



## **Public Health**

Prevent. Promote. Protect.

### **North Central Public Health District**

*“Caring For Our Communities.”*



***Community Health Improvement Plan  
Based on 2011 Community Health Assessment  
2011-2016***



**Public Health**  
Prevent. Promote. Protect.

**NORTH CENTRAL PUBLIC HEALTH DISTRICT**

*“Caring For Our Communities”*

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July 2012

To the Residents of Wasco, Sherman and Gilliam Counties,

North Central Public Health District is dedicated to improving the health and lives of all citizens. We do that by promoting health and preventing the leading causes of death, disease and injury.

Each County’s Board of Commissioners is the Local Public Health Authority, and is responsible for assuring that their County’s residents receive the essential health services mandated by Oregon law. In our region, the three Counties have chosen to come together and create a Board of Health comprised of elected officials and appointed citizens to assure public health mandates are fulfilled in an efficient manner.

In 2010, North Central Public Health District (NCPHD) received a grant to build and expand community partnerships and policies that work to prevent, detect, and manage chronic diseases. The “Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts” grant helped NCPHD to plan population-based approaches to reducing the burden of chronic diseases most closely linked to physical inactivity, poor nutrition and tobacco use. Such chronic diseases include arthritis, asthma, cancer, diabetes, heart disease, obesity and stroke.

The Community Health Improvement Plan for 2011-2016 is based on the results of community assessments conducted throughout the Region. We are grateful to the community partners who generously gave their time for assessments and providing expertise in planning for the future. Likewise, the community members who willingly provided us assessment information were critical to the process and are greatly appreciated.

We encourage you to read this plan to see what the future can hold. Through policy and environmental change, we have a vision of health throughout Wasco, Sherman and Gilliam Counties.

Sincerely,

Teri L. Thalhofer, RN, BSN  
Director  
North Central Public Health District



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## **EXECUTIVE SUMMARY**

A Community Health Improvement Plan is a long-term, systematic effort to address health barriers in a community based on the results of a community health assessment. The plan recommends priorities for action and is used by health and other governmental, education and social service agencies and organizations to implement policies and programs that promote health.

The North Central Public Health District (NCPHD) Community Health Improvement Plan reflects the understanding that the environmental standards of the communities where we live, work and play is as important to achieving good health as going to the doctor for regular checkups, proper nutrition and adequate physical activity. There are many factors, or determinants, that affect health and have a tremendous influence on health outcomes. The physical environment, social and economic factors, and clinical care all play a part in an individual's health and are all incorporated into the plan.

The community health improvement plan is a result of a 2011 comprehensive community health assessment. The plan guides policy and program decisions to optimize health and well-being. Analysis of health, social and economic data, as well as direct input from citizens and community agencies, led to the identification of the top preventable health threats in our community: obesity, chronic disease, and poor social and emotional wellness.

This is a community plan, designed to be implemented by community agencies, partners and residents across the three counties. Working together, we can create an environment where each resident has an opportunity for healthful living.



## SECTION I: COMMUNITY HEALTH IMPROVEMENT PLAN PARTNERSHIP

Community health assessment is an important tool in setting priorities, guiding health, land use and transportation planning, program development, coordination of community resources, and creation of new partnerships to improve the health of the population. The results are used to define improvement areas and guide a community toward implementing and sustaining policy, systems and environmental conditions that improve community health. The results also assist the community in prioritizing needs which lead to the appropriate allocation of available resources. The health assessment provides an evidence based core foundation for improving the health of a community.

In 2011, North Central Public Health District conducted a community health assessment using the Community Health Action and Response Team (CHART) in collaboration with several partners (see *Figure 1*) to guide future health planning and meet the state’s requirement for local health departments to update their community health action plans every five years.

### ***CHART Membership***

*Figure 1*

Organization Name	Organization Role	Organization Type (choose from the following)		Sector (choose from the following)
		Academia/Education An Individual Civic Organization Community Based Organization Cultural/Ethnic Organization Environmental Organization Foundations/Philanthropic Health Care Organization Nonprofit organization Professional Association Public Relations/Media	Advocacy Group Business/For Profit/Consultant Coalition/Alliance Community Health Center Elected/Appointed Official Faith-based Organization Government Organization Health Insurance Company Organization representing population Public Health Organization Other (specify)	
North Wasco County School District 21	Superintendent	Academic/Education K-12		School
Northern Wasco County Park & Recreation District	Activities Director	Community Based Organization		CIO
Mid-Columbia Medical Center	Community Outreach; Infection control	Health Care Organization: Hospital		Health Care
Wasco County Commission on Children & Families	Administrator	Government Organization		Community at Large
North Central Public Health District	School Health Nurse, Public Health Nurse	Government Organization		Healthcare
La Clinica del Cariño (FQHC)	Health Promoter	Health Care, Non-profit FQHC, Coalition Member, Organization representing priority population: Hispanic		Health Care
Oregon State University (OSU) Extension Service	Faculty	Academic/Education; Also, Healthy Communities Coordinator for Hood River Co., OSU Extension Agent		CIO

<i>Not Applicable</i>	Parent, PTA Member	Individual: Community Activist	Community at Large
The Next Door, Inc.	Health Promotion Coordinator	Community Based Organization, Non-Profit, and Organization representing priority population: Hispanic	Community Institution/ Organization
Gilliam County Education Service District	Gilliam Co. Commission on Children and Families Admin Assistant	Governmental Organization, Organization representing priority population: Children	Community Institution/ Organization
North Central Public Health District	Tobacco Prevention and Education Coordinator	Government Organization, Member of coalitions for Alcohol, Drug and Tobacco Prevention in all three counties	Community Institution/ Organization
North Central ESD Early Education	Health Coordinator, Oregon Head Start Pre-K	Academic/Education, Healthcare; Represents priority populations: Gilliam and Sherman Counties and Young vulnerable population	Community Institution/ Organization
Opportunity Connections	Director	Non-Profit, Workplace, Organization representing vulnerable population: developmentally disabled	Workplace, Community Institution/ Organization
Mid-Columbia Economic Development	Project Mobility Manager	Business/For Profit/Consultant, Economic Development, Transit	Community at Large
Gilliam County Commission on Children and Families	Director	Governmental Organization serving youth	Community Institution/ Organization
North Central Public Health District	Director	Government Organization; Health Care; Public Health	Community at Large
Mid-Columbia Children's Council	Health, Safety and Nutrition Director	Head Start: Represents Priority Population: Young Pre-K, at Risk; Non-Profit	Community Institution/ Organization
North Central Public Health District	Chronic Disease Health Educator	Government Organization; Health Care; Public Health	Community at Large
North Central Public Health District	Clinical Programs Manager	Government Organization; Health Care; Public Health	Community at Large

### ***CHART Vision***

CHART envisions a community that supports all citizens' desire for optimal health, a community that has low-cost or no-cost options for physical activity, has abundant availability of affordable healthy foods, an environment where it is easy to be tobacco free, and where all citizens are empowered with the knowledge to reduce the incidence and impact of chronic diseases.

### ***CHART Mission***

CHART is a diverse group of people representing various sectors of the community with an interest in the ultimate well being of their community; it is a group that possesses the desire and commitment to improve the opportunities for health via access to healthy foods, low-cost or no-cost physical activity, tobacco-free environments and access to tools to manage or prevent chronic illness. Strategies to accomplish optimal health in the community will aim at improving opportunities for health via community engagement, as well as policy and environmental change in places where people live, work, play and learn.



## SECTION II: COMMUNITY HEALTH ASSESSMENT

North Central Public Health District was funded in 2010 through the Oregon Public Health Division to complete a community health assessment and create an implementation plan. The Community Health Assessments for the three counties served, which include Gilliam, Sherman and Wasco Counties, were completed in June 2011.

The main objective of this Healthy Communities Program is working to engage communities and mobilize national networks to focus on chronic disease prevention. The Community Health Assessment focused on five main sectors. These sectors include:

1. Community at large
2. Community institutions/organizations
3. Worksites
4. Healthcare
5. Schools

Within each of these sectors, further assessment was conducted in additional focus areas for strengths and weaknesses in ***Policy*** and ***Environment***:

- Physical Activity
- Nutrition
- Tobacco Use
- Chronic Disease Management
- Leadership
- School District (*Schools only*)
- After School (*Schools only*)

By assessing places that people spend most of their time within the community, the assessment provides a community wide approach to focus on chronic disease prevention.

The Community Health Assessment and Group Evaluation (CHANGE) tool was designed by the Centers for Disease Control and Prevention (CDC) to:

- Identify community strengths and areas for improvement.
- Identify and understand the status of community health needs.
- Define improvement areas to guide the community toward implementing and sustaining policy, systems, and environmental changes around healthy living strategies (e.g., increased physical activity, improved nutrition, reduced tobacco use and exposure, and chronic disease management).
- Assist with prioritizing community needs and consider appropriate allocation of available resources.

## ***Community Health Assessment Results***

This document compiles the results of all three counties within the North Central Public Health District (NCPHD) for a summary of all sectors of the Community Health Assessment. NCPHD strives so that one day all people will live in a safe environment free from fear of preventable diseases; that all businesses, organizations and individuals will have access to health information and promote and be responsible for a healthy lifestyle for themselves and each other.

A snapshot of the results of the assessments for each of the five main sectors can be found on pages 18-19. This information includes a more comprehensive view of the scores discussed in sections i-v. Also included on pages 3 and 4 is a list of organizations who participated in completing the CHANGE tool.

### **i. Community Institutions/Organizations**

There were four community institutions that participated in the assessment. These four institutions provide service to 75 to 2,000 people. They are all located in rural areas, and are an array of public, private, and nonprofit organizations.

#### **Strengths:**

The greatest strength scores occurred in *Tobacco Use*. Three out of the four agencies had their highest policy scores in *Tobacco Use*. The Smoke Free Indoor Air Act in Oregon gave us relatively higher scores than in communities without such laws, but other aspects of *Tobacco Use* did not score as favorably. Health data (including tobacco related death rates) for our region point to the negative impacts of tobacco use, and there are higher rates of smokeless tobacco use in rural areas compared to urban areas. For *Environment* scores, two of the four agencies had scores highest in *Tobacco Use*, but the other two were high in either *Nutrition* or *Physical Activity*.

#### **Needs:**

Averaged scores show the weakest area to be *Leadership* by a large margin. *Leadership* was more consistently the low score overall, and *Leadership- Environment* scores were very weak in all. For *Policy* scores, *Physical Activity* was the weak score in two of four.

*Leadership* scores are primarily related to questions about health promotion and wellness committees, as well as mission and participation in health related coalitions and partnerships. Many of these roles represent a new perspective for organizations, and with time, the importance of this type of leadership will likely be valued.

### **ii. Worksites**

Worksites included in the assessment were very diverse. The worksites studied employed anywhere from 20 to 999 people. These worksites were a combination of both public and private, nonprofit and for profit. In total four worksites were participants of the assessment.

#### **Strengths:**

Worksites showed their greatest strengths in *Chronic Disease Management*, with high scores consistent in both *Policy* and *Environment*. Other high scores were in *Nutrition* and *Tobacco Use* and no strong pattern emerged across *Policy* or *Environment*.

Needs:

Worksites had their lowest overall average score in *Physical Activity*, with an almost equally low average in *Leadership* and three of the four worksites had low *Environment* scores for *Leadership*. *Leadership* scores reflect many factors in the realm of workplace wellness and health promotion activities.

### **iii. Healthcare**

The healthcare facilities studied in the assessment were both private and public establishments. All except one small clinic were non-profit. The establishments ranged from having less than 20 to greater than 900 employees. These healthcare facilities do their best to provide care to all residents in the NCPHD; over 7,900 people are served by these healthcare facilities per month.

Strengths:

*Chronic Disease Management* emerged as a great strength within the healthcare sector. *Chronic Disease Management* was not only the highest amongst the averaged scores; individually, all six healthcare facilities had their highest *Environment* scores and four of six had their highest *Policy* scores in *Chronic Disease Management* as well. They also had high scores in *Nutrition-Environment*.

Needs:

The greatest weakness of these healthcare providers was *Physical Activity*, and this was quite a low average due to the extremely low score of *Policy* supporting physical activity. Questions in this part of the assessment include the promotion of stairwell use, assessment of patient's level of physical activity in routine office visits, as well as referral systems to help client's access resources or services for physical activity. Many small clinics do not have stairwells and very rural communities have few community-based resources, but some of these questions were not calculated into the scores, as a "not applicable" option was available for scoring.

### **iv. Schools**

The schools that participated in the assessments were public schools; most districts chose one school to participate in the evaluation. Selected school's enrollment varied from 117 to 440 students. The median household income within the districts ranged from \$35,430 to \$46,709. The districts varied, having between 1 to 5 schools in the district. Schools had higher scores across the board than any other institution assessed. This may be a reflection of the amount of regulations that schools must follow.

Strengths:

The highest average scores within the seven factors affecting chronic disease were in the category of *School District* and the category for *Tobacco*. The *School District* part of the assessment looked primarily at various regulations within the district and it spanned the other categories of *Physical Activity*, *Nutrition*, *Chronic Disease Management*, *Tobacco* and *Leadership*. The questions were pertinent to the position the school takes to support health in students. Thirty percent of the highest individual scores were for *School District* and 50% of high scores for *Tobacco Use*. There were many areas scoring 100% but there were also some low scores which brought down the overall average.

Needs:

The lowest average score within the seven factors assessed, for schools, was in the *After School* section and 40% had their lowest score in this area. This may be due to the fact that after school care is not the primary function of schools, and perhaps it is not as thoroughly regulated as other aspects the school offers. Other low scores were spread out with *Physical Activity* coming in as the second lowest score.

#### **v. Preface to Community Health Assessment Findings & Recommendations**

Community at Large reports are individualized for each of the three counties. Guidance from the CDC and State Healthy Communities staff deemed it inappropriate to average these results to create one single report for the health district. Each County received a separate stand alone report and assessment. While these assessments and reports occurred on a county by county basis, they have a great deal of commonality. Therefore, some paragraphs are duplicated in the three Communities at Large reports.

## **Wasco County, Community at Large:**

**Methods, Timing of Assessment:** This assessment was conducted during the spring of 2011; Allyson Smith, NCPHD Health Communities Coordinator, interviewed Sherry Holliday, Wasco County Commissioner; Scott Turnoy, Mid Columbia Economic Development District Mobility Manager; Dick Gassman, Senior Planner, City of The Dalles; and Mary Gale, Tobacco and Prevention and Education Coordinator, NCPHD. Statistics from US Census, Oregon Healthy Teens data and Behavioral Risk Factor Surveillance System (BRFSS) data were also used.

**Background:** Wasco County had a population of 25,213 in the 2010 census; over 61 % of these people are residents of The Dalles. The County's economy is based upon agriculture (primarily cherry orchards, wheat farming, & livestock ranching), lumber, manufacturing, electric power, transportation, and tourism.

### **Demographics and health indicators:**

The most recent census and economic data for Wasco Co. indicate 16.2% live in poverty and over 10% are unemployed. Approximately 16% of people over the age of 25 lack a high school diploma. Residents self report as almost 78% non-Hispanic white, 14.8% Hispanic, 4.4% American Indian/Alaska Native and very small percentages of other race/ethnicities. North Central Public Health District serves approximately double the percentage of Hispanic clients as compared to the percentage of Hispanics in the population as a whole. This may represent inaccuracy in census data due to non-participation in census by undocumented aliens as well as migrant workers. Large numbers of socially disadvantaged citizens are associated with poorer diet, greater use of tobacco, and poorer health outcomes.

The most recent county level Oregon Healthy Teens data from 2007/2008 for this region indicate 32% of 8<sup>th</sup> graders in the region are either overweight or obese compared to 26.1% Statewide. Obesity rates in childhood have tripled across the United States over the past 31 years. Obesity rates mirror a rise in the costs of healthcare.

Sixty-seven percent of regional 8<sup>th</sup> graders reported no PE attendance during the average week. Almost half reported less physical activity per week than recommended by the CDC. Data is in aggregate form, including Wasco, Sherman, Gilliam and Wheeler Counties. CDC recommendations in 2008 are for school aged children to have 60 minutes moderate to vigorous physical activity seven days per week, with at least three of those days being vigorous activity.

According to one study in Oregon, 34% of real per capita growth in health care spending was attributed directly to the rise of obesity in Oregon in 7 years (1998-2005). Medical care for obesity in the United States is estimated to be as high as \$187 billion per year.<sup>1</sup> We can make a real impact on our nation's economy if we all increase our physical activity and eat a healthy diet.

According to Oregon Healthy Teens data for 2007/2008, tobacco smoking is higher in our 8<sup>th</sup> graders than statewide (13% compared to less than 9%) as is smokeless tobacco use (almost 8%

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1. Sources: American Diabetes Association; [http://nwhf.org/images/files/Thorpe\\_Oregon\\_Obesity\\_Study.pdf](http://nwhf.org/images/files/Thorpe_Oregon_Obesity_Study.pdf) and Finkelstein et al., Annual medical spending attributable to obesity: payer and service-specific estimates. Health Affairs 28, no. 5 (2009): w822-w831

compared with 3.2%) which partly explains the higher tobacco related death rates (age adjusted rates 246.9 per 100,000 compared with 184.8 per 100,000 in Oregon).

**Strengths:** *Physical Activity* scores were highest of the five main target areas within the assessment, yet barely above average. Wasco County has a comprehensive land use plan in place, supporting physical activity in future development, as well as a Policy for Mixed Land Use. It is beyond the scope of this document to explain the link between land use planning and physical activity, but suffice it to say, comprehensive land use planning incorporates alternative modes of transportation. “Residents from communities with higher density, greater connectivity, and more land use mix report higher rates of walking/cycling for utilitarian purposes than low-density, poorly connected, and single land use neighborhoods.”

Public sports facilities and greenways are well supported. The Riverfront Trail, over many decades, has been developed thanks to a dedicated committee of residents who continue to establish this important feature that supports walking and biking. The county also has a network of parks. This network includes a small Parks and Recreation Department within the City of The Dalles, which serves the majority of county residents. *Nutrition* is supported in our community by a thriving summertime farmers market that has recently added a second day per week, increasing the opportunity to buy fresh locally grown foods. Farm stands also operate within the county. Both farmers markets and some farm stands accept WIC and SNAP farmers market vouchers. Breast feeding is well supported, as is the WIC program, thus providing some access to healthy foods.

**Weaknesses:** We have many opportunities for improvement in Wasco County based on assessment scores. There are high rates of chronic disease and obesity throughout the U.S and Wasco County is no exception. The CHANGE tool is a one-size-fits-all assessment, which in some respects does not adequately represent rural communities. Our lowest score by this tool was in *Policy for Nutrition* (below 40%). For instance, there are no strategies to insure that fresh produce is available to underserved neighborhoods; access to public transportation is a challenge here as in many smaller communities, making it more difficult for many people to access large grocery retailers where less processed food options are available. There is little to indicate that locally grown produce is being highlighted in our local restaurants. Smaller portion sizes are not yet on the radar, and there is no organized movement in the direction of policies such as menu labeling.

*Tobacco Use* scores from our community assessments do not reflect the tobacco problem well because the indoor clean air act gives all Oregon assessments a better score on this national test. Where the State Law does not apply (i.e. “all” tobacco use policies) we do not fare as well. Policies for all types of tobacco use across the board are weak. Smokeless tobacco is used widely in the rural and frontier communities. Tobacco exposure is the number one preventable cause of death in Wasco County.

## Sherman County, Community at Large

**Methods, timing of Assessment:** Allyson Smith, NCPHD Healthy Communities Coordinator, conducted interviews with Mike Smith, Sherman County Commissioner; Mary Gale, NCPHD Tobacco Prevention and Education Program Coordinator; and Scott Turnoy, Mobility Manager, Mid-Columbia Economic Development District in February of 2011. Natalie Wilkins interviewed Georgia Macnab, Sherman County Community Development Planning Director and Dee Lieuallen and Theresa Mobley, Sherman County Commission on Children and Families staff. Also used are Statistics from U.S. Census, the 2007-2009 Columbia Gorge Community Food Assessment, Oregon Healthy Teens Data, and Oregon Behavioral Risk Surveillance System (BRFSS) data.

**Background:** Sherman County had a population of 1,765 people in 2010; two thirds of these residents reside in the small towns of Moro, Wasco, Rufus, Grass Valley and Biggs Junction. Sherman County's economy is based on wheat, barley and cattle farming as well as tourism.

### **Demographics and health indicators:**

The most recent census and economic data for Sherman Co. indicate 16.7% of residents are living in poverty and over 8.5% are unemployed. Eleven percent of people over the age of 25 lack a high school diploma. Residents self report as 91.6% non-Hispanic white, 5.6% Hispanic, 1.6% American Indian/Alaska Native and very small percentages of other race/ethnicities. Large numbers of socially disadvantaged citizens are associated with poorer diet, greater use of tobacco, and ultimately poorer health outcomes.

The most recent county level Oregon Healthy Teens data (2007/2008) for this region indicated 32% of 8<sup>th</sup> graders in the region are either overweight or obese compared to 26.1% Statewide. Obesity rates in childhood have tripled across the United States over the past 31 years. Obesity rates mirror a rise in the costs of healthcare.

67% of regional 8<sup>th</sup> graders reported no PE attendance during the average week. Almost half reported less physical activity per week than is recommended by the CDC. Data is in aggregate form, including Wasco, Sherman, Gilliam and Wheeler Counties. CDC Recommendations in 2008 are for school aged children to have 60 minutes moderate to vigorous physical activity seven days per week, with at least three of those days being vigorous.

According to one study, 34% of real per capita growth in health care spending was directly attributed to the rise of obesity in Oregon in 7 years (1998-2005). Medical care for obesity in the United States is estimated to be as high as \$187 billion per year.<sup>2</sup> We can make a real impact on our nation's economy if we all increase our physical activity and eat a healthy diet.

According to Oregon Healthy Teens data for 2007/2008, tobacco smoking is higher in our local eighth graders than statewide (13% compared to less than 9%) as is smokeless tobacco use (almost 8% compared with 3.2%) which partly explains the higher tobacco related death rates (age adjusted rates 246.9 per 100,000 compared with 184.8 per 100,000 in Oregon).

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2. Sources: American Diabetes Association; [http://nwhf.org/images/files/Thorpe\\_Oregon\\_Obesity\\_Study.pdf](http://nwhf.org/images/files/Thorpe_Oregon_Obesity_Study.pdf) and Finkelstein et al., Annual medical spending attributable to obesity: payer and service-specific estimates. Health Affairs 28, no. 5 (2009): w822-w831

**Strengths:** *Physical Activity* scores were highest, at just over 50%. Sherman County permits some mixed land use. Perhaps this can be enhanced to support mixes of residential and commercial use, and facilitate all forms of transportation. The County also has a substantial network of parks for a county with less than 2000 residents. Some Sherman County towns have worked hard to offer residents amenities such as bike paths, cross walks and side-walks, as well as city parks. Moro is one such example. No matter how small, these improvements make physical activity inviting. Some of the parks are accessible to disabled citizens, making physical activity an option for a broader group of people. As grant funds become available, accessibility is upgraded.

It was reported that some of the markets allow local residents to share garden fresh produce in boxes placed at the check-out counters. This brings a few locally grown options to a community that is lacking a farmers market.

While there might be less access to health care, fitness clubs, farmers markets, and bike paths in a rural community, it is important to realize Sherman County has other unique qualities. The CHANGE assessment tool is not able to evaluate strengths such as rural quality of life. There are many intangibles that draw a person to choose the rural life style, including feelings of personal safety, a less stressful lifestyle, close knit communities and the natural environment.

**Weaknesses:** We have many opportunities for improvement in Sherman County based on assessment scores. There are high rates of chronic disease and obesity throughout the U.S and Sherman County is no exception. The CHANGE tool is a one-size-fits-all assessment, which in some respects does not adequately represent rural communities. Some factors would be difficult to achieve in any community of this size.

The lowest score by this assessment was in *Policy* to support *Nutrition* (below 30%). Healthy foods such as fresh fruits and vegetables are not as accessible as they could be. The low score was based on several indicators, including the following:

- Lack of strategies promoting healthy food and beverage options by food retailers (grocery stores, convenience stores etc.)
- Limited access to public transportation.
- Lack of policy to protect and encourage breast feeding.
- Menu labeling and smaller portion size policies have not yet been considered.
- Locally grown produce is not featured in local restaurants and food venues.
- WIC vouchers cannot be redeemed at farmers markets or farm stands within the County.
- Healthy food and beverage items may not be available in local eating establishments.
- Healthy foods and beverages may not be promoted by signage and placement or by pricing strategies in local eating establishments.

*Tobacco Use* scores from our community assessments do not reflect the tobacco problem well because the indoor clean air act gives all Oregon assessments a better score on this national test. Where the State Law does not apply (i.e. “all” tobacco use policies) we do not fare as well. Policies for all types of tobacco use across the board are weak. Smokeless tobacco is used widely in the rural and frontier communities. Tobacco exposure is still the number one preventable cause of death in Sherman County.

## **Gilliam County, Community at Large**

**Methods, timing of Assessment:** In April and May of 2011 Natalie Wilkins, contracted by NCPHD through North Central Education Service District, interviewed Kathryn Greiner, City Administrator for the City of Condon; Leanne Durfey, Gilliam County Court Administrator; Shannon Coppock, Gilliam County Fire Services Coordinator; and Teddy Fennern and Marla Davies, Gilliam County Commission on Children and Families. Additional sources of information include statistics from U.S. Census, the 2007-2009 Columbia Gorge Community Food Assessment, Oregon Healthy Teens Data, and Oregon Behavioral Risk Surveillance System (BRFSS) data.

**Background:** Gilliam County had a population of 1,871 in 2010 census. More than two thirds of county residents live in Arlington and Condon. Most other residents live in the sparsely populated countryside. Gilliam County is 1,223 square miles, with a population density of less than 2 persons per square mile. Gilliam County is bordered on the north by the Columbia River and on the west by the John Day River. Gilliam County's economy is agricultural, with the average farm size of 4,200 acres. Farms produce mainly wheat, barley and beef cattle. The two largest employers are subsidiaries of Waste Management Inc., which run waste disposal landfills outside of Arlington. Gilliam County is considered a rural frontier community because of the distance one must drive for many services.

**Demographics and health indicators:** In 2009, 13.3 % of Gilliam County residents lived below the poverty level. This percentage is just a little less than the State of Oregon and significantly less poverty than the other two counties to the west. Close to 12% of residents 25 years and older do not have a high school diploma. Residents self report as 92.2% non-Hispanic White, 4.7% report Hispanic ethnicity, and 1% report American Indian/Alaska Native. Other races and ethnicities are less than 1%. Oregon Healthy Teens data from 2007/2008 for this region indicate 32% of 8<sup>th</sup> graders in the region are either overweight or obese compared to 26.1% Statewide. Sixty-seven percent of regional 8<sup>th</sup> graders reported no PE attendance during the average week. Almost half reported less than 60 minutes of physical activity 5 days per week, which is the amount recommended by the CDC. The data is in aggregate form, including Wasco, Sherman, Gilliam and Wheeler Counties.

According to Oregon Healthy Teens data for 2007/2008, tobacco smoking is higher in this age group than statewide (13% compared to less than 9%) as is smokeless tobacco use (almost 8% compared with 3.2%) which partly explains the higher tobacco related death rates (Age adjusted rates 246.9 per 100,000 compared with 184.8 per 100,000 in Oregon.) *Tobacco Use* scores from our community assessments do not reflect this problem well because the indoor clean air act gives all Oregon assessments a better score on this national test. Where the State Law does not apply (i.e. "all" tobacco use policies) we do not fare as well. Policies for all types of tobacco use across the board are still weak. Smokeless tobacco is used widely in the rural and frontier communities. Tobacco exposure is the number one preventable cause of death in Gilliam County.

**Strengths:** *Physical Activity* scores were highest, at 58% for *Policy* and 58.82% for *Environment* of the various factors that impact health and the incidence of chronic disease. This community supports parks that offer opportunities for residents to be physically active, such as its Earl Snell Memorial Park in Arlington, and the Condon City Park. Places to run and play can be found on

the various school grounds as well. Public transportation, a well recognized factor in facilitating access to healthy foods and health services, exists for Gilliam County's citizens on a call-in basis and has limited fixed route services as well. Public safety is provided by police officers within each small town and the County Sheriff's Office. Gilliam County residents can thank a handful of dedicated activists for bringing a farmers market to Condon one day per week in the summer. This provides an opportunity for residents to buy locally grown food during the summer months.

While there might be less access to health care, fitness clubs, farmers markets, and bike paths in a rural community, it is important to realize Gilliam County has other unique qualities. The CHANGE assessment tool is not able to evaluate strengths such as rural quality of life. There are many intangibles that draw a person to choose the rural life style, including feelings of personal safety, a less stressful lifestyle, close knit communities and the natural environment.

**Weaknesses:** The lowest score by this tool was in *Leadership* (23.64% for *Leadership- Policy*; 30.91% for *Leadership- Environment*.) The assessment of *Leadership* factors that affect chronic disease include:

- How well budgets include financing for walking and biking amenities
- Shared use trails and recreation facilities
- Pedestrian and bicycle enhancements
- How leadership promotes and creates incentives for mixed land use (i.e. mixing residential development in commercial areas)
- Participation in public policy process to promote community changes that address chronic disease and its risk factors (e.g. poor nutrition, physical inactivity, tobacco use and exposure)
- Participation in community coalitions and partnerships to impact these risk factors

*Nutrition, Tobacco Use and Chronic Disease Management* scores were all low when *Policy* and *Environment* scores were averaged. Scores were lowest for *Policy* by approximately 10% in most of the sections which might indicate that policy should be addressed first and foremost.

We have many opportunities for improvement in Gilliam County based on assessment scores. There are high rates of chronic disease and obesity throughout the U.S and Gilliam County is no exception. The CHANGE tool is a one-size-fits-all assessment, which in some respects does not adequately represent rural communities. Some factors would be difficult to achieve in any community of this size.

Gilliam County lacks amenities that promote bicycle and foot transportation and much of this is due to the low population density. When interpreting scores, is helpful to consider that the indicators of chronic disease and obesity in our region and across Oregon, including tobacco use, are climbing.

## ***Key Findings***

Across the board, *Policy* scores were typically lower than *Environmental* scores, and *Leadership* averaged behind all other target areas. *Leadership* scores are primarily related to questions about health promotion and wellness committees, as well as the mission of each institution, and how their missions encompass the good health of the populations they touch. *Leadership*, from a Healthy Communities focus, also pertains to participation in health related coalitions and partnerships. Many of these roles represent a new perspective for organizations.

One notable finding of the Community Health Assessment and Group Evaluation (CHANGE) assessments was that school districts fared better than any other sector. Almost all of the schools have incorporated salad bars during all lunches, and many also feature fresh fruits. Existing policies and laws dictate certain minimum standards for schools, for example school lunch programs. This example demonstrates the limitations of the tool. School lunches are assessed by the degree to which they conform to USDA standards, and it has been asserted that these standards are too low.

A great deal was learned from conducting the assessment and the process brought awareness of new possibilities to the institutions that participated. Results were shared with individual participants. Individual scores reflect more relevant information than aggregate scores.

The assessment results point to a need to strengthen policy in our region and to help support stronger leadership in the journey to a healthier community.

