

Community Health Assessment Yamhill County, Oregon

2013



Public Health
Prevent. Promote. Protect.



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Cover Photos: "Yamhill River" and "Peavine Road Barn" courtesy of Gary Halvorson, Oregon State Archives

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Executive Summary

A Community Health Assessment (CHA) is the process of identifying and prioritizing a community's health needs. This is accomplished through the collection and analysis of health data, and requires input from community stakeholders. Yamhill County Public Health worked with community partners to identify, collect, analyze, and share information about the community's health assets, strengths, resources, and needs.

The Mobilizing for Action through Planning and Partnerships, or MAPP, strategic planning tool was used to help community members prioritize public health concerns and identify assets to address them. The results create an accurate picture of "health" in Yamhill County. Every community member brought a unique perspective as to what specific health data would be included in the CHA and helped identify available assets and barriers.

There are six phases to the MAPP process:

- Organizing for success and developing partnerships
- Visioning
- Conducting the assessment
- Identifying strategic issues
- Formulating goals and strategies
- Taking action (planning, implementation, evaluation)

This report focuses on the assessment portion of the process, particularly the Community Health Status Assessment, the Forces of Change Assessment, and the Community Themes and Strengths Assessment. Results from the community survey identified thirteen top priority areas highlighted throughout the assessment.

Information gathered from the CHA will be used to inform and develop strategies and a Community Health Improvement Plan (CHIP) to address identified needs, with the overall goal of improving the community's health. This will be accomplished by answering the following questions:

- Where are the opportunities to intervene?
- What are the "root causes" of the strategic issues?
- What roles are there for the local health department, partner organizations and community groups?



Silas Halloran-Steiner, Director
Yamhill County Health and Human Services Department

Introduction

Community Health Status Assessment

What It Is:

The Community Health Status Assessment is a compilation of national, state, and local county data that was collected and analyzed to provide a deep understanding of the concerns community members feel are important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?"

Method:

We compiled and analyzed the most recent five years' worth of trend data and existing data sources for the nation, state, and county to complete our community health profile. The profile is based on a variety of community factors. Areas of research and summary of findings include:

Who We Are	Strengths and Risks	Our Health Status
Demographics (pp.8-9)	Quality of Life (pp.20-23)	Social and Mental Health (p.38)
Socioeconomic Characteristics (pp.10-12)	Behavioral Risk Factors (pp.24-33)	Maternal and Child Health (pp.39-42)
Health Resource Availability (pp.13-19)	Environmental Health Indicators (pp.34-36)	Death, Illness, and Injury (pp.43-45)
	Communicable Disease (p.37)	

Community Input Came From:

Government: Chehalem Parks and Recreation, Communities of Color, Healthy Kids, Confederated Tribes of Grand Ronde, Dayton Together Coalition, Department of Human Services Child Welfare, Housing Authority of Yamhill County, Mayor City of Carlton, Newberg City Council, Northwest Senior and Disability Services, Senator Merkley's Office, Yamhill County Board of Commissioners, Yamhill County Health and Human Services, and Yamhill County Juvenile Corrections

Faith-Based: Faith in Action, McMinnville Cooperative Ministries, McMinnville Covenant Church, Parish Nurse McMinnville, Hope Reentry Services, and Yamhill County Gospel Mission

Medical: Carlton Dental, Providence Newberg Medical Center, Springbrook Chiropractic & Natural Health, Virginia Garcia Memorial Health Center, and Willamette Valley Medical Center

Education: George Fox University, Linfield College, Newberg School District, McMinnville School District, Oregon State University Extension Services, School Health Advisory Council-Sheridan High School, Sheridan School District, and Willamette Educational Service District

Community Members/Students: Eleven individuals

Non-Profit: Chehalem Youth and Family Services, Henderson House, Lutheran Community Services Northwest, Tooth Troop, United Way, Yamhill Community Action Partnership, and Yamhill County Dental Society

Business: Anytime Fitness, Climax Portable Machine Tools, and News-Register

Survey Questions (Appendix A):

1. What are the top three health issues/concerns you see in our community?
2. What strengths, resources or assets does our community have that can be used to improve community health?
3. Are there any health indicators missing from this list?
4. Are there any health indicators that you find unnecessary on this list?
5. What agency, if any, do you represent?
6. What city do you live in?

Where health indicators came from:

The final list of health indicators used for the Yamhill County Community Health Status assessment came from the County Health Rankings, the Yamhill County Public Health Accreditation Team, and by survey responses from community members and organizations.

Where the targets came from:

Targets for each of the health indicators came from one of two sources: The County Health Rankings and Healthy People 2020. Targets are based on the most recent data available at the time of this assessment.

The County Health Rankings combines the most recent health information from a selection of national data sources, most of which are public. Measures based on vital statistics data, sexually transmitted disease rates, and Behavioral Risk Factor Surveillance System (BRFSS) survey data were calculated by staff at the National Center for Health Statistics and additional divisions of the Centers for Disease Control and Prevention (CDC). This is also true for the health care quality measures, which were calculated by the authors of the Dartmouth Atlas of Healthcare, using Medicare claims data.

Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. These specific, measurable objectives utilize nationally-represented data sources such as the National Vital Statistics System and the CDC. Ten-year targets are set for each objective and are used as benchmarks to compare State and local data.

Forces of Change Assessment

What It Is:

A Forces of Change Assessment is aimed at identifying forces—such as trends, factors, or events—that are or will be influencing the health and quality of life of the community and the local health system.

- Trends are patterns over time, such as migration in and out of a community.

- Factors are discrete elements, such as a community's large ethnic population, an urban setting, or the jurisdiction's proximity to a major waterway.
- Events are one-time occurrences, such as a hospital closure, a natural disaster, or the passage of new legislation.

Method:

Key stakeholders throughout Yamhill County were brought together to help identify what forces might be contributing to the health of the community. In all, 12 partners representing 9 agencies participated in the 1 ½ - hour long discussion. Participants helped to identify forces as well as potential threats and opportunities within the community under the following categories:

- Educational
- Collaborative
- Health Care
- Economic
- Social
- Environmental
- Legal/Political
- Technological/Scientific

Summary of Findings:

Several recurring themes emerged during the forces of change assessment. Participants identified collaborative partnerships and information sharing as opportunities across all determinants of health in the community while economic uncertainty continues to pose a threat. A growing number of grassroots efforts were identified to potentially meet that threat.

Community Themes and Strengths Assessment

What It Is:

The Community Themes and Strengths assessment provides a deep understanding of the issues residents feel are important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?"

Method:

Yamhill County hosted two Community Health Forums in McMinnville and Newberg to begin the dialogue with community members, organizations, businesses, and health professionals about health and wellness.

In addition to the Community Health Forums, 102 surveys and interviews were conducted with representatives of government, education, medicine, community members, non-profit and other organizations to help identify Yamhill County's assets, strengths and resources (Appendix B). Survey and interview responses were compiled and analyzed for common themes.

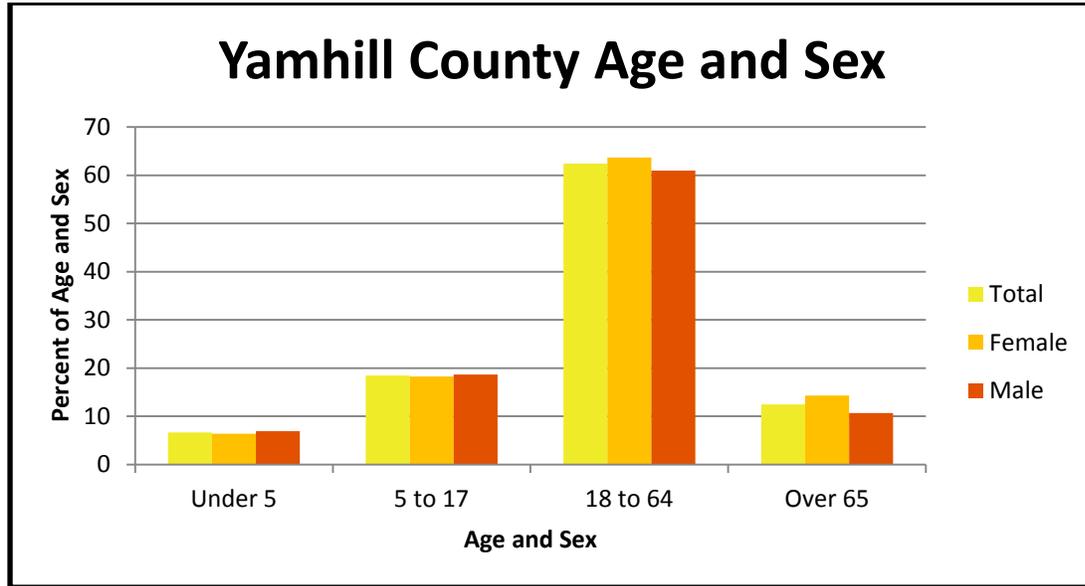
Summary of Findings:

Surveys, interviews, and health forums were conducted across diverse community partnerships. In accordance, community strengths and themes were found to be many and very diverse. Common themes included: obesity, nutrition, physical activity, chronic disease, health insurance, health care access, women, infant and children's health, physical abuse, elder care, poverty, homelessness, unemployment, substance abuse and dental care.

