 29.1 percent of respondents to the CPCCO community survey said that obesity was one of the three most critical health issues in their community. Obesity was the second-highest ranked response of 26 options. An additional 18 percent of respondents said that diabetes was one of the three most critical health issues. Diabetes was the fourth-highest ranked response.

In Clatsop County, 43 percent of all students were eligible for free or reduced price lunch, equal than the Oregon rate of 43 percent for all students. (County Health Rankings & Roadmaps, 2014).

In 2009, 25 percent of zip codes in Clatsop County did not have a healthy food outlet (grocery stores with more than four employees, produce stands and farmers markets), better than 36 percent of zip codes in Oregon overall (Health Indicators Warehouse, 2014).

Columbia County

In Columbia County, the adult obesity rate is 28 percent, higher than the overall Oregon rate of 26 percent (County Health Rankings & Roadmaps, 2014). In Columbia County, 33.7 percent of respondents to the CPCCO community survey said that obesity was one of the three most critical health issues in their community. Obesity was the second-highest ranked response of 26 options. An additional 24 percent of respondents said that diabetes was one of the three most critical health issues. Diabetes was the third-highest ranked response.

In Columbia County, 36 percent of all students were eligible for free or reduced price lunch, less than the Oregon rate of 43 percent for all students (County Health Rankings & Roadmaps, 2014). However, there are two other service areas in the County that are higher than the state average: Clatskanie at 57.4 percent and Rainier at 56.4 percent. (Annie E. Casey Foundation, 2012)

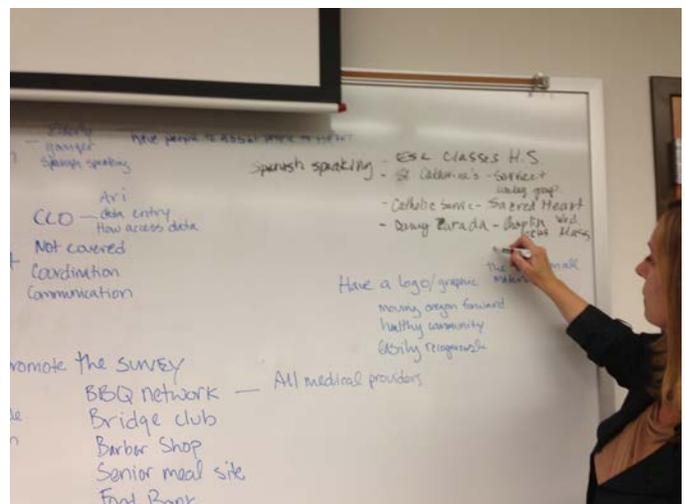
In 2009, 37 percent of zip codes in Columbia County did not have a healthy food outlet (grocery stores with more than four employees, produce and farmers markets), comparable to 36 percent of zip codes in Oregon overall (Health Indicators Warehouse, 2014).

Tillamook County

In Tillamook County, the adult obesity rate is 28 percent, higher than the overall Oregon rate of 26 percent. (County Health Rankings & Roadmaps, 2014). In Tillamook County 35 percent of respondents to the community survey said that obesity was one of the three most critical health issues in their community. Obesity was the third-highest ranked response of 26 options. An additional 21 percent of respondents said that diabetes was one of the three most critical health issues of concern in Tillamook County. Diabetes was the fourth-highest ranked response in the community survey.

In Tillamook County, 49 percent of all students were eligible for free or reduced price lunch, higher than the Oregon rate of 43 percent for all students. (County Health Rankings & Roadmaps, 2014).

In 2009, 50 percent of zip codes in Tillamook County did not have a healthy food outlet (grocery stores with more than four employees, produce and farmers markets), worse than the 36 percent of zip codes in Oregon overall (Health Indicators Warehouse, 2014).



Tillamook community health needs survey

Reedsport area of Douglas County

In Douglas County, the adult obesity rate is 33 percent, and is higher than the Oregon average of 26 percent. (County Health Rankings & Roadmaps, 2014). In the Reedsport area of Douglas County, there were 69.4 deaths due to diabetes per 100,000, compared to 43.8 per 100,000 in Douglas County and 27.6 per 100,000 in Oregon overall.

In the Reedsport-area, 32 percent of respondents to the community survey said that obesity was one of the three most critical health problems in the community. It was tied for the number one ranked response out of 26 options. An additional 25 percent of respondents said that diabetes was one of the three most critical health issues. Diabetes was the fourth-highest ranked response.

In 2012, of all the students in the Reedsport school district 78.3 percent were eligible for free or reduced price lunch, a much higher rate than the state average of 43 percent for all students.

In Douglas County, 43 percent of zip codes did not have healthy food outlets (grocery stores with more than four employees, produce and farmers markets) compared to 36 percent of zip codes in Oregon (Health Indicators Warehouse, 2014).



Reedsport selecting health priorities

Latino Community

In Oregon, the obesity rate among Latinos is 28.8 percent, higher than the Oregon average of 26 percent (Robert Wood Johnson Foundation). There is no data available for the obesity rate among ethnic and racial minorities at the county level. Of self-identifying Latino respondents, 26 percent to the community survey said that obesity was one of the three most critical health issues in their community.

Obesity was the third-highest ranked response of 26 options.

An additional 36.4 percent of Latino respondents said that diabetes was one of the three most critical health issues.

Diabetes was the second-highest ranked response.



B. Nutrition

Rural communities, long considered bastions of self-sufficiency, are seeing their grocery stores close, their food production become highly specialized and export-based, and their jobs – and younger generations – disappear to larger cities and urban areas. Many rural residents lack access to full-service grocery stores with fresh fruits and vegetables, to adequate and affordable transportation, and to basic services such as electricity. (Oregon Food Bank, 2013).

In Clatsop, Columbia, Tillamook, and Douglas Counties, 11%, 4%, 9%, and 11% of low-income residents have limited access to healthy foods respectively, compared to 5% of individuals statewide. Limited access to healthy foods is defined as living more than 10 miles from a grocery store in rural areas and more than 1 mile from a grocery store in urban areas. Low-income is defined as having an annual family income less than or equal to 200 percent of the federal poverty line, or less than \$47,100 for a family of four. (County Health Rankings & Roadmaps, 2014).

In Clatsop County, 37 percent of respondents to the community survey said that access to healthy foods was one of the three most important ways to create a healthier community. It was the third-highest ranked response of 14 options.

In Columbia County, 25 percent of respondents to the community survey said that access to healthy foods was one of the three most important ways to create a healthier community. It was the fourth-highest ranked response of 14 options.

In Tillamook County, 39 percent of respondents to the community survey said that access to healthy food was one of the three most important ways to create a healthier community. It was the second-highest ranked response of 14 options.

In the Reedsport area, 24 percent of respondents to the community survey said that access to healthy food was one of the three most important ways to create a healthier community. It was the fifth-highest ranked response of 14 options.

Of self-identifying Latinos, 40 percent of respondents to the community survey said that access to healthy food was one of the three most important ways to create a healthier community. It was the second-highest ranked response of 14 options. Additionally, 16.9 percent of Latino respondents said that poor eating habits was one of the three most critical health issues facing their community. It was the seventh response of 26.