**North Central Public Health District**  
 Healthy Communities Workgroup  
 Community Health Assessment and Group Evaluation (CHANGE)  
 2011 Results Snapshot

**Total Community Average Score (across all sectors): 54.91**

Sectors	Ave. Score	(Policy Av.)	(Env. Av.)
Community at Large: Wasco County	40.53	(39.0)	(42.06)
Community at Large: Sherman County	40.03	(35.95)	(44.11)
Community at Large: Gilliam County	46.42	(45.14)	(47.70)
Community Institution / Organization	55.88	(50.68)	(61.08)
Worksite	53.07	(49.42)	(57.53)
Healthcare	49.95	(37.29)	(62.61)
Schools	63.47	(55.23)	(71.71)
<b>Target Areas</b>	<b>Ave. Score</b>	<b>(Policy Av.)</b>	<b>(Env. Av.)</b>
Physical Activity	51.16	(43.84)	(58.47)
Nutrition	50.54	(43.44)	(57.64)
Tobacco Use	53.94	(49.81)	(58.05)
Chronic Disease Management	51.79	(46.89)	(56.69)
Leadership	43.09	(39.8)	(46.38)
District (Schools only)	71.2	(65.6)	(76.8)
After School (Schools Only)	51.0	(60)	(51)

	<b>LOW</b> 0-20%	21-40%	<b>MEDIUM</b> 41-60%	61-80%	<b>HIGH</b> 81-100%
Physical Activity			43.84	58.47E	
Nutrition			43.44P 57.64E		
Tobacco Use			49.81P 58.05E		
Chronic Disease Mgt.			46.89P 56.69E		
Leadership		39.80P	46.38E		
School District				65.6P 76.8E	
After School			42.0P 60.0E		

Little to no action being taken
High level action being taken

<b>Target Areas by Sector</b>	<b>Average Score</b>	<b>(Policy Av)</b>	<b>(Env. Av.)</b>
<b>Community at Large (Wasco County)</b>			
Physical Activity	56.3	56.72	55.88
Nutrition	40.09	37.1	43.08
Tobacco Use	44.0	42.0	46
Chronic Disease Management	44.44	44.44	44.44
Leadership	47.27	45.45	49.09
<b>Community at Large (Sherman County)</b>			
Physical Activity	50.98	50.98	50.98
Nutrition	35.48	29.03	41.94
Tobacco Use	37.0	34.0	40.0
Chronic Disease Management	35.56	35.56	35.56
Leadership	43.64	45.45	41.82
<b>Community at Large (Gilliam County)</b>			
Physical Activity	58.41	58.0	58.82
Nutrition	37.7	32.79	42.62
Tobacco Use	39.0	32.0	46.0
Chronic Disease Management	37.78	33.33	42.22
Leadership	27.28	23.64	30.91
<b>Community Institution/Organization</b>			
Physical Activity	53.42	42.81	64.02
Nutrition	64.36	56.75	71.97
Tobacco Use	73.63	71.25	76.0
Chronic Disease Management	50.51	45.09	55.93
Leadership	37.5	37.5	37.5
<b>Worksite</b>			
Physical Activity	40.56	33.57	47.55
Nutrition	58.83	52.1	65.57
Tobacco Use	61.75	57.45	66.06
Chronic Disease Management	63.92	62.83	65.0
Leadership	42.31	41.15	43.46
<b>Healthcare</b>			
Physical Activity	39.45	22.22	56.67
Nutrition	52.49	39.49	65.48
Tobacco Use	48.17	40.0	56.33
Chronic Disease Management	61.64	46.95	76.34
Leadership	47.99	37.77	58.21

<b>Schools</b>			
Physical Activity	59.0	42.6	75.4
Nutrition	64.8	56.8	72.8
Tobacco Use	74.0	72.0	76.0
Chronic Disease Management	68.67	60.0	77.34
Leadership	55.64	47.64	63.64
School District	71.2	65.6	76.8
After School	51.0	42.0	60.0

## **Change Tools Completed (22)**

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### **Community**

Wasco County  
 Sherman County  
 Gilliam County

### **Community Institutions/Organizations**

Opportunity Connections  
 Columbia Gorge Community College  
 Mid Columbia Children’s Council  
 Mid Columbia Center for Living

### **Worksites**

Wasco County  
 Mid-Columbia Medical Center  
 Mid Columbia Producers  
 Waste Management

### **Healthcare**

La Clinica del Carino (Federally Qualified Health Center)  
 Deschutes Rim Clinic (Rural Health Center)  
 Mid-Columbia Medical Center (Health System)  
 Moro Medical Center (Rural Health Center)  
 Condon Clinic (Rural Health Center)  
 Arlington Medical Center (Rural Health Center)

### **Schools**

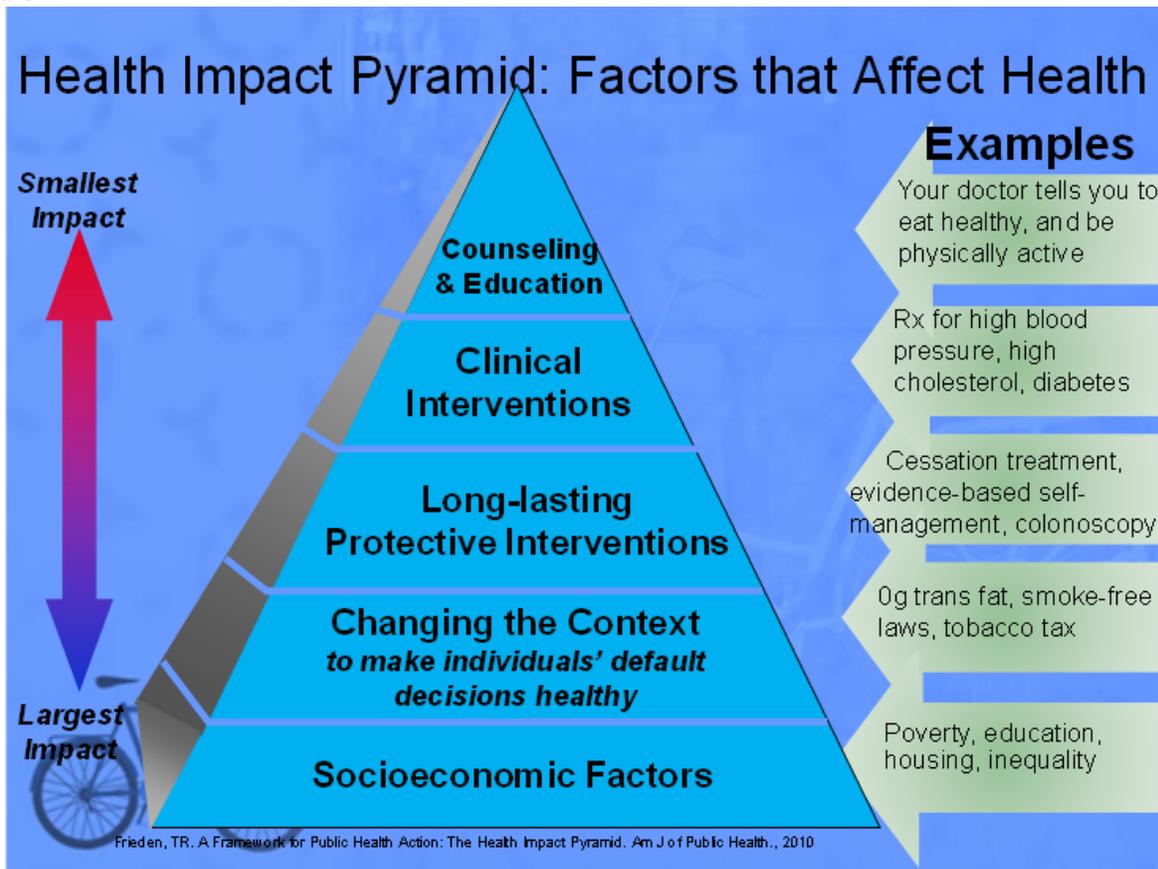
Chenoweth Elementary (The Dalles, North Wasco Co. School District 21)  
 South Wasco County High (Maupin, South Wasco District 1)  
 Dufur School (K-12, Dufur School District 29, Wasco Co.)  
 Sherman Elementary (Grass Valley, Sherman County School District)  
 Arlington School District (District wide assessment, Arlington, District 3, Gilliam County)

## SECTION III: REGIONAL COMMUNITY HEALTH PLANNING

### *Community Health Improvement Plan*

The results of the Community Health Assessment were presented to the Community Health Action and Response Team (CHART). The group determined priority areas to address in the Community Health Improvement Plan as a result of the findings made in the Community Health Assessment. Strategies were evaluated using the Health Impact Pyramid (below). Discussion centered on offering policy templates when appropriate, as well as chronic disease prevention and leadership training.

Figure 2



### Methodology: Identification and Prioritization of Focus Areas

To establish priority areas for the Community Health Improvement Plan, a vote was taken on focus areas from the Community Health Assessment. The vote was conducted in such a manner that each member of the CHART was allowed three votes to prioritize which topics should be addressed. All three votes could be used on one topic or spread over multiple topics. The results of the vote and some rationale are as follows:

Priority Area	Number of Votes
Physical Activity	19
Nutrition	13
Tobacco Prevention	4
Chronic Disease Management	1

#### I. Physical Activity

- Physical activity was chosen as a high priority because there is no formal lead agency responsible for physical activity planning and education region wide. In addition, policy regarding physical activity opportunities was lacking in assessed areas. Physical activity is likely to be a successful goal as it is applicable across all three Counties and improvements can be achieved that require little funding. Additionally, there is little to no cost to citizens to increase their levels of physical activity, so anyone could make personal changes regardless of economic status.

#### II. Nutrition

- Nutrition was chosen as the second highest priority because there is no formal lead agency responsible for nutrition planning and education region wide. Entities that work in nutrition education often work with a segmented portion of the population (i.e. seniors or pregnant and parenting women, children, etc.) as opposed to the population as a whole. In addition, policy regarding nutrition was lacking in assessed areas. Within the region, “food deserts” exist, where the public has little access to healthy foods such as fresh fruits and vegetables. This may be caused by longer distances to grocery stores, lack of transportation resources and limited healthy choices in centrally located convenience stores. North Wasco County School District #21 reports a significant increase in utilization of the summer meals program, indicating increased community need.

#### III. Tobacco Prevention

- Tobacco prevention received only 4 votes. Although tobacco use is a very serious threat to health in our community, North Central Public Health District has a robust Tobacco Prevention and Education Program. Additional efforts could be duplicative or non-productive. Data is available from the Oregon Health Division demonstrating that NCPHD’s Tobacco Prevention and Education Program, when funded, has made a positive impact on tobacco use and exposure in the region.

#### IV. Chronic Disease Management

- Chronic Disease Management received the lowest number of votes. Local community agencies, including the Area Agency on Aging, Mid-Columbia Council of Governments, La Clinica del Cariño, and Mid-Columbia Medical Center’s Center for Mind and Body Medicine, currently provide Chronic Disease Management to residents. In addition, both state and national health reform efforts include chronic disease management through the primary care medical home. Mid-Columbia Medical Center currently uses strategies such as the primary care medical home model to ensure high levels of service to patients suffering from chronic diseases.

#### *CHART Identified Communitywide Goals and Strategies*

Members of the CHART identified goals and strategies to be utilized by the community to improve health. Best and promising practice models should be explored, especially when seeking funding for implementation.

#### I. Physical Activity Strategies

Increase Physical Activity Levels of Regional Residents by:

<b>1. Creating a Culture of Walking and Biking</b>
a. Create Maps of detailed walks – levels, geographic locations, scenic, natural resources *
b. Lunch hour walking club
c. PSA’s/Media Campaign on Benefits of Walking
<b>2. Family /School – Based Programs</b>
a. Consider events like treasure hunts, geo-caching
b. End of trail event: kite-making
c. Start at school, teacher-guided expertise
d. Art walk/Music walk/jogathon/Mural walks with quizzes ( <i>music walk?</i> )
e. Parent focused walk-asset based
<b>3. Workplace Incentives</b>
a. Best parking place
b. Allow flex time to exercise: arriving to work 15 minutes later if exercising, and leaving 10 minutes earlier
c. Showers available in workplace
d. Foster break time group-walks within the workplace
e. Competitions between businesses/organizations with pedometers for most steps walked, or weight loss competitions
<b>4. Activities for the disabled</b>
a. Foster low impact exercises; i.e., swimming, weights
b. Support groups

\*(See Appendix I for Walkability Assessments)

## II. Nutrition Goals/Strategies

Improve nutrition of regional residents by:

<b>1. Strengthening Policy</b>
a. Establishing Wellness Committees
b. Search and Review Sample policies to share and build on. Equal options: suggest policy for organizations/workplaces that requires people who bring unhealthy foods “Junk” for sharing to bring equal amounts of healthy options
c. “Healthy Heroes” team who would educate leaders
d. Partner with OSU Extension Family and Community Health to promote healthy eating
<b>2. Encourage Development of Edible Landscapes</b>
a. Partner with Master Gardeners to educate about edible plants
b. Provide low cost/no cost seeds and starts
c. Media Marketing Campaign to promote edible landscapes: demarcating edible plants with “eat me” signs
<b>3. School Gardens/Community Gardens</b>
a. Businesses adopt-a-garden
b. Collaborate with county/city for land and water
c. Farms to schools and Schools to farms
d. FFA, Youth groups to continue school gardens through the summer months

## III. Tobacco Reduction Strategies

Reduce tobacco use and exposure to tobacco products in regional residents by:

<b>1. Reduce tobacco Exposure community wide</b>
a. Target education earlier and include smokeless tobacco, hookah etc.
b. Toughen tobacco laws and enforcement via citizen and community empowerment
<b>2. Revisit Assessment Participants to offer Quit Line Materials.=</b>
a. Train employers to increase their awareness of resources for their employees.
b. Convince employers to increase employee awareness of tobacco cessation benefits in their insurance plans, etc.
<b>3. Increase Awareness of Impacts of Tobacco -- All forms of Tobacco— (Health impacts, Social and Economic impacts as well)</b>
a. Explore the idea of group support model (similar to weight watchers, AA etc.)
b. Offer this option to community members who need the support of peers in cessation efforts.

#### **IV. Chronic Disease Management Strategies**

Reduce the incidence and impact of chronic diseases in regional residents by:

<b>1. Continue to promote and support strategies to reduce Chronic Disease incidence.</b>
<b>2. Formulate Templates/Suggestions for CD Awareness and Resources to share with organizations (Like Living Well with Chronic Diseases, Tobacco Quit Line, and resources they may have within their insurance packages like EAP, Weight loss resources, insurance benefits for tobacco cessation pharmaceuticals etc.)</b>

## ***NCPHD External Strategies for Community Health Improvement***

In addition to the larger, overarching regional goals chosen by the CHART, NCPHD will focus on the following four priorities. Staff time and resources has been and will continue to be dedicated to either lead or support efforts in these areas. Furthermore, NCPHD will continue to seek funding to support these four priorities.

<b>Priority: Support Health Behaviors that Promote Well-Being and Prevent Disease</b>
1. Reduce tobacco use and exposure to environmental tobacco smoke.
2. Increase access to and consumption of fresh fruits and vegetables.
3. Coordinate effective communication of tailored, accurate and actionable health information to Wasco, Sherman and Gilliam County residents across the lifespan.
4. Enhance Systems to support “Workplace Wellness” (“Healthy Behaviors”) programs.

The County Health Rankings model indicates that health behaviors account for 30% of health outcomes and the National Prevention Strategy recommends empowering people to make healthy choices as a method of improving community health<sup>3</sup>. The information gathered as part of the assessment, along with the evidence from County Health Rankings, emphasizes that personal health choices and behaviors are an important component in overall health and should be a key priority for the Community Health Improvement Plan.

### **Strategy 1: Reduce tobacco use and exposure to environmental tobacco smoke.**

Reducing use of tobacco and exposure to environmental tobacco smoke has a direct affect on chronic disease. Tobacco was identified as a key issue by the Community Health Assessment and Group Evaluation (CHANGE) group. As shown in Figures 13-14, tobacco use is a key health issue for residents of these three counties. According to the CDC, smoking causes certain types of cancer, bronchitis, emphysema, heart disease, and stroke<sup>4</sup>. Many people who do not use tobacco products are exposed to hazardous environmental tobacco smoke in many environments and therefore need to be protected through enhanced policies.

Appendices B and C detail some current tobacco prevention activities at the state and local level.

### **Strategy 2: Increase access to and consumption of fresh fruits and vegetables.**

The next strategy calls for increased access to and consumption of fresh fruits and vegetables. The Oregon Farm Direct Program has increased the availability of farmer’s market vouchers for

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<sup>3</sup> National Prevention Council, *National Prevention Strategy*, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011

<sup>4</sup> Centers for Disease Control and Prevention. Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 2000–2004. *Morbidity and Mortality Weekly Report* 2008;57(45):1226–8 (last accessed January 30, 2012)

WIC households, making access to healthy foods easier for a vulnerable section of the population.

As can be seen in Figure 20, obesity rates in Wasco, Sherman, and Gilliam Counties are above the state average. However, the County Health Rankings, Community Health Assessment, and Oregon Behavioral Risk Factor Surveillance System all report high levels of physical activity among residents of the health district. This suggests poor nutrition and lack of access to fresh fruits and vegetables may be underlying causes of this obesity disparity.

Increasing access to and consumption of fresh fruits and vegetables will help reduce obesity rates by providing residents with healthy options, particularly those residents in lower-income areas who do not have healthy options available in their neighborhoods. There is evidence that shows that access to supermarkets in an underserved area leads to an increased consumption of fruits and vegetables by adults<sup>5</sup>.

See Appendix D: Access to Healthy Foods for more information on the Oregon Farm Direct Program and highlights from the 2007-2010 Columbia River Gorge Community Food Assessment.

**Strategy 3: Coordinate effective communication of tailored, accurate and actionable health information to Wasco, Sherman and Gilliam County residents across the lifespan.**

Strategy 3 focuses on the coordination of effective communication, which has an impact on all barriers to community health. Health care and public health professionals are turning to the Internet and other technology-based methods of sharing information to reach as many people as possible.

However, not everyone has access to or is comfortable with these types of communications. The communication needs of all residents across the lifespan must be taken into account in order to ensure inclusion of all groups. We must continually advocate for equal access to information for all residents through promotion of technology-based sharing methods, outreach and education, and utilization of proven best practices when communicating with rural populations.

Healthy People 2020 reports that disparities in access to health information, services, and technology can result in lower usage rates of preventive services, less knowledge of chronic disease management, higher rates of hospitalization, and poorer reported health status.<sup>6</sup>

Appendix E discusses some strategies utilized by NCPHD to ensure effective communication in our region.

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<sup>5</sup> Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. MMWR 2009;58(7): 8

<sup>6</sup> <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=18>

**Strategy 4: Enhance systems to support “Workplace Wellness” (“Healthy Behaviors”) programs.**

We will support activities that enhance policy and environment around physical activity, nutrition, tobacco cessation and health education in the workplace. Research conclusively supports Workplace Wellness programs as an effective way to address health disparities:

- Comprehensive scientific reviews identified more than 370 peer-reviewed research studies showing that Workplace Wellness Programs improve health knowledge, health behaviors, and underlying health conditions.
- Research studies have demonstrated that lifestyle modification may frequently be more effective and cost-effective than health intervention in lowering morbidity and mortality.
- Scientific reviews indicate that Workplace Wellness Programs reduce health costs and rates of absenteeism and produce a positive return on investment.

Appendices C and G demonstrate local Workplace Wellness activities conducted or supported by NCPHD.



4. Wasco County Human Resources Department will offer a minimum of 2 best practice Workplace Wellness options to county employees.	a. Communications to employees; possibly a workplace wellness webpage	i. Yes or No	By end of June 2012	North Central Public Health District Tobacco Prevention and Education Coordinator (with Wasco County Wellness Committee)
5. Individualized results with recommendations will be shared with assessment participants.	a. Number of result summaries mailed	i. Tally	By End of September 2011	North Central Public Health District Accreditation Coordinator/ Clinical Programs Manager
6. Employers will choose to learn more about workplace wellness, tobacco policy or other strategies to address the needs discovered by the assessments.	a. Number of organizations who commit to making health supporting changes	i. Tally	End of October 2011	North Central Public Health District Accreditation Coordinator/ Clinical Programs Manager
7. Columbia Gorge Community College Students will support adoption of “tobacco free” policy.	a. Majority of students surveyed indicate support	i. Survey Monkey	End of June, 2012	North Central Public Health District Tobacco Prevention and Education Coordinator/ Healthy Communities Coordinator

***NCPHD Internal Strategies for Community Health Improvement***

The following program strategies were developed to help NCPHD improve community health and enhance delivery of services to clients. These strategies are based on input from local staff, clients and Public Health Division partners.

<p><b>1. Employ methods to decrease unintended pregnancy.</b></p>
<p><b><i>Goals for Gilliam, Sherman and Wasco Counties</i></b></p> <ol style="list-style-type: none"> <li>1. Train new public health nurse to see Maternity Case Management (MCM) clients one day per week.</li> <li>2. Decrease teen pregnancy rates.</li> <li>3. Implement Quality Improvement/Quality Assurance activities.</li> </ol>
<p><b><i>Activities</i></b></p> <ol style="list-style-type: none"> <li>1. Provide community education regarding teen pregnancy.</li> <li>2. Consult with community partners to identify solutions to decrease teen pregnancy rates.</li> </ol>
<p><b><i>Evaluation</i></b></p> <ol style="list-style-type: none"> <li>1. Identify and implement evaluation criteria.</li> </ol>
<p><b>2. Improve customer service to family planning clients.</b></p>
<p><b><i>Goals-for Gilliam, Sherman and Wasco Counties</i></b></p> <ol style="list-style-type: none"> <li>1. Improve and maintain the health status of women and men by providing reproductive health care services and assure that all residents have access to effective family planning methods.</li> <li>2. Assure continued high quality family planning and related preventative health services to improve overall individual and community health.</li> <li>3. Reduce risk of unintended pregnancy.</li> </ol>
<p><b><i>Activities</i></b></p> <ol style="list-style-type: none"> <li>1. Ensure adequate follow-up for abnormal pap smears through pap tracking system.</li> <li>2. Ensure adequate screening for Chlamydia following the screening guidelines from Region X Infertility Prevention Project.</li> <li>3. Give clients the widest possible choice of contraceptive methods from which to choose the method they are most likely to be able to use consistently and correctly over time. Methods include hormonal contraceptives, implantable contraceptives, intrauterine contraceptives, barrier methods, abstinence, natural family planning, and vasectomy.</li> <li>4. Provide access to emergency contraception (EC) for current and future needs for all clients.</li> <li>5. Evaluate texting of appointment reminders to clients and evaluate for improvement in missed appointments.</li> <li>6. Continue to provide reproductive health exams, contraceptive counseling visits and education.</li> <li>7. Maintain continuing education opportunities for all medical, nursing and support staff.</li> <li>8. Continue to share information with all clients about primary care providers, behavioral health providers and community health centers in the area to promote access to health services that are not available in our clinic.</li> </ol>
<p><b><i>Evaluation</i></b></p> <ol style="list-style-type: none"> <li>1. Review Netsmart Insight data.</li> <li>2. Conduct monthly chart audits.</li> </ol>

Coalition training was held on July 19, 2011 to help address the regional need for leadership development. In November 2011, NCPHD sponsored Quality Improvement Training and invited members of the CHART to participate.

### *Update on Past Strategies*

#### **Communitywide Strategies for Health Improvement**

NCPHD is still working to strengthen coalition participation in our region. We have been actively engaged with a variety of community partners to improve health over the past few years.

NCPHD had funding from Northwest Health Foundation to conduct coalition work aimed at improving physical activity and nutrition. This funded the Physical Activity and Nutrition Coalition, or PANC, which brought local public health together with partners from Mid-Columbia Medical Center, School District 21, school nursing, The Dalles Cycling Assn., and health promoters from The Next Door and La Clinica del Cariño. The grant period for PANC ended in 2010. Projects supported during the funding period included the ‘Go Red for Women’ event every February, Walk and Bike to School Day in the fall, and promotion of The Dalles Farmers Market and the Utopia Community Garden.

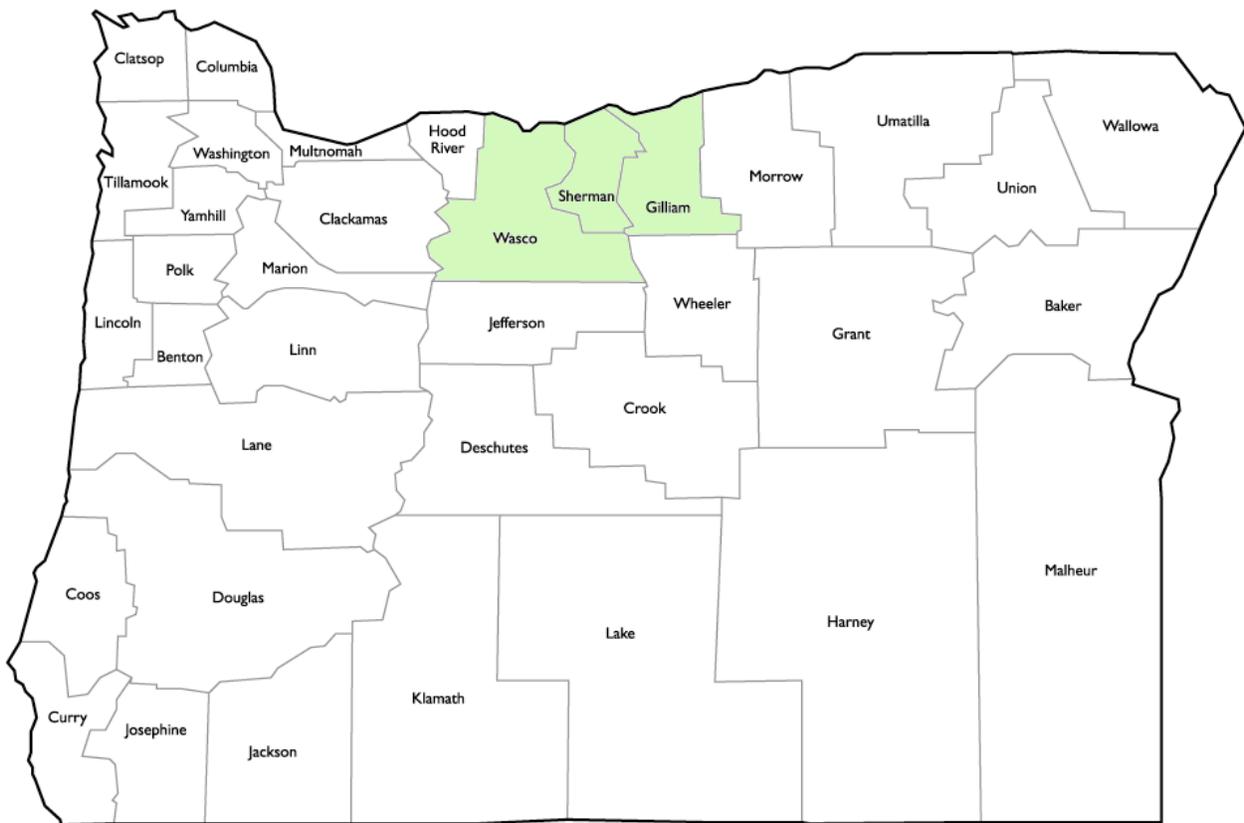
We have worked to bring Living Well with Chronic Conditions to the region. Additionally, we have partnered with City and County Planning Departments in Health Impact Assessment (HIA) training in the fall of 2009. We were awarded an HIA mini-grant from the Oregon Department of Human Services to conduct a walkability study within the boundaries of Chenoweth Elementary School in The Dalles. More recently, a grant from the Northwest Health Foundation to conduct a Wellness & Walkability project in that same school district, extending walkability studies to the remaining two grade school boundaries in District 21. Work to revise the school wellness policy and introducing Workplace Wellness to the district was also initiated.

## SECTION IV: NCPHD DEMOGRAPHICS

### Overview

North Central Public Health District (NCPHD) is the only three-county health district in Oregon, serving Wasco, Sherman and Gilliam counties. Serving these primarily rural counties as a region allows NCPHD to coordinate efforts and pool resources, facilitating higher quality care and more efficient service delivery for its clients. Wasco, Sherman and Gilliam counties have a combined population of approximately 28,000 residents and cover more than 4,400 square miles.

Figure 3



*NCPHD provides services to Wasco, Sherman, and Gilliam Counties located in the mid-Columbia River Gorge<sup>7</sup>.*

Wasco County is the largest county within the health district at 2,381 square miles, while Sherman and Gilliam both have land areas less than 1,205 square miles. Wasco County also has the largest population with 24,280 residents, while Sherman and Gilliam have 1,825 and 1,885 residents respectively. Wasco County has 6 incorporated cities: Antelope, Dufur, Maupin, Mosier, Shaniko and The Dalles. Sherman County has 4 incorporated cities: Grass Valley, Moro, Rufus, and Wasco. Gilliam County has 3 incorporated cities: Arlington, Condon and Lonerock. In addition to the 13 incorporated cities within the health district, there are numerous smaller communities scattered throughout the countryside. The largest population center in the health district is The Dalles, in Wasco County, and this is where NCPHD's main office is located.

<sup>7</sup> NCPHD Project Public Health Ready

Figure 4

Population, 2010				
	Oregon	Wasco County	Sherman County	Gilliam County
Population	3,831,074	25,213	1,765	1,871

Source: US Census Bureau State and County QuickFacts, 2010<sup>8</sup>

Figure 5

Projected Population Growth, 2010-2040				
	Oregon	Wasco County	Sherman County	Gilliam County
2010 Population	3,831,074	25,213	1,765	1,871
2040 Projected Population	5,425,408	28,653	2,165	2,464
Projected Population Growth	42%	14%	23%	32%

Source: US Census Bureau State and County QuickFacts, 2010<sup>7</sup>; Oregon Office of Economic Analysis<sup>9</sup>

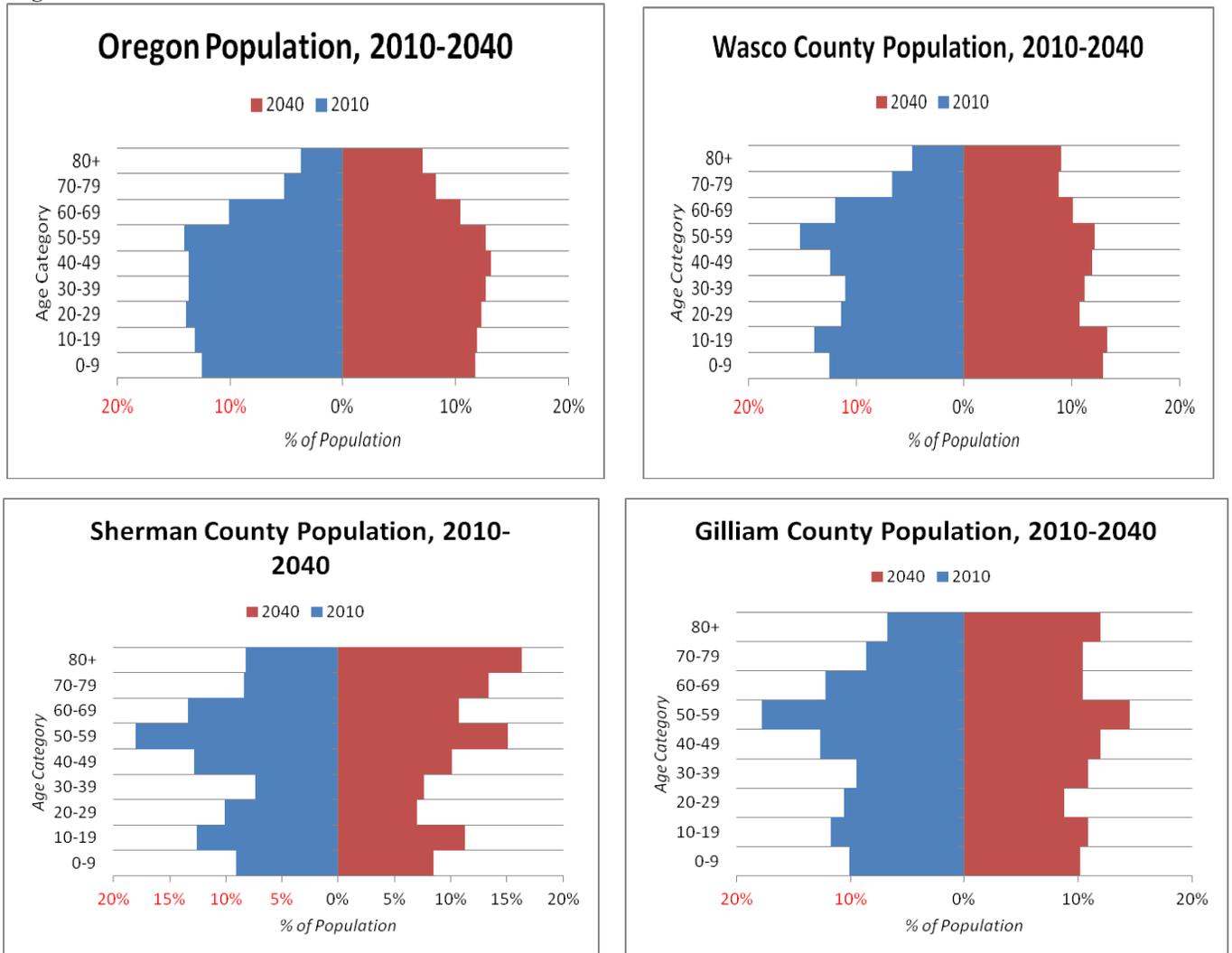
<sup>8</sup> <http://quickfacts.census.gov/qfd/states/41000.html>

<sup>9</sup> <http://www.oea.das.state.or.us/DAS/OEA/demographic.shtml>

## Population Age

Wasco, Sherman, and Gilliam’s population growth rates are projected to be lower than the state growth rate, with Gilliam County experiencing the highest population growth within these three counties. Figure 6 compares the age structures of these four areas in 2010 versus 2040 projections.

Figure 6



Source: Oregon Office of Economic Analysis<sup>9</sup>

The blue side of the graph shows the current (2010) age distribution in each county and the state. The red side of the graph shows predicted population distribution by age category in 2040. Projections of population changes can help health agencies anticipate changes in service utilization and disease profile in a population over time.

The proportion of adults 70+ increases in each graph, with Sherman County experiencing the greatest increase in elderly population. Oregon’s overall distribution remains very similar to the

2010 distribution, with a slight increase in the population 70+ and a slight decrease in the age categories under 50.