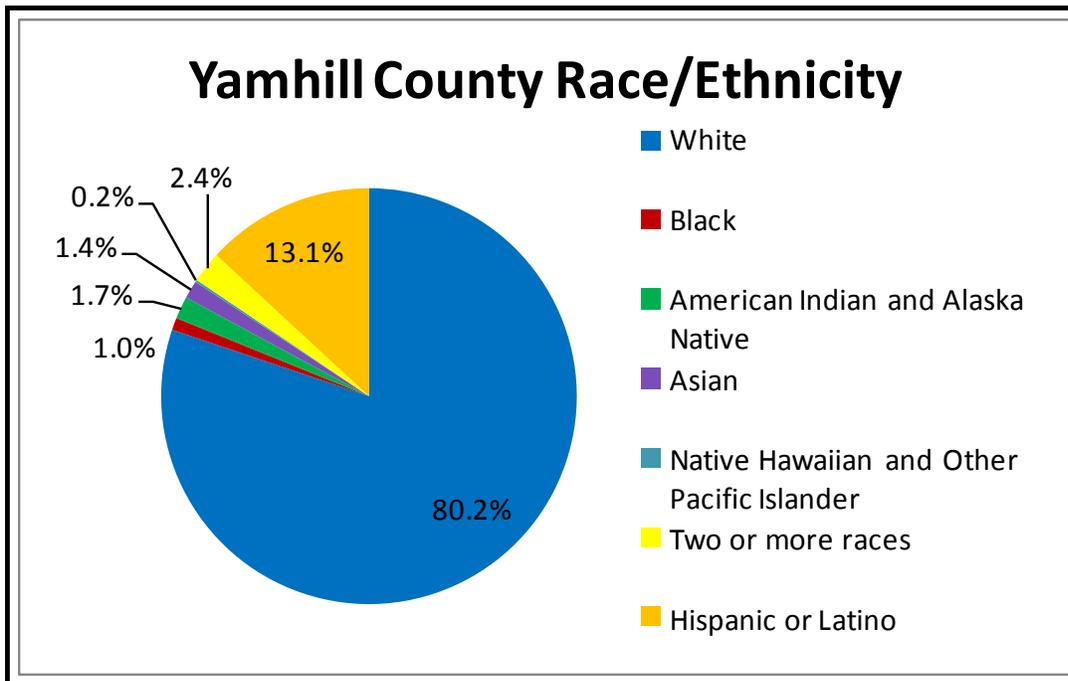
Community Health Status Assessment Findings

WHO WE ARE

DEMOGRAPHIC CHARACTERISTICS

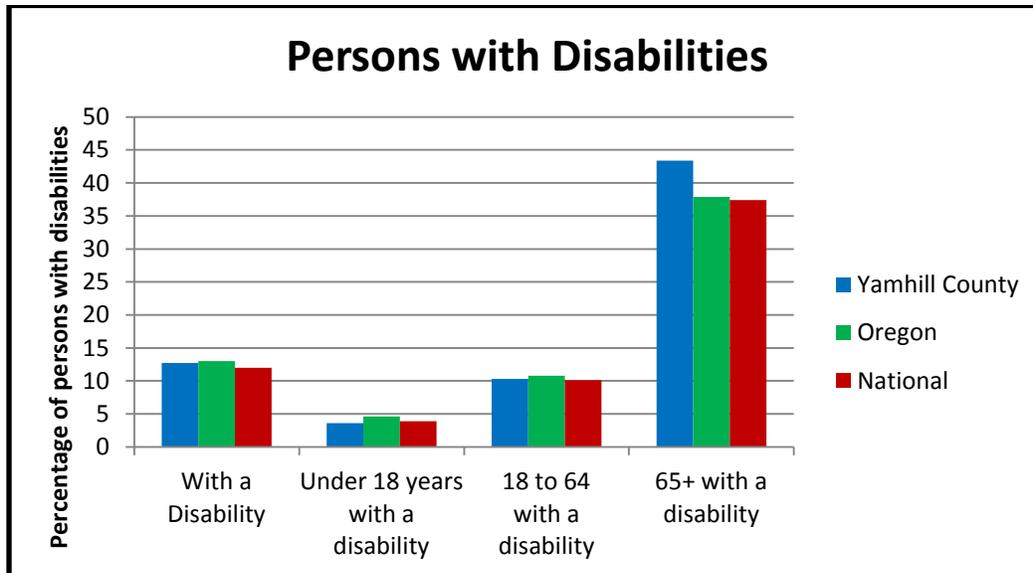


Source: American Community Survey, 2005-2009



Source: U.S. Census Bureau, 2010

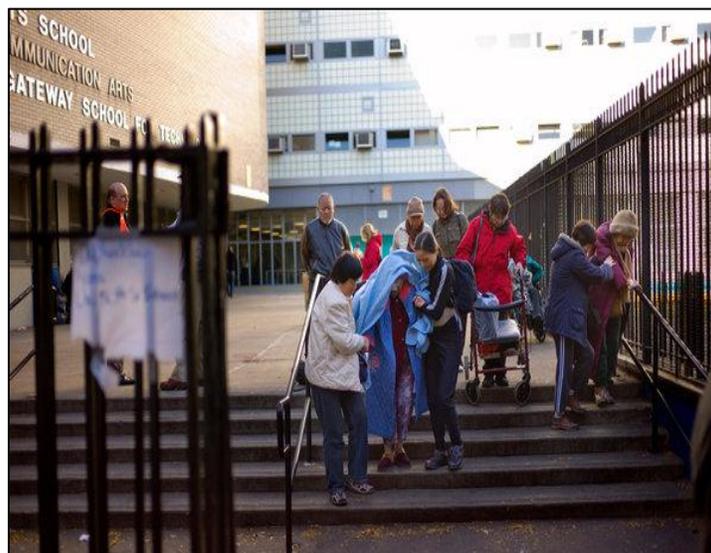
WHO WE ARE DEMOGRAPHIC CHARACTERISTICS



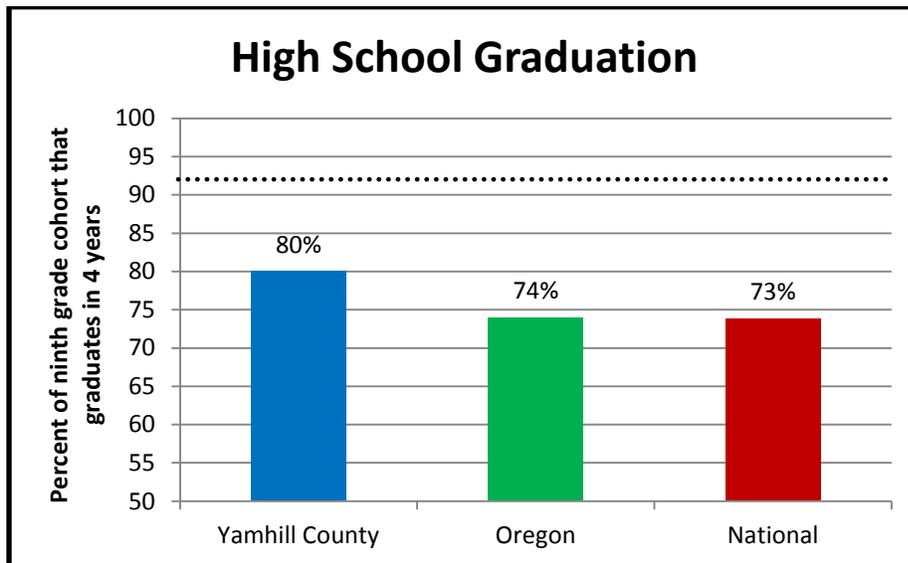
Source: American Community Survey, 2009

Disability status of the non-institutionalized population may include physical, intellectual, or sensory impairment, medical conditions or mental illness. Such impairments, conditions, or illnesses may be permanent or transitory in nature.