Reedsport survey collection
at community health fair

Best Practices

- Offer and provide coverage for evidence-based weight management educational opportunities and programs for people with pre-diabetes. (National Diabetes Prevention Program)
- Encourage employers with less than 25 employees to adopt breast-feeding friendly policies.
- Promote breast-feeding and assure systems are in place to support exclusivity and duration, including support for the Baby-Friendly Hospital Initiative. (Baby Friendly USA, 2014)
- Develop policies to ensure access to fresh fruits and vegetables, such as expanding the number of farmers markets that accept SNAP EBT, WIC Farmers Market Nutrition Program and Senior Farm Direct Nutrition Program coupons. (State Indicator Report, Nutrition, 2014)
- Assist limited-resource audiences to acquire access to fresh produce and acquire the knowledge, skills, attitudes and behaviors necessary to incorporate healthy diets with the intention of preventing or delaying the onset of chronic disease through a community nutrition program. (NACCHO Toolbox, 2014)
- Supply local convenience stores with fresh produce to stock in a customized display twice weekly and include site-specific marketing, local agricultural products and rotation of produce to increase the availability of local- and culturally-appropriate produce. (NACCHO Toolbox, 2014)
- Fresh Food Financing is a public-private partnership which supports the financing needs of large and small grocery store operators who operate in underserved communities, where infrastructure costs and credit needs cannot be accommodated solely by conventional financial institutions.
- The Healthy Living Partnership to Prevent Diabetes is a community-based lifestyle weight-loss program of overweight or obese adults with pre-diabetes. This includes group sessions and one-on-one meetings with community health workers in community settings over 24 months. (Social Programs That Work HELP PD, 2014)
- Obesity Treatment through Behavioral Coaching is a community-based program for obese adults delivered through primary care practices, that was found in a well-conducted randomized controlled trial to produce meaningful, sustained weight loss. (Social Programs That Work HELP PD, 2014)
- Promote increased access to fresh produce and health-related programs in the low income population through large-scale distribution of donated produce in partnership with a large food bank to increase awareness of local resources, increase participation in community programs that work to decrease health disparities on a local level and develop a community-based partnership among health promoting organizations for greater networking and collaboration potential in the future. (NACCHO Toolbox, 2014)
- Walk with Us, the Arthritis Foundation's guide developed to help groups create fitness programs that improve flexibility, strength and stamina. (Walk with Ease, 2009)
- FoodRX, provides mobile grocery trolleys at local health providers (behavioral and mental health). FoodRX is a model that can be utilized by health care professionals who prescribe medications. The health provider writes a prescription for food that is a voucher to be used to buy food at a fruit and vegetable food cart and/or pantry.
- Having public drinking fountains at city parks.



FoodRX provides mobile groceries

Opportunities for Health: (Three year goals)

Goal 1: Decrease the rate of low-income residents that are unable to access healthy foods.

Outcome Objectives/Indicators

There is a decrease in the current trend of low-income residents who report having limited access to healthy foods.

There is an increase in the number of people who are able to acquire the knowledge, skills, attitudes and behaviors to improve their nutrition.

Goal 2: Decrease of the current upward trend of obesity in the CPCCO service area.

Outcome Objectives/Indicators

There is a decrease in the number of adults who report being physically inactive.

There is a reduction in children who are diagnosed as obese by their health care provider in the CPCCO service area.

There is access to quality nutrition and education resources for every pregnant woman in the CPCCO service region including increased access to pre- and post-natal care and lactation support.

Action Steps for Community Health

Assessment

Collaborate with community partners to develop a service gap analysis.

Identify positive community norms related to nutrition and well-being.

Support communities to engage in vitality studies and collaborate with programs already in place that have conducted community vitality studies.

Support and sponsor our community partners who provide the food safety net to participate in and use the Healthy Pantries Project assessment tool.

Using GIS technology and other mapping software, describe points of food access for all communities in CPCCO service region

Partner with Oregon Food Banks's FEAST programs to assess impact of limited healthy food access on community health and the local economy.

Work with local primary care providers to understand and remove the barriers patients face that prevents physical activity.

Outreach and Education

Coordinate with public health, behavioral health, farmer market providers, OSU Extension Services and local outpatient health care providers to assist community members with limited resources to acquire access to fresh produce.

Sponsor events that support increasing community awareness of the links and social factors that cause obesity and the resulting health problems and issues.

Increase the capacity in the CPCCO service region for health education programs that target low-income children and families.

Increase the number of local food retailers that participate in the “Fresh Alliance” program, donating fresh foods to local food pantries.

Participation in Policy and Planning Processes

Modify beliefs and create sustainable policies that eliminate constraints to creating a regional healthy food system.

CPCCO participation in Parks and Recreation Advisory Committees and other identified community partners who work toward health community goals.

Support and sponsor school wellness or wellness policies in schools and worksites.

Support the cities in the CPCCO region to adopt ordinances that create a safe environment for all modes of transportation, i.e., traffic calming measures and green space community gardens.

Partners

Clatsop County

- City of Astoria Parks & Recreation
- Clatsop CHART (Community Health Advocacy & Resource Team)
- Clatsop Community Action & Regional Food Bank
- Clatsop County Public Health
- Coastal Family Health Center
- Columbia Memorial Hospital and Outpatient Clinics
- Food Web
- Fort Clatsop – National Park Service
- Fort Stevens
- North Coast Food Web
- Parks and Recreation Advisory Committees for all Clatsop County cities
- Providence Seaside Hospital and Outpatient Clinics
- Sunday Market
- Sunset Empire Park & Recreation
- The Harbor for Safe Relationships
- Thursday Market
- Warrenton Trails Association

Columbia County

- CC Rider Transportation
- Columbia Pacific Food Bank
- Community Action Team of Columbia County
- Local prevention coalitions (Vernonia Prevention Coalition)
- Legacy Clinic St. Helens
- OHSU Family Medicine at Scappoose
- Public Health Foundation of Columbia County

Tillamook County

- FEAST- Food Education Agriculture Solutions Together
- Food Roots
- Kiwanda Community Center
- Rinehart Clinic
- Tillamook County Futures Council
- Tillamook County Good Food For All
- Tillamook County Health Department and Family Health Center
- Tillamook County YMCA
- Tillamook Regional Medical Center and Clinics

Reedsport Area of Douglas County

- Community Center Gym
- Farmers Market
- Fitness Challenge Events (5k walk/run, health fair)
- Garden Club at Great Afternoons
- Health Food Store
- Overeaters Anonymous
- Project Blessing Food Pantry
- Public Swimming Pool
- School Open Gym Night
- Senior Center
- Taking Off Pounds Sensibly (TOPS)
- Walking Path Booklet

Regional Resources

- Breast-feeding Coalition
- Community Garden Advocates
- Culinary programs at local community colleges
- Department of Human Services (DHS)
- Farm-to-table groups
- Farmers markets
- Food Pantries and Food Bank
- Fresh Alliance Program
- Local Fitness Facilities
- La Leche League
- OSU Extension Services
- Resource Assistance for Rural Environments (RARE)
- Supplemental Nutrition Assistance Program (SNAP)
- Women Infants and Children (WIC)



Priority Health Issue: Mental Health

Situational Analysis: why this is a concern

Mental health refers to a broad array of activities directly or indirectly related to mental well-being. The World Health Organization not only includes good mental health in their definition of “health” but further defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively, fruitfully and is able to make a contribution to her or his community.” (World Health Organization (WHO), 2007).