Wasco County’s proportion of older adults also increases, and the highest concentration of individuals shifts from adults 50-59 in 2010 to children 19 and younger in 2040. This is an interesting distribution because the oldest and youngest segments of a population have very different health needs. These two population groups will both become more prevalent. Sherman County, on the other hand, has a steadily aging population. The distribution changes substantially from being concentrated in adults 50-59 to having the highest percentage of adults 80+. The percentage of children 10-19 is also projected to increase in this county.

Gilliam County’s population distribution remains roughly the same, with a slight increase in adults 80+ and a decrease in the proportion of adults 50-59. These population age distribution shifts have implications on the most necessary services and most prevalent diseases in the health district, currently and in the future.

***Race and Ethnicity***

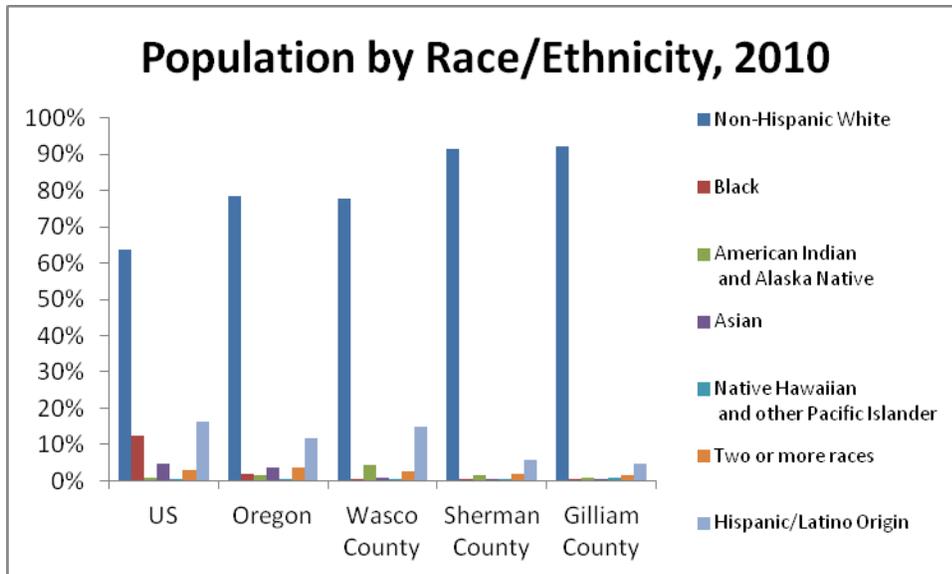
The demographics of the population vary somewhat depending on your location. Figure 7 below shows a comparison between the three Counties, Oregon, and the Unites States. This data represents the race/ethnicity of the designated populated area. White persons make up the largest population group in all three counties, with persons of Hispanic or Latino origin constituting the second largest population group. This data parallels the demographic data for both Oregon and the Unites States.

Figure 7

<b>Population by Race/Ethnicity, 2010</b>					
	<b>US</b>	<b>Oregon</b>	<b>Wasco County</b>	<b>Sherman County</b>	<b>Gilliam County</b>
Non-Hispanic White	63.7%	78.5%	77.6%	91.6%	92.2%
Black	12.6%	1.8%	0.4%	0.2%	0.2%
American Indian and Alaska Native	0.9%	1.4%	4.4%	1.6%	1.0%
Asian	4.8%	3.7%	0.8%	0.2%	0.2%
Native Hawaiian and other Pacific Islander	0.2%	0.3%	0.6%	0.1%	0.7%
Two or more races	2.9%	3.8%	2.5%	1.8%	1.4%
Hispanic/Latino Origin	16.3%	11.7%	14.8%	5.6%	4.7%

Source: US Census Bureau State and County QuickFacts, 2010<sup>10</sup>

<sup>10</sup> <http://quickfacts.census.gov/qfd/states/41000.html>



Source: US Census Bureau State and County QuickFacts, 2010<sup>11</sup>

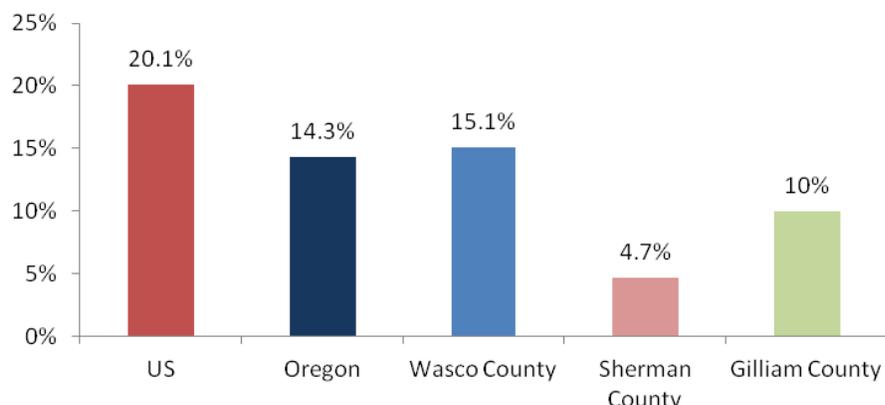
### Language

NCPHD works to provide all information in both English and Spanish. Many NCPHD employees are bilingual, allowing clients greater access to services. Equal access to services and care helps prevent or eliminate barriers from forming as a result of language differences. These barriers can create disparities in healthcare, which NCPHD actively strives to eliminate.

Wasco County has a higher percentage of people speaking a language other than English in the home than Gilliam and Sherman Counties, as noted in Figure 6 below. Providing access to information in multiple languages is critical to successful community outreach. This helps community members to be empowered, stay more informed and feel more comfortable. Community outreach plays a pivotal role in making our health department successful.

Figure 8

### Language Other Than English Spoken at Home, 2006-2010



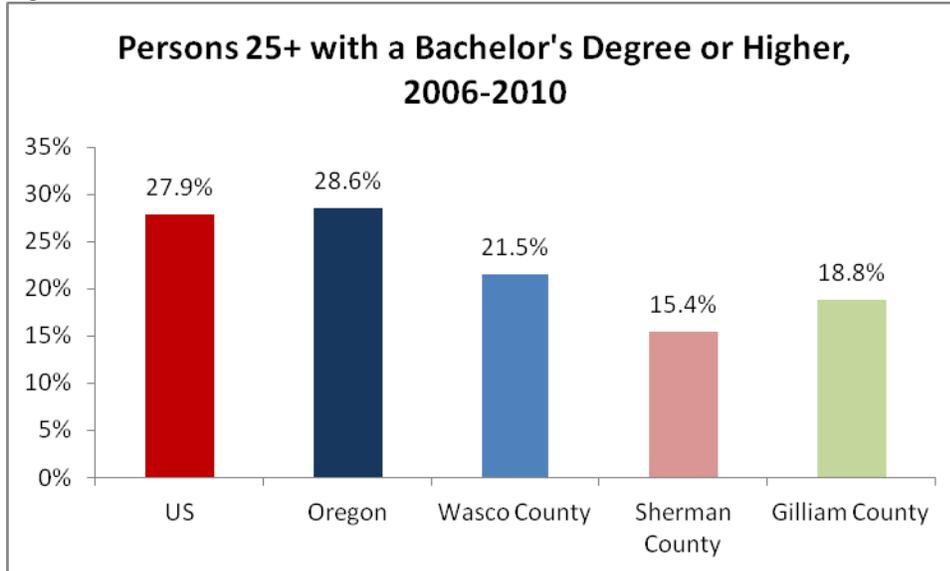
Source: U.S. Census Bureau State and County Quick Facts, 2010<sup>12</sup>

<sup>11</sup> <http://quickfacts.census.gov/qfd/states/41000.html>

## Education

In Oregon, about 39 percent of the State’s nearly 2.1 million working-age adults (25-64 years old) hold at least a two-year degree, according to 2008 Census data. This compares to a national average of approximately 38 percent.

Figure 9



Source: Us Census Bureau State and County QuickFacts, 2010<sup>13</sup>

### Percentage of Oregon Adults (25+) with at Least a Four Year Degree, 2006-2010:

Benton	47.9	Jackson	24.4	Polk	28.1
Clackamas	31.4	Jefferson	15.9	Tillamook	20
Clatsop	21.6	Josephine	16.5	Umatilla	14.6
Columbia	16.8	Klamath	18.1	Union	20.3
Coos	18.3	Lane	27.7	Wasco	21.5
Crook	15.4	Lincoln	23.8	Washington	38.9
Curry	18.5	Linn	16.3	Yamhill	23.0
Deschutes	29.1	Malheur	13.8	Sherman	15.4
Douglas	15.5	Marion	20.9	Gilliam	13.8
Hood River	25.9	Multnomah	37.5	<b>Oregon</b>	<b>28.6</b>

Source: U.S. Census Bureau State and County QuickFacts, 2006-2010<sup>14</sup>

<sup>12</sup> U.S. Census Bureau: State and County Quick Facts. <http://quickfacts.census.gov/qfd/states/41000.html>

<sup>13</sup> U.S. Census Bureau: State and County Quick Facts. <http://quickfacts.census.gov/qfd/states/41000.html>

<sup>14</sup> <http://quickfacts.census.gov/qfd/states/41000.html>

### ***Income***

Per capita income across all three counties is approximately 17% lower than the State average. Yet rural residents often pay higher prices for groceries and gas while often driving more miles for work and other services. In Oregon, 13.5 % of citizens live below the poverty level, whereas in Wasco, Sherman and Gilliam Counties, 17.1%, 15.5% and 11.1% respectively are below the poverty level.

### ***Migrant Workers***

Many factors restrict migrant and seasonal farm workers' access to health care. These factors include a lack of knowledge of local resources, transportation challenges, limited English proficiency or being non-English speaking, limited economic resources, and cultural, legal and political barriers. Additionally, a great percentage of migrant workers and their children are uninsured.

Seasonal migrant workers are an important population for North Central Public Health District to serve. An estimated total of approximately 7,500 seasonal workers are employed in Wasco, Sherman and Gilliam counties, remaining in the area throughout the summer harvest months. Considering that the year-round population is slightly more than 24,000 people, a surge of nearly 1/3 the population places extra demands on the Health District<sup>15</sup>.

### ***Homeless***

In the three-county area served by NCPHD, many people live below the poverty level. Many are homeless according to the Federal definition of homelessness. Indigent populations struggle with finding personal shelter, food, safety and security. As a result, they experience a significant lack of access to other resources including physical and mental health services, transportation, communication, public information, education and access to the media. Furthermore, they experience an increased risk of suffering from violence and abuse. In a 2011 survey it was determined that there are over 400 homeless in the NCPHD region<sup>16</sup>. This number includes those who are chronically homeless, unsheltered, in emergency shelters or in transitional housing. The homeless population requires special planning for emergency situations, especially winter storms and other hazards.

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<sup>15</sup> NCPHD Project Public Health Ready

<sup>16</sup> Oregon Housing and Community Services: Point in Time Homeless Count 2011  
[http://cms.oregon.egov.com/OHCS/Pages/RA\\_2011\\_Point\\_In\\_Time\\_Homeless\\_Counts.aspx](http://cms.oregon.egov.com/OHCS/Pages/RA_2011_Point_In_Time_Homeless_Counts.aspx)



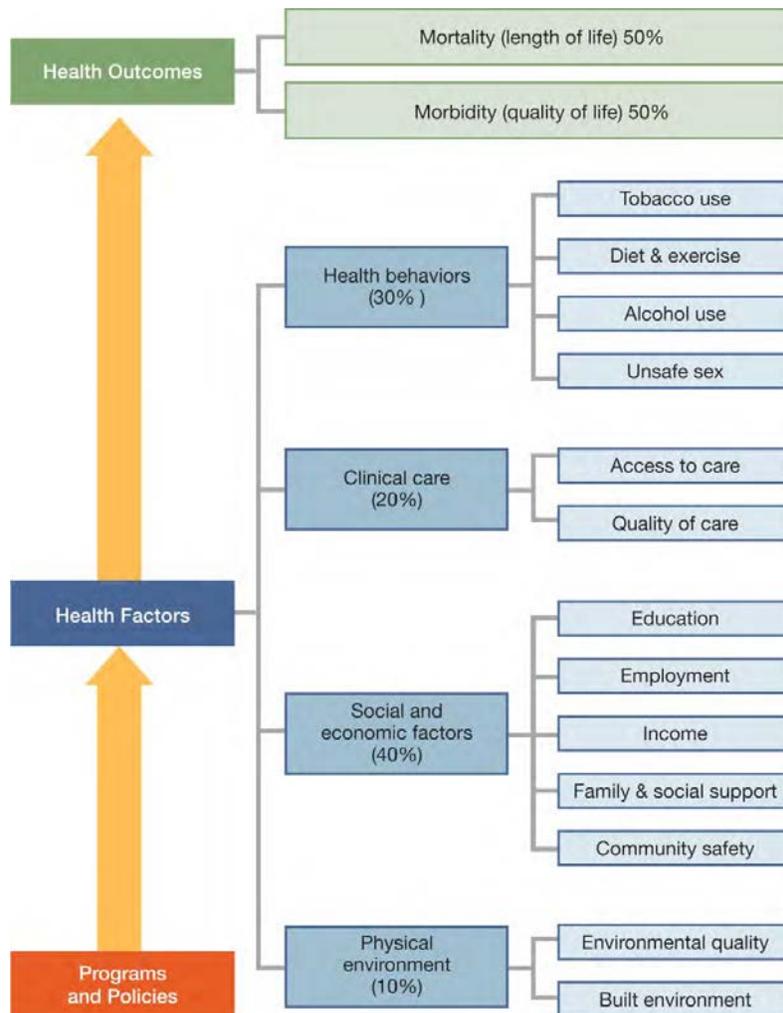
## SECTION V: COUNTY HEALTH RANKINGS

In 2009, the Robert Wood Johnson Foundation collaborated with the University of Wisconsin Population Health Institute to create health reports for all counties in all 50 states. Called the County Health Rankings, these reports allow counties to be compared, or ranked, relative to other counties within each state. The University of Wisconsin Population Health Institute developed a model for measuring health that includes several determinants of health including:

- Physical Environment
- Social and Economic Factors
- Clinical Care
- Health Behaviors

Figure 10 shows how the various determinants of health, combined with programs and policies, lead to certain health outcomes, measured by mortality (how long people live) and morbidity (how healthy people feel when alive).<sup>17</sup>

Figure 10



<sup>17</sup> <http://www.countyhealthrankings.org/oregon>

With this model, a full 50% of health outcomes come from social and economic factors and the physical environment, two areas that were not traditionally considered when assessing overall health. Looking at Figure 8, health behaviors like tobacco use, alcohol consumption, and diet and exercise can be directly related to the physical environment through land use policies and zoning. For example, by increasing the number of outlets that offer fresh fruits and vegetables, the healthy choice is the easier choice than if there is limited access to fresh produce in a neighborhood. People living in food deserts cannot easily find healthy food options and often choose the unhealthy, accessible food prevalent in their community. To decrease tobacco and alcohol use, the density of outlets that offer tobacco and alcohol can be limited, making it more difficult to access these products which are known to have a detrimental effect on health.

Housing infrastructure plays a key role in the health of residents as well. Providing affordable housing for all residents allows many people to live in healthier communities and lower their risk for health problems caused by the environment. Residents who live in substandard housing have an increased risk of being exposed to pollution, which can lead to health problems like asthma. In addition, homes built before 1970 may have lead paint, exposing families to lead. Lead exposure has negative impacts on the growth and development of young children and can be prevented by a combined effort of public health, the medical community, parents, landlords, contractors and local decision makers.

Land use and transportation planners can plan walkable neighborhoods which provide residents with the necessary amenities (sidewalks, access to trails, complete streets) to incorporate exercise into a daily routine which leads to better health outcomes. Access to parks and recreational facilities also make physical activity more convenient. These factors are influenced by land use and transportation planning policies and ordinances.

Low socioeconomic status is associated with an increased risk for many diseases, including cardiovascular disease, arthritis, diabetes, chronic respiratory diseases, and cervical cancer as well as frequent mental distress<sup>18</sup>.

NCPHD is able to analyze the information collected during a health assessment and compare it by factors like age, income, race/ethnicity, and educational attainment. Looking at these factors can help expose other disparities in the community and allow the entire health system to focus on where help is needed most.

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<sup>18</sup> Brennan Ramirez LK, Baker EA, Metzler M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, CDC

## Wasco County Health Rankings\*

Figure 11

<b>Wasco County Health Rankings**, 2010-11</b>			
	2010 Ranking	2011 Ranking	2012 Ranking
<b>Health Outcomes</b>			
Summary	8	9	13
Mortality	20	14	22
Morbidity	3	4	4
<b>Health Factors</b>			
Summary	16	16	12
Health Behaviors	22	27	19
Clinical Care	14	15	19
Social & Economic Factors	14	14	11
Physical Environment	12	7	16

Source: Oregon County Health Rankings<sup>19</sup>

\* Sherman and Gilliam Counties are not ranked due to small size of population.

\*\*Out of 33 Oregon Counties ranked

NB: Specific measures vary by year. For further description of measures, data sources, and years of data refer to County Health Rankings<sup>11</sup>

Thirty-three Oregon Counties are ranked annually through the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute County Health Rankings. These ranks include measures such as premature death, adult smoking, adult obesity, teen birth rate, educational attainment, physical activity, air quality, and access to healthy foods and recreational facilities, among others. This ranking methodology allows NCPHD to compare its performance on various health outcomes and factors over time, and to performance of other counties in the state.

<sup>19</sup> [www.countyhealthrankings.org/oregon](http://www.countyhealthrankings.org/oregon)



## SECTION VI: STATE AND LOCAL HEALTH DATA

The following data supports the Community Health Assessment and Community Health Improvement Plan. Not all data is available for every county individually due to population size. Data is reported per county when available.

### *Leading Causes of Death in Oregon*

Oregon has the 38<sup>th</sup> highest death rate from cardiovascular disease in the country. \*\*

• Cancer is the No. 1 killer in Oregon*	• 7,487 people in Oregon died of cancer in 2009*
• Heart disease is the No. 2 killer in Oregon*	• Stroke is the No. 4 killer in Oregon*
• 6,262 people in Oregon died of heart disease in 2009*	• 1,912 people in Oregon died of stroke in 2009*

### *Heart Disease and Stroke Risk Factors in Oregon*

	Oregon	US
Adults who are current smokers	15.1%	17.3%
Adults who participated in a physical activity in the last month	82.5%	76%
Adults who are overweight or obese+	60.9%	63.8%
Adults who have been told that they have had a heart attack	3.5%	4.2%
Adults who have been told that they have had a stroke	2.5%	2.6%
Adults who have been told that they have angina or coronary heart disease	3.6%	4.1%
Population of adults (16-64) who do not have any kind of health care coverage	80%	82.1%
High school students who are obese++	N/A	12%

Source: Oregon State Fact Sheet, American Heart Association, American Stroke Association<sup>20</sup>

\* List includes Puerto Rico and D.C. Based on total number of deaths in 2009. Centers for Disease Control and Prevention. WIWQARS Leading Cause of Death Reports, 2009.

\*\* Based on 2007 age-adjusted death rates. American Heart Association. Heart Disease and Stroke Statistics: 2012 Update. A Report from the American Heart Association. Circulation, Assessed January 20, 2012

+ Overweight is defined as having a body mass index (BMI) of 25.0-29.9. Obese is defined as having a body mass index of 30.0 or more.

++ Student who were  $\geq$  95<sup>th</sup> percentile for body mass index, by age and sex. Center for Disease Control and Prevention, Your risk Behavior Surveillance system, 2009.

### *Adult Tobacco Smokers, 2006-2009*

Oregon	Gilliam/Wheeler	Wasco/Sherman
17.5%	29.6%*	22.1%

\*Due to small sample size, this number may be statistically unreliable; interpret with caution.

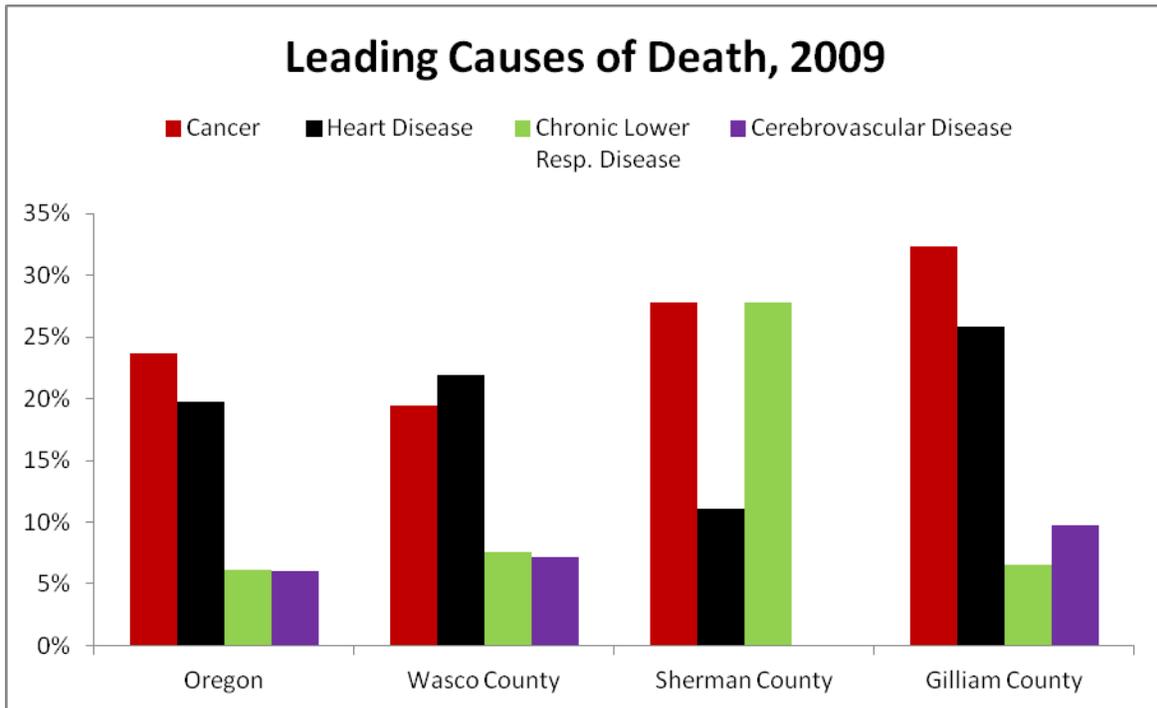
Source: Oregon Health Authority Tobacco Prevention and Education Program: Oregon Tobacco Facts and Laws, 2011<sup>21</sup>

<sup>20</sup> Oregon State Fact Sheet,

[http://www.heart.org/idc/groups/heartpublic/@wcm/@adv/documents/downloadable/ucm\\_307208.pdf](http://www.heart.org/idc/groups/heartpublic/@wcm/@adv/documents/downloadable/ucm_307208.pdf)

**Leading Causes of Death 2009 per County**

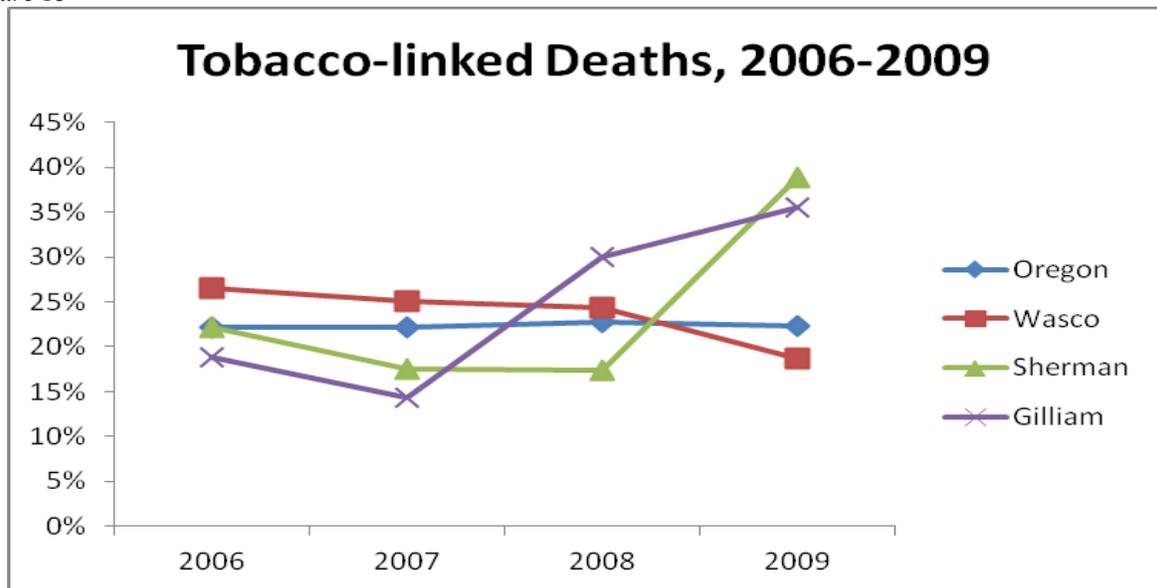
Figure 12



Source: Leading Causes of Death by County of Residence, Oregon, 2009<sup>22</sup>

**Tobacco-Linked Death, 2006-2009 per County**

Figure 13



Source: Oregon Tobacco Facts and Law, 2011<sup>23</sup>

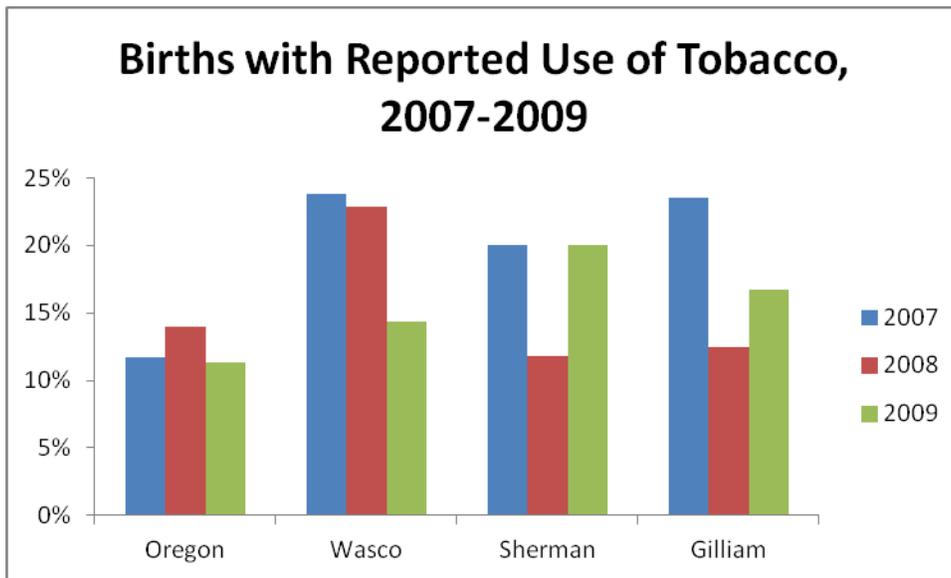
<sup>21</sup> <http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx>

<sup>22</sup> Leading Causes of Death by County of Residence, Oregon, 2009, [http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/CountyDataBook/cdb2009/Documents/tbl18\\_09.pdf](http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/CountyDataBook/cdb2009/Documents/tbl18_09.pdf)

Figure 14

Births with Reported Use of Tobacco			
	2007	2008	2009
Oregon	11.7%	14%	11.3%
Wasco	23.8%	22.9%	14.4%
Sherman	20%	11.8%	20%
Gilliam	23.5%	12.5%	16.7%

Source: Oregon Vital Statistics County Data<sup>24</sup>



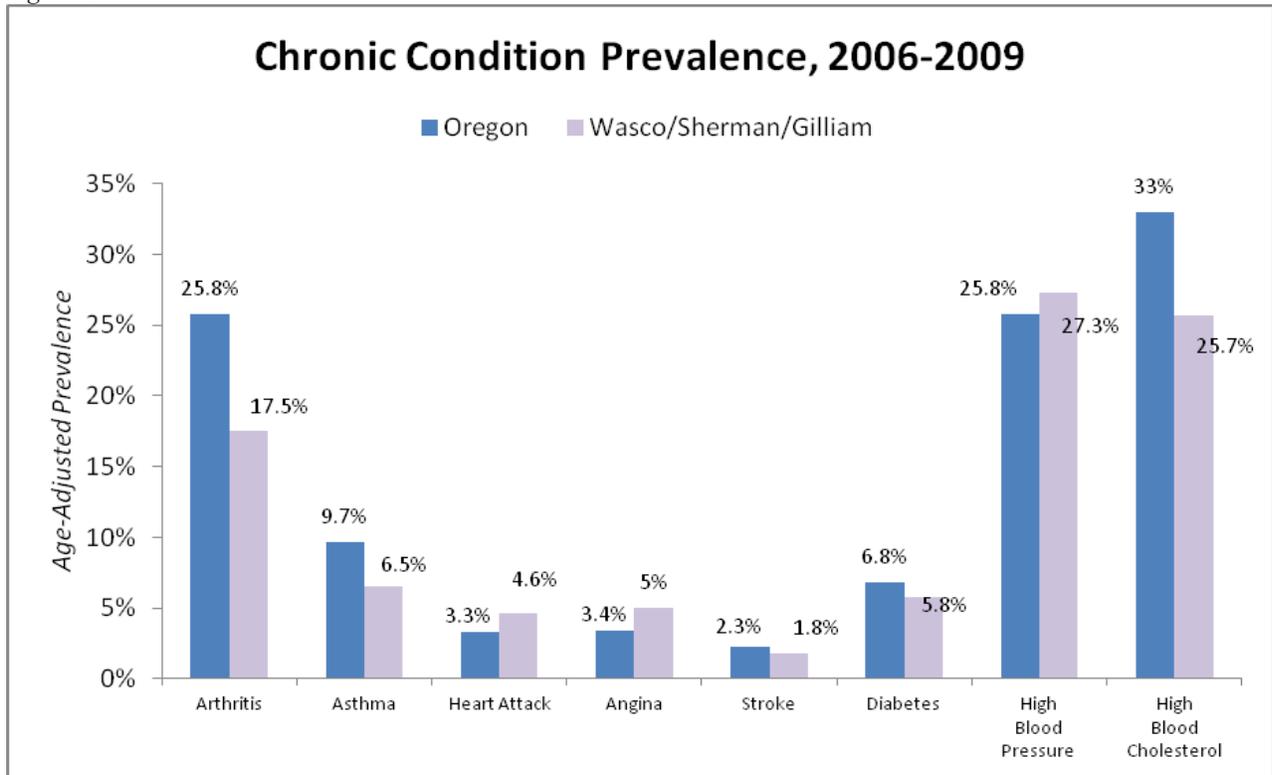
<sup>23</sup> Oregon Tobacco Facts and Law, January 2011,

<http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tobfacts.pdf>

<sup>24</sup> <http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/CountyDataBook/Pages/cdb.aspx>

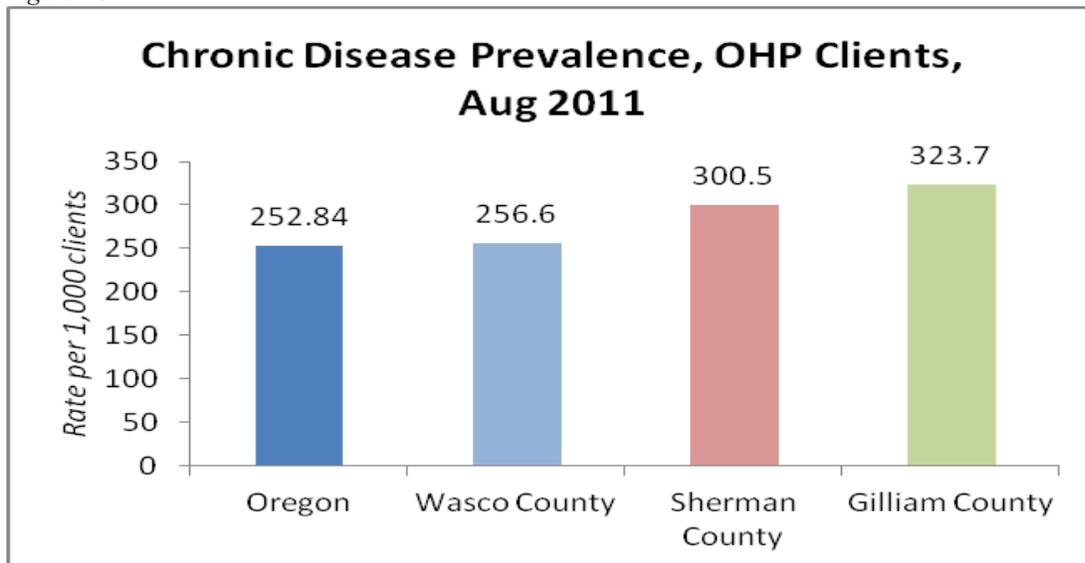
## Chronic Conditions

Figure 15



Source: Oregon Health Authority Chronic Disease Data and Publications<sup>25</sup>