People with disabilities need health care and health programs for the same reasons anyone else does—to stay well, active, and to reach their full potential. A clear relationship exists between disability and poverty in that those living with a disability often do not enjoy the same opportunities and may lack access to essential services.



WHO WE ARE
SOCIOECONOMIC CHARACTERISTICS



Target:
92%
 2006-2007
 County Health Rankings

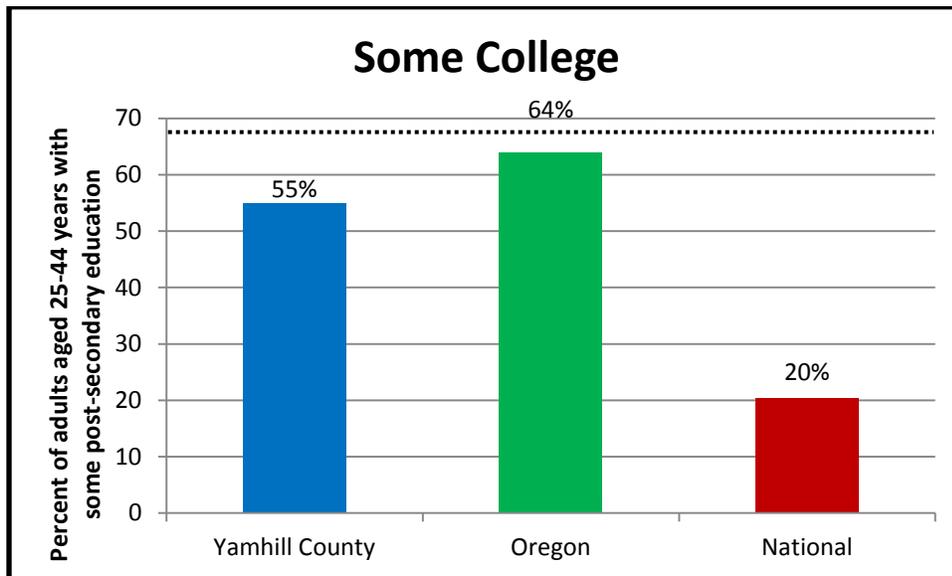
Source: National Center for Education Statistics, Common Core of Data (CCD), 2006-2007

High school graduation, commonly referred to as the averaged freshman graduation rate, is reported as the percent of a county’s ninth-grade cohort in public schools that graduates from high school in four years.

The relationship between more education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.



WHO WE ARE
SOCIOECONOMIC CHARACTERISTICS



Target:
68%
 2005-2009
 County Health Rankings

Source: American Community Survey, 2005-2009

This measure, **some college**, represents the percent of the population ages 25-44 with some post-secondary education, such as enrollment at vocation/technical schools, junior colleges, or four-year colleges. It includes individuals who pursued education following high school but did not receive a degree.

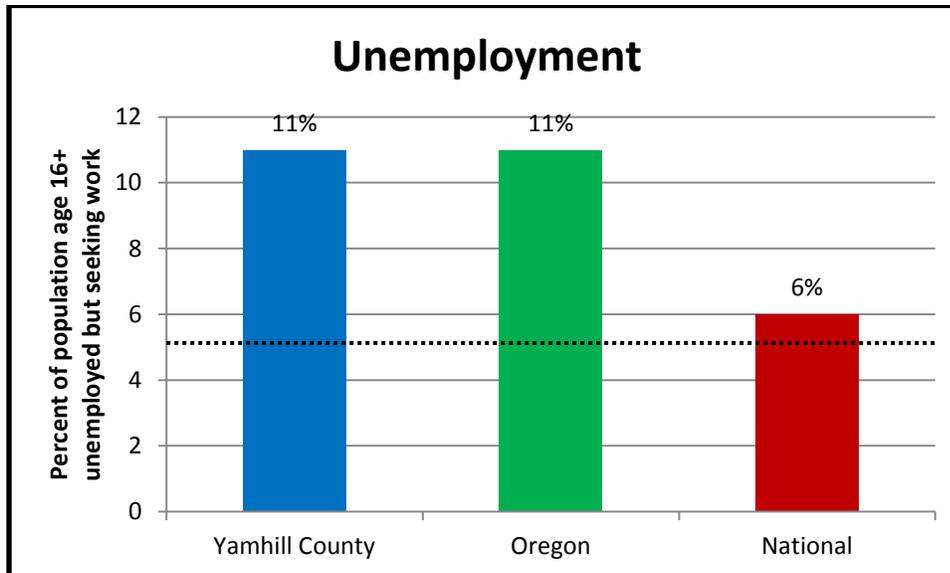
The relationship between higher education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.



WHO WE ARE
SOCIOECONOMICS CHARACTERISTICS

Community Survey
Top Concerns
Ranking:*

11



Target:
5%
2009
County Health Rankings

Source: American Community Survey, 2009

Unemployment is measured as the percent of the civilian labor force, age 16 and older, that is unemployed but seeking work.

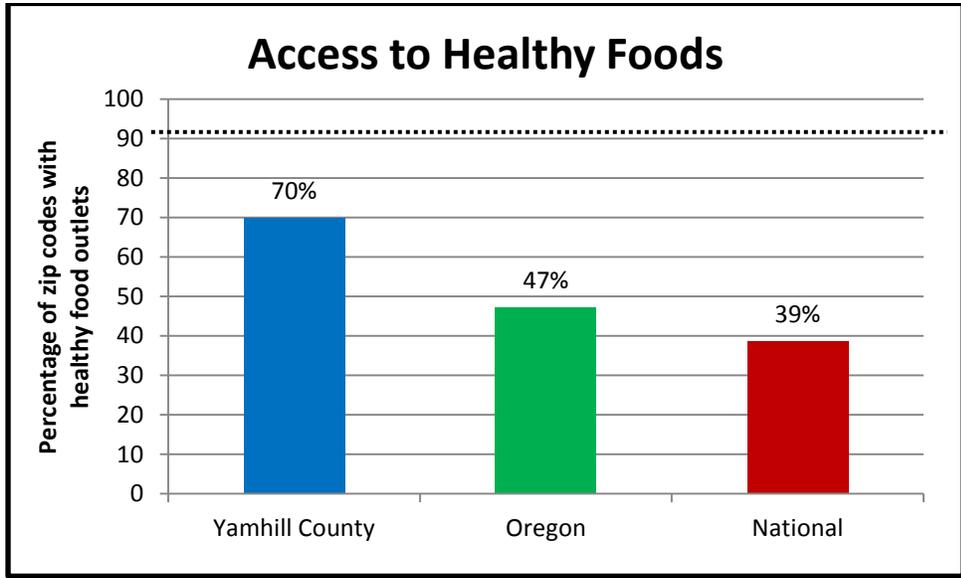


Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. It has also been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors, which in turn can lead to increased risk for disease or mortality. Because employee-sponsored health insurance is the most common source of health insurance coverage, unemployment can also limit access to health care.

***Note:** Community members were surveyed on their top health concerns (Appendix A). The results were ranked and included in this assessment.

WHO WE ARE
HEALTH RESOURCE AVAILABILITY

*Community Survey
Top Concerns
Ranking*:
5*



Target:
92%
2008
County Health Rankings

Source: Health Indicators Warehouse, 2006

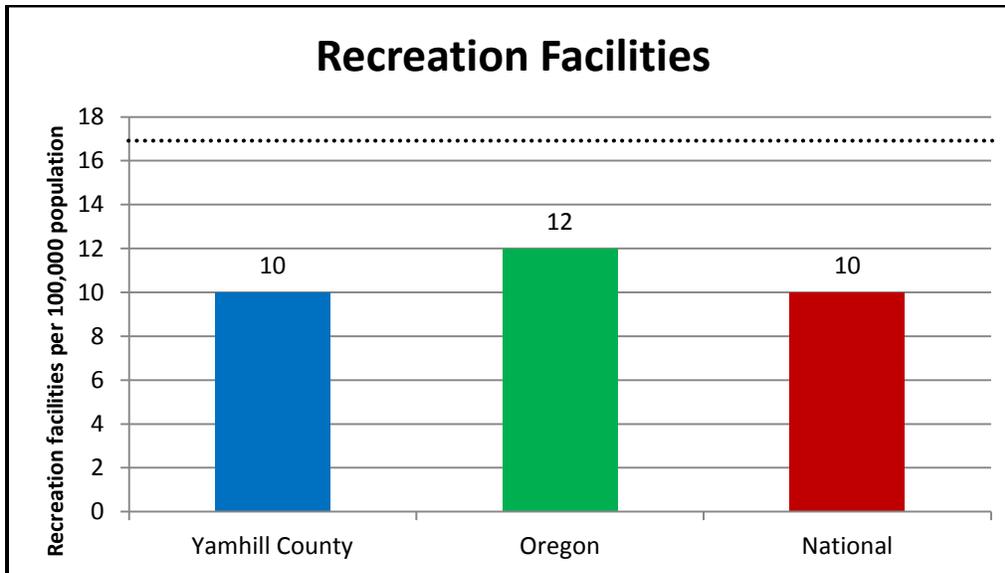
Access to healthy foods is measured as the number of zip codes out of all zip codes in a county with a healthy food outlet. Healthy food outlets include produce/farmers’ markets, as defined by their North American Industrial Classification System (NAICS) codes and grocery stores with more than four employees.