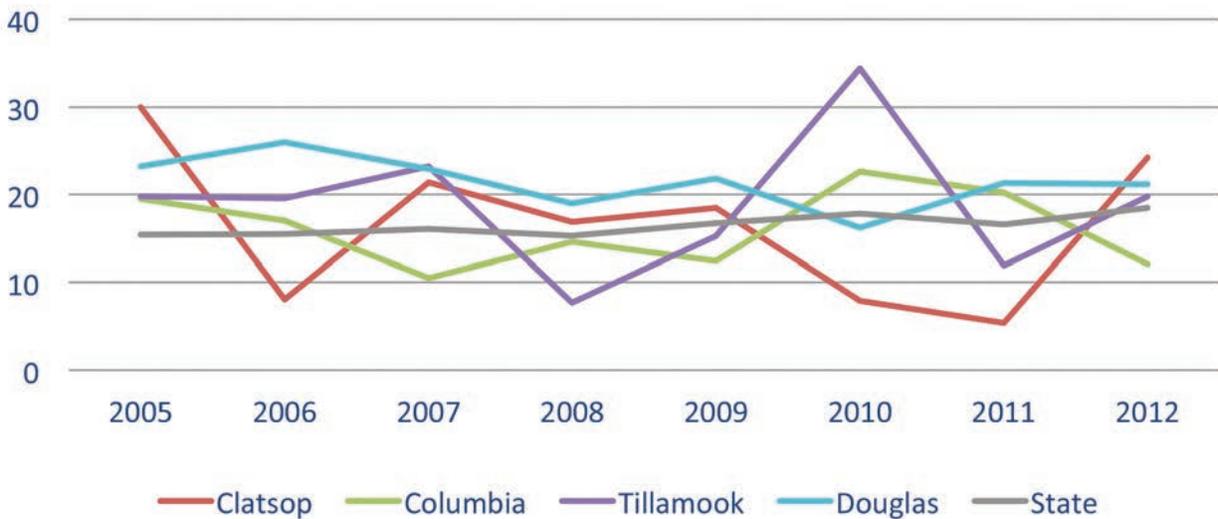
CPCCO's CACs have defined good mental health as having a strong sense of community, a high quality of life and maintaining quality relationships. Good mental health is related to the promotion of well-being, the prevention of mental disorders and the treatment and rehabilitation of people affected by mental disorders.

On average, people with serious and persistent mental illness die 25 years earlier than the general population, due largely to higher rates of chronic illnesses. Tobacco use by people with serious and persistent mental illness is almost twice that of the general population. Other health related associations include high rates of cardiovascular disease, diabetes, obesity, asthma, arthritis, epilepsy and cancer. Additionally, the rates for both intentional and unintentional injuries are 26 times higher among people with a history of mental illness than for the general population. (Mauer, 2006).

One of the top 10 causes of death for Oregonians is suicide. Oregon has more deaths from suicide each year than from motor vehicle crashes. There are more than 600 deaths by suicide and more than 1,800 hospitalizations for suicide attempts each year in Oregon; nearly two people die every day by suicide. Suicide rates vary between racial and ethnic groups and are highest among whites and Native Americans. (Oregon Public Health Division, Strategic Plan 2012-2017, 2013).

Suicide death rate (per 100,000*)					
Year	Clatsop	Columbia	Tillamook	Douglas	State
2005	30.0	19.5	19.8	23.2	14.4
2006	8.1	17.0	19.6	26.0	15.5
2007	21.4	10.5	23.2	22.9	16.1
2008	16.9	14.6	7.7	19.0	15.3
2009	18.5	12.4	15.3	21.8	16.7
2010	7.9	22.6	34.4	16.2	17.8
2011	5.4	20.2	11.9	21.3	16.6
2012	24.2	12.1	19.8	21.2	18.5

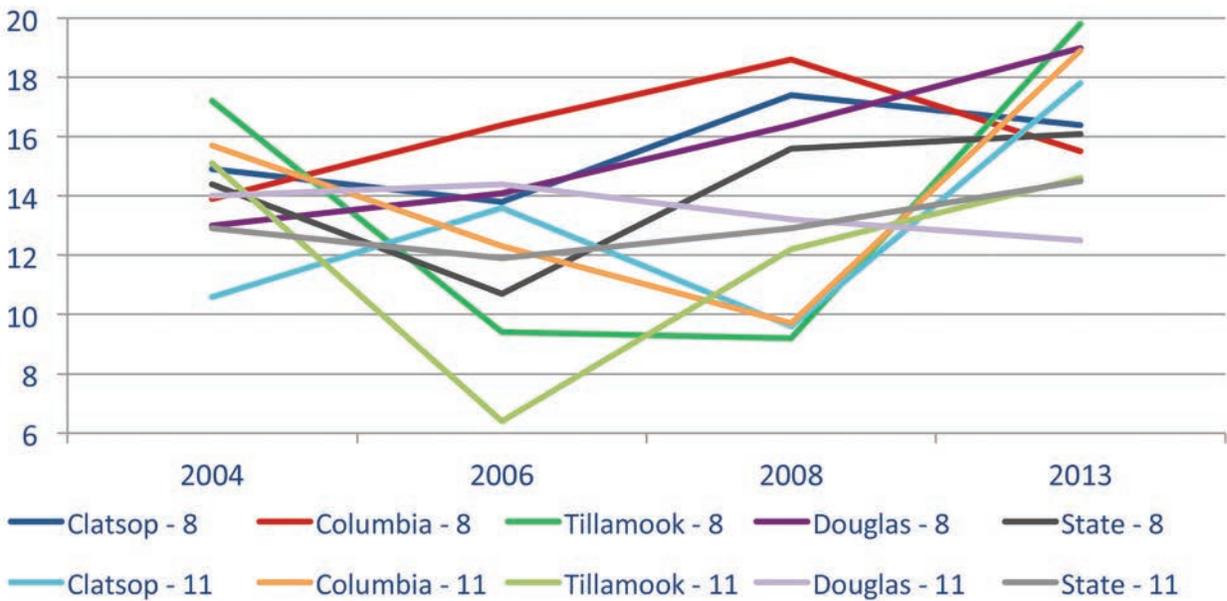
*Rates based on less than 5 events are considered unreliable: Clatsop 2006, 2010, 2011; Tillamook 2008, 2009, 2011. Oregon Vital Statistics Annual Report.



Approximately 75 Oregon youths die by suicide each year, making it the second leading cause of death among those aged 10-24 years. Even greater numbers of youth are treated in Oregon’s emergency rooms for suicide attempts, with over 750 attempts reported each year. Oregon youth participating in the 2013 Oregon Healthy Teens Survey reported relatively few suicide attempts that required medical care in the past 12 months, but more than one in four reported that they felt “sad or hopeless” every day for two weeks and approximately 8 percent of eighth-graders and approximately 5 percent of 11th-graders said they attempted suicide one or more times in the past 12 months. (Oregon Health Authority, 2013).

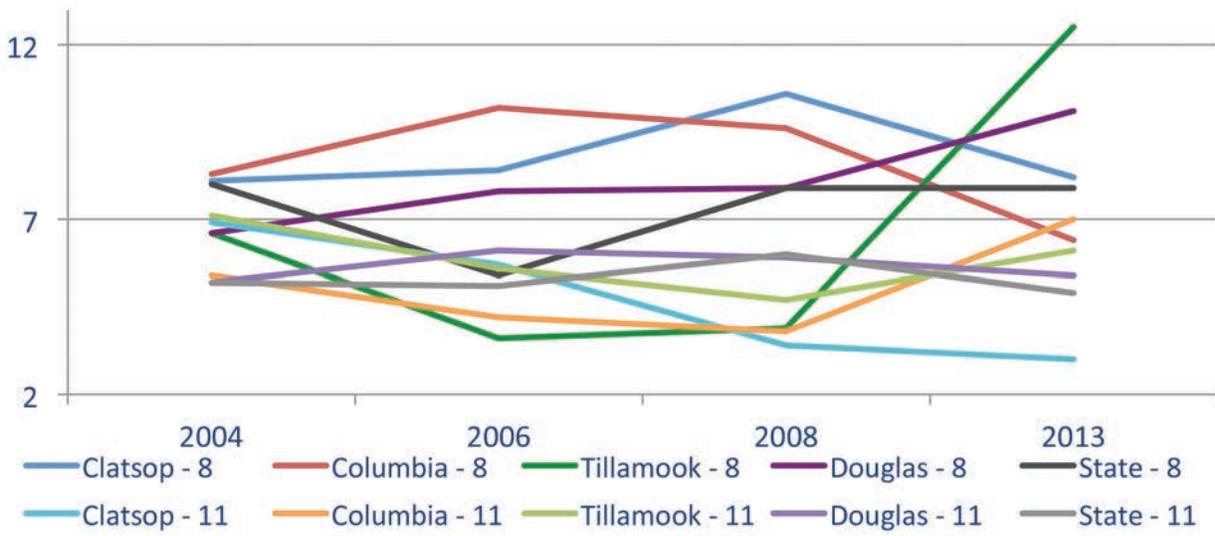
Seriously considered suicide in past year (percent)