Figure 16

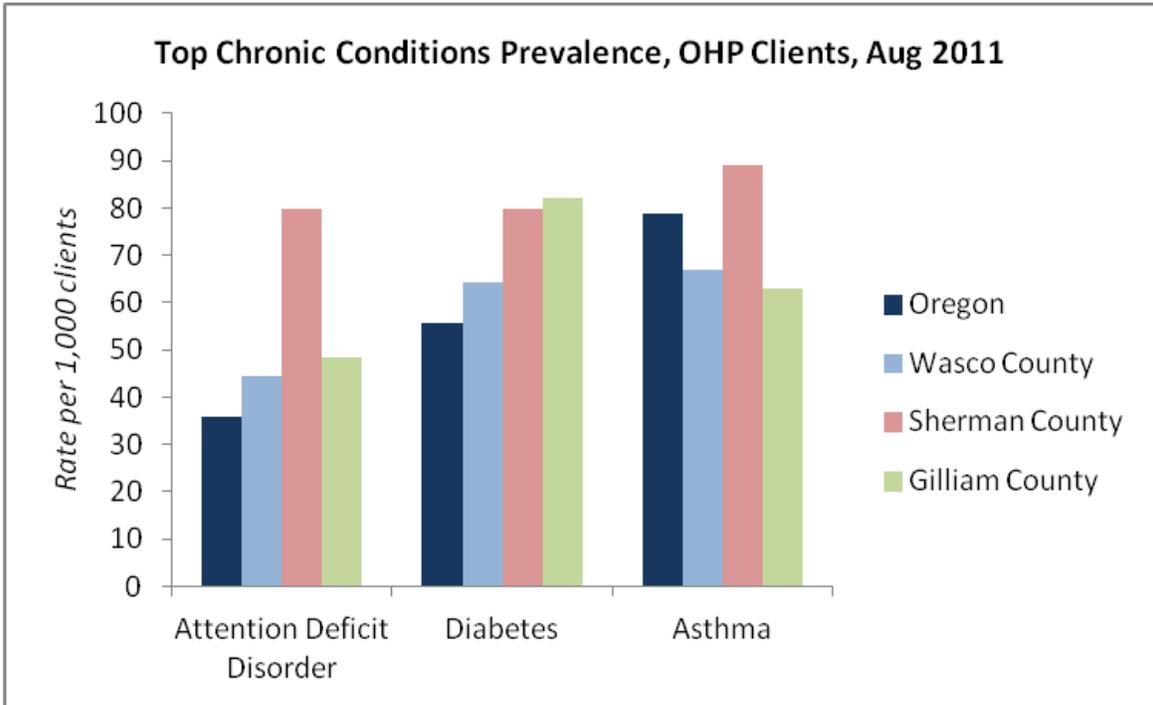


Source: OHP Data and Reports<sup>26</sup>

<sup>25</sup> Oregon Health Authority Chronic Disease Data and Publications, <http://public.health.oregon.gov/diseasesconditions/chronicdisease/pages/pubs.aspx>

<sup>26</sup> OHP Data and Reports, [http://www.oregon.gov/OHA/healthplan/data\\_pubs/main.shtml](http://www.oregon.gov/OHA/healthplan/data_pubs/main.shtml)

Figure 17



Source: OHP Data and Reports<sup>27</sup>

<sup>27</sup> Oregon Health Authority Chronic Disease Data and Publications, <http://public.health.oregon.gov/diseasesconditions/chronicdisease/pages/pubs.aspx>

**Communicable Disease**

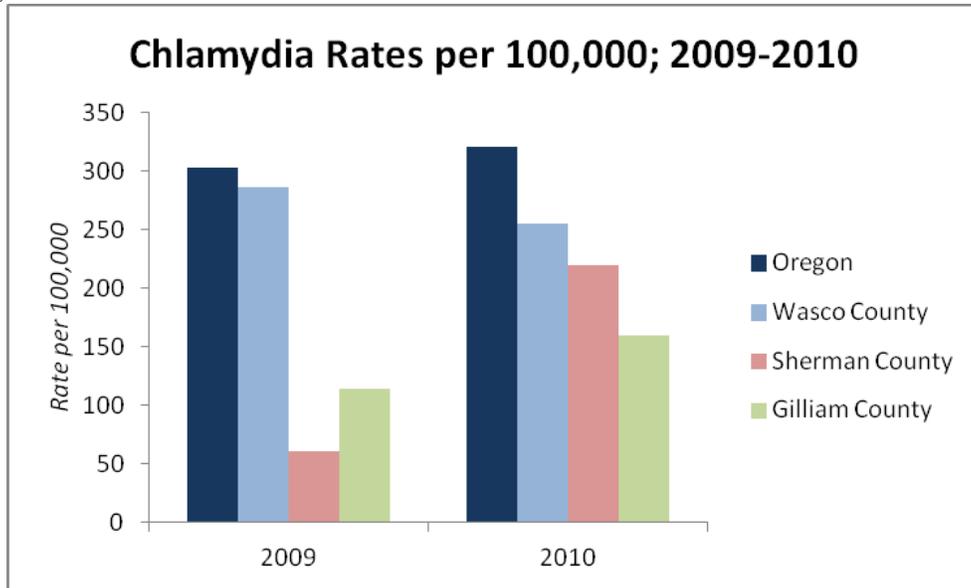
Figure 18

<b>Communicable Disease Reports, 2007-2011</b>					
<b>Wasco/Sherman/Gilliam Counties</b>					
	2007	2008	2009	2010	2011
Campylobacter	5	4	5	5	6
Chlamydia	64	61	71	69	63
Cryptosporidium	0	0	0	2	1
E. Coli (STEC)	0	0	1	2	1
Giardia	1	0	2	1	6
Gonorrhea	8	4	1	5	1
Hepatitis B (acute)	0	0	3	1	2
Hepatitis B (chronic)	4	2	4	5	1
Hepatitis C (acute)	2	1	0	0	0
Hepatitis C (chronic)	65	37	26	38	28
HIV	3	2	3	2	2
HUS	1	0	0	1	0
Legionella	0	1	0	1	0
Listeria	1	0	1	0	1
Lyme	0	1	1	0	0
Malaria	1	0	0	0	1
Meningitis	0	2	1	0	0
Pertussis	0	0	1	0	2
Q Fever	0	0	1	1	0
Rabies (animal)	0	1	0	0	0
Salmonella	3	4	4	5	2
Shigella	7	0	0	0	0
Syphilis	1	0	0	0	0
Taeniasis	0	1	0	0	0
Tuberculosis	0	0	0	1	0

Source: North Central Public Health District 2012-13 Annual Plan<sup>28</sup>

<sup>28</sup> [http://www.wshd.org/wshd/resources\\_health\\_district\\_data.htm](http://www.wshd.org/wshd/resources_health_district_data.htm)

Figure 19



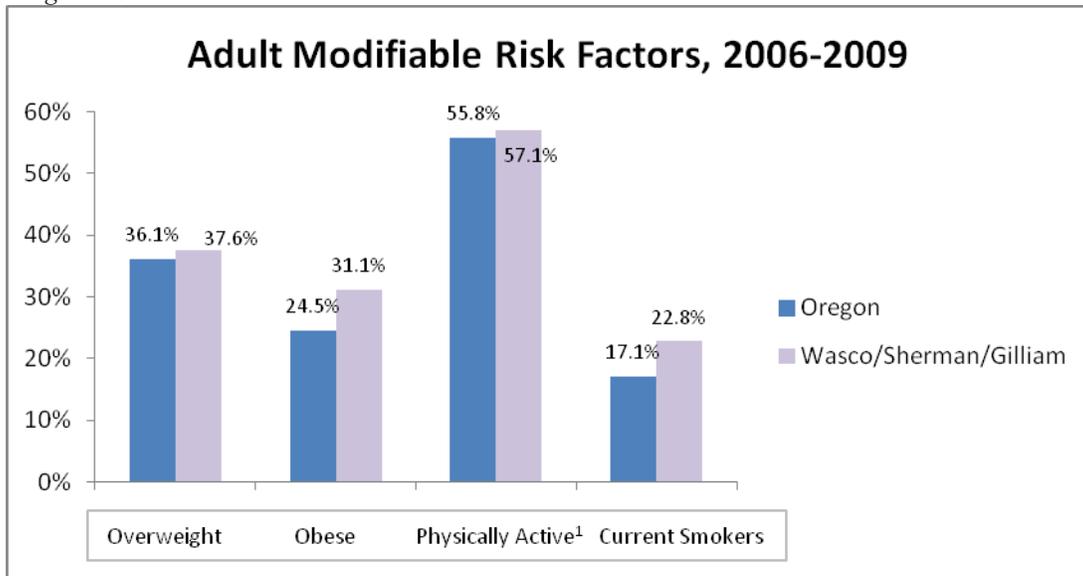
Source: Oregon Health Authority: Oregon STD Statistics<sup>29</sup>

Although Chlamydia is one of the top two most reported communicable diseases in the health district, and has been the top reported communicable disease from 2008-2011, Chlamydia rates for all three counties remain below the state average.

<sup>29</sup> <http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Pages/annrep.aspx>

**Modifiable Risk Factors**

Figure 20



Percent of adults who met CDC recommendations for physical activity  
Estimates age-adjusted to the 2000 Standard Population using three age groups (18-34, 35-54, and 55+).  
Source: Oregon Behavioral Risk Factor Surveillance System<sup>30</sup>

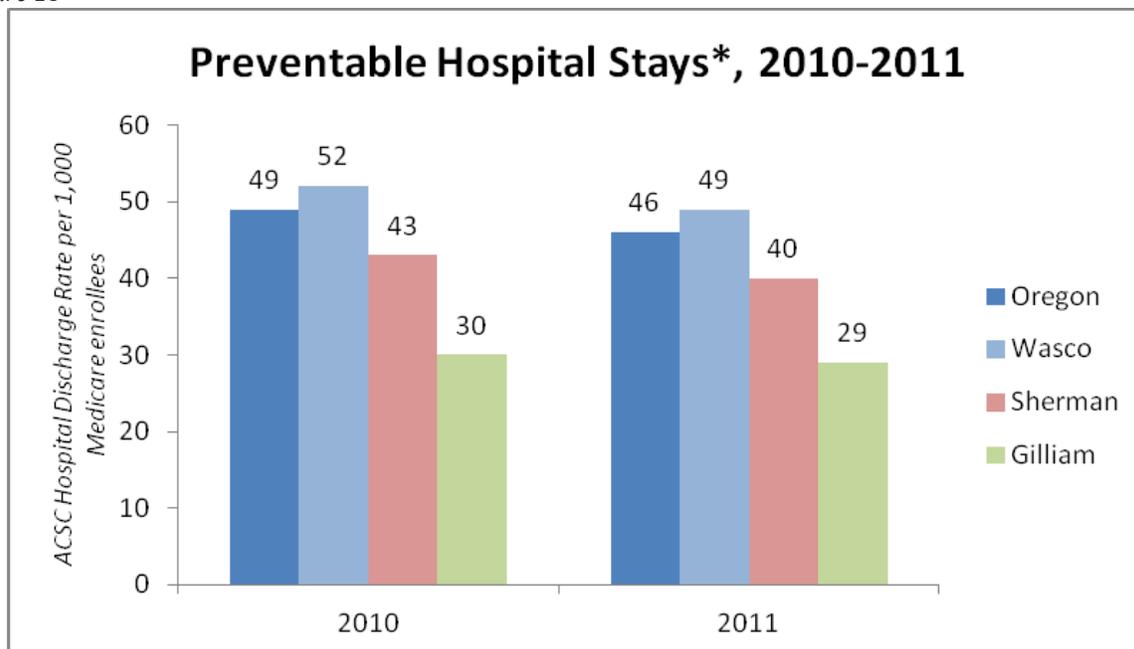
<sup>30</sup>

<http://public.health.oregon.gov/BIRTHDEATHCERTIFICATES/SURVEYS/ADULTBEHAVIORRISK/COUNTY/INDEX/Pages/index.aspx>

## SECTION VII: HEALTHCARE DATA

### *Hospital Utilization*

Figure 21



Source: County Health Rankings 2011<sup>31</sup>

Preventable hospital stays are measured as the hospital discharge rate for ambulatory care-sensitive conditions per 1,000 Medicare enrollees. Estimates of preventable hospital stays were calculated for the County Health Rankings by the authors of the Dartmouth Atlas of Health Care using Medicare claims data.

Reason for Ranking: Hospitalization for diagnoses amenable to outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal. The measure may also represent the population's tendency to overuse the hospital as a main source of care.

The payments shown in Figure 21 are the average payments to treat patients covered by a health plan. It is a guide for how much a hospital stay might cost. Oregon hospitals submit monthly utilization and financial summaries via the electronic DataBank system. The Oregon Association of Hospitals and Health Systems (OAHHS) make these files available to Oregon Health Policy and Research (OHPR) at quarterly intervals. DataBank files contain monthly, aggregate data for each hospital, including utilization and financial information by primary payer for a wide range of hospital services including acute, sub-acute, swing bed, distinct-part units, and home health care.

<sup>31</sup> County Health Rankings 2011, <http://m.countyhealthrankings.org/node/2356/5>

## Hospital Utilization Data for 2010

Figure 22

<b>Hospital Utilization Data, 2010</b>		
	<b><i>Mid-Columbia Medical Center</i></b>	<b><i>Providence Hood River Hospital</i></b>
Number Inpatient Surgeries	678	544
Admissions from E.D.	979	516
Emergency Room Visits	16,775	8,041
Ambulatory Surgery Visits	2,133	2,557
Total Outpatient Visits	129,621	137,081
<b>Medicare</b>		
Total Discharges	958	572
Total Pat Days	3,712	1,967
Inpatient Charges	28,541,910	10,324,000
Outpatient Charges	55,277,868	29,762,000
Total Charges	83,819,778	40,086,000
<b>Medicaid</b>		
Total Discharges	504	357
Total Pat Days	1239	839
Inpatient Charges	7,046,748	4,541,000
Outpatient Charges	13,670,297	7,852,000
Total Charges	20,717,045	12,393,000
<b>Self-Pay</b>		
Total Discharges	126	110
Total Pat Days	546	285
Inpatient Charges	3,370,416	1,801,000
Outpatient Charges	6,539,025	5,434,000
Total Charges	9,909,441	7,235,000
<b>Others</b>		
Total Discharges	613	501
Total Pat Days	1650	1254
Inpatient Charges	21,083,043	8,152,000
Outpatient Charges	40,855,238	31,427,000
Total Charges	61,938,281	39,579,000
<b>Medicaid % of Total</b>		
Total Discharges	22.9%	23.2%
Total Pat Days	17.3%	19.3%
Inpatient Charges	11.7%	18.3%
Outpatient Charges	11.8%	10.5%
Total Charges	11.7%	12.5%

Figure 22 Source (Previous Page): Oregon Health Policy and Research: Hospital Utilization Data<sup>32</sup>

**Access to Care**

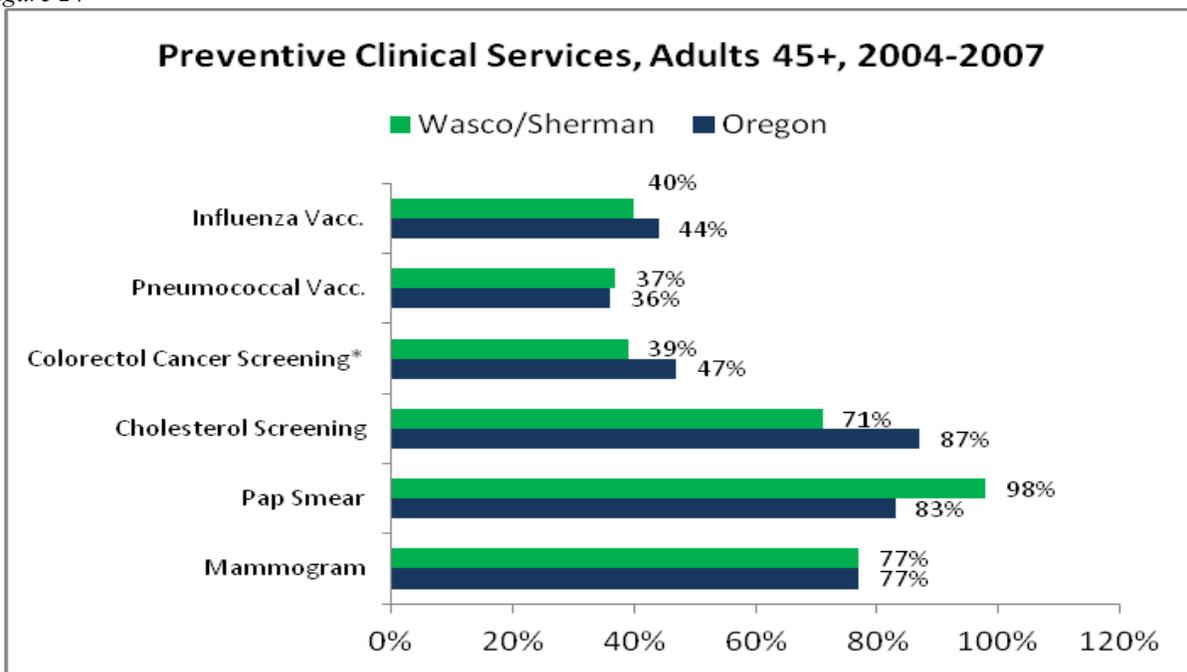
Figure 23

<b>Adult Access to Health Care, 2006-2009</b>		
	<b>Oregon</b>	<b>Wasco/Sherman/Gilliam</b>
<b>Access to Personal Doctor</b>	79.1%	71.3%
<b>Any Health Insurance</b>	83.6%	77.1%

Note: Age-adjusted to 2000 US Census Bureau population

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS)<sup>33</sup>

Figure 24



Source: Healthy Aging In Oregon Counties, 2009<sup>34</sup>

\*Colonoscopy/Sigmoidoscopy

As can be seen in Figure 24, rates between Wasco and Sherman counties and the state average are comparable for preventive clinical services for adults aged 45+, except in the case of cholesterol screenings. Oregon has a cholesterol screening rate of 87%, whereas Wasco/Sherman’s rate is 71%. Additionally, high cholesterol is one of the top three most prevalent chronic conditions in the health district and in Oregon as a whole, as shown in Figure 24.

<sup>32</sup> Oregon Health Policy and Research: Hospital Utilization Data, <http://www.oregon.gov/OHA/OHPR/RSCH/comparehospitalcosts.shtml>

<sup>33</sup> <http://public.health.oregon.gov/BirthDeathCertificates/Surveys/AdultBehaviorRisk/Pages/index.aspx>

<sup>34</sup> <http://public.health.oregon.gov/diseasesconditions/chronicdisease/pages/healthyaginginoregoncounties.aspx>

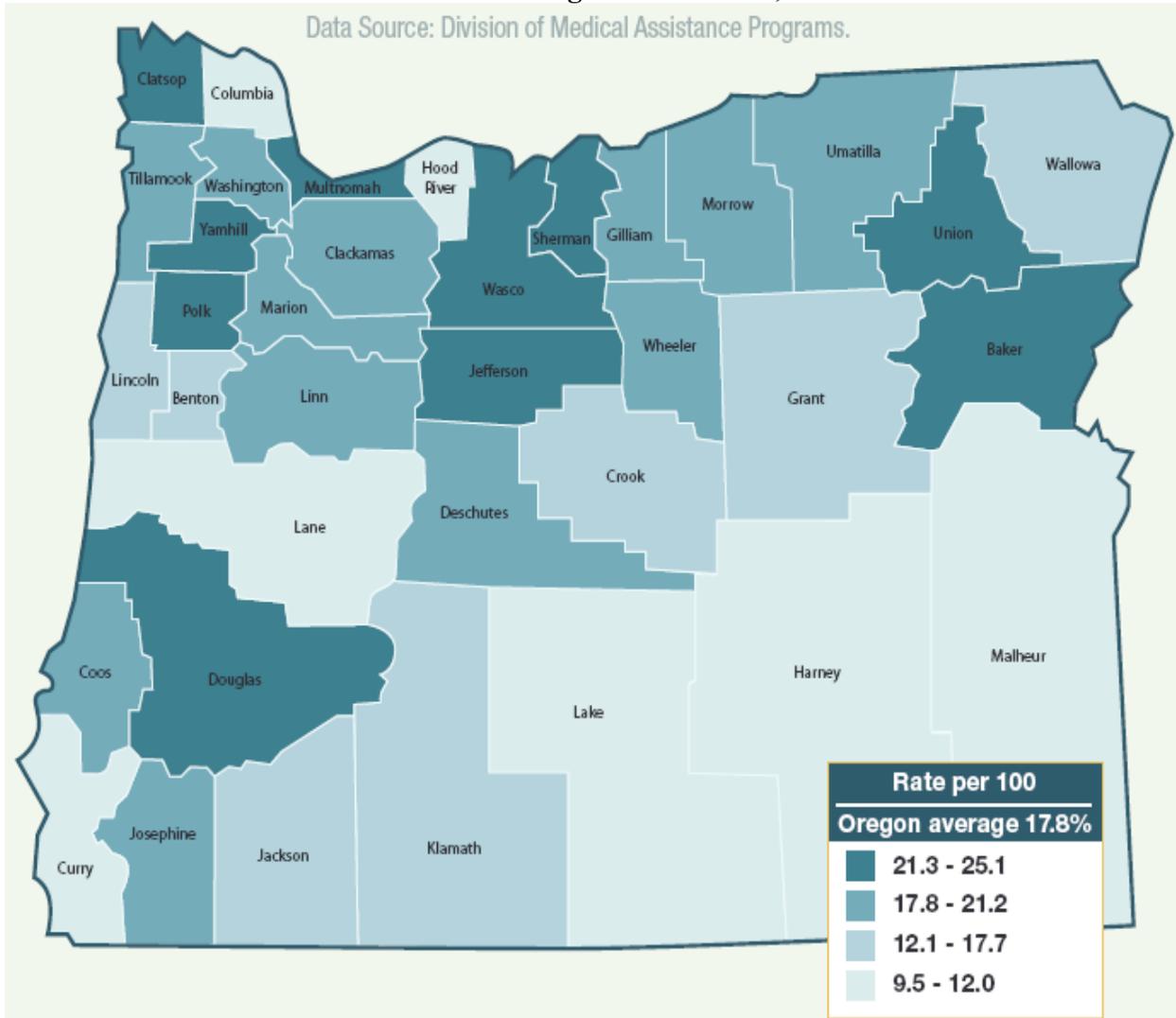
NCPHD and its community partners work to increase access to preventive clinical services through events such as an annual 'Go Red for Women' health fair, held every February in The Dalles. Fair attendees can have their blood pressure, BMI, and blood glucose checked. They are also given a discounted voucher to have a cholesterol screening at Mid-Columbia Medical Center (MCMC). Although the fair is targeted at increasing awareness about heart disease in women, these vouchers are available to all attendees.

These vouchers were also available at an additional Go Red health fair targeted to the Spanish-speaking community, reaching an often under-served section of the population

As can be seen in Figures 25-26 on the following pages, Wasco and Sherman counties rank among the highest counties in Oregon for asthma related emergency department visits for Oregon Health Plan (OHP) adults and children. The data reveals that emergency rooms are being utilized for asthma symptoms more often in Wasco and Sherman Counties compared to much of the rest of Oregon. This suggests that there may be a need for increased outpatient support for management of asthma symptoms, particularly for low-income/OHP individuals.

Figure 25

**Asthma emergency department visits per 100 children (0-17 years of age) with asthma on the Oregon Health Plan, 2004-2006**

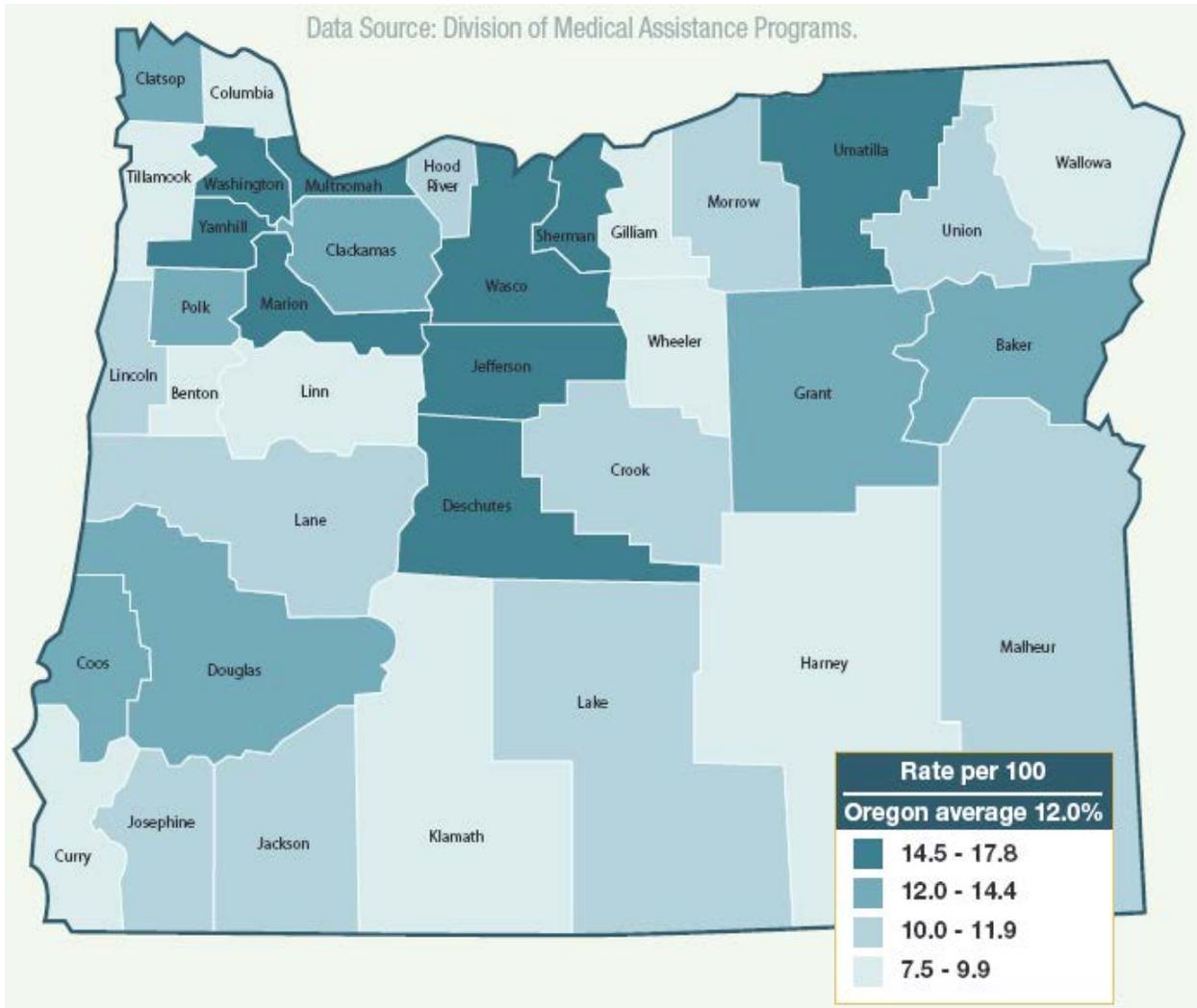


Source: Oregon Health Authority: The Burden of Asthma in Oregon (2010)<sup>35</sup>

<sup>35</sup> <http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Asthma/Pages/burdenrpt.aspx>

Figure 26

**Asthma emergency department visits per 100 adults (18 years old and older) with asthma on the Oregon Health Plan, 2004-2006**



Source: Oregon Health Authority: The Burden of Asthma in Oregon (2010)<sup>36</sup>

<sup>36</sup> <http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Asthma/Pages/burdenrpt.aspx>

## SECTION VIII: FAMILY PLANNING, MATERNAL & CHILD HEALTH DATA

### *Family Planning and Teen Birth Rate*

#### *Family Planning in Wasco County 2010*

Clients served .....	<b>1,138</b>
Female .....	<b>1,123</b>
Male .....	<b>15</b>
Teens .....	<b>319</b>
Hispanic .....	<b>382</b>
Racial minorities .....	<b>39</b>

#### **Women In Need of publicly funded contraceptive services and supplies** ..... **1,475**

Women In Need (WIN) are between 13 and 44 years old, fertile, sexually active, neither intentionally pregnant nor trying to become pregnant, and at an income below 250 percent of the federal poverty level (FPL). Women In Need may require public assistance to get services and avoid unintended pregnancy.

#### **Percentage of Women in Need served** ..... **74.2%**

#### **Teen pregnancy rate (15- to 17-year-olds)** ..... **25.6 per 1,000**

(Teen pregnancy rate in 2008 is the same as 2010 with a rate of 25.6 per 1,000)

#### **Access**

#### **Clients benefiting from public investment in family planning dollars\*** ..... **861(76%)**

\*Includes clients covered by Title X and Oregon Contraceptive Care (CCare) monies.

Free or low-cost services are available for these clients to reduce barriers to care.

#### **Clients with limited English-language skills** ..... **135**

Most family planning clinics have Spanish-speaking staff, offer culturally appropriate services, and produce client materials in Spanish and other languages.

Family planning clinics reach Oregonians who traditionally have difficulties getting services they need. These underserved clients include low-income clients, those in rural communities, who are incarcerated, those with limited English-language skills, and many others.

#### **Services and connections**

#### **Cervical cancer screenings** conducted ..... **413**

#### **Tests for sexually transmitted diseases** provided ..... **388**

#### **Contraceptive counseling** sessions delivered ..... **2,080**

#### **Referrals** offered (e.g., mammography, other medical services, prenatal, social services) ..... **579**

#### **Economic and social benefits**

#### **Dollars leveraged in federal funds for CCare** (Oregon's Medicaid waiver for family planning services) ..... **\$168,811**

#### New clients receiving a **more effective birth-control method** ..... **23%**

#### **Unintended pregnancies prevented** ..... **220**

Estimated taxpayer savings in prenatal, labor and delivery, and infant health care costs for every unintended birth prevented by the Oregon Reproductive Health Program is about \$9,450.