A link has been established between the consumption of healthy food and overall health outcomes.



* See note on page 12.

WHO WE ARE
HEALTH RESOURCE AVAILABILITY



Target:
17
 2008
 County Health Rankings

Source: County Business Patterns, 2008

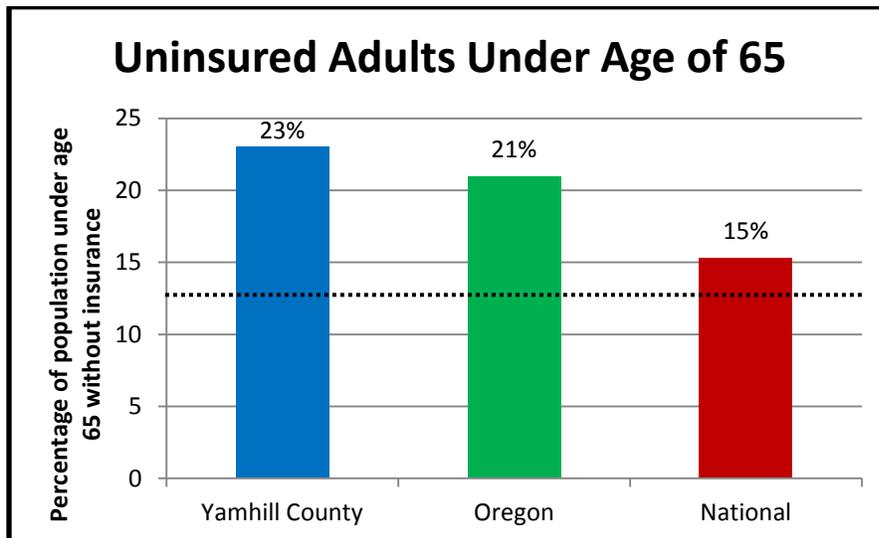
This measure represents the number of **recreational facilities** per 100,000 population in a given county. Recreational facilities are defined as establishments primarily engaged in operating fitness and recreational sports facilities, featuring exercise and other active physical fitness conditioning or recreational sports activities such as swimming, skating, or racquet sports.



The availability of recreational facilities can influence individuals' and communities' choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse health outcomes associated with poor diet, lack of physical activity, and obesity.

WHO WE ARE
HEALTH RESOURCE AVAILABILITY

*Community Survey
Top Concerns
Ranking*:
2*

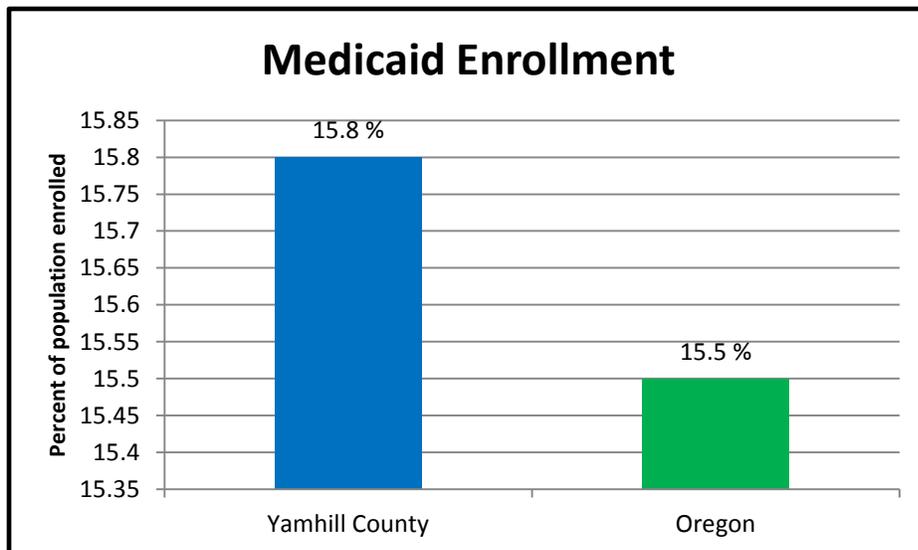


Target:
13%
2007
County Health Rankings

Source: Current Population Survey, 2007

The **uninsured adults**' measure represents the estimated percentage of the adult population under age 65 that has no health insurance coverage.

Lack of health insurance coverage is a significant barrier to accessing needed health care.



Health resource availability is partially measured by the percent of the population enrolled in the state's **Medicaid** programs. At the time of publication, national data was not available.

Source: Oregon Division of Medical Assistance Programs Summary, Dec 2010

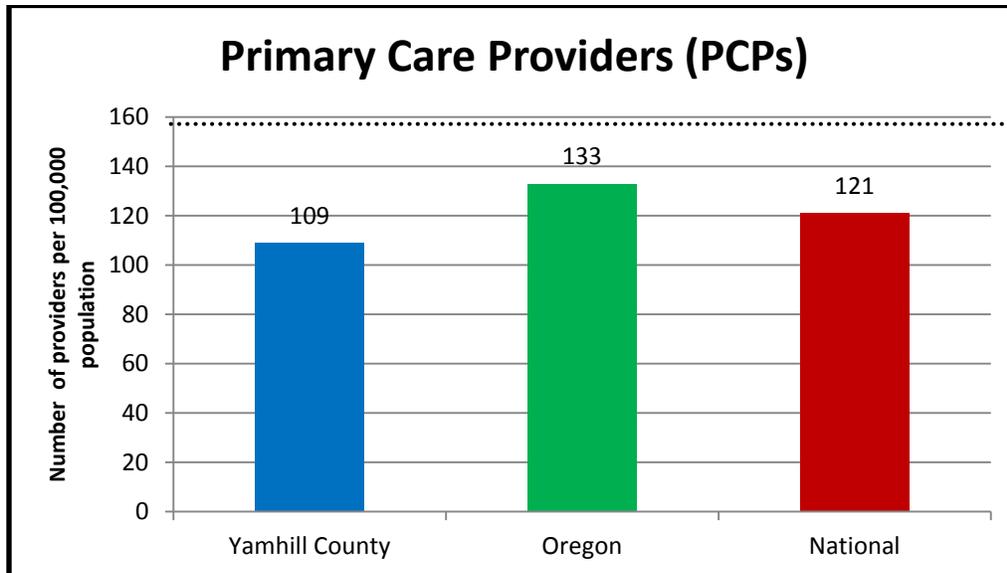
Health insurance coverage helps patients gain access to the health care system. Uninsured people are less likely to receive medical care, more likely to die early, and more likely to have poor health status. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills.

* See note on page 12.