Year	Grade	Clatsop	Columbia	Tillamook	Douglas	State
2004	8th	14.9	13.9	17.2	13.0	14.4
	11th	10.6	15.7	15.1	14.0	12.9
2006	8th	13.8	16.4	9.4	14.1	10.7
	11th	13.6	12.3	6.4	14.4	11.9
2008	8th	17.4	18.6	9.2	16.4	15.6
	11th	9.6	9.7	12.2	13.2	12.9
2013	8th	16.4	15.5	19.8	19.0	16.1
	11th	17.8	18.9	14.6	12.5	14.5



Suicide attempt in the past year (percent)						
Year	Grade	Clatsop	Columbia	Tillamook	Douglas	State
2004	8th	8.1	8.3	6.6	6.6	8.0
	11th	6.9	5.4	7.1	5.2	5.2
2006	8th	8.4	10.2	3.6	7.8	5.4
	11th	5.7	4.2	5.6	6.1	5.1
2008	8th	10.6	9.6	3.9	7.9	7.9
	11th	3.4	3.8	4.7	5.9	6.0
2013	8th	8.2	6.4	12.5	10.1	7.9
	11th	3.0	7.0	6.1	5.4	4.9

Oregon Healthy Teens Survey.



In Oregon, 36 percent of low-income women and 16 percent of high-income women experience maternal depression. Current smokers were 50 percent more likely to report depressive symptoms than non-smokers. By ethnicity, 31 percent of Hispanic women experience maternal depression in contrast with 17 percent of white women. (Oregon Health Authority: Public Health Division, 2010).

Clatsop County

There are 982 residents per mental health provider, compared to the average of 419 residents per mental health provider in Oregon as a whole. (County Health Rankings & Roadmaps, 2014).

Of 11th-grade students, 31 percent in Clatsop County have experienced a depressive episode in the past year, compared to 28 percent of 11th-grade students statewide. 10 percent of 11th-grade students in Clatsop County attempted suicide in the past year, compared to 6 percent of 11th-grade students statewide. (State Epidemiological Outcomes Workgroup, 2013).

In Clatsop County, 15 percent of respondents to the community survey said that mental illness was one of three most critical health issues in their community. It was the fifth-highest ranked response of 26 options.

Columbia County

There are 858 residents per mental health provider, less than half the providers per person found statewide (County Health Rankings & Roadmaps, 2014).

Residents in Columbia County report 4.1 days of poor mental health in the past month, compared to the state average of 3.3 days (County Health Rankings & Roadmaps, 2014).

In Columbia County, 25 percent of eighth-grade students and 27 percent of 11th-grade students report experiencing a depressive episode in the past year. 12 percent of eighth-grade students and 10 percent of 11th-grade students exhibit psychological distress (report symptoms which indicate having a mental disorder, such as anxiety or mood disorder), compared to 4 percent of eighth-grade students and 7 percent of 11th-grade students in Oregon. (State Epidemiological Outcomes Workgroup, 2013).

In Columbia County, 21 percent of respondents to the community survey said that mental illness was one of the three most critical health issues in the community. It was the sixth-highest ranked response of 26 options. An additional 10 percent of respondents said that the lack of mental health treatment facilities was one of the three most critical health issues.

Tillamook County

There are 1,226 residents per mental health provider, compared to the average of 419 residents per mental health provider in Oregon as a whole (County Health Rankings & Roadmaps, 2014). There are 18 suicide deaths per 100,000 people in Tillamook County, compared to 16 deaths per 100,000 across Oregon.

In Tillamook County, 10 percent of eighth-grade students and 9 percent of 11th-grade students have attempted suicide in the past year, compared to 8 percent of eighth-grade students and 6 percent of 11th-grade students statewide. (State Epidemiological Outcomes Workgroup, 2013).

In Tillamook County, 15 percent of respondents to the community survey said that the lack of mental health treatment facilities was one of the three most critical health issues in the community. It was the seventh-highest ranked response of 26 options. An additional 10 percent of respondents said that mental illness was one of the three most critical health issues.

Reedsport area of Douglas County

In the Reedsport area of Douglas County, there were 37 suicide deaths per 100,000 people, higher than both the Douglas County rate of 18.4 suicide deaths per 100,000 and the Oregon overall rate of 16.2 deaths per 100,000 (Oregon Public Health Division, Strategic Plan 2012-2017, 2013).

In Douglas County, 4.3 percent of eighth-graders and 2.2 percent of 11th-graders report attempting suicide two to three times during the past 12 months compared to 2.6 percent of eighth-graders and 1.6 percent of 11th-graders in the state (Oregon Health Authority, 2013).

Latino Community

Of self-identifying Latinos, 10 percent respondents to the community survey said that mental illness was one of the three most critical health issues in the community. It was the 13th highest ranked response of 26 options. An additional 7 percent of Latino respondents said that the cost of mental health services and lack of mental health treatment facilities were priorities.

Best Practices

- The Adverse Childhood Experiences Study has found that almost two-thirds of suicide attempts could be attributed to having several adverse experiences as a child. Adverse childhood experiences included in the study were: psychological, physical or sexual abuse; violence against mother; living with household members who were substance abusers, mentally ill or suicidal or had ever been in the correctional system. These findings suggest that prevention of childhood exposure to these experiences, or interventions that minimize the impact of these exposures could have a dramatic impact on the incidence of suicide. (Oregon Public Health Division, Strategic Plan 2012-2017, 2013)
- Establishing and maintaining collaborative relationships with local crisis and emergency services: The National Suicide Prevention Lifeline's policy requires the development of both formal and informal relationships with community services that can assist in the use of less invasive interventions and or better ensure optimal continuity of care for people at imminent risk of suicide. (National Suicide Prevention Lifeline, 2014)
- Implement school-based programs to reduce violence and promote emotional self-awareness, self-esteem, positive social skills, social problems solving and conflict resolution. (Violence Schoolbased Programs, 2014)
- Develop systems and policies that support ongoing health care providers training to screen for depression as part of a comprehensive well-child exam. (Bright Futures, 2014)
- Integrate mental health screening into the health care standard of care for all ages. (Public Health Oregon, 2014)
- Reducing stigma through education about the signs and symptoms of mental illness. Mental Health First Aid is an evidenced-based approach to public education that helps reduce stigma and equips the public with key skills to help individuals who are developing a mental health problem or experiencing a mental health crisis. The clinical and qualitative evidence behind the program demonstrates that it helps the public better identify, understand, and

respond to signs of mental illness, improving outcomes for individuals experiencing mental health symptoms. (Mental Health First Aid, 2014)

- Applied Suicide Intervention Skills Training (ASIST)
- Question, Persuade and Refer (QPR)
- Response is a comprehensive high school based suicide prevention program designed to increase awareness, heighten sensitivity to depression and suicidal ideation, change attitudes and offer response procedures to refer a student at risk for suicide.
- David Romprey Warmline is a warm line designed and provided by people who have or had challenges in mental health and are able to support their peers who are struggling with a variety of mental health issues.

Opportunities for Health: (Three year goals)

Goal 1: Reduce and prevent youth and adult suicide attempts.