**NCPHD Current Family Planning Title X Data**

<b>Women in Need (WIN), 2010</b>			
<i>County/Service Area</i>	<i>20-44 Years</i>	<i>Teens 10-19</i>	<i>Total 10-44</i>
Oregon-ALL	184,615	58,649	243,264
Gilliam County	51	15	66
Sherman County	46	23	69
Wasco County	1,115	354	1,469
<b>Total Three Counties</b>	1,212	392	1,604

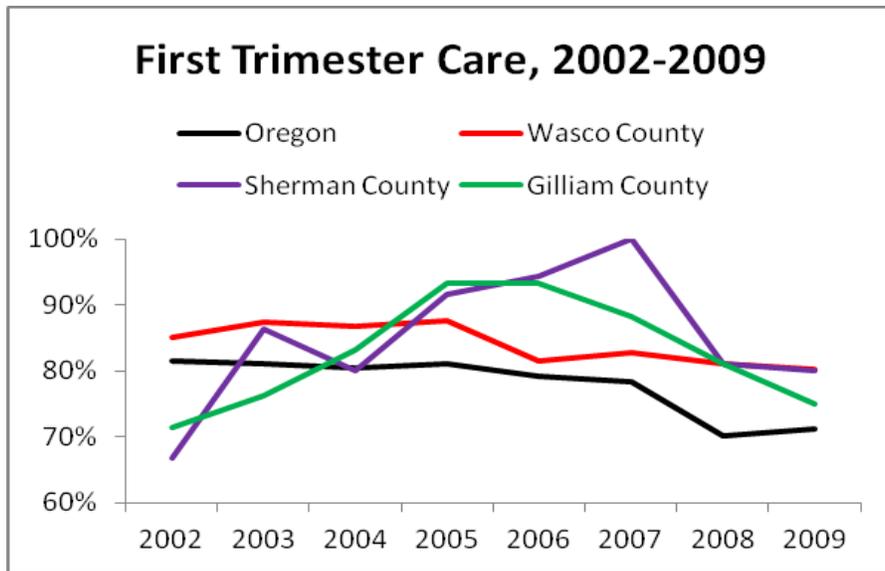
<b>Unduplicated Female Clients Served, FY 2011</b>			
<i>County/Service Area</i>	<i>20-44 Years</i>	<i>Teens 10-19</i>	<i>Total 10-44</i>
Oregon-ALL	36,566	13,317	49,883
<b>Total Gilliam, Sherman and Wasco County</b>	685	283	968

<i>County/Service Area</i>	<i>Proportion of WIN Served</i>	<i>Pregnancies Averted, FY 2011</i>	<i>Teen Clients as % of Total Clients, FY 2011</i>	<i>Male Clients as % of Total Clients, FY 2011</i>	<i>Proportion of Visits where Clients Rev'd Equally or More Effective Method, FY 2011</i>
Oregon-ALL	20.5	10,048	26.0%	2.9%	90.5%
<b>Total Gilliam, Sherman and Wasco County</b>	62.9	243	28.5%	1.1%	93.3%

<b>Proportion of Visits at Which Female Clients Received EC for Future Use, FY 2011</b>			
<i>County/Service Area</i>	<i>Teens (&lt;20)</i>	<i>Adults (20+)</i>	<i>Total</i>
Oregon-ALL	34.3%	22.0%	26.6%
<b>Total Gilliam, Sherman and Wasco County</b>	41.2%	25.2%	30.4%

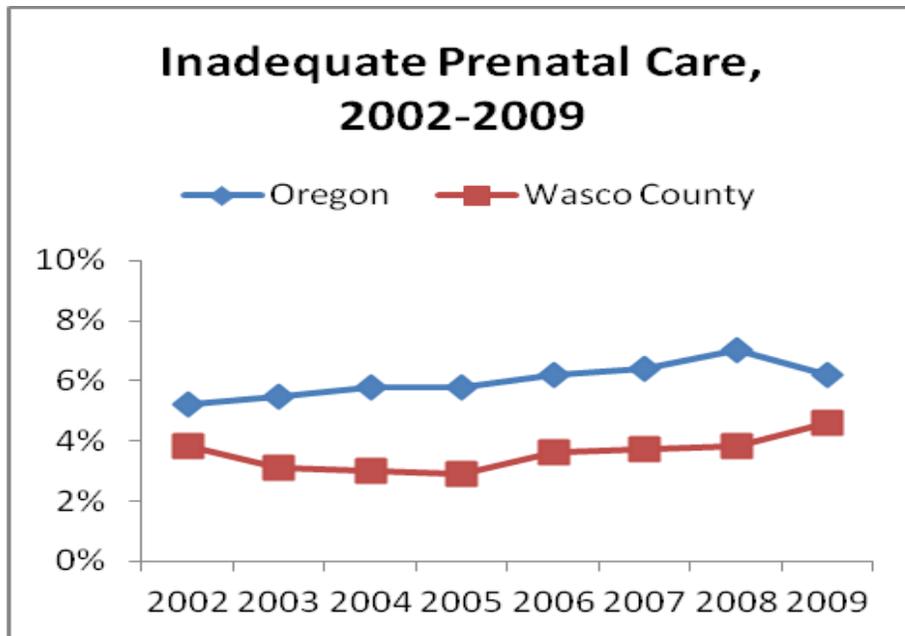
<b>Teen Pregnancy Rate (per 1,000 Females Aged 10-17) CY 2009</b>	
<i>County/Service Area</i>	
Oregon-ALL	8.7
<b>Total Gilliam, Sherman and Wasco County</b>	10

Figure 27



Source: Oregon Health Authority Perinatal Trends<sup>37</sup>; Oregon Vital Statistics County Data<sup>38</sup>

Figure 28



Source: Oregon Health Authority Perinatal Trends<sup>39</sup>; Oregon Vital Statistics County Data<sup>40</sup>

Figure 27 above shows that Wasco, Sherman and Gilliam Counties consistently rank above the state for percentage of mothers who receive first trimester care. Additionally, Wasco County has reported lower levels of inadequate prenatal care than Oregon since at least 2002, as shown in Figure 28.

<sup>37</sup> <http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/PerinatalDataBook/Pages/index.aspx>

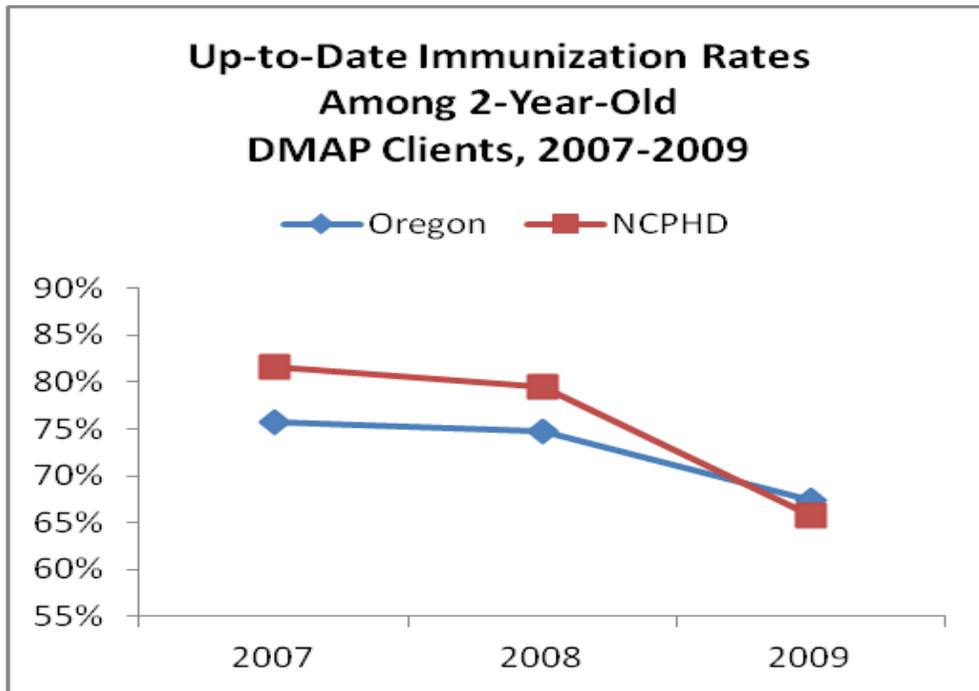
<sup>38</sup> <http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/CountyDataBook/Pages/cdb.aspx>

<sup>39</sup> <http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/PerinatalDataBook/Pages/index.aspx>

<sup>40</sup> <http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/CountyDataBook/Pages/cdb.aspx>

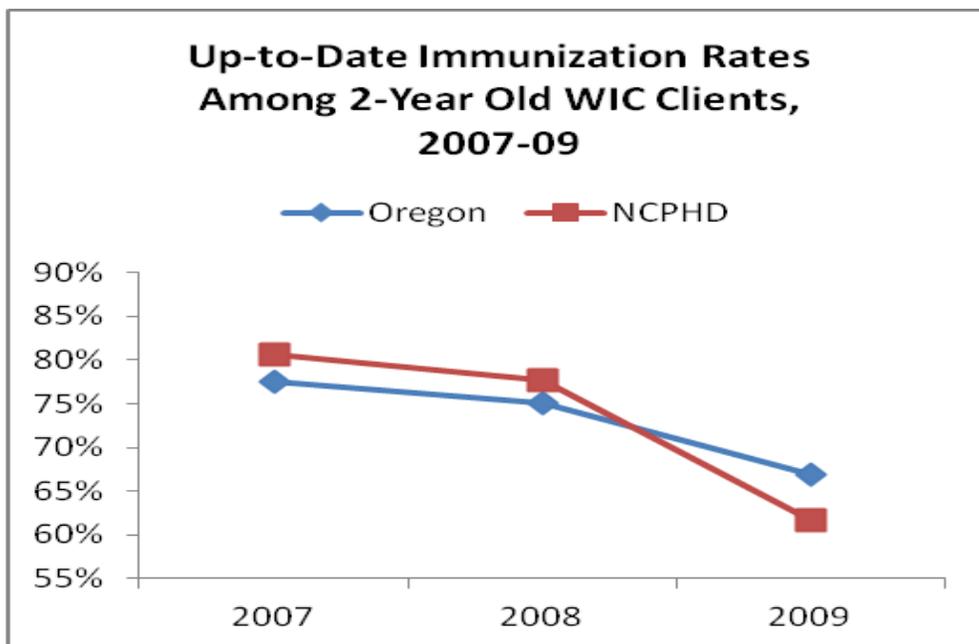
## Childhood Immunizations

Figure 29



Source: Oregon Immunization Program<sup>41</sup>

Figure 30

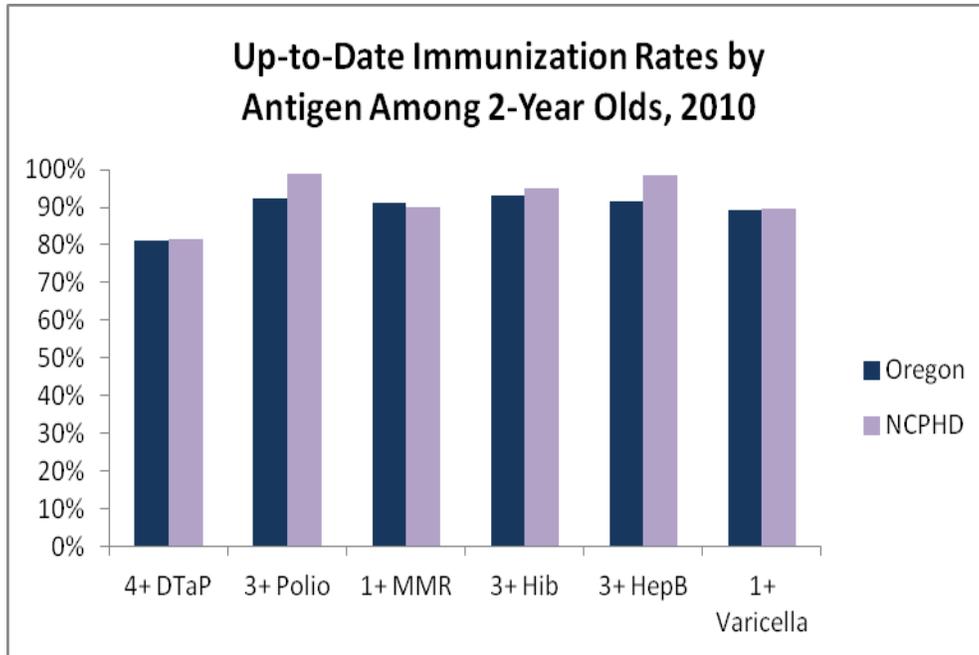


Source: Oregon Immunization Program<sup>42</sup>

<sup>41</sup> <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/research.aspx>

<sup>42</sup> <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/research.aspx>

Figure 31



Source: Oregon Immunization Program<sup>43</sup>

Figure 32

**NCPHD Final Exclusion Report 2011**

TYPE OF FACILITY	RELIGIOUS EXEMPTIONS	EXCLUSIONS
Children's Facility	11	10
Head Start	0	9
Private School	5	1
Public School	114	29
<b>TOTALS:</b>	<b>130</b>	<b>49</b>

**NCPHD Final Exclusion Report 2012**

TYPE OF FACILITY	RELIGIOUS EXEMPTIONS	EXCLUSIONS
Children's Facility	20	4
Head Start	2	3
Private School	10	4
Public School	120	27
<b>TOTALS:</b>	<b>152</b>	<b>38</b>

Figures 29-30 clearly show that immunization rates have experienced a decline for OHP and WIC two-year-olds in both Oregon and the health district since 2008. However, Figure 31 shows that NCPHD's up-to-date immunization rates for all two-year-olds remain at or above the state average. Part of the reason for this decline in immunization rates may be the increase in religious exemptions and exclusions on immunization requirements, as is shown in Figure 32 above. The following article, from a September 2011 Oregon Imminews report, highlights this trend across Oregon.

<sup>43</sup> <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/research.aspx>



## **SECTION IX: CONCLUSION**

At the time of the creation of the Community Health Improvement Plan, no funding was available to support the implementation of health improvement strategies identified as priority areas by the CHART. Current regional activities continue despite lack of funding through a variety of efforts.

### **CHART Strategies**

#### Strategy 1: Physical Activity

Efforts continue by various agencies within the region including Northern Wasco County Parks and Recreation District, through a variety of programs; Wasco, Sherman and Gilliam County Commissions on Children and Families, by encouraging physical activity through children's fairs; and Sherman County, through the development of an exercise area supported by Sherman County funding.

#### Strategy 2: Nutrition

Community nutrition improvement efforts continue despite lack of funding for programs: the farmers market in The Dalles has grown, a regional mobile farmers market continues to expand to new areas and Gorge Grown Food Network continues to serve the mid-Columbia region.

#### Strategy 3: Tobacco Prevention

Reduction of tobacco use and exposure is currently being addressed by the NCPHD Tobacco Prevention and Education program. (*See NCPHD Strategy 1.*) This work is coordinated through coalitions including prevention advocates across the three Counties.

#### Strategy 4

Chronic Disease Management is addressed through area providers, including Area Agency on Aging, Mid-Columbia Council of Governments and La Clinica del Cariño. Additional larger scale work is being undertaken through the Community Care Organization formation, which will address management of chronic disease within the Medicaid client population through primary care medical homes.

### **NCPHD Strategies**

NCPHD continues to work on enhancing current activities supporting strategies identified to improve community health:

- Strategy 1, reduction of tobacco use and exposure to environmental tobacco smoke, was identified as the highest priority due in part to the availability of funding to support tobacco prevention and education efforts. All Local Health Departments receive funding toward this goal. Work on this area will continue through the Tobacco Prevention and Education program at NCPHD. Examples of current tobacco prevention outreach and education efforts can be seen in Appendices B and C.

- Strategy 2, increasing access to and consumption of fresh fruits and vegetables, is promoted through the NCPHD WIC office. This promotion will continue directly with clients and as outreach at community fairs. NCPHD will continue to seek additional funding to support this work. Additionally, the 2007-2010 Columbia River Gorge Community Food Assessment informs this work. Information about the WIC Program and the Community Food Assessment can be found in Appendix D.
- Strategy 3, addressing effective communication with Wasco, Sherman and Gilliam County residents, has no current source of funding. However, NCPHD utilizes best practices for reaching rural residents and vulnerable populations. NCPHD will continue to explore opportunities to improve communications. Relevant findings will be shared across programs within NCPHD and among partners. Appendix E details current communication methods employed by NCPHD.
- Strategy 4, Workplace Wellness, is one of the most widely adoptable strategies of the four. Although there is no funding available to support this, many organizations are choosing to pursue Workplace Wellness due to the potential cost savings it affords. Wasco County has two groups of volunteers- one at the County level and one within the NCPHD staff- who have been brought together to address this issue. Additional funding will continue to be sought. Examples of current Workplace Wellness activities conducted or supported in part by NCPHD can be found in Appendices C and G.

This version of the Community Health Improvement Plan is valid through 2016, when the plan is due to be updated. In the meantime, NCPHD staff together with the Board of Health will seek continued opportunities to make progress on identified strategies. Likewise, NCPHD will support community partners in their own efforts.

## SECTION X: ACKNOWLEDGEMENTS

North Central Public Health District wishes to extend sincere thanks to all partners who supported the efforts of the Community Health Assessment and Community Health Improvement Plan:

NCPHD Board of Health	Wasco County Board of Commissioners
Sherman County Court	Gilliam County Court
Oregon Health Authority- Public Health Division	Wasco Co. Commission on Children and Families
Sherman Co. Commission on Children and Families	Gilliam Co. Commission on Children and Families
Mid-Columbia Medical Center	North Central Education Service District
La Clinica del Cariño	Gilliam Co. Education Service District
Arlington Medical Center	Mid-Columbia Children’s Council
Deschutes Rim Health Clinic	Columbia Gorge Community College
South Gilliam Heath Center	Arlington School District #3
Moro Medical Center	Dufur School District #29
Mid-Columbia Economic Development District	Sherman County School District #1 (Including Sherman Elementary)
Northern Wasco Co. Parks and Recreation District	South Wasco County School District #1 (Including South Wasco County H.S.)
Waste Management’s <i>Chemical Waste of the Northwest</i> and <i>Columbia Ridge Landfill</i>	Northern Wasco Co. School District #21 (Including Chenowith Elementary)
The Next Door, Inc.	OSU Extension Service
Opportunity Connections	Mid-Columbia Producers
Mid-Columbia Center for Living	Gorge Grown Food Network

And finally, a special thanks to the citizens of Wasco, Sherman and Gilliam Counties.



## Appendix A: PSA- Health Communities Grant (2010)



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**NORTH CENTRAL PUBLIC HEALTH DISTRICT**  
*“Caring For Our Communities”*

419 East Seventh Street, The Dalles, OR 97058  
Teléfono: 541-506-2600 Fax: 541-506-2601  
Internet website: [www.wshd.org](http://www.wshd.org)

### **PSA FOR IMMEDIATE RELEASE**

Contact: Allyson Smith, RN  
Healthy Communities Coordinator  
Email: [allysons@co.wasco.or.us](mailto:allysons@co.wasco.or.us)

December 17, 2010

### **North Central Public Health District receives Healthy Communities grant to perform broad Community Health Assessment**

**The Dalles, Ore.** – North Central Public Health District has received a \$32,500 grant for each of its three counties from the Oregon Public Health Division to build and expand community partnerships and policies that work to prevent, detect and manage chronic diseases. The funding covers the first phases of Healthy Community work: performing an assessment, and creating a three year plan. The “Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts” grant will help local health officials plan population-based approaches to reducing the burden of chronic diseases most closely linked to physical inactivity, poor nutrition and tobacco use. Such chronic diseases include arthritis, asthma, cancer, diabetes, heart disease, obesity and stroke. Tobacco use is the most preventable cause of death and disease in Oregon, claiming more than 7,000 lives each year (due to tobacco related cardiovascular disease, cancer, respiratory disease and others). It is important to note that in our health district, tobacco related death rates significantly exceed the state rates<sup>1</sup>. Poor nutrition and physical inactivity together are the second leading cause of preventable death and disease, leading to more than 1,400 deaths annually. Oregon Healthy Teens Surveys<sup>2</sup> indicate that our region’s 8<sup>th</sup> and 11<sup>th</sup> grade students meet or exceed state incidence for overweight and “at risk for overweight”, both of which are closely linked to poor nutrition and physical inactivity.

A population-based approach to addressing chronic diseases fosters new partnerships between public health and community partners, and focuses broadly on policy, environmental and system changes that influence the prevention and management of chronic diseases, rather than just on individual services, health education or access to health care.

The one-time grant, provided by the Oregon Public Health Division's Health Promotion and Chronic Disease Prevention Section (HPCDP), will fund North Central Public Health District officials' participation in a 12-month Healthy Communities Training Institute that offers guidance on community assessment, planning, and implementation of local Healthy Communities programs.

"The Healthy Community Building Capacity grant will help North Central Public Health District health coordinators develop skills to evaluate the community's needs and health outcomes, and provide leadership for integrating chronic disease prevention, early detection and management into community planning," said Teri Thalhofer, Director.

North Central Public Health Districts' Healthy Communities coordinators will convene and facilitate partnerships with community and health organizations representing various population groups to promote and support tobacco use prevention, increased physical activity, health eating, and early detection of risk factors and chronic diseases. They also will learn to promote the availability of resources for managing chronic diseases and risk factors, primarily through policy and environmental change.

In addition, North Central Public Health Districts coordinators will use assessment tools provided through the Healthy Communities Training Institute, such as surveys, focus groups and health data, to conduct a robust community needs evaluation. Available data can include disease prevalence, risk factors, management, quality of life, disparities, morbidity, mortality and economic burden. It is important to note, that the health district plans to make good use of any recent and applicable assessments that have been conducted in our region.

Finally, training institute participants will build three-year community action plans to launch interventions that address prevention, early detection and management of tobacco-related and other chronic diseases where people live, work, play and receive care. Interventions can include establishing diabetes self-management education programs; guiding development of community trails to increase physical activity; working with schools to enhance physical education programs; supporting local farmers markets and farm to school programs, establishing walking groups to increase physical activity among residents; and working with health systems to improve tobacco-use treatments for patients.

"Healthy Community Building Capacity grantees are pioneers in their regions because they're planning innovative approaches to addressing chronic diseases long before they become burdens to their communities' overall health," said Jane Moore, Ph.D., R.D., manager of the state Health Promotion and Chronic Disease Prevention section. "We applaud their efforts."

1. Oregon Tobacco Facts & Laws, April 2009: Tobacco Prevention and Education Program, Health Promotion and Chronic Disease Prevention Department of Human Services. [www.healthoregon.org/tobacco](http://www.healthoregon.org/tobacco)
2. Keeping Oregonians Healthy: Preventing Chronic Diseases by Reducing Tobacco Use, Improving Diet and Promoting Physical Activity and Preventive Screenings, Oregon DHS (Oregon Healthy Teens data)

## Appendix B: Tobacco Prevention Activities (Strategy 1)

The following examples demonstrate State and Local tobacco prevention and education outreach activities.

### North Central Public Health District Website Tobacco Prevention and Education

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419 E. 7th Street, The Dalles, OR 97058

Tuesday, May 29, 2012

Home

Food/Environ. Health

Emergency Readiness

Infectious Diseases

**Tobacco Program**

Family Health

Teen Health

Women's Health

WIC/Food Vouchers

Hazardous Waste & Recycling

Resources & Forms

### Tobacco Prevention

In November 1996, Oregon voters passed Measure 44 that increased the tax on tobacco products. Most of the increased revenue was used to help pay the huge medical costs that tobacco use means for sick Oregon smokers, but a portion was dedicated to a statewide tobacco education and prevention program.

The program has four major goals:

1. Reduce youth access to tobacco products
2. Create additional tobacco-free environments
3. Decrease advertising and promotion of tobacco products
4. Link to already existing cessation programs

These goals were supported by research based "best practices" which are activities that have been proven to work. Statewide, these "best practices" are applied in three areas:

- Media - to develop a campaign that included tobacco-free facts and messages on billboards, in local newspapers, on television stations, and over radio stations.
- School districts - to apply for funding to create and run tobacco-free programs K-12, but aimed mainly at vulnerable middle school aged kids.
- Communities - to develop a coalition of interested citizens and agencies to work on local tobacco issues in an attempt to support and enhance the norms of the community that do not support tobacco use.

In Wasco and Sherman Counties over the last few years, the results of the Measure 44 funds are seen in many ways. Our citizens regularly see ads in the paper, over the radio, and on TV with powerful messages about the dangers of tobacco use. Two of our school districts applied for and receive funding to implement a very successful tobacco prevention and education program in their curriculums. And TPEP, The Tobacco Prevention & Education Program, was created as the link to bring agencies and individuals together to work on tobacco issues in many different ways.

The vision and focus of this work is not just to support the individual who would like to stop smoking. It is the hope that, in our counties, community norms will not support the use of tobacco by anyone. Many of the activities of the Coalition attempt to enhance the goal of encouraging healthy living practices in a smoke-free environment for all of our Wasco County and Sherman County citizens. Enjoy the information our web site has to offer and please feel free to contact us with your comments, suggestions, or questions.

**More Information**

- ▶ [The Oregon Tobacco Prevention and Education Program \(TPEP\)](#)

Wasco County Home | Contact Us | Privacy Policy | Legal | © 2009

Hours M/F 8:30 - 5:00 | fax: 541.506.2601 | TTY 800-735-2900 | Email: PublicHealth@co.wasco.or.us

Link: [http://www.wshd.org/wshd/tobacco\\_prevention.htm](http://www.wshd.org/wshd/tobacco_prevention.htm)



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Tuesday, May 29, 2012

- Home
- Food/Environ. Health
- Emergency Readiness
- Infectious Diseases
- Tobacco Program**
- Family Health
- Teen Health
- Women's Health
- WIC/Food Vouchers
- Hazardous Waste & Recycling
- Resources & Forms

### Tobacco Education

The Oregon Tobacco Quit Line is a free telephone service available to all Oregon residents who want to stop using tobacco. The Quit Line offers you free quitting information, one-on-one, telephone counseling, and referrals for you or a loved one.



ENGLISH: 1-877-270-STOP (877-270-7867)  
 ESPANOL: 1-877-2NO-FUME (877-266-3863)  
 TTY ACCESS: 1-877-777-6534

**HOURS**  
 Monday to Thursday:  
 9:00 am - 8:00 PM  
 Friday: 9:00 am - 5:00 PM  
 Saturday: 9:00 am - 1:00 PM

Also the tobacco collection at the Planetree Health Resource Center is a part of the ESD Courier Circuit. Resource materials can be ordered directly from Planetree at 541-296-8444. The ESD Courier will pick up orders and return materials to Planetree on a weekly schedule.

**ESD Courier Schedule**  
 Mondays & Wednesdays  
 The Dalles  
 Tuesdays & Thursdays  
 Dufur, Sherman County and South Wasco County

**More Information**

- ▶ [Oregon Tobacco Quit Line](#)
- ▶ [Americans for Non-smokers' Rights](#)
- ▶ [Campaign for Tobacco-Free Kids](#)
- ▶ [Centers for Disease Control and Prevention Office on Smoking and Health](#)
- ▶ [Oregon Department of Human Services Tobacco Prevention and Education](#)
- ▶ [Smokefree.gov](#)
- ▶ [QuitNet](#)

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Hours M/F 8:30 - 5:00 | fax: 541.506.2601 | TTY 800-735-2900 | Email: PublicHealth@co.wasco.or.us

Link: [http://www.wshd.org/wshd/tobacco\\_education.htm](http://www.wshd.org/wshd/tobacco_education.htm)

# Tobacco Prevention and Education Program - Oregon.gov Website

The screenshot shows the Oregon.gov website interface. At the top, there is a header with the Oregon.gov logo, text size options (A+ A- A), a text-only site link, a language selection dropdown, and a Google Custom Search box. A banner for Memorial Day (May 28, 2012) is visible. Below the header is a navigation bar with links for 'About Us', 'Using This Site', and a dropdown menu for 'All Public Health'. A secondary navigation bar includes categories like 'Topics A-Z', 'Data & Statistics', 'Forms & Publications', 'News & Advisories', 'Licensing & Certification', 'Rules & Regulations', and 'Public Health Directory'. The main content area is titled 'Tobacco Prevention and Education Program' and includes a breadcrumb trail: 'Public Health > Public Health Directory > Office of Disease Prevention and Epidemiology > Health Promotion and Chronic Disease Prevention > Tobacco Prevention and Education Program'. The page features a 'Taking Action' section with three paragraphs of text, a 'Program Activities' sidebar with links to 'Tobacco Control Integration Project', 'Tobacco Program Data and Publications', 'Get Help Quitting Tobacco', and 'Smokefree Workplace Law', and a 'Healthy Kids' logo in the left sidebar.

OREGON.gov

MEMORIAL DAY  
MAY 28, 2012

Public Health

Tobacco Prevention and Education Program

Contact Us

Healthy Kids  
FOR A HEALTHY OREGON

Public Health > Public Health Directory > Office of Disease Prevention and Epidemiology > Health Promotion and Chronic Disease Prevention > Tobacco Prevention and Education Program

## Tobacco Prevention and Education Program

### Taking Action

Oregon's Tobacco Prevention and Education Program (TPEP) was launched in 1997 with a clear and simple mandate — to reduce tobacco-related illness and death. Since its inception, TPEP has been a comprehensive program, addressing the issues of tobacco use and Oregon's anti-tobacco efforts are saving lives and money.

Each year in Oregon, tobacco use kills nearly 7,000 people. It claims more lives than motor vehicle crashes, suicide, AIDS, and murders combined. Tobacco use is the leading preventable cause of death in Oregon and the nation.

Tobacco use costs Oregonians almost \$2.4 billion annually - a staggering financial burden - of particular concern at a time of serious economic difficulties in the state.

As a state, we simply cannot afford tobacco. Read the complete [Oregon Statewide Tobacco Control Plan](#).

### Program Activities

- [Tobacco Control Integration Project](#)
- [Tobacco Program Data and Publications](#)
- [Get Help Quitting Tobacco](#)
- [Smokefree Workplace Law](#)
- [More...](#)

Link: <http://public.health.oregon.gov/PHD/ODPE/HPCDP/TOBACCO/Pages/index.aspx>

# Oregon Tobacco Quit Line



Smokers spend an average of **\$1,500 a year** on cigarettes.  
*Quit today and start saving money.*

[ENROLL ONLINE NOW ▶](#)

**Already Enrolled?**  
[Log In Now >](#)

**SMOKEFREE**  
oregon

0 7 0 9 4 6

Lives Helped Counter

### You can quit. We'll show you how.

We understand that quitting is about more than just not smoking. So we teach people how to become experts in living without tobacco using "The 4 Essential Practices to Quit For Life," principles based on 25 years of research and experience helping people quit tobacco.

[Learn More About the Program >](#)  
[Learn More About Smokefree Oregon >](#)

[facebook](#) BECOME A FAN    [twitter](#) FOLLOW US

### What's New

#### Meet Our Quit Coaches

Did you know that many of our Quit Coaches are former smokers, just like you? They know how hard it can be to change old habits and learn to live a life free of tobacco. But they also know firsthand that with the right tools and support, it is entirely possible to quit for good.

If you haven't had a chance to watch our Quit Coach tips on YouTube, take a minute to check them out. You'll learn tips about how to have a smoke-free morning, how to start a money jar (for saving all that hard-earned cash you used to spend on cigarettes!), how to deal with stress, and much more. Most importantly, you'll see that when you pick up the phone to call us, you'll be talking to a real person - someone just like you.

### Participant Testimonials

**Steven Drier**  
"If you're thinking about quitting it's not impossible to do it, but you **MUST** do it for yourself and be ready to make some serious changes to get there. If you don't give it your full effort to quit then you won't. It doesn't matter how many patches you put on, or how many pieces of gum you use it won't work if you don't want it too."

[Read More >](#)

**Alberta Faye**  
"Yes I am still absolutely smoke free and absolutely loving it...I can't say thanks enough for your program."

[Read More >](#)

**Sue Kahler**  
"What a great feeling to be able to breathe again (and breathe quietly)! The little hints from my Quit Coaches were very helpful."

[Read More >](#)

**Elizabeth McCammon**  
"This quit program was the key for me. First thing the coach made me realize was that I was a "slave" to my smoking. I never looked at it quite like that."

[Read More >](#)

### Thinking About Quitting?

Download our free e-book and learn how to make quitting manageable.  
[Download e-book >](#)

### Refer A Friend

Refer a friend to this program.  
[Send to a Friend >](#)

### Have a Question?

Chat or Speak with a live Enrollment Specialist.  
[Chat or Call Me >](#)

### Instant Poll

What helps keep your mind off using tobacco?

- Playing games
- Eating
- Watching TV
- Browsing the web
- Other

Link: <https://www.quitnow.net/oregon/>

## Appendix C: Tobacco Prevention Activity– Wasco Wire (Strategies 1 & 4)

The following article from the November 22<sup>nd</sup>, 2011 issue of the Wasco Wire demonstrates NCPHD's tobacco prevention activities (Strategy 1), as well as Workplace Wellness activities (Strategy 4). The Wasco Wire is distributed electronically to all Wasco County employees, including those at NCPHD.

### Oregon Tobacco Quit Line

**The Oregon Tobacco Quit Line is an important and effective resource for anyone looking to end his or her addiction to tobacco.**

- While most Oregonians don't use tobacco, there are still almost half a million who do. Almost 70 percent of tobacco users want to quit, but struggle to do so.

The Oregon Tobacco Quit Line--which is free and available to Oregonians regardless of income or insurance status--helps people stay strong and quit tobacco for good.

**Online Counseling is a new Quit Line service that helps tobacco users build their own quit plans, connect with others like them and quit for good.**

- Participants who enroll in online counseling will:

- Build a quitting plan that fits their life and receive recommendations tailored for their own unique needs.

- Be able to talk to other quitters in online forums and join online support groups with people who share their experiences, challenges and triumphs.

- Be able to chat or e-mail with Quit Coaches, real people who understand the challenges of

quitting tobacco.

- Receive free nicotine patches or gum, if eligible.

Stay strong with post-quit tools and tips.

**Online Counseling gives tobacco users more options to access the help they need to quit in the way they want.**

- Not all tobacco users want to talk on the phone: having other counseling options makes help more accessible for more people wanting to quit.

- Online Counseling services are self-directed and can be accessed at any time, for as long as the participant needs. Access

to Online Counseling is unlimited.

Online Counseling sessions are shorter and more flexible than telephone-based counseling, to fit peoples' busy schedules.

**Online Counseling is something people have asked for.**

- In recent TPEP focus groups with tobacco users who were thinking about quitting, we heard loudly that people

wanted the option of online counseling.

- In the same focus groups, many tobacco users reported they went online for information and would like to find out more about the Quit Line online.

Providing online counseling services was a specific recommendation from a 2009 evaluation of Asian Oregonians' attitudes towards the Tobacco Quit Line.

**Online Counseling is available now and can be accessed in multiple ways.**

People can sign up for Online Counseling by going to [www.quitnow.net/Oregon/](http://www.quitnow.net/Oregon/) and registering for the online program.

- People can also sign up by calling 1.800.QUIT.NOW and selecting the "chat online with a counselor" option.

Online Counseling services are currently available in English only. Online Counseling in Spanish will be available in 2012.

**Quitting tobacco is one of the best things a tobacco user can do for his or her health, and the Oregon Tobacco Quit Line can help.**

- Each year thousands of Oregonians access the Quit Line for help quitting tobacco or to help someone they love quit.