WHO WE ARE
HEALTH RESOURCE AVAILABILITY

*Community Survey
 Top Concerns
 Ranking*:*

12



Target:
159
 2008
 County Health Rankings

Source: American Medical Association Master File and from the Census Population Estimates, 2006

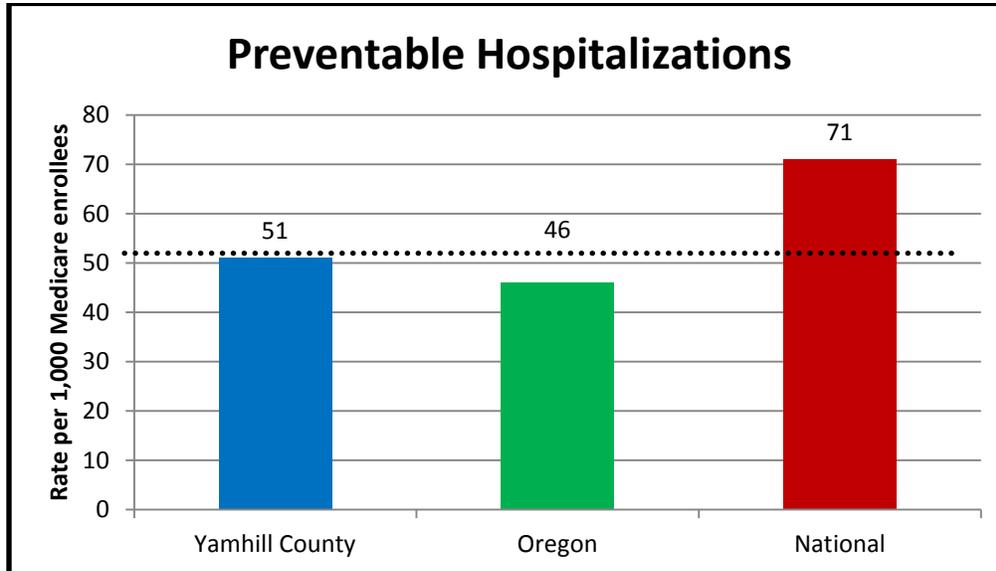
The availability of **Primary Care Physicians** was measured as the number of physicians in primary care (general practice, internal medicine, obstetrics and gynecology, or pediatrics) per 100,000 population.

Having access to care requires not only having financial coverage but also access to providers. While high rates of specialized physicians has been shown to be associated with higher, and perhaps unnecessary, utilization, having sufficient availability of primary care physicians is essential so that people can get preventive and primary care, and when needed, referrals to appropriate specialty care. To improve the nation's health, it is important to increase and track the number of practicing PCPs.



* See note on page 12.

WHO WE ARE
HEALTH RESOURCE AVAILABILITY



Target:
52
 2006-2007
 County Health Rankings

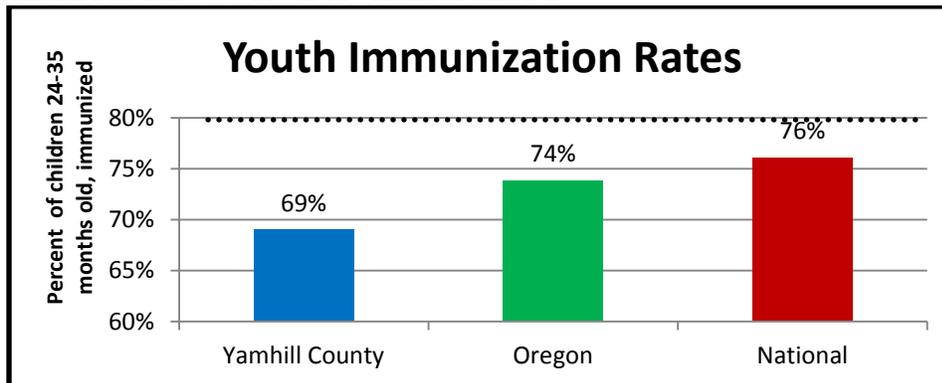
Source: Dartmouth Atlas of Health Care, 2007

Preventable hospital stays are measured as the hospital discharge rate for ambulatory care-sensitive conditions per 1,000 Medicare enrollees.



Hospitalization for diagnoses suitable for outpatient services suggests that outpatient services are underutilized and/or there is a shortage of providers. The measure may also represent the population’s tendency to overuse the hospital as a main source of care especially in communities experiencing lack of access to Primary Care Providers.

WHO WE ARE
HEALTH RESOURCE AVAILABILITY



Target:
80%
Healthy People
2020

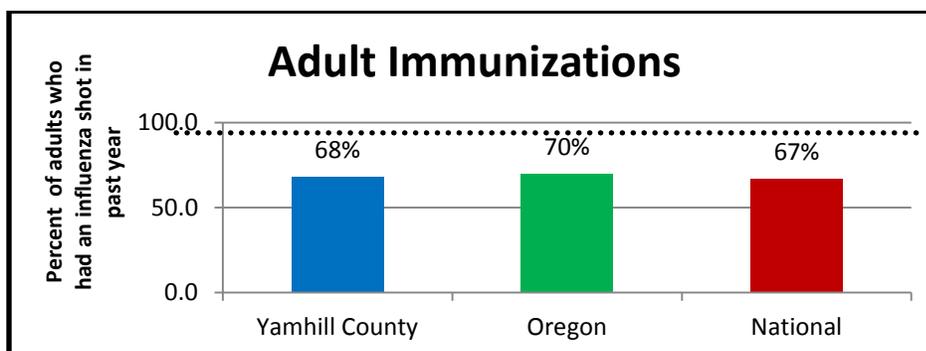
Sources: ALERT Immunization System, 2008; National Immunization Survey, 2008

Youth immunization rates were measured as two year olds up-to date rate having had 4+ diphtheria, pertussis and tetanus (DTaP), 3+ Polio, 1+ Measles, Mumps and Rubella (MMR), 3+ Haemophilus influenzae type b (Hib), 3+ Hepatitis B, 1+ Varicella (4:3:1:3:3:1).

According to Healthy People 2020, vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule (this includes DTaP, Td, Hib, Polio, MMR, Hep B, and varicella vaccines), society saves 33,000 lives, prevents 14 million cases of disease, reduces direct health care costs by \$9.9 billion and saves \$33.4 billion in indirect costs.

Adult immunizations were measured as non-institutionalized adults aged 65 and over, who have had an influenza shot within the past year.

Despite progress, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases (Healthy People 2020). Communities with pockets of unvaccinated and under vaccinated populations are at increased risk for outbreaks of vaccine-preventable diseases, whereas herd immunity protects the unvaccinated when a majority of members are vaccinated.

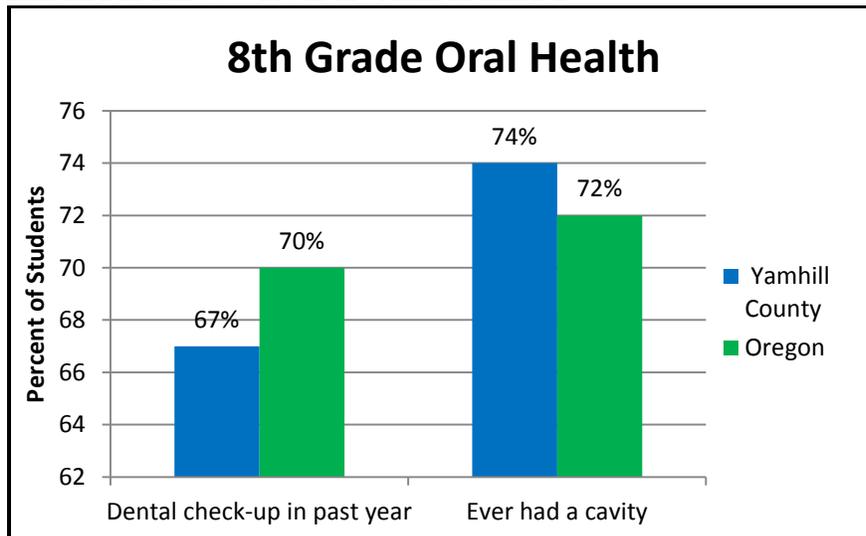


Target:
90%
Healthy People
2020

Sources: ALERT Immunization Information System, 2007, 2008; National Health Interview Survey, 2008