Outcome Objectives/Indicators

See a reduction each year in the current upward trend of eighth- and 11th-graders reporting a suicide attempt in the last year.

See an incremental reduction in the current upward trend of suicide attempt for all ages in the CPCCO service area each year.

There is an increase in the number of schools that have access to and utilize evidence-based practices such as RESPONSE, ASIST and Mental Health First Aid to support schools to improve their capacity to recognize the signs of mental health support needs in students.

There is an increase in the number of community members in the CPCCO service area who are aware of services and supports that are available to improve their mental health and well-being.

Goal 2: Better educate the community about the resources for mental health services.

Outcome Objectives/Indicators

There is an increase in the number of community partners involved in local and regional planning in establishing crisis respite support for persons in mental health crisis.

There is a development of baseline data indicating the use and knowledge of the mental health crisis hotline(s).

Use of the mental health crisis hotline baseline data to increase in the use and knowledge of the 24-hour crisis hotline.

There is an increase in education and supports related to mental wellness and community wide prevention models that all community members have access to.

Action Steps for Community Health

Assessment

Collaborate with community partners to develop a service gap analysis.
Identify positive community norms related to mental health and well-being.

Outreach and Education

Educate the community about the signs and symptoms of depression and the resources available in the community to help community members who experience increased feelings of sadness or thoughts of suicide.

Support development of services that increase the awareness and access to prenatal and perinatal mental health for all mothers, babies, and families.

Participation in Policy and Planning Processes

Support community partners to work toward improving access to mental health services including the development of the workforce who provides direct service.

Support policy that supports the improvement of outpatient and inpatient services that are comprehensive and collaborative to meet the needs of a diverse population.

There is a mental health suicide awareness policy at all schools to allow front line people to get trained in QPR and Mental Health First Aid.

Partners

Clatsop County

- Clatsop Behavioral Healthcare
- Clatsop County Public Health
- Coastal Family Health Center
- Columbia Memorial Hospital
- Connect the Dots
- National Alliance on Mental Illness
- Northwest Parenting Education and Support Hub
- Providence Seaside Hospital

Columbia County

- Columbia Community Mental Health
- Legacy Health Clinic
- National Alliance on Mental Illness
- OHSU Family Medicine at Scappoose
- Public Health Foundation of Columbia County
- School Based Health Centers
- Vernonia Health Center

Tillamook County

- Community Action Resource Enterprises, Inc.
- National Alliance on Mental Illness
- Tillamook County Health Department and Centers for Family Health
- Tillamook Family Counseling Center

Reedsport area of Douglas County

- Douglas County Mental Health
- Dunes Family Clinic
- Family Resource Center
- Lower Umpqua Hospital

Regional Resources

- 211
- 911
- Child Welfare Services
- Community Behavioral Health Providers
- Educational Service Districts
- Emergency Medical Responders
- Fire Departments
- Law Enforcement
- Local Government
- Non-emergency 24/7 Crisis Lines

Priority Health Issue: Substance Abuse

Situational Analysis: why this is a concern

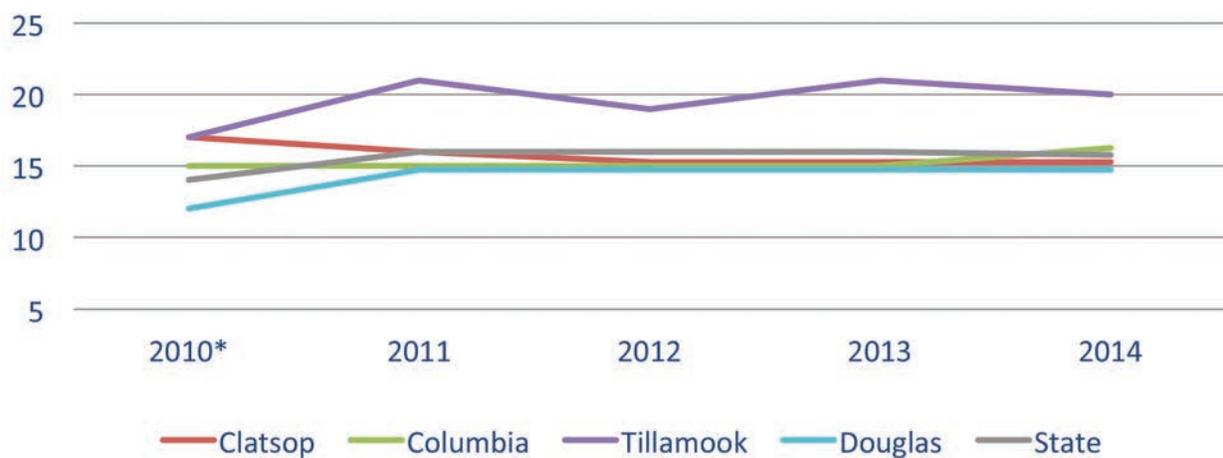
Substance abuse is the harmful use and or abuse of illegal drugs, prescription drugs, alcohol or tobacco and when the use of the substance causes demonstrable harm, either for the individual or society, in terms of negative health, social or economic effects.

Specifically in the CPCCO region, binge drinking is a significant risk factor for injury, violence, and chronic substance abuse for adults and youth. During 2010, 14.4 percent of adults reported binge drinking on at least one occasion during the past 30 days.



Excessive drinking (percent)					
Year	Clatsop	Columbia	Tillamook	Douglas	State
2010*	17	15	17	12	14
2011	16	15	21	15	16
2012	15	15	19	15	16
2013	15	15	21	15	16
2014	15	16	20	15	16

*Excessive drinking is defined as either binge drinking or heavy drinking. The 2010 measure is for binge drinking alone. County Health Rankings

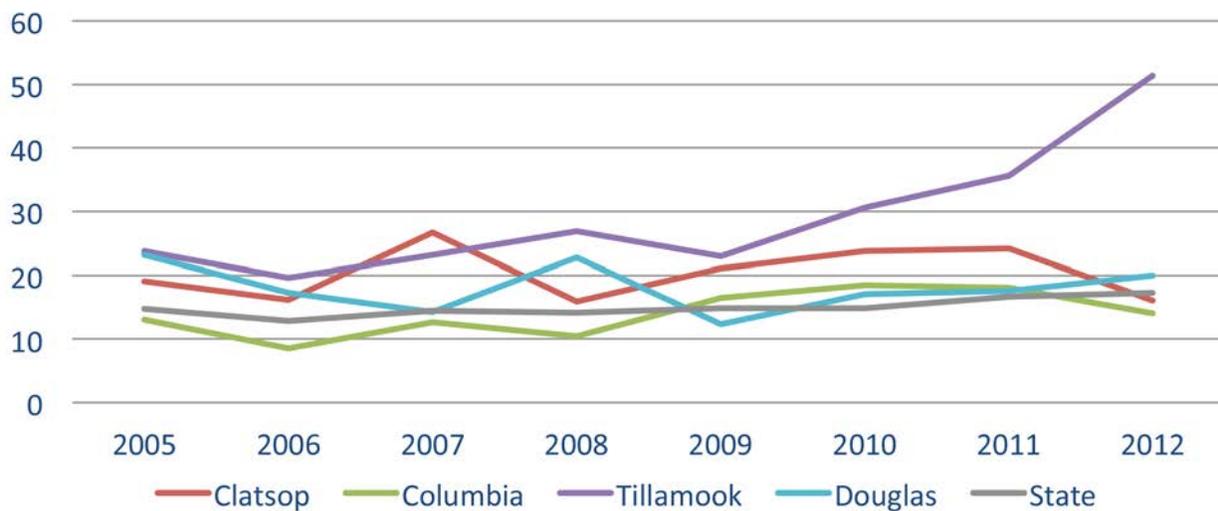


Oregon students in the eighth- and 11th-grade who participated in the Oregon Healthy Teens Survey were asked about their alcohol and binge drinking (defined as five or more drinks within two hours) during the past month. More than half (57.9 percent) of eighth-graders and almost one-third (33 percent) of 11th-graders reported that they had never consumed alcohol. 42 percent of eighth-graders reported using alcohol at age 14 years or younger, placing them at a four times greater risk of lifetime alcohol-related problems cited above. Likewise, 38 percent of the 11th-graders said they were aged 14 years or younger when first having more than a sip or two of alcohol. As might be expected, alcohol use for 11th-graders exceeded rates reported by eighth-graders on most items. (Oregon Health Authority, 2013).