- Oregon joins Florida, Oklahoma and Kansas in offering interactive online counseling services.





## Appendix D: Access to Health Foods (Strategy 2)

### Oregon Farm Direct Program

*The Farm Direct Nutrition Program (FDNP) distributes approximately \$1 million dollars to seniors (identified by Seniors & People with Disabilities Division as of April 1 each year), and families enrolled in the WIC (Women Infants & Children) program. Eligible participants will receive these funds as \$4 checks (WIC families receive \$20, and each senior client will receive \$32), specifically to purchase locally produced fresh fruit and vegetables directly from authorized farmers at farm stands and farmers markets from June 1 to October 31<sup>44</sup>.*

#### **What is the Oregon Farm Direct Nutrition Program?**

Families in the Women, Infants and Children Special Supplemental Nutrition Program (WIC) and limited-income seniors receive checks to spend directly with local farmers who grow fruits and vegetables. The Farm Direct Nutrition Program (“Farm Direct”) provides families and seniors an additional source of nutritious food and education on selecting and preparing fresh produce. Farm Direct also supports local farmers’ markets and farmers.

#### **How do Farm Direct checks benefit local farmers?**

Participating farmers are paid the face value of Farm Direct checks; this increases their earnings and helps them to keep farming. In turn, farmers spend those dollars in their local communities, which promotes local economic development. Farm Direct brought over \$1.16 million into the hands of local farmers in 2010. Keeping local farmers in business is important to our communities as well as our health.

#### **What foods can be purchased with Farm Direct checks?**

The checks can ONLY be used for fresh locally grown fruits, vegetables and herbs. Items that can NOT be purchased include hot foods, dried foods, jams, nuts, honey, eggs, cider, meat, cheese, seafood, baked goods, plants, cut flowers, or fruits/vegetables not grown in Oregon (such as bananas, oranges, lemons, pineapples).

Source: Oregon Health Authority 2011 Farm Direct Nutrition Program Fact Sheet (<http://oregon.gov/ODA/ADMD/docs/pdf/fdnfactsheet.pdf>).

In previous years, WIC Farm Direct vouchers were distributed on a first-come, first-serve basis, and were limited to one \$20 voucher per WIC household. In 2012, for the first time, Farm Direct vouchers will be distributed to every WIC household. Each household will receive at least \$20, and households that have more than one WIC participant may receive up to 2 vouchers, for a total of \$40. These vouchers will be distributed in June, and are valid until October 31<sup>st</sup>, 2012. Distributing a Farm Direct voucher to every WIC household and doubling the amount of vouchers for households with more than one WIC participant will widen access to healthy, local fruits and vegetables. In addition, no longer distributing the vouchers on a first-come, first-serve basis will increase access for families who live rurally or do not have easy transportation to the health department.

<sup>44</sup> Oregon Health Authority 2011 Farm Direct Nutrition Program Fact Sheet (<http://oregon.gov/ODA/ADMD/docs/pdf/fdnfactsheet.pdf>).



## **Appendix E: Coordinate Effective Communications (Strategy 3)**

In the era of health care reform where more emphasis is being placed on community resiliency and population health, the third strategy of our Community Health Improvement plan is an integral part of the Health Department's mission. While North Central Public Health District currently utilizes messaging and outreach strategies tailored to specific audiences within the community, we continue to explore ways to ensure effective communications.

Some examples of messaging strategies used by NCPHD include:

- Working with Spanish speaking radio stations and other verbal communications in addition to distribution of printed material.
- Maintaining effective communications with our Hispanic population by attending culturally specific events, working with faith based organizations and collaborating with agencies that serve the migrant and seasonal worker population.
- Employment of bilingual/bicultural staff and utilization of cultural ambassadors.
- Serving vulnerable populations by participating in committee meetings that include representation from nursing homes, adult foster homes, day care centers, developmental disability services, Early Intervention and Head Start.
- Reaching rural populations through nontraditional information dissemination including use of visiting health care, EMS personnel and home visiting programs.
- Continuing to build capabilities to share all public health messages with populations of lower socioeconomic status through the WIC program.

Some future concepts for improving messaging include:

- Advocacy for equal access to information for all residents through promotion of technology-based sharing methods, outreach and education, and utilization of proven communications best practices.
- Better utilization of available technologies, including social networking, to promote public health messages.
- Continuing to seek improved communitywide collaboration around creation and dissemination of health related messages.
- Establishing additional communications with migrant and seasonal workers through pay day contact.
- Increasing outreach to long term care facilities, assisted living facilities and adult foster homes.

By integrating public health messages across programs, we ensure increased access to and impact of messages to the public. We believe that through continued use of existing messaging/communication methods and by employing additional outreach concepts, we will increase health literacy and improve health outcomes in the district.



## Appendix F: Workplace Wellness Activities– Wasco County (Strategy 4)

The following flyer for the Riverfront Walking Club was shared by Wasco County Human Resources with all Wasco County staff:



**Riverfront Walking Club**

Reaching your fitness goal is easier with the support of a group. We welcome new members! Joining fee: \$5.00



**First week of the month: Seufert Park near DMV**  
**Second week of the month: Riverfront Park/Marina**  
**Third week of the month: Klindt's Cove Pocket Park**  
**Fourth week of the month: Discovery Center**  
**Fifth week of the month: Sorosis Park**

**6:30 am & 8:00 am**      **Every Tuesday and Thursday**

\* Two meeting times for early and late risers! Walk the entire trail in a month. Join today! 541-296-9533

Northern Wasco County Parks and Recreation District

[www.nwprd.org](http://www.nwprd.org)

This American Heart Month article, with information provided by NCPHD staff, was shared through the Wasco Wire issued March 3<sup>rd</sup>, 2012 with all Wasco County staff:

**The Wasco Wire**  
**HR Corner - American Heart Month-February 2012**

February is American Heart Month! Mary Clites of our Public Health Department was kind enough to share some information that I would like to pass on to you all.

Cardiovascular disease is the leading cause of death in the United States; one in every three deaths is from heart disease and stroke, equal to 2,200 deaths per day. American Heart Month is a time to battle cardiovascular disease and educate Americans on what we can do to live heart-healthy lives. Heart disease, including stroke, is the leading cause of death for men and women in the United States.

You are at higher risk of heart disease if you are:

- A woman age 55 or older
- A man age 45 or older
- Or a person with a family history of early heart disease

Heart disease can be prevented. To keep your heart healthy:

- Watch your weight
- Quit smoking and stay away from secondhand smoke
- Control your cholesterol and blood pressure
- If you drink alcohol, drink only in moderation
- Get active and eat healthy
- Talk to your doctor about taking aspirin every day if you are a man over the age of 45 or a woman over 55
- Manage stress

Did you know that more women die of heart disease than all forms of cancer combined? That's why you need to know these four warning signs:

1. Chest discomfort
2. Discomfort in other areas
3. Shortness of breath
4. Cold sweat, nausea or lightheadedness

Also, the warning signs of a stroke include:

- Sudden numbness or weakness in your face, arm or leg (especially on one side of your body)
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness or loss of balance
- Sudden severe headache

If you have any of these signs, don't wait more than 5 minutes before calling for help!

Yes, a lot of information, but in small pieces that can be remembered easily. Let's all be heart healthy and wise!

In recognition of starting, or keeping, a healthy lifestyle, please contact Hope Vance if you would like to be a part of a lunchtime walking group. It would be nice to take a stroll around town, or down along the river, and exercising in a group is a lot more fun and inspiring than doing it alone!

## Appendix G: Workplace Wellness Activities– Local Schools (Strategy 4)

Workplace Wellness Surveys were completed in the following schools:

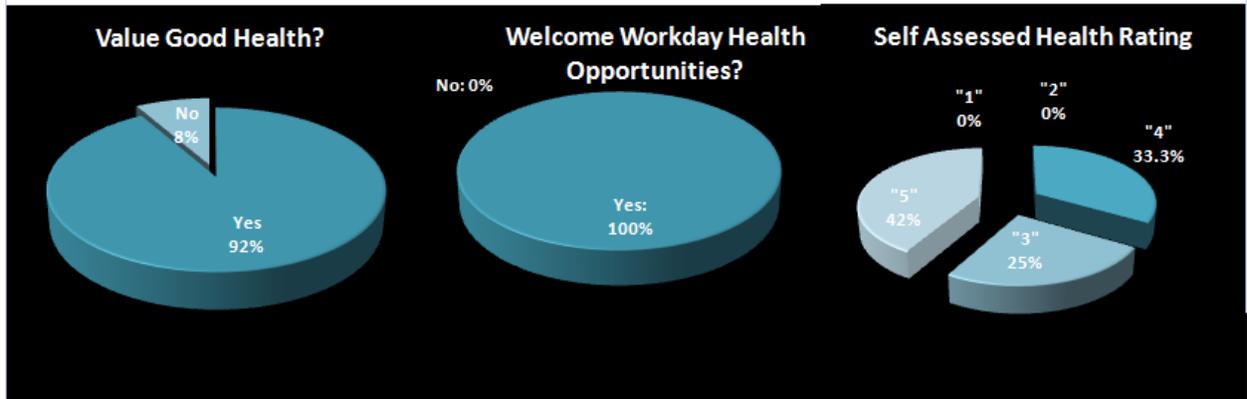
Dry Hollow Wellness Interest Survey 11/2011									
Question	Yes	No	No ans.	maybe	1	2	3	4	5
Value good health?	20	0	2		0				
Self Assessed Health Rating (1-5)					0	1	8	9	4
Welcome workday health opportunities?	17	5							
Welcome stress reduction?	17	5							
Include Employee Input?	21	1							
Willing to participate in planning?	7	14		1					
Willing to serve on wellness committee?	5	15		2					
Willing to take a leading role?	1	21							
Prefer leader is determined by vote?	6	14	1	1					
Interest in discussing with Allyson?	3	17	1	1					
Willing to participate in Wellness Policy?	7	14	1						



**Colonel Wright Wellness Interest Survey 11/2011**

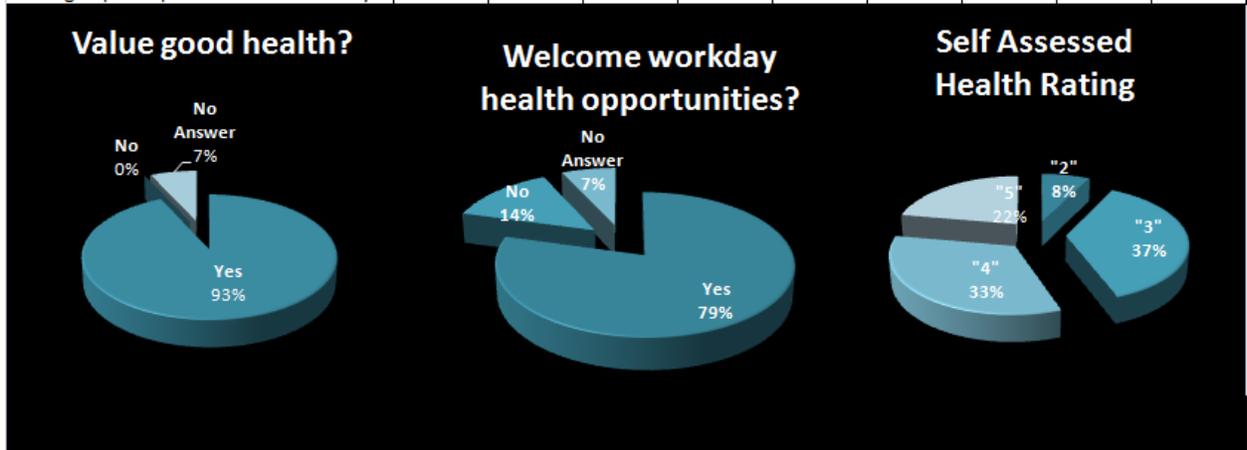
Question	Yes	No	No ans.	maybe	1	2	3	4	5
Value good health?	11	1	0	0					
Self Assessed Health Rating (1-5)					0	0	4	3	5
Welcome workday health opportunities?	12	0	0	0					
Welcome stress reduction?	11			1					
Include Employee Input?	12	0	0	0					
Willing to participate in planning?	3	8	1	0					
Willing to serve on wellness committee?	4	7	1	0					
Willing to take a leading role?	0	10	1	1					
Prefer leader is determined by vote?	6	6	0	0	0				
Interest in discussing with Allyson?	0	12	0	0					
Willing to participate in Wellness Policy?	0	10	1	1					

Note, there were two responses that rated personal health as either 3.5 or 3-5. One was entered as 3 and one as 4 for the sake of simplicity.



**THE DALLES WAHTONKA HIGH SCHOOL**

Question	Yes	No	No ans.	maybe	1	2	3	4	5
Value good health?	27	0	2	0					
Self Assessed Health Rating (1-5)					0	2	10	9	6
Welcome workday health opportunities?	23	4	2	0					
Welcome stress reduction?	24	4	1	0					
Include Employee Input?	29	0	0	0					
Willing to participate in planning?	11	15	0	3					
Willing to serve on wellness committee?	8	17		4					
Willing to take a leading role?	3	23	0	3					
Prefer leader is determined by vote?	15	12	2	0					
Interest in discussing with Allyson?	8	18	2	1					
Willing to participate in Wellness Policy?	8	17	3	1					



CHENOWITH ELEMENTARY 11/2011										
Question	Yes	No	No ans.	maybe	1	2	3	4	5	5
Value good health?										
Self Assessed Health Rating (1-5)										
Welcome workday health opportunities?										
Welcome stress reduction?										
Include Employee Input?										
Willing to participate in planning?										
Willing to serve on wellness committee?										
Willing to take a leading role?										
Prefer leader is determined by vote?										
Interest in discussing with Allyson?										
Willing to participate in Wellness Policy?										

Note: Matt Ihle, Principle of Chenowith Elementary advised me that the school had started their own Wellness Committee and had been meeting for a year and also recognized nationally. It was decided in November that I would attend their next committee meeting, but for the time being, not confuse staff by introducing another effort. The December meeting was then cancelled and postponed until the 4th of January. I attended their meeting and discovered that their wellness committee focus was exclusively on the students. Employee wellness was not included, and there was some interest in pursuing that subject further.

*NOTE: Chenowith Elementary School has a wellness committee who received Bronze National Recognition in 2010-2011. See below.*

### ***Healthy Schools Program in Oregon***

Oregon is one of the nation’s healthiest states when it comes to measuring rates of childhood obesity. The state ranks third in overall presence of childhood obesity, yet despite that impressive ranking still 24.3 percent of Oregon children are considered overweight or obese. To help improve that statistic, close to 100 schools in Oregon have joined the Alliance for a Healthier Generation’s Healthy Schools Program and are taking advantage of free tools and resources to help schools create a wellness council, start staff wellness programs, offer healthier foods and more physical activities. The Robert Wood Johnson Foundation supports the work of the Healthy Schools Program in the state.

The Healthy Schools Program recognizes that all schools are unique and there is no one size fits all approach when it comes to school health. For instance, schools participating in the Healthy Schools Program in Oregon are more likely to require health education in high school, to offer recess and to offer whole grains at breakfast and lunch, as compared to Healthy Schools Program schools in other states. On the other side, they are less likely to offer the recommended amount of 150 minutes of physical education or to implement an employee wellness plan.

As part of the Healthy Schools Program, every school creates an action plan that will work for their community. Many schools in Oregon have decided to work on employee wellness and 75 percent of participating schools have made improvements in this area. These gains, noted Oregon Relationship Manager Maricela Urzua, were achieved in part through a focus on staff employee wellness by Governor Kitzhaber.

Twenty-one Oregon schools are receiving national recognition from the Healthy Schools Program this summer, one at the Silver level and 20 at the Bronze level. Each recognized school has distinguished itself with healthy eating and physical activity programs and policies that meet or exceed stringent standards set by the Alliance's Healthy Schools Program.

Silver award winning Griffin Creek Elementary of Medford, Oregon has a school motto: "Together we are Fit, Strong and Healthy!" The school's commitment to physical activity is represented by the Friday recess running club, where students earn charm bracelet feet for every mile run, Fitness Fridays where students "move, dance and boogie" at assemblies, and intramurals during recess that include soccer, volleyball, football and slow pitch. At "lunch and learn" events, local doctors come in and discuss nutrition best practices. To improve employee wellness, the school received a \$25,000 grant from OEA Choice Trust, staff participate in Body-Age testing and the school is in the process of setting up a mini-staff workout room onsite.<sup>4524</sup>

### ***2010-11 Recognized Schools***

The Alliance for a Healthier Generation celebrated these schools at the Healthy Schools Program Forum in Little Rock, Arkansas on June 13, 2011 where they received a National Recognition Award from President Bill Clinton, American Heart Association President Ralph Sacco, M.D. and Alliance for a Healthier Generation CEO Ginny Ehrlich.

#### **Silver National Recognition Award**

Griffin Creek Elementary School

#### **Bronze National Recognition Award**

Madison Elementary School

Garfield Elementary School

Pine Grove Elementary School

Robert Frost School

North Marion Primary School

Bonanza Elementary School

Chiloquin Elementary School

Keno Elementary School

Fairview Elementary School

Klamath Union High School

Link River High School

Mills Elementary School

Ponderosa Junior High School

Roosevelt Elementary School

Henley Elementary School

Peterson Elementary School

Stearns Elementary School

Buff Intermediate School

Griffin Creek Elementary School

Parkdale Elementary School

**Chenowith Elementary School (The Dalles, Oregon)**

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<sup>45</sup> Healthy Schools Program in Oregon,

<http://www.healthiergeneration.org/schools.aspx?id=4294967381&terms=chenowith%20school>

*State Report Progress in Healthy Schools Program Oregon 2011*

**State Reports**  
**Progress in the Healthy Schools Program**  
**Oregon 2011**

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HealthierGeneration.org



American Heart Association  
Clinton Foundation

Generation support is provided by:



**The Alliance for a Healthier Generation**

The Alliance for a Healthier Generation, founded by the American Heart Association and the William J. Clinton Foundation, was formed in 2005 as a response to the dramatic increase in prevalence of childhood obesity across the nation. Currently, as many as 1 in 3 students in many states meet the criteria for overweight.

The goal of the Alliance is to reduce the prevalence of childhood obesity by 2015 by fostering an environment that helps all kids pursue healthy and active lifestyles. To that end the Alliance is working to positively affect the health of children by forging voluntary agreements with the healthcare and food service industries and by working with kids and schools across the nation.

The Alliance believes that helping schools is one of the most efficient and effective ways to shape the lifelong health and well-being of children and adolescents. That is why the Alliance has created the Healthy Schools Program, which aims to improve schools in the areas of nutrition, physical activity and staff wellness. The Alliance launched the Healthy Schools Program in February of 2006 with funding from the Robert Wood Johnson Foundation.



**Major Accomplishments**

By engaging and activating the leaders who can transform the environments and communities that nurture our children, the Alliance for a Healthier Generation:

- ◆ Supports nearly 12,000 schools in all 50 states in transforming their environments into places where students have better access to physical activity and healthier foods before, during and after school.
- ◆ **Activates more than 2.5 million teens and tweens** to commit to eat better, move more and serve as leaders to their peers.
- ◆ Brokered voluntary agreements with the beverage, snack and dairy industries that has contributed to a **88 percent decrease in total beverage calories** shipped to U.S. schools between 2004 and 2009.
- ◆ Negotiated agreements with 13 of the leading school meals manufacturers, group purchasing organizations and technology companies to **develop, market and competitively price** healthier school meal options.
- ◆ Convened national medical associations, leading insurers and employers that agreed to **offer comprehensive health benefits** to children and families for the prevention and treatment of childhood obesity.

**A Quick Look at Childhood Obesity in Oregon**

	OR	National
Percentage of children ages 10- 17 years who are overweight or obese <sup>1</sup>	24.3%	31.6%
State rank for overweight or obese children (1 is best) <sup>1</sup>	3	Rank in 2003: 11
Estimated adult obesity-attributable medical expenditures, 1998-2000 (in 2003 dollars) <sup>2</sup>	\$781 M	\$75 Billion

1. 2007 National Survey of Children's Health. [www.childhealthdata.org/](http://www.childhealthdata.org/)  
 2. 2009 edition of *F as in Fat*, published by Trust for America's Health. [www.reversechildhoodobesity.org](http://www.reversechildhoodobesity.org).

Link: [http://www.healthiergeneration.org/uploadedfiles/For\\_Schools/StateReports/10-1943.pdf](http://www.healthiergeneration.org/uploadedfiles/For_Schools/StateReports/10-1943.pdf)



## **Appendix H: Columbia River Gorge Community Food Assessment (Strategy 2)**

The following document, *Highlights from the 2007-2010 Columbia River Gorge Community Food Assessment*, addresses Strategy 2: Increase access to and consumption of fresh fruits and vegetables. North Central Public Health District participated in the assessment process. This document provides an in-depth perspective on the food system within the district, both how it works and areas for improvement.

A special thanks to Gorge Grown Food Network for sharing this document.



*Highlights from the*  
**2007-2010 Columbia River Gorge  
Community Food Assessment**



**Covering: Klickitat and Skamania Counties in Washington State, and  
Hood River, Sherman, and Wasco Counties in Oregon.**

**Gorge Grown Food Network** partnered with the following organizations to conduct this assessment:

**Klickitat and Skamania Counties:**

*Klickitat County Health Department, Klickitat County WSU Extension, Skamania County WSU Extension, Mid-Columbia Children's Council, Oregon Food Bank, and the WSU Horizons Program, and Crossroads Resource Center*

**Wasco and Sherman Counties:**

*Wy'East Resource Conservation & Development, Mid-Columbia Community Action Council, North Central Public Health District, Sherman County Commission on Children and Families, Sherman County Senior Center, the Oregon Department of Human Services, Wasco County OSU Extension, Mid-Columbia Medical Center, North Wasco County Commission on Children and Families, Mid-Columbia Senior Center, Oregon Food Bank, the City of Maupin, and Crossroads Resource Center*

**Hood River County:**

*Hood River County OSU Extension, Hood River County Health Department, the Oregon Department of Human Services, FISH Food Bank, Soul Café, Mid-Columbia Community Action Council, The Next Door, Inc. / Nuestra Comunidad Sana, Hood River County Commission on Children and Families, Oregon Food Bank, and Crossroads Resource Center*

**Project Coordinator and Editor:** Sarah Hackney

**Contributing Authors:** Kate Stoysich, Meghann Dallin, Katherine Loeck

**Contributing Advisers and Researchers:** Ken Meter, Sharon Thornberry, Gail Aloisio, Johanna Wyers, Ann Kramer, Lauren Fein

## Why Food and Farms?

Drive in any direction along the Columbia River in Oregon or Washington – north, south, east, west - and you're bound to see acre upon acre of agricultural land. The Columbia River Gorge Region produces a diverse bounty of food, including orchard fruits, grains, livestock, vegetables, and more. Much of the region's land base is devoted to agriculture, and farms, ranches, and the businesses that serve them are a primary driver of the regional economy.

Yet every day, some Gorge residents go hungry. Others are forced to make the choice between healthy food for their families and rent, medical bills, and other expenses. More residents than ever are accessing local food banks as supermarket prices rise along with the cost of living.

This is not a scene seen only in the Gorge. For the last 50 years, the US agricultural system has been dominated by international interests as our rural communities and local infrastructure have suffered. Family farmers and small food processors have found it increasingly difficult to make a living growing and selling real, fresh, healthy food, even as federal subsidies rendered some food products – highly processed ones made from commodity crops – artificially cheap. A family can purchase a six-pack of soda for less than the price of a pound of fresh, healthy, local cherries.

Where does the food we grow go? And how can we ensure everyone who lives here has access to the food they need? Most of us know very little about where our food comes from, and much less about how it was grown, packed, sold or shipped to the store. But food is a basic human need and a major economic driver in our community.

*It is time to take a serious look at our local food system and find out how we can make things better: how we can reduce hunger, improve health and nutrition, and strengthen our regional economy.*

## What is a Community Food Assessment (CFA)?

A CFA is a collaborative, participatory project that takes a big picture look at our food system in all its parts – production, distribution, consumption – so we can learn how it works and how to improve our food and farms. It shows what our most pressing needs are, as well as the key community assets on which to build. It is a resource and an organizing tool. Actions identified in this CFA approach issues of real need in Columbia Gorge communities, and the information gathered here helps make that case.

## Goals

This purpose guided our work: *to identify both resources and needs in the community surrounding food security, agriculture, and health, and to ultimately improve access to locally grown food, especially for people with low and moderate incomes.*

## Financial Support

This project was supported financially by the generosity of the following organizational partners and grants:

- Gorge Grown Food Network, Oregon Food Bank, Wy'East Resource Conservation & Development Council, Klickitat County Health Department
- Community Food Projects Program of the USDA Cooperative State Research, Education, and Extension Service, *Planning Grant # 2007-33800-18520*

## Contact Gorge Grown Food Network for More Information

[info@gorgegrown.com](mailto:info@gorgegrown.com)

541-490-6420

PO Box 752, Hood River, OR 97031

Full report available by request or at [www.gorgegrown.com](http://www.gorgegrown.com)



## **Growing Food: Farms, Ranches and Local Markets for Local Produce**

The Columbia River Gorge region is known for its agricultural character and heritage. In addition to its famous mountains, rivers, and spectacular natural scenery, a drive in any direction through the Gorge takes one past fruit-laden orchards, waving golden wheat, cows and calves on open range, neat rows of vegetables, and much more. Agriculture is a significant regional economic driver, totaling over \$281 million in gross sales in 2007.\* The region's farms received \$18.4 million in government payments. Farms and the businesses that serve them make up a substantial portion of the region's employment base, and the majority of farms in the region are family-owned. The average age of a Gorge farmer is 56.3, just below the national average of 57.1.

Family-owned farms come in many different sizes in the region – the eastern Gorge farms are larger, reflecting their primary crops: grains (wheat, barley) and beef cattle. Both of these types of operations require large acreage for production. In the western Gorge, smaller parcels dominate, with blocks of orchard fruit trees and grapes comprising much of the agricultural acreage. Certain portions of the Gorge are more agriculturally-focused than others; while Hood River, Wasco, Sherman, and Klickitat Counties all had from \$31 - \$100 million in agricultural sales, Skamania County, which has most of its land area in National Forest lands, had only \$2.6 million in sales. A substantial portion – 74% -- of farms in the Gorge region reported sales of less than \$50,000 in 2007, and 88% of farms reported less than \$250,000 in sales in 2007.

The region's farm production expenses in 2007 totaled just over \$249 million, for a regional net income of \$32.5 million. 2007 was a good year for many of the region's commodity crops; not all years fare so well for the region. Examining Bureau of Economic Analysis figures from 1977-2006, the region's farms average \$234 million per year in cash receipts and report \$254 million per year in farm production expenses – an annual loss of \$20 million. Farmers and ranchers earn another \$23 million per year of farm-related income — primarily custom work, and rental income (30-year average for 1977-2006). This underscores the difficulty producers face in making a living farming; additional sources of income, be they farm-based or second jobs, are an important part of staying financially viable for many of the region's farmers and ranchers. Only 49% of farm principal operators in the Gorge list farming as their primary occupation.

Unlike many parts of the country, the Gorge is actually seeing an increase in the number of farms – the region saw a 15% increase in the number of farms from 2002 to 2007. However, at the same time, the amount of actual land in farms decreased modestly across the region, as did the average farm size.

The region's unique climate, spanning near-rainforest rainfalls to the west and near-desert aridity to the east, allows for a wide range of crops and farm products. The challenge for the Gorge is in getting these crops to market. The vast majority of crops produced here are commodity products, destined for national and international markets via wholesale channels. Growers' wheat co-ops and cooperative fruit packing houses are the primary channels through which the region's top two agricultural products are sold and then shipped. However, in addition to these high volume sales areas, many area farmers also produce crops for local markets: orchard fruit for fresh eating, grains for flour milling, fresh vegetables, cut flowers, and free ranging cattle, pigs, poultry, and other meat animals.

Across the nation, the percent of farm products sold direct to consumer – the USDA Census of Agriculture's closest proxy to measuring "local" sales – is only 0.4% of gross farm receipts. In the Gorge, the percentage is 0.8% - a small amount, but one that is twice the national average.

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\* 2007 is the most recent agricultural data available from the USDA Census of Agriculture.

### Hood River County Agriculture at a Glance

Hood River Co	Total Sales (millions)	Direct to Consumer Sales	Land in Farms (acres)	Number of Farms	Average Farm Size (acres)
2007	\$100,443,000	\$1,237,000	26,952	553	49

Hood River County is predominantly a fruit-growing county, with over three quarters of its farmland in pears, apples, and cherries. It is the top fruit-growing county in the state of Oregon, and the county's pear crop represents 1/3 of the winter pears eaten in the US. County farmers also report producing hay, wine grapes, vegetables, berries, other tree fruit crops such as peaches and nectarines, poultry/eggs, beef, cut flowers, live plants and bulbs, and seed stock (beans, grains), among other items.

Most of the food grown in the county is destined for national and international markets by way of traditional wholesale markets. County farms were responsible for over \$100 million in sales in 2007 – with \$95.9 million of that in fruit. Another \$2.1 million went into nursery crops, leaving just \$2.4 million for all other crops – including vegetables and livestock. 69% of the county's farms are under 50 acres in size, and 57% of farms sold under \$50,000 worth of products in 2007. Only one in five Hood River County farms sells direct to consumers, bringing in \$1.2 million in sales in 2007; this represents 1.2% of total ag sales in the county.

### Wasco County Agriculture at a Glance

Wasco Co	Total Sales (millions)	Direct to Consumer Sales	Land in Farms (acres)	Number of Farms	Average Farm Size (acres)
2007	\$89,862,000	\$432,000	949,462	649	1463

Wasco County has a sizable agricultural sector and is one of the top state producers of sweet cherries (first in Oregon) and wheat (fifth in Oregon). County farmers and ranchers also report producing other grains (barley, triticale), wine grapes, vegetables, berries, other tree fruit crops such as pears, poultry/eggs, beef, pork, cut flowers, live plants and bulbs, and seed stock. Approximately 40% of the county's farms are less than 50 acres in size, and 24% are more than 500 acres.

Most of the food grown in the county is destined for national and international markets. County farms were responsible for just under \$90 million in sales in 2007 – with 66%, or \$59 million, in fruit. Livestock sales accounted for \$10.5 million and grain sales for \$15.8 million. Vegetable sales represented only \$252,000 of farm sales in the county. Only 13% of Wasco County farms sell directly to consumers, bringing in \$432,000 in sales in 2007. That \$432,000 represents slightly less than 0.5% of total agricultural sales in the county.

### Sherman County Agriculture at a Glance

Sherman Co	Total Sales (millions)	Direct to Consumer Sales	Land in Farms (acres)	Number of Farms	Average Farm Size (acres)
2007	\$31,749,000	\$81,000	514,004	208	2471

More than 96% of the land in Sherman County is in agricultural use, with the vast majority of that land devoted to grain production and range for cattle. Sherman County ranks third in Oregon for grain production. County farmers also report producing hay, vegetables, tree fruit crops such as cherries, poultry/eggs, beef, pork and lamb. Only 5% of the county's farms are less than 50 acres in size, and 73% are more than 500 acres, reflecting the prevalence of grain and cattle operations.

Most of the food grown in the county is destined for national and international markets. County farms were responsible for more than \$31 million in sales in 2007 — with 93%, or \$29 million, in grain. Livestock sales accounted for \$1.6 million. Only 3% of Sherman County farms sell directly to consumers, generating \$81,000 in sales in 2007. That \$81,000 represents just 0.25% of total agricultural sales in the county.

### Klickitat County Agriculture at a Glance

Klickitat Co	Total Sales (millions)	Direct to Consumer Sales	Land in Farms (acres)	Number of Farms	Average Farm Size (acres)
2007	\$57,298,000	\$525,000	601,216	893	673

Klickitat County has a sizable agricultural sector and is in the top third of Washington counties for production of several crops, including grains (wheat and barley), forage, tree fruit, livestock, and grapes (fourth in the state for grapes). County farmers and ranchers also report producing vegetables, berries, poultry/eggs, beef, pork, and live plants. Approximately 65% of the county's farms are less than 50 acres in size and 26% are more than 500 acres.

Most of the food grown in the county is destined for large national and international markets. County farms were responsible for \$57.2 million in sales in 2007 – with 51 percent, or \$29.5 million, in fruit (and nuts). Livestock sales accounted for \$13.4 million and grain sales for \$8.6 million. Only 15 % of Klickitat County farms and ranches sell directly to consumers, bringing in \$525,000 in sales in 2007. That \$525,000 represents just under 1% of total agricultural sales in the county.