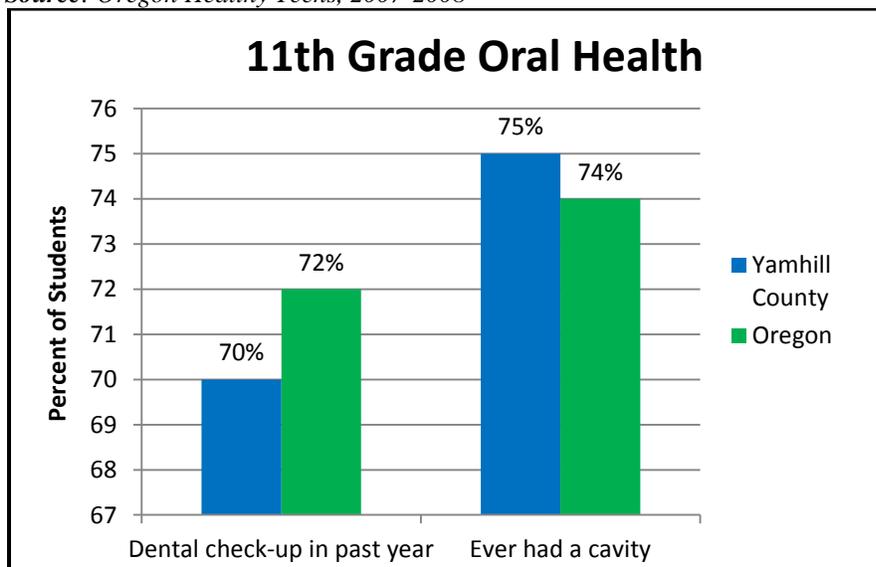
WHO WE ARE
HEALTH RESOURCE AVAILABILITY

*Community Survey
Top Concerns
Ranking*:
4*



Target:
10% improvement
Healthy People 2020

Source: Oregon Healthy Teens, 2007-2008



Target:
10% improvement
Healthy People 2020

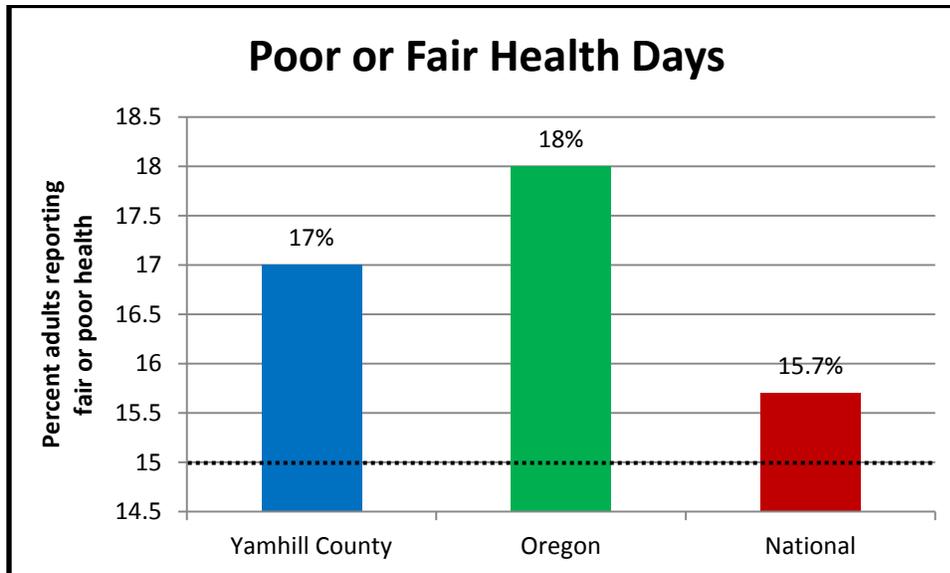
*Dental Care Health Professional Shortage Area**

According to the U.S. Department of Health & Human Services, low income; migrant farmworkers are a group and the Sheridan Federal Correctional Institution is a facility qualifying for the status of a Dental Health Professional Shortage Area (HPSA) in Yamhill County. This designation provides eligibility for workforce funding opportunities. *As designated by Health Resources and Services Administration (HRSA)

The health of the mouth and surrounding facial structures is central to an individual’s overall health and well-being. Good oral health improves and individual’s ability to speak, smile, chew, swallow, and make facial expressions to show emotion. Poor oral health is linked to heart disease, premature and low birth weight babies and tooth loss.

* See note on page 12.

STRENGTHS AND RISKS
QUALITY OF LIFE



Target:
15%
2003-2009
County Health Rankings

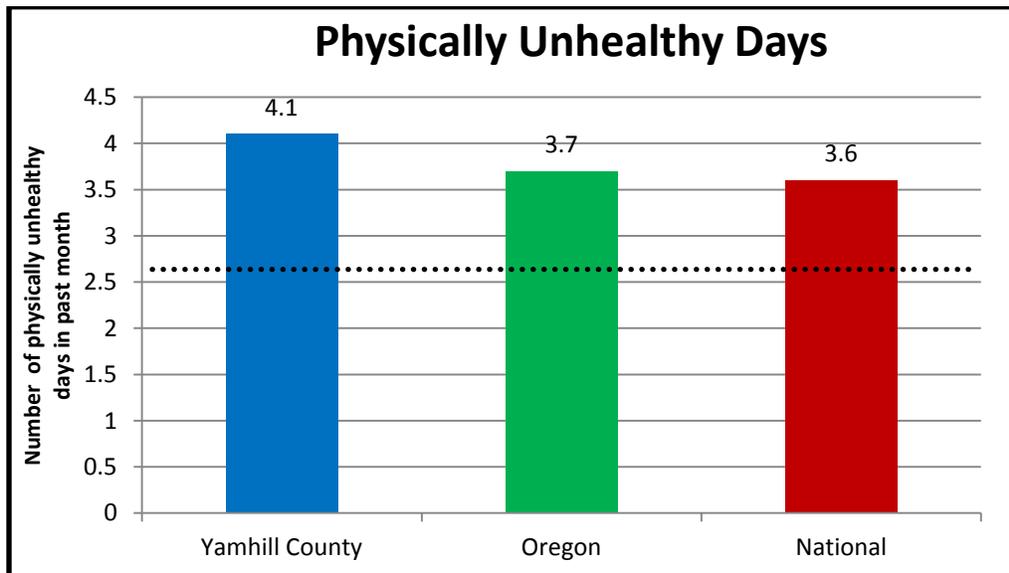
Source: Behavioral Risk Factor Surveillance System, 2003- 2009

Self-reported health status is a general measure of health-related quality of life in a population. This measure is based on survey responses to the question: “In general, would you say that your health is excellent, very good, good, fair, or poor?” The value reported in the County Health Rankings is the percent of adult respondents who rate their health “fair” or “poor.” The measure is age-adjusted to the 2000 U.S. population.

Self-reported health status is a widely used measure of people’s health-related quality of life. In addition to measuring how long people live, it is important to also include measures of how healthy people are while alive. The County Health Rankings considers self-reported health status to be a reliable measure of current health.



STRENGTHS AND RISKS
QUALITY OF LIFE



Target:
2.6
2003-2009
County Health Rankings

Source: Behavioral Risk Factor Surveillance System, 2003-2009

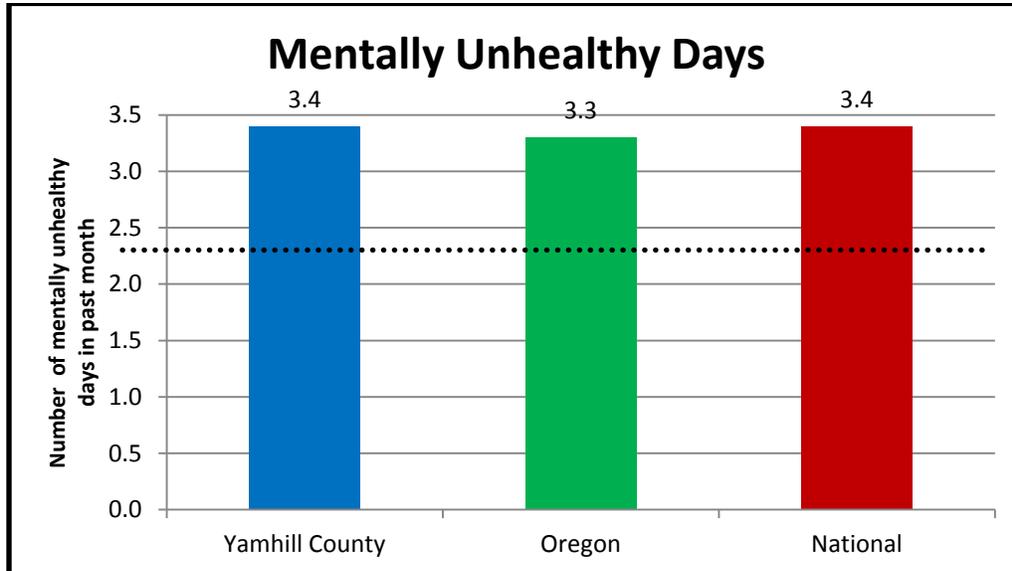
The **poor physical health days** measure represents one of four measures of morbidity used in the County Health Rankings, and is based on responses to the question: “Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?” We present the average number of days a county’s adult respondents report that their physical health was not good. The measure is age-adjusted to the 2000 U.S. population.



In addition to measuring how long people live, it is also important to include measures of how healthy people are while alive. The County Health Rankings considers people’s reports of days when their physical health was not good a reliable estimate of their recent health.