Alcohol-induced death rate (per 100,000*)

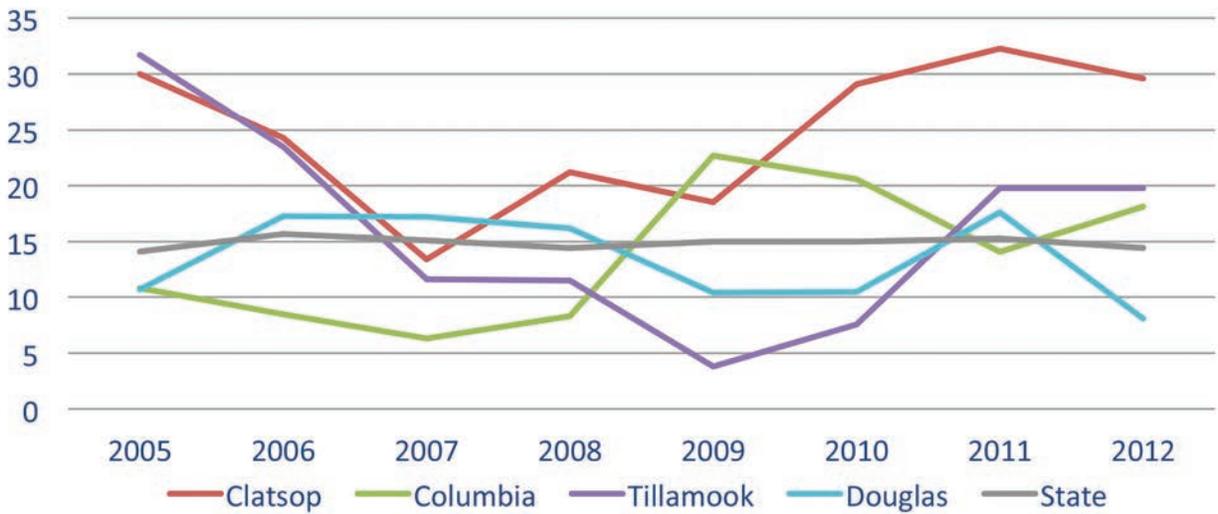
Year	Clatsop	Columbia	Tillamook	Douglas	State
2005	19.1	13.0	23.8	23.2	14.8
2006	16.2	8.5	19.6	17.3	12.8
2007	26.7	12.6	23.2	14.3	14.5
2008	15.9	10.4	26.9	22.8	14.2
2009	21.1	16.5	23.0	12.3	14.9
2010	23.8	18.5	30.6	17.1	14.9
2011	24.2	18.1	35.6	17.6	16.7
2012	16.1	14.1	51.4	20.0	17.3

*Rates based on less than 5 deaths are unreliable: Columbia 2006. Oregon Vital Statistics Annual Report



Drug-induced death rate (per 100,000*)					
Year	Clatsop	Columbia	Tillamook	Douglas	State
2005	30.0	10.8	31.7	10.7	14.1
2006	24.3	8.5	23.5	17.3	15.7
2007	13.4	6.3	11.6	17.2	15.1
2008	21.2	8.3	11.5	16.2	14.4
2009	18.5	22.7	3.8	10.4	15.0
2010	29.1	20.6	7.6	10.5	15.0
2011	32.3	14.1	19.8	17.6	15.3
2012	29.6	18.1	19.8	8.1	14.4

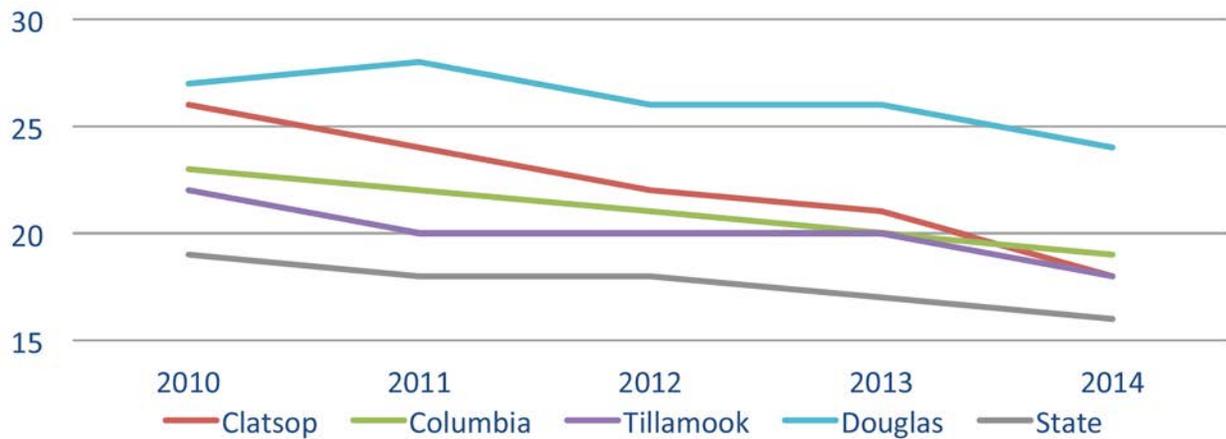
*Rates based on less than 5 deaths are considered unreliable: Columbia 2006, 2007, 2008; Tillamook 2007, 2008, 2009, 2010. Oregon Vital Statistics Annual Report



Smoking is the most common root cause of avoidable death and disease in Oregon. It kills more than 7,000 Oregonians annually, and costs the state \$2.4 billion in health care costs and lost productivity due to premature death. Most adult smokers start smoking before the age of 18. (Oregon Public Health Division, Strategic Plan 2012-2017, 2013).

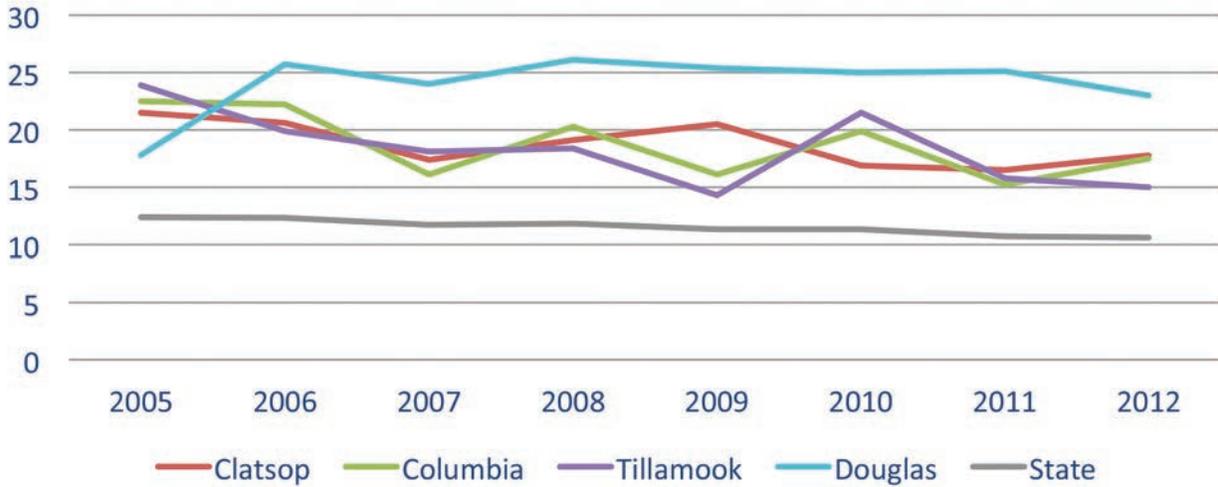
Adult smoking rate (percent) (County Health Rankings)					
Year	Clatsop	Columbia	Tillamook	Douglas	State
2010	26	23	22	27	19
2011	24	22	20	28	18
2012	22	21	20	26	18
2013	21	20	20	26	17
2014	18	19	18	24	16