### Skamania County Agriculture at a Glance

Skamania Co	Total Sales (millions)	Direct to Consumer Sales	Land in Farms (acres)	Number of Farms	Average Farm Size (acres)
2007	\$2,661,000	\$68,000	5,472	123	44

Skamania County has a history as an agricultural community but in recent years has not had as much agricultural activity as its neighbors in Oregon and Washington. The only agriculture sector for which Skamania County is in the top half of state producers is aquaculture. County farmers and ranchers also report producing wine grapes, vegetables, berries, tree fruit crops such as pears, poultry/eggs, beef, pork, cut flowers, and nursery plants. Approximately 45% of the county's farms are less than 50 acres in size. County farms were responsible for \$2.6 million in sales in 2007 – with 33% in fruit. Livestock sales accounted for \$1.6 million. Only 22% of Skamania County farms sell directly to consumers, bringing in \$68,000 in sales in 2007, which represents 2.5% of agricultural sales in the county.

### Challenges and Opportunities for Gorge Agriculture

Farmers and ranchers in the Gorge are determined to succeed into the future. In interviews, they report numerous substantial challenges and barriers to success, but also a commitment to working with their peers and partners like Gorge Grown to seek solutions. Top issues in farmer interviews were:

- Difficulty making a living

- Challenge getting crops to market (distribution and marketing)
- Land prices
- Government regulatory issues
- Energy and input costs
- Water rights and shortages
- Labor issues

Difficulty making a living was the top concern among farmers in most counties. As the regional data show, agriculture as an industry is not always profitable in the Gorge, and many farmers have second jobs or spouses with full-time jobs to make ends meet. The other barriers listed above contribute to the difficulty making a living in farming in the region. However, in these challenges lie opportunities to strengthen agriculture and increase farmers’ ability to succeed into the future in the Gorge.

Opportunities to sell farm products direct to local consumers, through farmers’ markets, community supported agriculture, farm stands, and more, are growing at a fast pace across the nation, including here in the Gorge. However, because these opportunities are limited in this rural region, farmers report using 2-5 different direct to market channels, including the above listed channels in addition to online orders, restaurant and caterer sales, and more.

While only 0.8% of farm products in this region are currently sold direct to consumer, this is twice the national average. In addition, direct marketing is growing at a much faster rate than conventional sales methods in both Oregon and Washington. From 1997-2007, Oregon had the fastest-growing rate of growth for direct marketing, 259.1% over 44.1% for other agricultural sales – the greatest increase in the nation. Washington, with the tenth-greatest increase nationally, reported a 163.2% increase over the same time period compared to 37.3% for total agricultural sales.

It would not be feasible for the residents of the Gorge to attempt to consume all – or even a substantial portion – of the crops farmers here grow for national and international markets. The scale of production is far beyond local market capacity to absorb. However, there are opportunities for these producers to identify local channels for some of their harvest, or to develop value-added products for Gorge-wide and Pacific Northwest-wide sales. There is little local or regional market for raw commodities such as wheat or barley, especially given the lack of milling and processing facilities, but there are opportunities for the development of local products, such as flour or animal feed. For this to happen at any scale, we need supply chain infrastructure improvements – distribution, processing, marketing – in the Gorge. Not only would developing this infrastructure help farmers get their crops and value-added products to market, they would create local jobs and keep more dollars in our regional economy.

The potential market value of additional local and regional direct to consumer sales is substantial. Based on the Bureau of Economic Analysis’s estimates of household food purchases, the residents of the Gorge spend \$201.8 million on food each year, including \$118.7 million for home use. The vast majority of these dollars are spent on food that does not come from local sources. There is significant potential to strengthen our local economy with even a modest increase in local and regional food purchases, and an increase in farms growing crops for local markets.

If Gorge residents purchased just 20% of their fresh food – meats, poultry, fish, eggs, fruits, and vegetables – from local sources, the economic impact on the region would be significant:

**Potential Value of 20% Local Purchases (in millions)**

Product	GORGE	Hood River	Wasco	Sherman	Klickitat	Skamania
Meats, poultry, fish and eggs	\$5.1	\$1.3	\$1.7	\$.14	\$1.3	\$.67
Fruits and vegetables	\$4.5	\$1.1	\$1.5	\$.13	\$1.2	\$.59
<b>TOTAL</b>	<b>\$9.6</b>	<b>\$2.4</b>	<b>\$3.2</b>	<b>\$.27</b>	<b>\$2.5</b>	<b>\$1.26</b>

## GROWING FOOD: Recommendation Summary

- Encourage the development of more locally-focused farm and food businesses, and the success and growth of existing operations
  - *Expand and improve producer education and cooperative marketing and networking opportunities to increase farm viability and growth*
  - *Assist beginning and transitioning farmers in securing land on which to operate and start-up capital and materials*
- Develop and improve local markets for local products, including direct to consumer sales opportunities
  - *Strengthen and develop new direct to consumer market outlets, such as farmers' markets*
  - *Identify opportunities for commodity producers to develop products for local direct markets*
  - *Identify potential new locally marketed value-added products appropriate to local producers*
  - *Work with larger buyers, including institutions and businesses, to encourage and aid them in regularly purchasing locally produced farm products*
- Fill in regional supply chain gaps with local businesses and cooperative opportunities for producers
  - *Develop stronger food processing (including value added) infrastructure for products destined for local markets*
  - *Develop stronger food distribution infrastructure, including partnership efforts, for products destined for local and regional markets*

## Accessing Food: Food Security, Emergency Food, and Shopping

While the Gorge is a heavily agricultural region, access to food is difficult for many residents. The region's population of over 75,000 is geographically dispersed across over 7,500 square miles, meaning many residents must drive long distances to access a full service grocery store. Others have limited incomes and depend on emergency food pantries to supplement their monthly food budget.

Across the Gorge, 15.1% of residents live below the federal poverty line. These residents struggle to balance housing, utilities, transportation, and health care costs, as well as accessing food for their families.

### Poverty Rates in the Columbia River Gorge

Gorge Average	Hood River	Wasco	Sherman	Klickitat	Skamania
15.1%	13.2%	14.6%	15.5%	19.3%	13.1%

Most survey respondents from each county do the majority of their grocery shopping within their county, with the exception of Sherman County (only 11.2% of residents drive less than 25 miles to purchase their groceries). However, because of the rural characteristics of the region, a significant portion of respondents report traveling 26 or more miles to do their shopping, often to a larger grocery store that has lower costs and a greater variety of food. Large grocery stores in The Dalles and Hood River are primary destinations, as are discount grocers in the Portland area.

### Distance Driven to Shop by County (Percentage of Survey Respondents)

Distance Driven	Hood River	Wasco	Sherman	Klickitat	Skamania
25 miles or less	86.4%	85.9%	11.2%	73.1%	71.1%
26+ miles	13.6%	14.1%	88.8%	26.9%	28.9%

In addition, residents across the region utilize a wide variety of secondary food sources, including: home gardens, farmers' markets, farm stands, food pantries, senior centers, hunting, fishing, and convenience stores or gas stations.

Over 90% of respondents to the survey in all five counties report choosing to buy products grown or produced locally some or all of the time when they are available. Lack of availability and cost are the two primary reported barriers to purchasing local products.

When asked what barriers they face accessing the food they need to feed themselves and their families, Gorge residents report *cost* and *time for shopping* as their two biggest issues. While many residents drive long distances to access food, transportation was not as highly ranked as an issue for respondents.

A grocery store assessment was conducted as part of the CFA to better understand the reality of shopping for food in the Gorge, especially for families living at or below the poverty line. The assessment was conducted using the USDA's Thrifty Food Plan survey, which meets the dietary requirements of a family of four for one week. The assessment revealed that, with some exceptions, rural stores tend to be more expensive and provide less variety of healthy, fresh foods than full service supermarkets located in larger towns. Rural grocery store owners were interviewed as part of this assessment, and the majority of owners report a need for assistance in getting more frequent, affordable delivery service to their stores so as to better serve their customers and offer a wider variety of products. Both small and large grocery stores in the region accept food stamps (SNAP) and benefit from this service.

Below is a table of some of the costs of the Thrifty Food Plan across the region.

### Cost of Shopping for Groceries in the Columbia River Gorge (Thrifty Food Plan, One Year)

Highest Cost in Region	\$ 9,372.00
Lowest Cost in Region	\$ 4,567.20
Average Price across Region	\$ 7,671.42

While most residents of the Gorge, and Oregon and Washington, do not need to worry on a regular basis about where their food comes from, many do. As of 2009, approximately 12% of American households reported that they had so little money for food that they worried over how to feed their families and took actions like cutting portions, skipping meals, and serving foods that they knew were less healthy but cost less. These people are considered "food insecure." When households report a high frequency of these actions, particularly skipping meals, they are considered to have "very low food security." Our community survey included two questions to address food security in the Gorge:

### Skipping Meals in the Columbia River Gorge

	Hood River	Wasco	Sherman	Klickitat	Skamania
% of People Skipping Meals Once a Month or More Because They Can't Afford to Buy Food	12.7%	10.1%	9.2%	7.9%	14.0%
% of People Skipping Meals so That Their Children Can Eat	8.1%	11.6%	11.6%	8.0%	13.4%

*\* The full USDA Food Security survey includes a broader range of food security-related questions; responses to these two questions are intended to gain an approximation of food insecurity issues in the Gorge*

The figures from these Oregon counties are comparable to the state of Oregon, which has a food insecurity rate of 13.1%. USDA uses a complement of food questions each year to gauge food security across the nation. There is no official tracking of levels of food insecurity by county in Oregon. As of 2008, 17% of Klickitat County residents, the fourth most food insecure county in the state, and 8% of Skamania County residents are considered to be food insecure. Food insecurity across the Gorge is higher among families with children, low-income families, Latinos, and Native Americans in some counties.

Food pantry efforts are often very minimal and limited in the outlying rural regions of the Gorge, with efforts often concentrated in main towns. The following data is from 2008 in Hood River County and 2009 in Wasco and Sherman Counties:

### Emergency Food Usage in Oregon Counties

	Individuals served per month	Percent increase in services since 2007
Hood River County	1319	48%
Wasco County	1392	17%
Sherman County	88	25.7%

Data is reported differently across state lines for food pantry usage, which makes five-county comparison difficult. Data collected from the food banks in Washington are total numbers with no distinction made for duplicate individuals or households. In Skamania County, 3,708 food boxes went to households in 2008, with an average of about 300 boxes going out per month. In Klickitat County, the food pantries served almost 10,000 food boxes to 6,799 households, impacting a total of 19,066 individuals in 2008. Over the past few years demand has risen regionally for emergency food, as has the number of repeat customers. A common problem among the food pantries and food banks around the region is the low capacity for storing and stocking fresh produce, making availability irregular and limited for food pantry clients.

Government food assistance programs across the region, including Women, Infants, and Children (WIC), SNAP (Supplemental Nutrition Assistance Program or food stamps), and Senior Services would benefit from additional services, including access to fresh, local produce for their cooking and nutrition education classes and the establishment of farmers' markets to allow access to government programs, such as WIC Farmers' Market Nutrition Program and the Senior Farmers' Market Nutrition Program.

In November 2009, the following statistics about the SNAP (Supplemental Nutrition Assistance Program or food stamps) were released:

### SNAP in the Columbia River Gorge

County	% of Residents Accessing SNAP (Nov. 2009)	% Increase in SNAP Usage since 2007	Purchasing Power of SNAP (per year)
Hood River	14%	28%	\$2.3 million
Wasco	19%	20%	\$5 million
Sherman	17%	9%	\$320,000
Klickitat	17%	35%	\$2.6 million
Skamania	12%	60%	\$1 million

All counties in the Gorge, with the exception of Sherman County, have seen a significant increase of over 20% of SNAP usage since 2007. Most SNAP clients report having sufficient access to EBT-accepting grocery stores and markets. WIC coupons and food stamp EBT cards are accepted at local farmers' markets in Hood River and Wasco Counties, though there is need to expand these opportunities in

Sherman, Klickitat, and Skamania Counties, where opportunities for SNAP and WIC clients to use their purchasing power for fresh, local products are limited to nonexistent.

## **ACCESSING FOOD: Recommendation Summary**

- Increase amount of fresh local produce available in food pantries, school meal programs, and community meal sites
  - *Coordinate multiple food donation streams to ensure steady and sufficient supply from orchards, farmers' markets, farmstands and home gardens*
  - *Explore opportunity to use the Gorge Grown Food Network truck to pick up and deliver surplus produce and donations in coordination with rural mobile market sites*
- Improve local emergency food infrastructure for increased capacity
  - *Work with communities lacking food pantries (including Maupin, Wishram, and Odell) to seek resources and identify potential sites*
  - *Partner with home gardeners to conduct produce drives*
- Increase sustainability of community meal programs and expand into rural county communities
  - *Work with community groups to increase volunteer initiative and support*
- Support rural food stores to provide a larger quantity of healthy, fresh, and affordable foods
  - *Work with rural grocers to evaluate interest and barriers to sourcing fresh produce*
- Improve current Farmers' Markets outreach and marketing to underrepresented populations and expand the establishment of Farmers' Markets that provide WIC and Senior Nutrition Programs.
  - *Work with market staff and Gorge Grown Food Network to ensure vendors are effectively trained and familiar with the EBT/SNAP program*
  - *Explore financial incentives for low-income residents to access farm direct shopping (including farmers' markets) opportunities*

## **Food Skills: Cooking, Nutrition, and Gardening**

Information on the food skills (cooking, preserving, etc) of families in the Gorge is scarce. Local service providers offering cooking classes do not typically survey their clients on these topics, nor do the national Census or USDA Food Security supplement offer county- or state-level data on food skills. Thus our community food survey included several questions specifically about these skills to get a better picture of what's happening in the region's home kitchens.

On the whole, people across the Gorge report having some food skills: an average of 81.9% of respondents report cooking most or all meals at home, though it is important to note that cooking was not defined in the survey and may include food preparation other than cooking from scratch, including heating frozen food.

An average of 64.9% of respondents in the Gorge cultivate at least a few fruit and vegetable plants; and an average 69.2% report eating fresh fruits and vegetables at least once a day. The reporting of high fruit and

vegetable consumption is higher than comparable state figures for Washington and Oregon, which indicates respondents may be over-reporting, but may also indicate that people understand the importance of fruit and vegetable consumption. In addition, just over half the respondents (an average of 57.5%) self-report that at least half of their food purchases are fresh fruits and vegetables.

Families with gardens eat more fruits and vegetables: an average of 78.1% of Gorge gardeners consume fruits and vegetables at least once a day. 81.8% of families with gardens already share their excess produce with friends and neighbors.

Gardening has a positive impact on food security: the food insecurity of families with gardens in most counties decreased, with the exception of Sherman County, an anomaly which suggests a need for further exploration in that county.

### Percent of Gardeners who Skip Meals

County	% Skipping Meals Once a Day because Food is Scarce	% Increase or Decrease in Food Insecurity from Total Survey Population
Hood River	9.1%	-28%
Wasco	5.8%	-43%
Sherman	9.6%	4%
Klickitat	7.0%	-11%
Skamania	9.1%	-35%

Most survey respondents (69.7%) across the Gorge already freeze, dry, can, or smoke food to preserve it; an additional 8.2% want to learn more about how to preserve food. When it comes to cooking, 71.4% of respondents across the region responded yes or maybe when asked if they would be interested in cooking classes featuring fresh food and time-saving tips. The two biggest barriers to cooking at home in the Gorge include not having time to cook and being away from home at meal times for work/school.

There is a limited amount of cooking and preserving education currently offered around the region, mainly available through WSU and OSU Extension, 4-H, Community Education, and for low income households through government food assistance programs such as SNAP-Ed. Cooking classes that address residents' biggest issues, by saving families time and being adapted to on-the-go lifestyles, could benefit Gorge families.

School gardens are starting to appear around the Gorge: 9 elementary schools, 3 middle schools, and 4 high schools have gardens or greenhouses. It is important to mention that efforts are limited in Sherman County, with only one school garden established, and are non-existent in Skamania County, with no school gardens identified as of 2009. Garden coordinators at schools were interviewed, and respondents reported a desire for one of more of the following: more financial and material resources, support from volunteers and the community, better coordination across the region, and additional materials and space.

School gardens could also play an important role in an increase in fruit and vegetable consumption for youth. 4<sup>th</sup> and 5<sup>th</sup> graders in Hood River County had a high level of fruit and vegetable consumption (81.3% ate fruits and vegetables at least once a day). That number is substantially higher than data on 8<sup>th</sup> and 11<sup>th</sup> graders in The Dalles, who have very low consumption rates (24.5% and 26.1% eat fruits and vegetables once a day or more). In the two Washington counties, fruit and vegetable consumption were not much higher among youth (an average of 29.5% of 8<sup>th</sup> graders, 19% of 10<sup>th</sup> graders, and 24.5% of 12<sup>th</sup> graders eat 5 or more fruits and vegetables per day.) Incomplete data prevents a direct comparison for Hood River or The Dalles children from 4<sup>th</sup> and 5<sup>th</sup> grade to 8<sup>th</sup> and 11<sup>th</sup> grade.

Community garden efforts are slowly appearing around the Gorge as well, with 13 gardens established in four of the counties. There are currently no known community garden efforts taking place in Sherman County. While most Gorge residents do not currently have plots in community gardens, they report a fair amount of interest in having a plot (12.0%). Community gardens around the region could benefit from the following: better coordination, resource and infrastructure support, shared equipment, increased

technical support for novice gardeners, and volunteer support. There is potential for working with both local churches and county government to find and develop land for additional community garden space across the Gorge. This would be most beneficial for people who would like to plant, but do not own property.

The faith community currently has varying levels of participation in food efforts across the Gorge. Congregations and churches currently involved in food efforts are often active by helping to host and run Senior Potlatch meals, food pantries, general community meal sites, food drives, and community gardens. In general, faith-based organizations could benefit from a more centralized effort to become partners in improving food security around the Gorge.

## **FOOD SKILLS: Recommendation Summary**

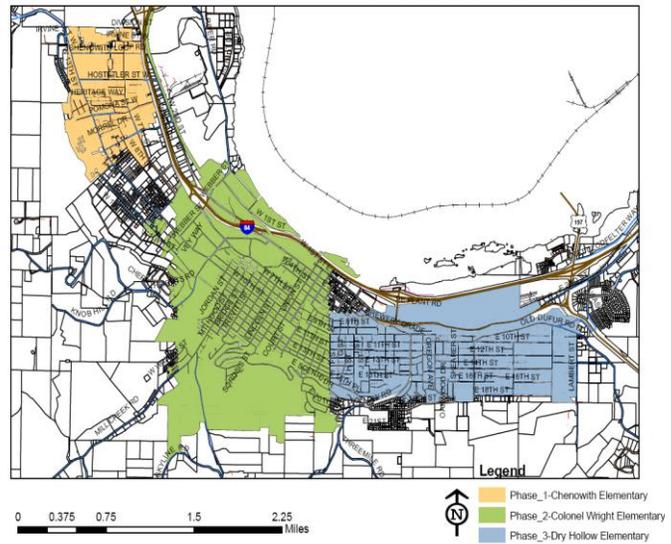
- Expand local availability of cooking and nutrition classes
  - *Maintain current cooking and nutrition educational opportunities in the region*
  - *Develop cooking resources and instruction for on-site demonstration at food pantry sites*
- Improve and integrate food skills, nutrition, and self-sufficiency help
  - Make home cooking and preserving resources available in easy to find and utilize places in the region
- Expand and coordinate local gardening resources for home gardeners
  - *Offer gardening education targeted at the demographic of survey respondents who indicated an interest in learning to garden: younger, low income, also interested in gaining other food skills.*
  - *Partner with Master Gardeners and others on management of gardens and development of workshops to maximize space in a garden plot, manage pests, etc.*
  - *Identify additional space and partnership opportunities for community gardens in the region.*
- Work with school gardens to coordinate efforts, share resources, and expand programs
- Work with schools to find additional means of increasing students' exposure to and consumption of fresh food, especially fruits and vegetables
  - *Work with school districts and community stakeholders to access additional food purchasing funding to make it possible to afford, and thus prioritize, local food and improve quality of school meals*
- Centralize and coordinate food and faith efforts among churches
  - *Build a centralized support system for churches doing emergency food outreach*

## **Appendix I: School Based “Wellness & Walkability” Project in North Wasco County School District #21 (Strategy 4)**

The following document, *School Based “Wellness & Walkability” Project in North Wasco County School District #21* addresses Strategy 4: Enhance systems to support “Workplace Wellness” (“Healthy Behaviors”) programs. North Central Public Health District, in collaboration with North Wasco County School District #21, conducted an assessment of the conditions supporting walking within District #21 elementary school boundaries. Wellness Policy within District #21 was also evaluated and an introduction of “Worksite Wellness” was shared with school employees in The Dalles, Oregon. Appendices referenced in *School Based “Wellness & Walkability” Project in North Wasco County School District #21* are available upon request at North Central Public Health District.



School Based  
“Wellness & Walkability”  
Project in  
North Wasco County  
School District # 21



*Assessment of the conditions supporting walking in North Wasco County School District 21 Elementary School boundaries paired with a renewed focus on Wellness Policy within the district and introduction of “Worksite Wellness” to school employees in The Dalles, Oregon*



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## Introduction

This paper will report on the wellness-focused collaboration between North Central Public Health District and North Wasco County School District 21 that began in 2010, and was made possible by grant funding from the Northwest Health Foundation in a response to a request for proposals to conduct Health Impact Assessments (HIA's). Background information is included to provide the context within which this project was conceived. Similarities with HIA, in terms of screening and scoping will be discussed. Demographic description of the community will be reviewed, followed by methodologies of the three parts of this wellness grant: a brief discussion of the survey instrument used for walkability assessment and the processes, resources used to establish workplace wellness committees and resources for wellness policy groundwork. Finally results will follow each, and a discussion of evaluation. Challenges and lessons learned will be shared and in the appendices various tools and documents will be attached.

## Background Information

Prior to the Wellness and Walkability grant, in the spring of 2010, Wasco County Planning collaborated with North Central Public Health District in conducting a Walkability Assessment within in the Chenoweth Elementary School Boundary using the Pedestrian Environmental Quality Index (PEQI) developed by the San Francisco Public Health department. That project was made possible by a grant from the Oregon Health Authority for Health Impact Assessments. It did not quite fit the conditions for a true Health Impact Assessment but it had some of the features: primarily the ability to influence decisions that impact health. This project was inspired by the fact that children attending Chenoweth Elementary were not able to participate in national Safe Walk to School events because it was not deemed safe.

Opportunities are limited for classic Health Impact Assessments (HIA's) in rural environments. New policies or projects that meet the criteria for HIA are infrequent occurrences, especially in tough economic times. That said, conditions that impact health are numerous, and the needs are great. The Chenoweth Walkability project generated a great deal of interest in The Dalles, and it was a first for collaborations between public health and planning departments in the community. With interest in mapping walkability in the other two grade schools in the district,

the possibility of continuing these studies was discussed with Chris Kabel, Program Officer from the Northwest Health Foundation, which was funding some Health Impact Assessment projects. Knowing our project would not meet classic HIA parameters, he encouraged us to apply for grant funding anyway, but suggested that it would be more beneficial to try to impact policy change as well as walkability; this suggestion inspired a much more comprehensive health promotion effort.

A meeting was arranged with District 21 School Superintendent, Candy Armstrong to explore possibilities for policy work within the school district. She suggested that NCPHD and District 21 work together to update the district wellness policy. The wellness policy had not been reviewed or updated since its inception, and they no longer had an active wellness committee. She described earlier wellness efforts as challenging with expectations brought forward that the district and board members felt were unattainable at that time. Having participated in the previous walkability assessment, and supportive of efforts to combat childhood obesity, Armstrong hoped to revisit the wellness policy again, and through it, achieve positive change. There was mutual agreement that we would try to accomplish this project in a way that would be collaborative, and she agreed to the suggestion of including workplace wellness in the new policy. We applied for the grant and our proposal was accepted.

### Health Impact Assessment?

Collaboration between the school and the health department on policy work brought this project closer to traditional HIAs but it still veers away from that framework in many ways. We were not bringing a health focus to a policy previously unrecognized for having health consequences, because this was, in fact, a “wellness policy”. What we could do for the benefit of the school district and the community was to insure that the policy was built around best practices, and we had an opportunity to introduce the concept of “workplace wellness” to the school district as well. We had convinced the district and the community that a focus on walking and the walking environment of the community mattered with our first walkability study in early 2010. The ground work had been laid, but there were areas still in need of mapping. Viewing this three-tiered project through the HIA lens is somewhat possible in terms of screening and scoping; after that, it differs substantially from most other HIA’s.

**Screening:** This project was begun with great enthusiasm and optimism that the project had significant potential to positively impact policy and health and it seemed to have reasonable chances for success. There was every reason to believe we would not only succeed in extending the walkability projects, it seemed probable that it would be easier a second time, having completed one before. Many people expressed enthusiasm after the first walkability study, and many voiced their support for continuing the studies. Furthermore, workplace wellness seemed like an idea that would be embraced by most; after all, most people value health, even if they cannot figure out how to fit it into their lives. Clearly, the superintendent supported wellness, and since there is research supporting the return on investment for Workplace Wellness<sup>1</sup> (Numerous studies show ROI's as high as 3:1 less commonly as high as 6:1 for well executed worksite health promotion investment) this seemed like a sure thing. Policy upgrades seemed very much within reach. The health department was in a position to research best practice and guide the district to incorporate such language into the policy that they had identified as in-need-of-upgrading. The workplace wellness component would be incorporated into the wellness policy as well. The superintendent had participated in other coalition work with the community and health department. The three-tiered project looked very promising.

**Scoping:** This project had the potential for counteracting chronic disease and childhood obesity, as it focused on improving health opportunities for both adults and children. School District 21 serves a large majority of our young people in the health district, and the school district is also one of the largest employers in our district, employing around 385 people. Wellness policies encompass primarily nutrition, physical education and tobacco. The school has in place a very strong tobacco free campus policy, and from their surveys, most employees are non-tobacco-users. Because of this, improvements will primarily be seen in physical activity and nutrition; workplace wellness may also include stress reduction, which impacts both mental health and physical health. There was a strong interest in stress reduction voiced by D-21 staff members at three school staff meetings that were attended.

**Walkability:** As with the previous walkability project, an advisory group was brought together to determine the scope of the study area for walkability. School principals, the district's

transportation manager, parents, community members and city planning department staff were invited. Colonel Wright Elementary was in a neighborhood with traditional grids and sidewalks, and choosing boundaries for their study was straightforward. Dry Hollow Elementary school had some children who lived far from the school who walk as far as the middle school then ride buses the remaining distance. This made the area much larger than the other two schools. There were very rural boundaries without sidewalks or curbs, and many steep hills. The Dry Hollow walkability study was broken up into three phases in case the entire area proved more than we could do. Multiple issues were raised in that first advisory meeting and both schools face challenging situations at the beginning and end of the school day with some very real hazards to walkers and bikers due to large numbers of parents providing rides to and from school for their children, and of course, the buses; it was apparent that future meetings would be beneficial to address some of the complex issues around safety surrounding the schools. Many of these issues we did not expect to solve in the course of this project, but it clearly seemed possible that our advisory group could be instrumental in future safety discussions and decisions and a venue of The Dalles Traffic and Safety Committee seemed a good avenue for problem solving between the school district and the City Public Works Department.

**Demographics:** NWCSO #21 serves nearly 3,000 students in rural The Dalles, Oregon, a town of approximately 14,000 people (including unincorporated Chenoweth district.) located 80 miles east of Portland. Nearly one-third (29%) of students are Hispanic, with 14% of students receiving ESL services. Fourteen percent (14%) of students are also identified as Migrant. Students in NWCSO are identified for special education at 130% of the state average (16.7% of district students compared to 12.9% for the state.) While only half (51%) of elementary students statewide were in poverty (using free and reduced lunch data –Oregon 2009 Statewide Annual Report Card,) over two-thirds (71%) of elementary students attending schools in The Dalles qualified. Data from the Oregon Healthy Teens Surveys show that half (50%) of 11<sup>th</sup> graders (and over 40% of 8<sup>th</sup> graders) do not meet CDC guidelines for physical activity. 13% of 11<sup>th</sup> graders in Wasco County are overweight, and 17% are “at risk for overweight” compared to statewide numbers of 11% and 13 % respectively

Needs: Low socioeconomic factors, current health indicators (overweight & at risk for overweight,) and low levels of students reporting adequate physical activity all point to a need for enhancing health opportunities on work/school days. Walkability studies can increase awareness, and they can be used to identify and address safety issues and thereby increase walking in the school boundaries. Stronger wellness policies support nutrition, physical activity, and tobacco, and workplace wellness supports employee health in the schools.

There is mounting evidence that supports changing behaviors via policy and environmental change as compared to more traditional individual centered efforts. Compelling research published in the *American Journal of Public Health*, August of 2010 demonstrated the health benefits of walking and biking: research authored by Professor David Basset Jr. from the Department of Kinesiology, Recreation and Sport Studies at the University of Tennessee, Knoxville, and three other renowned researchers demonstrates that people from communities with higher rates of active transportation enjoy better health than those communities that rely more heavily on cars. Obesity rates and active travel (bicycling and walking) were compared within American cities and states as well as 15 countries, and differences in obesity rates were significantly linked to the quantity of active transportation in the various community settings.<sup>2</sup> By focusing simultaneously on the built environment, the social environment, and policy enhancement seems more likely to result in tangible improvements in health than either activity or policy alone, as is suggested in CDC recommended community strategies.<sup>3</sup>

### Methodologies:

I: **Walkability:** The San Francisco Pedestrian Environmental Quality Index (PEQI): The Walking environments of Colonel Wright and Dry Hollow Elementary Schools were assessed using the same survey tool used in the Chenoweth school boundary earlier, the PEQI. San Francisco Public Health Department (SFDPH) chose street and intersection indicators based on a review of transportation, planning and public health literature, which included existing pedestrian quality indices and level of service metrics design guidelines and factors associated with walking and improved pedestrian safety in empirical research. This process also was part of the scoring, and experts helped to guide the weighting of various indicators. The PEQI is comprised of 21 street segment and 9 intersection factors associated with pedestrian

environmental quality and safety; the factors are grouped into five domains: Intersection Safety, Traffic, Street Design, Land Use and Perceived Safety. (See appendices 1&2&3.)

### Data Collection and Processing

Recruitment of volunteers was done similarly to our first walkability study in 2010 when we had 20 volunteers. We expected to have better results, as we had made more contacts and learned of a lot more people who were interested in the projects. Since the two remaining schools had Parent-Teacher groups, those were attended and sign up lists distributed. Fliers were sent out to parents, (see appendix 4) and posted in the schools. Our email list had become quite extensive, and announcements were sent out far and wide. All participants from the first study who had expressed interest in doing the process again were contacted. In spite of all efforts, turnout for both studies amounted to only about 4 volunteers each time.

Unfortunately the Colonel Wright survey date coincided with the Community Clean up day, something we were unaware of when choosing a date. The second time, there were no obvious conflicts on the community calendar. The surveys of Colonel Wright Elementary boundaries took place on May 21st, 2011 from 9:00 am -3:00 pm. The Dry Hollow Elementary walkability study took May 5<sup>th</sup> of 2012

Because of low turnouts, we abandoned the original plan to provide training by power point and test run, and the few people who arrived were provided one on one training instead, as this method was faster, and it allowed for more time spent gathering data. Everyone who showed up to help was offered lunch and refreshments in the schools which we used as a home base.

Survey participants recorded data on individualized survey forms. There was a section on each survey form for an intersection and a street segment: a space to record common data such as number of lanes, two way traffic or one way, speed etc, and columns for each side of the street to record lighting, sidewalk conditions, gardens, trees, and so on.

At the health department, data from individual survey packets was painstakingly entered into the MS Access database by one of NCPHD's administrative assistants, who fit this in between breaks in her regular work. Data was then converted into an Excel spreadsheet and brought into ArcGIS by Wasco County's GIS department. Both study areas were done in this way. The

mapping in GIS and some help from the planning department were paid for with grant funds, and the PEQI Access database provided by SFPHD was also paid for by the grant. Some time contributed by Jeanette Montour from the Wasco County Planning Department was not billed for, because she was promoted and therefore was not eligible for being paid for extra hours anymore. Otherwise, the remainder of the grant went to pay for NCPHD staff time.

## Results of the Colonel Wright and Dry Hollow Walkability Studies

Results were compiled for each side of 370 street segments and for 240 intersections in the study areas (see tables below). A few conclusions can be drawn from those results. Not surprisingly, the intersections proved to be the least friendly elements to walkers, and there were remarkable differences between the walking environments in the Colonel Wright Elementary neighborhood compared with Dry Hollow. (Note, Chenoweth Elementary walkability table is included for reference, as is the corresponding map in the appendices, because they are all part of the district and there are some interesting comparisons). Both the east end of town and the west end have many streets that lack curbs, storm drains, and sidewalks, and many of those roads are unpaved. Since Colonel Wright is located in the older part of town, it has a more traditional gridded layout and paved roads with sidewalks and curbs, as it predated America's heavy dependency on cars. None of the street segments or intersections fell into the highest range. Part of this may be explained by a tool that was created for a more urban environment, but also, we have large numbers of streets without cross walks, signs for pedestrians, and other features that would protect pedestrians. Stoplights and pedestrian amenities are almost completely lacking within walking distance of the schools. In conclusion, there is a great deal of room for improvement, and the intersections need the most work.