STRENGTHS AND RISKS
QUALITY OF LIFE

*Community Survey
Top Concerns
Ranking*:*
3



Target:
2.3
2003-2009
County Health Rankings

Source: Behavioral Risk Factor Surveillance System, 2003-2009

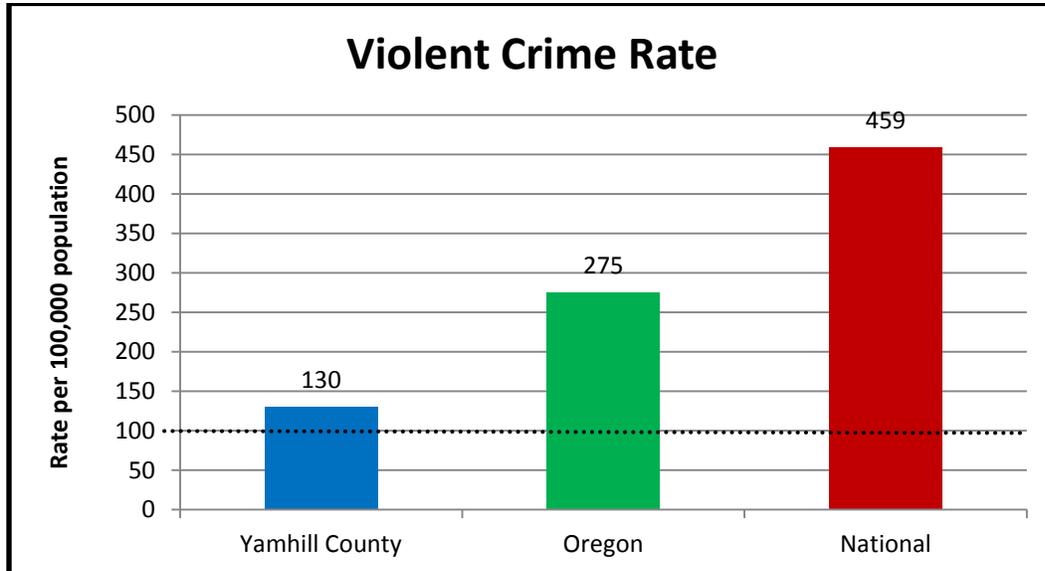
The **poor mental health days** measure is a companion measure to the poor physical health days reported in the County Health Rankings. The estimates are based on responses to the question: “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” We present the average number of days a county’s adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 U.S. population.

Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good represents an important facet of health-related quality of life. The County Health Rankings considers health-related quality of life to be an important health outcome.



* See note on page 12.

STRENGTHS AND RISKS
QUALITY OF LIFE



Source: Criminal Justice Information Services, 2008

Violent crime is represented as an annual rate per 100,000 populations. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.

High levels of violent crime compromise physical safety and psychological well-being. Crime rates can also deter residents from pursuing healthy behaviors such as exercising out-of-doors.

Domestic violence may be abuse between current or former partners and can also be abuse by a household member. Not all domestic violence cases are considered aggravated assault. The chart below shows that Yamhill County has an increasing number of domestic violence cases.

Yamhill County Domestic Violence

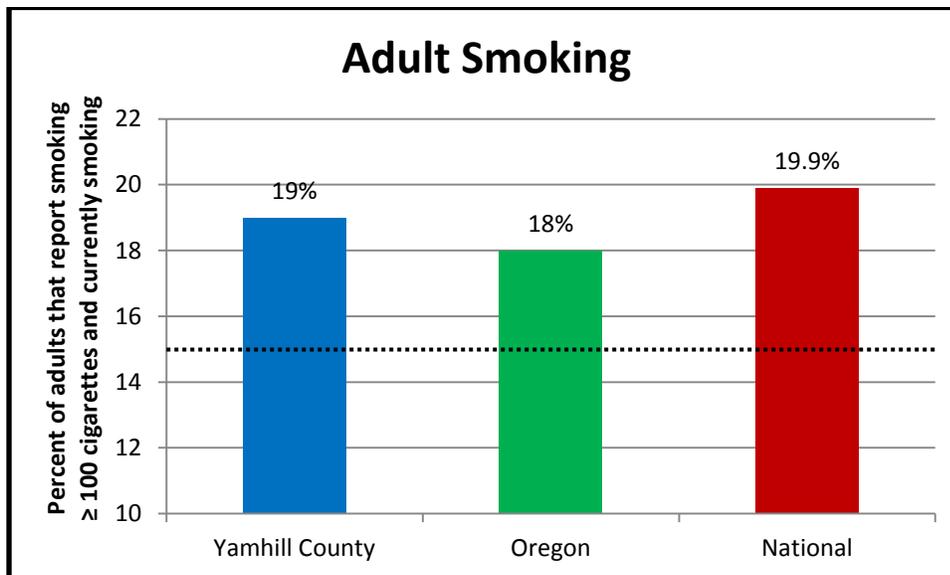
	2008	2009	2010	2011
Rate per 100,000 population	269.3	282.4	280.3	301.5

Source: Yamhill County District Attorney's office, 2008-2011 (includes all forms of domestic violence, not just intimate partner violence)

**STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS**

*Community Survey
Top Concerns
Ranking*:*

8



Target:
15%
2003-2009
County Health Rankings

Source: Behavioral Risk Factor Surveillance System, 2003-2009



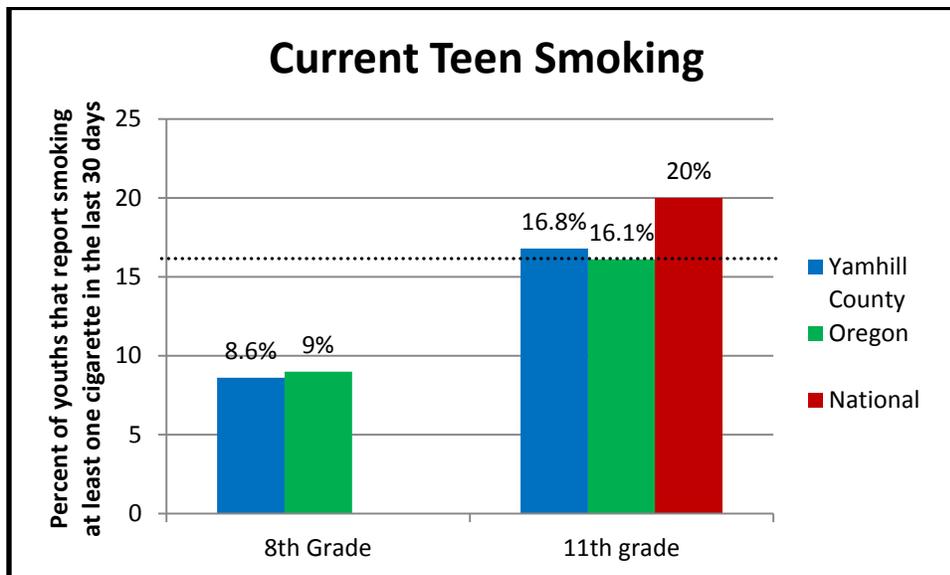
Adult smoking prevalence is the estimated percent of the adult population that reports currently smoking every day or “most days” and has smoked at least 100 cigarettes in their lifetime.

Each year approximately 443,000 premature deaths occur in the United States primarily due to smoking (Centers for Disease Control and Prevention). Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birth weight, and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs.

* See note on page 12.

**STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS**

*Community Survey
Top Concerns
Ranking*:
8*



Target:
16%*
Healthy People
2020
*Target set for
high school youth

Sources: Oregon Healthy Teens, 2007-2008; Youth Risk Behavior Surveillance System, 2007 (8th grade national data is unavailable)

Current Teen Smoking: The percent of 8th and 11th graders who currently smoke, measured as those who report they have smoked at least one cigarette in the past 30 days.

If current youth tobacco use trends continue in the United States, 6.4 million of today's young people will die from tobacco-related diseases (Centers for Disease Control and Prevention). Nearly all first-time tobacco use occurs before high school graduation. This suggests that if kept tobacco-free, most youth will never start using tobacco.