County Health Rankings



Reported tobacco use in pregnant mothers (percent) (Oregon Vital Statistics)					
Year	Clatsop	Columbia	Tillamook	Douglas	State
2005	21.5	22.5	23.9	17.8	12.4
2006	20.6	22.2	19.9	25.7	12.3
2007	17.4	16.1	18.1	24	11.7
2008	19.1	20.3	18.4	26.1	11.8
2009	20.5	16.1	14.3	25.4	11.3
2010	16.9	19.9	21.5	25	11.3
2011	16.5	15.2	15.8	25.1	10.7
2012	17.8	17.5	15	23	10.6

Oregon Vital Statistics Annual Report



Clatsop County

In Clatsop County, the death rate from alcohol-induced causes was 18 deaths per 100,000 people between 2007 and 2011, compared to 14 deaths per 100,000 people in Oregon in the same period. In Clatsop County, 10 percent of women report heavy drinking, or having more than one drink daily in the past month, compared to 6 percent of women in Oregon.

In Oregon, 16 percent of eighth-grade students report binge drinking in the past month, compared to 8 percent of Clatsop County eighth-grade students. In Clatsop County, 8 percent of 11th-grade students reported driving while drunk in the past month, compared to 5 percent of 11th-grade students statewide. (State Epidemiological Outcomes Workgroup, 2013).

The death rate from drug-induced causes in Clatsop County was 24 deaths per 100,000 people between 2007 and 2011, much higher than the state rate of 14 deaths per 100,000 people. Of individuals aged 18-25, 17 percent report using prescription pain relievers non-medically in the past year, slightly higher than the state rate of 15 percent. In Clatsop County, 6 percent of 11th-grade students report using illicit drugs (other than marijuana) in the past month, double the state rate of 3 percent. (State Epidemiological Outcomes Workgroup, 2013).

At 18 percent, the adult smoking rate in Clatsop County is slightly higher than the statewide rate at 16 percent. (County Health Rankings & Roadmaps, 2014). In Clatsop County, 17 percent of infants in were born to mothers who reported using tobacco during pregnancy, compared to 11 percent of infants in Oregon. (Oregon Vital Statistics County Data 2012).

In Clatsop County, 36 percent of respondents to the community survey said that alcohol and drug addiction was one of the three most critical health issues in the community. It was the number one response of 26 options. Additionally, 21 percent of Clatsop County respondents said that alcohol and drug prevention and treatment were one of the three most important ways to create a healthier community. It was the seventh-highest ranked response of 14 options. Additionally, 16 percent of respondents said that tobacco use was one of the three most critical health issues. It was the sixth-highest ranked response of 26.

Columbia County

In Columbia County, there are higher rates of binge drinking and heavy drinking by females compared to the state as a whole. In Columbia County, 13 percent of women report binge drinking, or drinking more than four drinks in about two hours, in the past month, compared to 11 percent of women in Oregon. Also in Columbia County, 9 percent of women report heavy drinking in the past month, compared to 6 percent of women in Oregon. (State Epideiological Outcomes Workgroup, 2013).

The death rate from drug-induced causes in Columbia County was 14.0 deaths per 100,000 people between 2007 and 2011, equal to the state rate. Of individuals aged 18-25, 17 percent report using prescription pain relievers non-medically in the past year, slightly higher than the state rate of 15 percent. (State Epideiological Outcomes Workgroup, 2013).

At 19 percent, the adult smoking rate in Columbia County is slightly higher than the statewide rate of 16 percent. (County Health Rankings & Roadmaps, 2014). In Columbia County, 26 percent of deaths are linked to tobacco, compared to 22 percent of deaths in Oregon. 18 percent of infants in were born to mothers who reported using tobacco during pregnancy, compared to 11 percent of infants in Oregon. (Oregon Vital Statistics County Data 2012).

In Columbia County, 45 percent of respondents to the community survey said that alcohol and drug addiction was one of the three most critical health issues in their community. Alcohol and drug addiction was the number one response of 26 options. Additionally, 29 percent of Columbia County respondents said that alcohol and drug prevention and treatment were one of the three most important ways to create a healthier community. It was the second-highest ranked response of 14 options. In Columbia County, 26 percent of respondents said that tobacco use was one of the three most critical health issues. It was the third-highest ranked response of 26.

Tillamook County

In Tillamook County, the death rate from alcohol-induced diseases was 18 deaths per 100,000 people between 2007 and 2011, compared to 14 deaths per 100,000 people in Oregon in the same period. (State Epidemiological Outcomes Workgroup, 2013). Of Tillamook County residents, 22 percent report excessive drinking, defined as either binge or heavy drinking, in the past month, compared to 16 percent of individuals in Oregon. (County Health Rankings & Roadmaps, 2014) In particular, 17 percent of women report binge drinking in the past month in Tillamook County, compared to 11 percent of women in Oregon.

In Tillamook County, 11 percent of eighth-grade students and 24 percent of 11th-grade students report binge drinking within the past month, compared to 8 percent of eighth-grade students and 21 percent of 11th-grade students in Oregon. Additionally, 7 percent of 11th-grade students report driving while drunk in the past month, compared to 5 percent of 11th-grade students in Oregon. (State Epidemiological Outcomes Workgroup, 2013).

The death rate from drug-induced causes in Tillamook County between 2007 and 2011 was 14 deaths per 100,000 people, equal to the state rate. 17 percent of individuals aged 18-25 report using prescription pain relievers non-medically in the past year, slightly higher than the state rate of 15 percent. (State Epidemiological Outcomes Workgroup, 2013).

At 18 percent, the adult smoking rate in Tillamook County is slightly higher than the statewide rate of 16 percent (County Health Rankings & Roadmaps, 2014). In Tillamook County, 29 percent of deaths are linked to tobacco, compared to 22 percent of deaths in Oregon. 15 percent of infants in were born to mothers who reported using tobacco during pregnancy, compared to 11 percent of infants in Oregon. (Oregon Vital Statistics County Data 2012).

In Tillamook County, 41 percent of respondents to the community survey said that alcohol and drug addiction was one of the most critical health issues in their community. Alcohol and drug addiction was the number one ranked response of 26 options. Additionally, 25 percent

of Tillamook County respondents said that alcohol and drug prevention and treatment were one of the three most important ways to create a healthier community. It was the seventh-highest ranked response of 14 options. Additionally, 12 percent of respondents said that tobacco use was one of the three most critical health issues. It was the ninth highest ranked response of 26.

Reedsport area of Douglas County

In Reedsport, the death rate for alcohol-induced diseases was 40 deaths per 100,000 people between 2007 and 2011, compared to 14 deaths per 100,000 people in Oregon in the same period. In Douglas County, 8 percent of men report heavy drinking in the past month, compared to 15 percent of men in Oregon. (State Epidemiological Outcomes Workgroup, 2013).