Chenoweth Walkability Project: 2010 (provided here for comparison only)

Chenoweth Elementary (February 2010)				
	Intersections		Street segment sides	
	number	percent	number	percent
Poor	11	26%	1	2 %
Low	32	74 %	32	59.2 %
Average	0	0 %	21	38.8 %
High	0	0. %	0	0. %
Highest	0	0. %	0	0 %
TOTAL	44	100 %	54	100 %

Wellness & Walkability: Colonel Wright Elementary 2011

Colonel Wright Elementary Walkability Scores				
	Intersections		Street segment sides	
	number	percent	number	percent
Poor	0	0 %	0	0 %
Low	9	11 %.	19	7.5 %
Average	55	70 %	150	59 %
High	15	19 %	85	33.5 %
Highest	0	0 %	0	0 %
TOTAL	79	100 %	254	100 %

Wellness & Walkability: Dry Hollow Elementary 2012

Dry Hollow Elementary Walkability Scores				
	Intersections		Street segment sides	
	number	percent	number	percent
Poor	144	85 %	0	0 %
Low	26	15 %	107	22 %
Average	0	0 %	270	56 %
High	0	0 %	109	22 %
Highest	0	0 %	0	0 %
TOTAL	170	100 %	486	100 %

The walkability studies are a first step in a longer term process to identify problems in the walking environment and to base planning decisions on, for the schools and planning departments. Doing more traffic count studies has been one suggestion put forward to the City of The Dalles public works department, as this information would help identify greater variabilities between the different streets and intersections that was not captured by the survey tool. It has also been suggested that the district consider designating certain routes primarily for walkers and bicycle riders and drivers could be encouraged to avoid those routes. The concepts of walking school buses and participation in safe routes to schools have also been suggested..

## II. Worksite Wellness:

A presentation was given at the Colonel Wright Elementary staff meeting In April of 2011 to introduce the concept of workplace wellness and stress reduction. These concepts were accepted enthusiastically (a brief survey was performed using a show of hands.) Staff preferred to delay any initiation of employee wellness activities until the following school year, since staffing cuts had everyone in a state of stress and uncertainty. Ironically, Colonel Wright was unable to recruit a leader to take on this activity and their principal made the decision to opt out of it for the time being. Colonel Wright Elementary responses had been the indicator that Workplace Wellness could be embraced amongst school employees, but it became apparent that many things must align to make this possible, and ultimately, not all necessary factors were there at the time within their school.

Every school where the principal was willing was given an introduction to Worksite Wellness information via a quick talk, handouts (see appendix 5) and web resources, and a survey (see appendix 6) to obtain indicators of readiness, interest in serving on a committee and interest in taking a leading role in workplace wellness or wellness policy in general. (See appendices 7,8, & 9.) In all, principals in three out of five schools allowed some access to staff members to introduce worksite wellness. In another school, Chenoweth Elementary, I was told a wellness committee already existed. Of three schools that were given presentations and in which surveys were conducted, Workplace Wellness Committees were formed in two: The Dalles Wahtonka High School and Dry Hollow Elementary. By attending the wellness committee at Chenoweth it was discovered that their wellness committee focused exclusively on supporting

health in school children. They were interested in the worksite wellness component and information was shared with them, but they were not yet ready to add this component to their work at that time. It is very likely they will add it later on.

Methodology included initial surveys and a number of online resources that were shared with the committees. The most important tool that was given, downloaded and in binders was the Worksite Wellness Committee Workbook that North Carolina has made available for download <http://www.eatsmartmovemorenc.com/SchoolWellnessTikt/SchoolWellnessTikt.html> (See appendix 10.) Wellness committee members were provided with the website and other web resources that will make various activities easier to introduce.

The committee workbook had all the basics laid out for the committee to begin their process. It had a snapshot timeline of what the first year in a school worksite wellness committee might look like; it has samples of mission statements, templates for agendas and action plans, sample employee surveys and so on. There are other workbooks available on their website as well for “Eat Smart”, “Move More”, “Quit Now”, and “Manage Stress”. Online resources were periodically sent by email to Worksite Wellness committee leaders, and further support offered on an as needed basis.

Results: The current status of the Wellness committees at end of school year 2011/2012 was that both committees had adopted Mission Statements. Both were conducting surveys of interest with plans to gather more information from employees early next school year to get baseline data for future evaluation. Both committees were careful to recruit diverse membership in their committees, including teaching and non-teaching staff and a mix of males and females. They were also encouraged to apply for grant funding via Oregon Education Association. Both committees embraced the structure of the North Carolina School Worksite Wellness and the website had an enormous number of resources, tools and success stories, so they didn't have to find time to re-invent the wheel. Examples of Agendas & Minutes from one committee, The Dalles Wahtonka High School are attached in Appendix 11.

III. Policy Review and Revision: It was initially envisioned that one large district wide committee could be formed with representatives from all of the district's schools, and that the

committee members could initiate worksite wellness in the various school environments and also participate in the overall wellness policy update. This proved to be erroneous thinking, as each school operates very independently from the others and one high school teacher mentioned that teachers in a single school can go months without much opportunity to interact with one another. The organizational structure of the schools dictated how the grant activities could be accomplished. It was clear as well that some principals were more ready to embrace wellness activities within their schools than others, and approval from the superintendent was not enough in itself to gain entry and access to employees in all the schools. It also became clear after extensive work setting up committees and promoting worksite wellness that overall district wellness policy work would need to occur separately, even though members would probably be recruited from these groups; staff time is so precious and no one wished to travel away from their own school to join a multi-school committee.

Work was then begun with the Superintendent and the district Nutrition Services Director reviewing the old policy and introducing new policy language. This got off to a late start, but had promise for coming together by the end of June. For various reasons, some meetings had to be rescheduled, and the administration and board members asked to have this process put on hold until the fall. Later, a committee made up of parents, community members, school officials and representatives from the various schools would join in the process.

Ultimately, the most that could be accomplished by the grant was to provide the groundwork to make the process easier for district officials. The district was given a Menu of Sample Policy Language (see Appendix: 12) which originated in the WellSat School Policy Evaluation Tool (located online @ <http://www.wellsat.org/resources.aspx>) with additions of Worksite Wellness language. The superintendent and Nutrition Services Director were provided with links to the WellSat website and evaluation tool. They were also provided with a list of potential committee members. This did not include middle school employees, as there had been no opportunity to interact with those employees. While the goal was to get the policy revision to completion before the end of 2011/2012 school year, it looks promising that this can be finished in the fall, NCPHD will continue to provide guidance if the district desires our involvement.

## Dissemination of grant activities and how evaluation was part of the process:

All maps from the walkability studies have been shared with the school district's transportation department, and will be posted on their website. A PSA was sent to our local papers and are just now in the process of setting up media coverage on two local radio stations. (See Appendix 13.) This work was also mentioned in an article submitted to The Dalles Chronicle for inclusion in their special "Back to School" publication and the public was directed to our website for that. (See Appendix 14.) Currently, the walkability maps are on the NCPHD website: @ <http://www.wshd.org/wshd/> (See Appendices 15 – 19; Note that map #1 of the Dry Hollow Elementary walkability areas is simply a more close up view of a portion of map#2 because that was necessary to see some of the traffic counts on the map.) A meeting with The City of The Dalles Traffic and Safety Committee on August 15<sup>th</sup> 2012 will feature these new walkability maps and will be an opportunity for District 21's Transportation Department, Candy Armstrong, and North Central Public Health District to discuss ways these maps can be used and to start a conversation about safe walking conditions for school children. This is very timely, since the district has just redrawn the lines for bus service and more children will be walking to school because of it. There are concerns by many that this may put children at risk, so it is also a good time to start a campaign that presents the opposite view, i.e. : "Riding instead of walking to school may rob your child of exercise that can keep your child healthy".

Evaluation, as we have come to understand, is something that we think about at the beginning of a project as well as at the end. For the Wellness Policy, the policy is being built from an evaluation tool, and that same evaluation tool has been recommended for its annual review. For walkability, the walkability assessment is an evaluation of its own; it measures how safe the current walking environment is. It would be a relatively easy matter to tweak the results of our maps if the City incorporates more safety features into these areas. Another way to evaluate this, although certainly more indirectly and multi-factorial, would be to follow this by surveying numbers of children who walk to school vs. children who ride, be it bus or private vehicle. This is something that will be discussed at the Traffic and Safety committee meeting. District 21 superintendent, Candy Armstrong notes that for the first time ever, there are many children of middle school age who have type 2 diabetes and require insulin shots and fairly complicated support from school employees. She sees the link between unhealthy lifestyles

and poor health for such children and the impact it has on the district as a whole. The numbers of children with previously adult associated chronic diseases will be another indicator of how well we are addressing the health needs of school children. Finally, for Workplace Wellness, school wellness committees have been advised to incorporate evaluation into their wellness programs by tracking employee health indicators. The district has been urged to apply for School Worksite Wellness grant funds to get their wellness activities more established and to hire a coordinator who can help the committees plan activities including a health fair. It is quite likely that their health insurance provider might help to fund a few wellness measures such as blood pressure, lipids, glucose, BMI, and so on. At the very least, the committees are planning on doing some more easily accessible tracking for those factors that don't require medical tests.

### Challenges:

Several developments occurred following our grant proposal, the most concerning one being budgetary cutbacks within District 21. At the end of the 2010/2011 school year, the district was facing a 20% reduction in funding and district employees were justifiably preoccupied with this development, not knowing who would have a job the following year. Advice from District 21 grant writer, Brian Goodwin, and a survey of teachers at the Colonel Wright Elementary pointed to a need to postpone work on wellness and policy work to the beginning of the 2011/2012 school year when cuts would be finalized and the dust would settle. The reduction in resources placed tremendous stress on school employees and it has been palpable during visits to the schools this past year. Crowded classrooms have stressed the school environment. Wellness would become more important than ever, yet more challenging to accomplish. The walkability of the Colonel Wright Elementary neighborhoods was then scheduled for May of 2011 and policy work was put on hold until the 2011/2012 school year. With time, and ongoing work with schools it is likely that one would learn how to synchronize efforts with the timing within a school year.. There are events that come up that make it difficult for school employees to be available; many of these events are foreseeable, like deadlines for grading, school testing, parent teacher nights, and the many school breaks (Winter break, Spring Break, and Summer Break) as well as teacher work days and so on. Learning the

school calendar could help a great deal in efforts to coordinate and to be available when school employees are free.

In addition to factors within the school district, small rural health departments such as ours require that people wear many hats, and within the various programs there are peaks and valleys that occur naturally and dictate how time is managed; priorities are often dictated by outside forces and can be somewhat unpredictable. As far as that goes, a lesson learned for this grantee might also be that proposals should be written with some flexibility in mind and with an expectation that the unexpected will happen, it's just that the details don't become clear until later on. A grantee must think through what they promise to do and be aware of the many factors that are not within your control. Careful attention should be given to deciphering what the chain of command is within the organizations you partner with and learning who needs to be on board from the very start. Top down strategies don't always pave the way as one might expect.

Our collaborator from the planning department was promoted to a supervisory status in her department, and became exempt, which no longer allowed for her to be paid extra hours for working on this project. This status and the change in her workload meant she would not be able to spend as much time on this as we had anticipated. In the end, she helped whenever there were issues that she alone understood, (she was an equal partner in the first walkability study). She was especially helpful with setting up the maps and excel database from which the individual volunteer assignments would be drawn. She was very gracious and helped us out whenever we were stuck with something. This is the sort of occurrence that was unforeseeable, and as far as lessons learned, there is not strategy except to be flexible and ready to improvise.

San Francisco Public Health Department also presented challenges in how they could be reimbursed for the work we asked them to do. The project was not large enough for them to invest time in setting up a mechanism for payment, and creativity was needed to address this problem. Since this is a problem in our own department at times (the county had difficulties figuring how to disperse grant funds to reimburse our county planner for her part in the Chenowith study) it seems apparent that these are problems that may be common to governmental entities such as counties, and more effort should perhaps occur upfront to

explore how to make this process easier. So far, people have been paid for their efforts, but it isn't easy.

As mentioned earlier, each of the walkability studies were performed with only a small handful of volunteers. This sort of project is very time intensive, and this presented a real hardship. It is hard to know how this could have been more successful in terms of volunteer recruitment, but perhaps it serves as a sign that a simpler tool might be more realistic in the future.

In the end, it was apparent that although we didn't reach some of our goals, we accomplished a great deal. The walkability studies were completed and the policy work is well on its way; workplace wellness was adopted in two of the schools and the concept introduced to two others who may join at a later date.

A summary can be seen in Appendix 20: one page reports of the overall process of each of the three phases of this project as well as the overall project. A budget summary can be found in Appendix 21.

Our community owes thanks to the Northwest Health Foundation for funding this project and taking an interest in improving health in rural counties such as ours. They have been incredibly generous and patient with us throughout this project and we feel incredibly grateful for this.

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# Healthy Communities Update December 2013

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## **Introduction:**

The Community Health Improvement Plan for 2011-2016 was developed using the results of the community assessments conducted throughout the Region. In response to the Federal Government's Affordable Care Act, the State of Oregon launched the creation of Regional Coordinated Care Organizations. North Central Public Health District has partnered with partners to the west and to the east to conduct a Health Assessment.

Wasco County is a participant in the Columbia Gorge CCO with Hood River County. The CGCCO is governed by the Columbia Gorge Health Council. While assessing the best way to meet the needs of multiple partners around community health assessment, the CGHC made the decision to include the Columbia Gorge Region as a whole in their assessment. The Oregon Counties of Hood River, Wasco, Sherman and Gilliam and the Washington Counties of Klickitat and Skamania are assessed. The process is led by the Community Advisory Committee of the CGCCO.

Gilliam and Sherman Counties participate in the Eastern Oregon CCO. The community assessment process used by EOCCO is slightly different. Each County in the EOCCO Region convenes a Local Community Advisory Council. Each LCAC sends a member to the Regional CAC. The LCAC's are evaluating local data and information gathered from community members. This information will provide a local assessment as well as inform the regional assessment.

When the CCO Community Health Assessments are complete, NCPHD plans to cross walk the 2011-2016 assessment completed for public health. With the input of community partners, we will evaluate the needs to adjust priorities and plans to work in concert with community partners.

In the following pages, North Central Public Health has provided their updates to the 4 objectives outlined in the original CHIP. Subsequent to that update, is the result of a survey of community partners and their response to implementing strategies across the 4 key objectives.

Lastly is a reflection on areas of focus for all community partners in the year to come.

# Healthy Communities Update December 2013

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## North Central Public Health District Healthy Community Action Plan Update 2013

### Objective 1: Low/no cost physical activity opportunities

- Provided education to clients concerning local pool initiative
- Supported participation in monthly family bike rides, community fun run/walks

### Objective 2: Healthy, fresh, local fruits and vegetables

- Offered WIC Farmer's Market vouchers
- Taught WIC "Seasonal Produce" classes at local park prior to School free-lunch distribution & local Farmer's Markets
- Successfully hired VISTA volunteer to promote healthy community strategies
- VISTA volunteer and OSU Extension promoted Food Day activities and initiated "Tasting Tables" in local elementary school
- Began working with local elementary school and parents to address healthy weight and lifestyle

### Objective 3: Tobacco-free environments

- Worked with Wasco County to declare "Tobacco-Free" campus
- Continue to work with Sherman and Gilliam Counties, CGCC, Substance Abuse Treatment facilities to adopt "Tobacco-Free" campus
- Created and offer "Tobacco Cessation" quit kits to those interested

### Objective 4: Prevention, management and control of chronic diseases

- Participated in community "Go Red" event designed to educate re: Heart Disease
- Participate in Gorge-wide Breast Health Coalition, promoting screening, early detection and treatment of breast cancer
- Active member in 2 Coordinated Care Organizations in crafting future approaches to support health in all people
- Actively support Employee Wellness internally via monthly activities, healthy food policy and positive moral boosting boards as well as participating in county sponsored events/activities

# Healthy Communities Update December 2013

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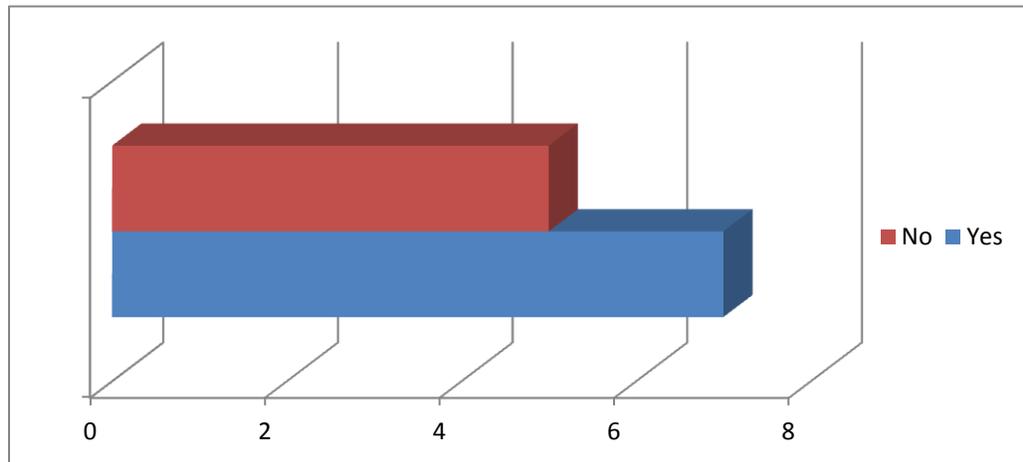
Healthy Communities Partner  
Healthy Community Action Plan Update 2013

## Question 1:

**In the past year, did your organization implement any strategies aimed at increasing physical activity levels of residents?**

Yes: 7 - 58.33%

No: 5 - 41.67%



## If yes, was the strategy:

Policy – 0%

Systems Change: 2 – 28.57%

Environmental Change: 2 – 28.57%

Other: 5 – 71.43%

- Steps to Wellness (Pasos a las Salud) 12 wk course offered to Spanish speaking community members; Primary medical Care encouraging physical activity as key to health, OCH
- Offered free Zumba classes to parents
- Curriculum - I am Moving, I am Learning - Early Childhood
- added weekly Yoga sessions, taking walking breaks, outdoor physical/activities with clients
- Use of transportation options such as walking and biking

## Healthy Communities Update December 2013

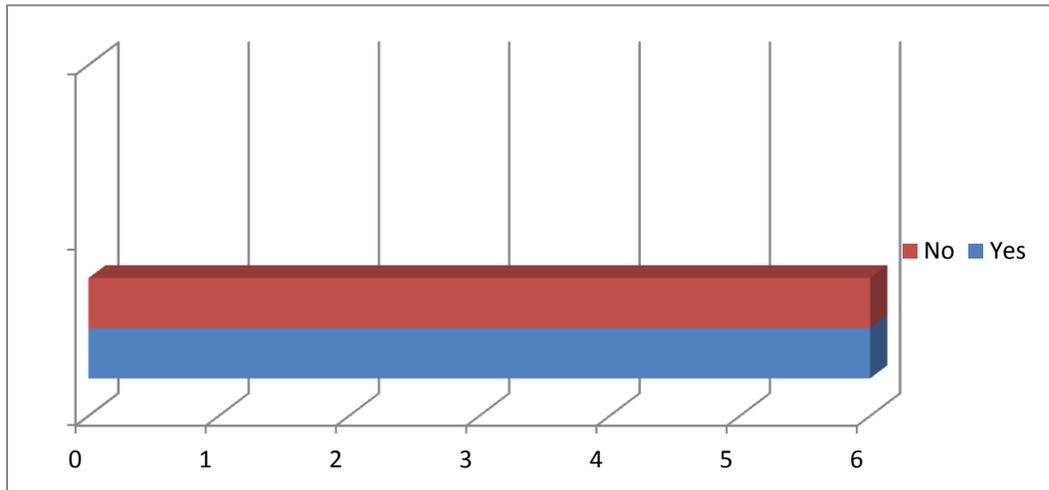
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### Question 2:

**In the past year, did your organization implement any strategies aimed at improving the nutrition of residents?**

Yes: 6 – 50%

No: 6 – 50%



### **If yes, was the strategy:**

Policy – 0%

Systems Change: 1 – 14.29%

Environmental Change: 2 – 28.57%

Other: 5 – 71.43%

Steps to Wellness (Pasos a las Salud) 12 wk course offered to Spanish speaking community members; Primary medical Care encouraging accessible, affordable nutritious foods as key to health, OCH

Parent Meetings aimed at nutrition content, sugar and cooking classes

Direct education

CACFP Nutrition Requirements

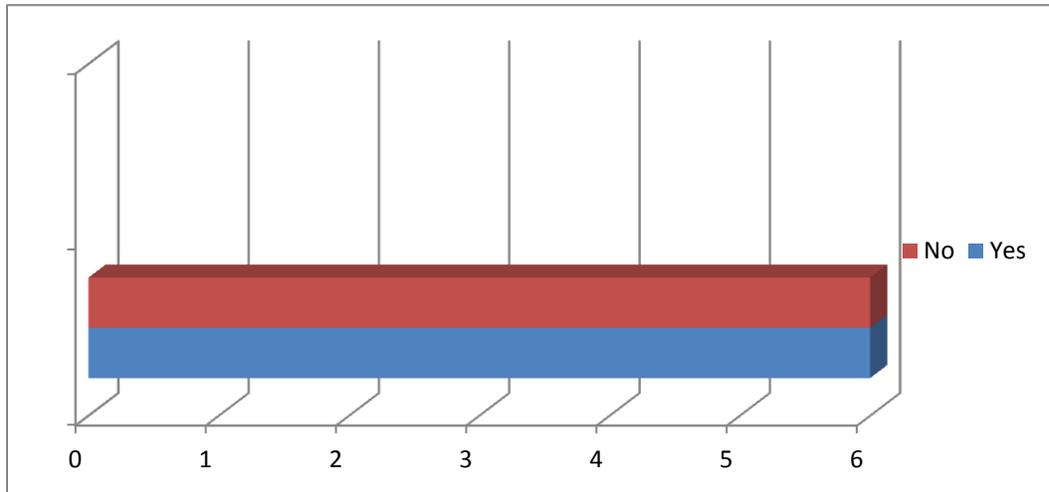
In the past 4 years, we have implemented a Health Committee and practice having healthy choices of food (low fat, sugars, calories, and high whole grains, natural sweeteners) during any activities that serve families in the community as well as staff.

## Question 3:

In the past year, did your organization implement any strategies aimed at reducing tobacco use of residents?

Yes: 6 – 50%

No: 6 – 50%



### If yes, was the strategy:

Policy- 2 – 33.33%

Systems – 0

Environmental: 3 – 50%

Other: 3 – 50%

Community Education

Primary Medical care offering motivational discussion and tools to QUIT, OCH

Beginning/end of year questionnaire, education

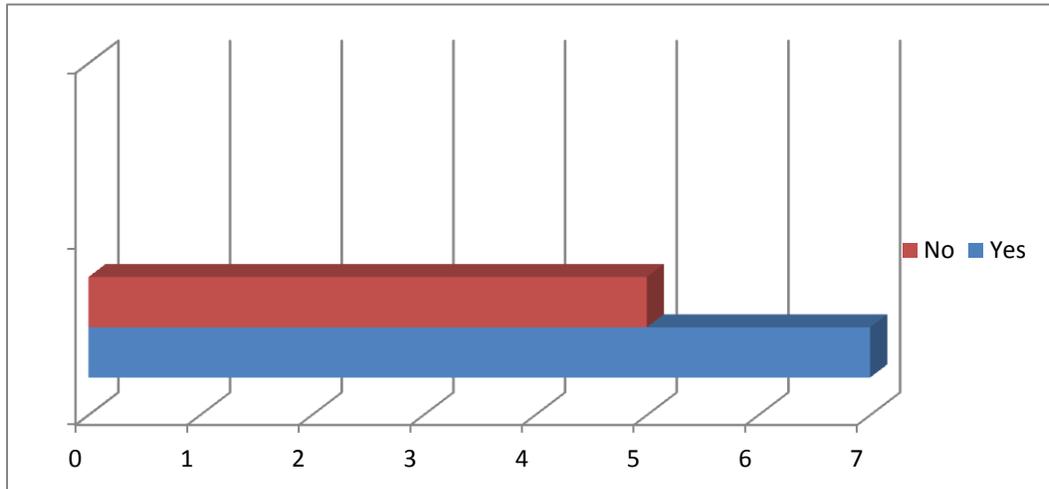
## Healthy Communities Update December 2013

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**In the past year, did your organization implement any strategies aimed at reducing the incidence of chronic disease levels of residents?**

Yes: 7 – 58.33%

No: 5 – 41.67%



**If yes, was the strategy:**

Policy: 1 – 14.29%

Systems: 2 – 28.57%

Environmental: 1 – 14.29%

Other: 4 – 57.14%

Steps to Wellness (Pasos a Salud) 12 wk course offered to Spanish speaking community members; Primary Medical Care, OCH

Promoted "Give Kids a Smile Day", promoted "Family Fun Day" with Kidz Dental, hearing/vision screens, well child/dental exams

Regular Well Child Exams – Prevention

Participants in ACE's trainings, introduction to Sanctuary, use of meditation

**In 2014, does your agency plan to?**

Continue the efforts begun this year: 7 responses – 63.64%

Expand efforts and activities: 5 responses – 45.45%

Engage in new partnerships: 7 responses – 63.64%

Other: 1 response – 9.09%

Same, continuing Primary medical/dental Care and offering Steps to Wellness classes in Spanish

# Healthy Communities Update December 2013

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## Summary:

12 Community partners, excluding NCPHD, responded to the survey. The goal of the survey was to determine the extent to which Healthy Communities partner agencies engaged in strategies targeting the top 4 areas identified in the 2011- 2016 Community Health Improvement Plan. Those target areas are: Improving Opportunities for Physical Activity, Improving Nutrition, Decreasing Tobacco Use and Reducing the Incidence of Chronic Disease.

Over all, Community Partners implemented strategies across all areas at the rate of 54%. The areas of Improving Opportunities for Physical Activity and Reducing the Incidence of Chronic Disease were rated highest.

Policy level changes were least likely to be developed, while Environmental changes were most likely to be implemented.

Partners indicated their interest in continuing the efforts begun this year as well as engaging in new partnerships in the future.

Opportunities for continued successes include:

- Provide policy level change awareness and networking with partner groups
- Identify and share Key monitoring metrics with partner groups
  1. County Health Ranking<sup>1</sup>
  2. Leading Cause of Death<sup>2</sup>
  3. Tobacco-linked Deaths<sup>3</sup>
  4. Births with Reported use of Tobacco<sup>4</sup>
  5. Adult Tobacco use Rates<sup>3</sup>
  6. Heart Disease and Stroke Risk Factors<sup>2</sup>
  7. Chronic Condition Prevalence<sup>5</sup>
- Continue to share lessons learned and opportunities to network
- Seek collaborative/innovative evidence-based strategies to improve the health of community members

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<sup>1</sup> [www.countyhealthrankings.org/oregon](http://www.countyhealthrankings.org/oregon)

<sup>2</sup> Oregon State Fact Sheet, American Heart Association, American Stroke Association

<sup>3</sup> <http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tobfacts.pdf>

<sup>4</sup> Oregon Vital Statistics County Data

<sup>5</sup> Oregon health Authority Chronic Disease Data and Publications,

<http://public.health.oregon.gov/diseasesconditions/chronicdisease/pages/pubs.aspx>

Plan for compliance with minimum standards for the Local Public Health Administrator:

In cooperation with the Board of Health of NCPHD, opportunities for graduate level course work will be explored. Funding for such course work remains a challenge. The local administrator will present a budget that funds one course per year until the standard is satisfied.

**Local Public Health Authority:**

**Date:**

**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.

**Local Public Health Authority:**

**Date:**

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.

## **Local Public Health Authority:**

### **Date:**

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.

## **Local Public Health Authority:**

### **Date:**

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.

**Local Public Health Authority:**

**Date:**

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.

## **Local Public Health Authority:**

**Date:**

### **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.

**Local Public Health Authority:****Date:****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.

## **Local Public Health Authority:**

**Date:**

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.

**Local Public Health Authority:**

**Date:**

**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: Teri Thalhoffer, RN, BSN

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.**

**Local Public Health Authority:**

**Date:**

**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.**

**Local Public Health Authority:**

**Date:**

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.**

*Julie F. Hoffner, RN, BSN*

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North Central Public  
Health District (Wasco, Sherman , Gilliam)

\_\_\_\_\_  
Local Public Health Authority

\_\_\_\_\_  
County

03012014

Date

## BUDGET INFORMATION

The NPCHD budget can be found at the following links within the Wasco County budget for the 2013-2014 year.

<http://co.wasco.or.us/county/documents/adoptedrequirements.pdf>

<http://co.wasco.or.us/county/documents/adoptedresources.pdf>

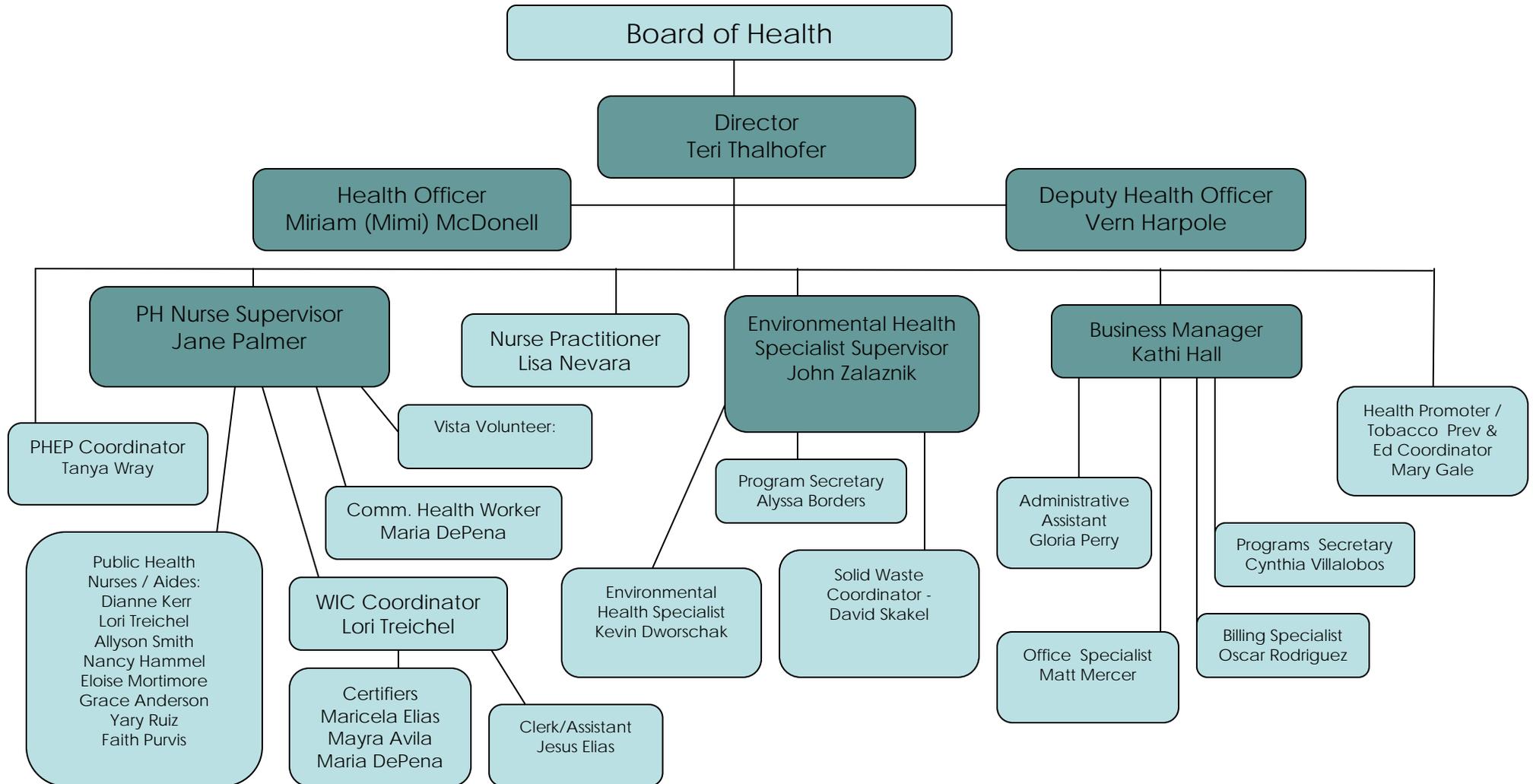


**Public Health**  
Prevent. Promote. Protect.

**NORTH CENTRAL PUBLIC HEALTH DISTRICT**

*"Caring For Our Communities"*

# North Central Public Health District *Organizational Chart*



Revised: December 16, 2013

*Signifies Leadership Team*