The death rate from drug-induced causes in Douglas County was 14 deaths per 100,000 people between 2007 and 2011, equal to the state rate. 15 percent of individuals aged 18-25 report using prescription pain relievers non-medically in the past year, equal of the state rate. (State Epidemiological Outcomes Workgroup, 2013).

At 24 percent, the adult smoking rate in Douglas County is significantly higher than the state rate of 16 percent (County Health Rankings & Roadmaps, 2014). In Douglas County, 26 percent of deaths are linked to tobacco, compared to 22 percent of deaths in Oregon. 19 percent of infants were born to mothers who reported using tobacco during pregnancy, compared to 11 percent of infants in Oregon. (Oregon Vital Statistics County Data 2012)

In the Reedsport-area, 32 percent of respondents to the community survey said that alcohol and drug addiction was one of the most critical health issues in their community. Alcohol and drug addiction was the first response of 26 options. Additionally, 19 percent of Reedsport-area respondents said that alcohol and drug prevention and treatment were one of the three most important ways to create a healthier community. It was the ninth response of 14.

Latino Community

Of self-identifying Latino, 39 percent respondents to the community survey said that alcohol and drug addiction was one of the most critical health issues in their community. Alcohol and drug addiction was the first response of 26 options. Additionally, 30 percent of Latino respondents said that alcohol and drug prevention and treatment were one of the three most important ways to create a healthier community. It was the fifth response of 14.

Best Practices

- Develop systems and policies that support ongoing healthcare provider training, such as SBIRT, (screening, brief intervention, referral to treatment) for alcohol and other drug screening, depression, and early detection of mental illness, along with brief interventions, and referral to treatment.
- Enhance enforcement of laws prohibiting sales to minors. Educate the public about the risks of underage drinking binge drinking and opioid use and enhance enforcement of laws prohibiting sales to minors. (Alcohol, 2014) (NREPP, 2014)
- Baby & Me Tobacco Free is an incentive program to get prenatal women to quit smoking while pregnant and stay quit for at least one year after the birth of the baby. Program includes cessation training and materials, a program curriculum and protocols, brochures and application materials, testing and diaper vouchers. (Baby & Me Tobacco Free, 2014)
- Referral to the Oregon Tobacco Quit Line
- Support policies and ordinances banning flavored tobacco. Support tobacco sampling ban. Create age restrictions on emerging tobacco products such as electronic cigarettes.
- Life Skills Training, a middle-school substance abuse prevention program. The program teaches students social and self-management skills, including skills in resisting peer and media pressure to smoke, drink, or uses drugs and informs students of the immediate consequences of substance abuse. It's delivered by classroom teachers who receive brief trainings. They provide the program to students in fifteen classroom sessions about 45 minutes in length during the student's first year of middle school. The following years, the teachers provide a total of five to fifteen review sessions. (Substance Abuse Prevention/Treatment, 2014)

Opportunities for Health: (Three year goals)

Goal 1: Decrease youth and adult substance abuse.

Outcome Objectives/Indicators

There is an increase in the number of completed referrals to behavioral health services.

There is a marked decrease in the percentage of pregnant mothers who smoke annually.

There is a decrease in the percentage of people who report excessive drinking and substance abuse.

There is a decrease in the percentage of adolescents who report using harmful substances.

Goal 2: Increase the public's awareness of the risk of substance abuse and the long term health effects of the abuse of alcohol, drugs, and tobacco.

Outcome Objectives/Indicators

There is an increase in the number of community members in the CPCCO service area who are aware of services and supports that are available to stop or reduce the abuse of alcohol, drugs and tobacco.

The number of 12-20 year olds that are on Oregon Health Plan who receive SBIRT (screening, brief intervention, referral to treatment) screening through their primary care doctor increases by three percent every year.

There is an increase in public properties that are tobacco-free zones.

Action Steps for Community Health

Assessment

Collaborate with community partners to develop a service gap analysis.

Identify positive community norms related to reducing substance abuse and improving wellbeing.

Outreach and Education

Support the recruitment and training of more mentors (including peer mentors) for our young people to increase the protective factors amongst our youth and redirect them towards more positive life choices.

Support community events and trainings that normalize the discussion of the use and abuse of substances and the effect substance abuse issues have on the health and wellbeing of the community as a whole.

Support community attendance/participation in sponsored events that educate the community regarding the physical, mental and emotional costs of drug and alcohol abuse.

Participation in Policy and Planning Processes

Support policies that ban smoking in all parks and public properties in the Reedsport area Tillamook, Clatsop, and Columbia Counties.

Partners

Clatsop County

- AA, NA
- Caring Adults Developing Youth
- Clatsop Behavioral Healthcare
- Clatsop County Public Health
- Coastal Family Health Center
- North Coast Pain Clinic
- Northwest Parenting Education and Support Hub
- Prevention Works

Columbia County

- AA, NA
- Columbia Community Mental Health
- Dual Diagnosis Anonymous
- Prevention Works

Tillamook County

- Rinehart Clinic
- Tillamook Family Counseling Center
- Tillamook Health Department and Family Health Center
- Tillamook Regional Medical Center and Clinics

Reedsport area of Douglas County

- AA, NA
- ADAPT
- Battered Persons Advocacy
- Better Breathers

Regional Resources

- Afterschool Programs
- Behavioral Health Providers
- Emergency Medical Responders
- Fire Departments
- First Responders
- Law Enforcement
- Lunch Buddy
- Outpatient Physical Health Providers
- Parks and Recreation departments
- Prevention works programs
- Public Health Department
- School Districts
- SNAP
- Young Life
- WIC



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Columbia Pacific CCO

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07.08.14

**Columbia County
Public Health Foundation of Columbia County
2014-2015 Minimum Standards**

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

I. Organization

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

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

28. Yes No A system to obtain reports of deaths of public health significance is in place.

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

30. Yes No Health department administration and county medical examiner review collaborative efforts at least annually.

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

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

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

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

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

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

Control of Communicable Diseases

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

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

39. Yes No Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.

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

Environmental Health

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

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

Health Education and Health Promotion

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

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

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

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

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

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

Nutrition

73. Yes No Local health department reviews population data to promote appropriate nutritional services.

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

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

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

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

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

Older Adult Health

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

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

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

81. Yes No Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education.

Parent and Child Health

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

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

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

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

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

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

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

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

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

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

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

Primary Health Care

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

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

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

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

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

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

Cultural Competency

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

100. Yes No The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.

101. Yes No The local health department assures that advisory groups reflect the population to be served.

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

Health Department Personnel Qualifications

Local health department Health Administrator minimum qualifications:

The Administrator must have a Bachelor degree plus graduate courses (or equivalents) that align with those recommended by the Council on Education for Public Health. These are: Biostatistics, Epidemiology, Environmental health sciences, Health services administration, and Social and behavioral sciences relevant to public health problems. The Administrator must demonstrate at least 3 years of increasing responsibility and experience in public health or a related field.

Answer the following questions:

Administrator name: Sherrie L. Ford, MPH

Does the Administrator have a Bachelor degree? Yes No

Does the Administrator have at least 3 years experience in Yes No
public health or a related field?

Has the Administrator taken a graduate level course in Yes No
biostatistics?

Has the Administrator taken a graduate level course in Yes No
epidemiology?

Has the Administrator taken a graduate level course Yes No
in environmental health?

Has the Administrator taken a graduate level course Yes No
in health services administration?

Has the Administrator taken a graduate level course in Yes No
social and behavioral sciences relevant to public health problems?

a. Yes No **The local health department Health Administrator meets minimum qualifications:**

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

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

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

AND

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

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

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

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

OR

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

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

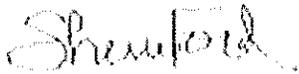
d. Yes No The local health department Health Officer meets minimum qualifications:

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

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

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

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



Local Public Health Authority

Columbia
County

06/12/2014
Date