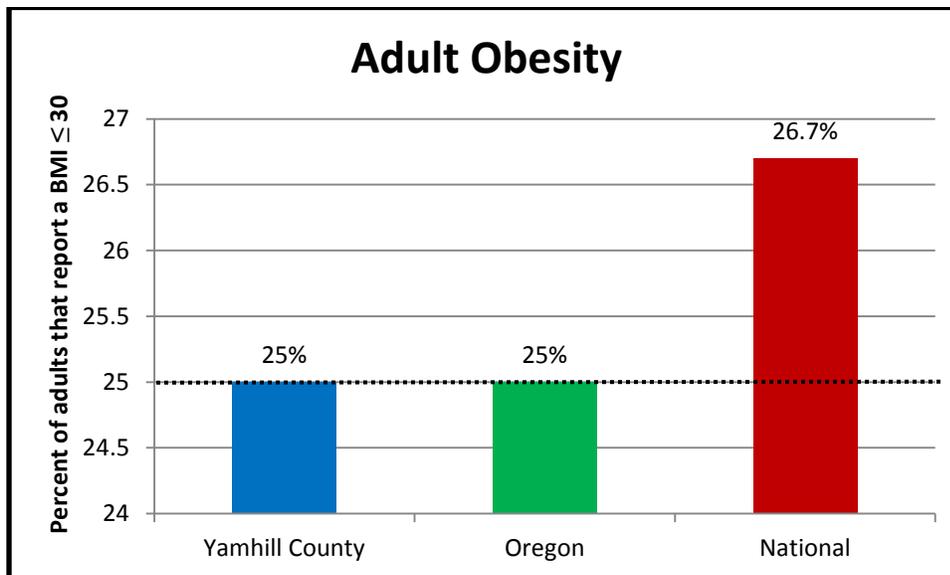


* See note on page 12.

**STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS**

*Community Survey
Top Concerns
Ranking*:*

1



Target:
25%
2008
County Health Rankings

Source: Behavioral Risk Factor Surveillance System, 2008



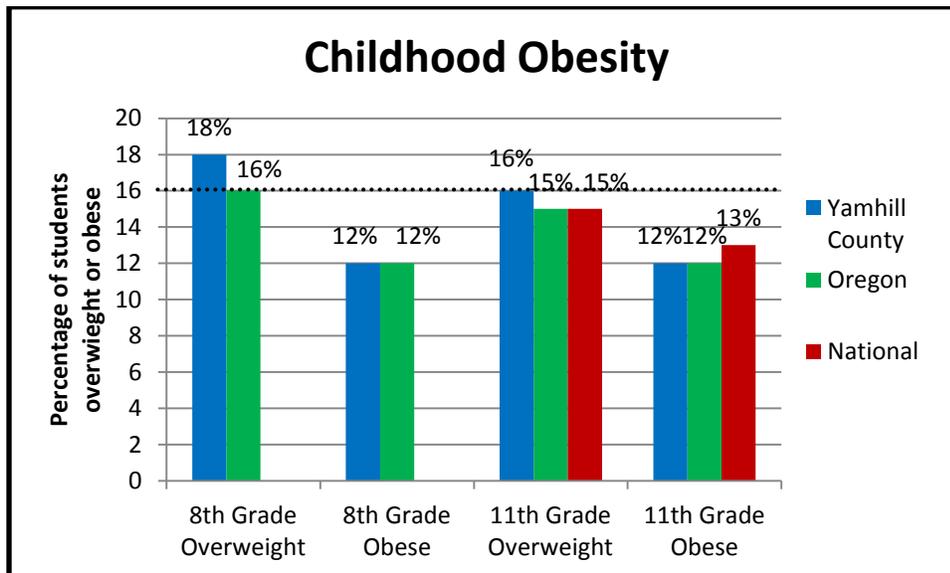
The **adult obesity** measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m².

Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder diseases, sleep apnea and respiratory problems, and osteoarthritis.

* See note on page 12.

**STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS**

Community Survey
Top Concerns
Ranking*:
1



Target:
16%**
Healthy People
2020
**Target set for
high school youth

Sources: Oregon Healthy Teens Survey, 2007-2008; Youth Behavioral Risk Surveillance Survey, 2007-2008 (National data for 8th grade overweight and obesity unavailable)

Childhood obesity is the percentage of children in 8th and 11th grade who are defined as overweight or obese as determined by their body mass index (BMI) weight to height ratio. Overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex. Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

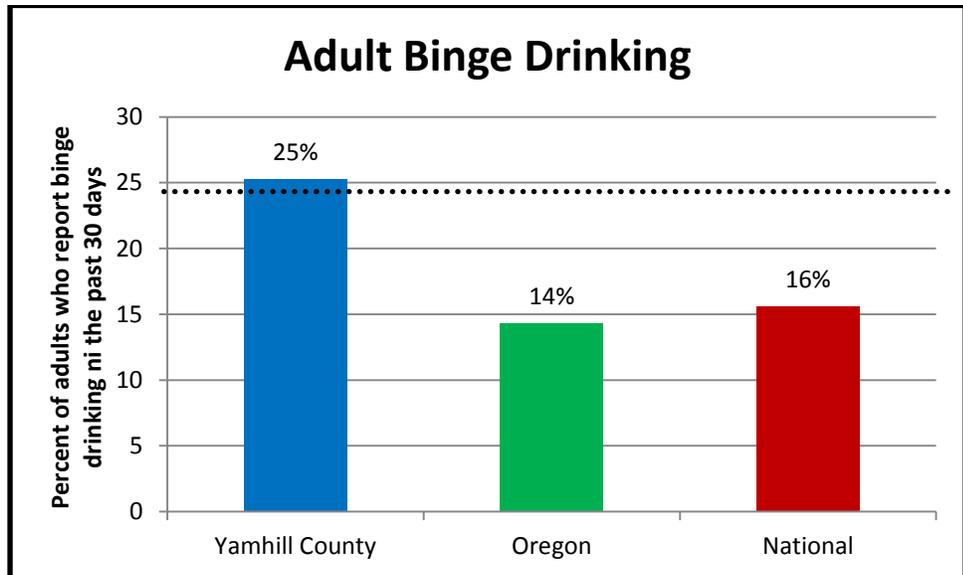
Childhood obesity can have a harmful effect on the body in a variety of ways. Obese children are more likely to have high blood pressure and high cholesterol, which are risk factors for cardiovascular disease, increases risk for type 2 diabetes, breathing problems, joint problems, fatty liver disease, gallstones, and heartburn. Obese children and adolescents have a greater risk of social and psychological problems, such as discrimination and poor self-esteem, which can continue into adulthood. Obese children are more likely to become obese adults. Adult obesity is associated with a number of serious health conditions including heart disease, diabetes, and some cancers. If children are overweight, obesity in adulthood is likely to be more severe.



* See note on page 12.

**STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS**

Community Survey
Top Concerns
Ranking*:
6



Target:
24%
2003-2009
County Health Rankings

Source: Behavioral Risk Factor Surveillance System, 2003-2009

The National Institute on Alcohol Abuse and Alcoholism defines **binge drinking** as a pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 grams percent or above. The excessive drinking measure reflects the percent of the adult population that reports either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than 1 (women) or 2 (men) drinks per day on average.

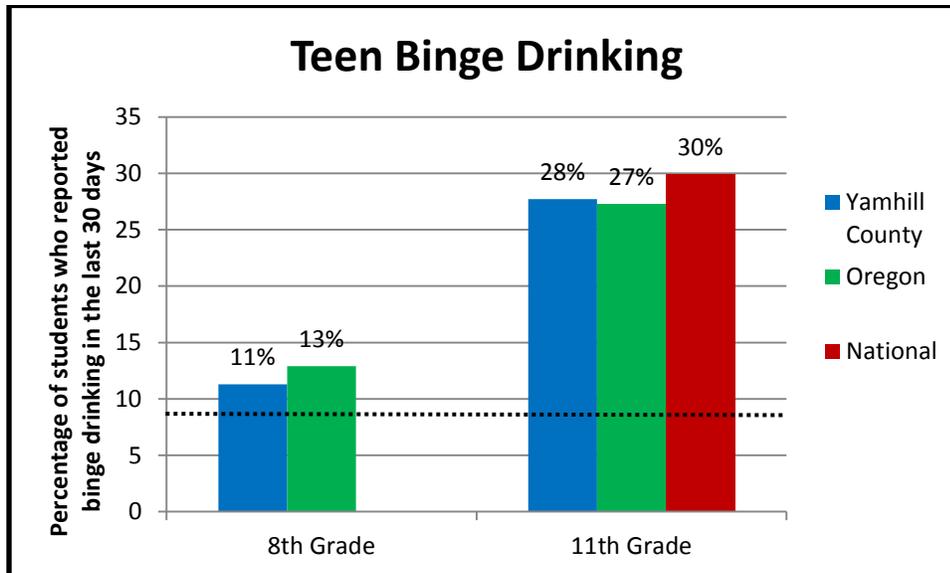


Binge drinking is a risk factor for a number of adverse health outcomes such as unintentional injuries, intentional injuries, alcohol poisoning, high blood pressure, stroke and other cardiovascular diseases, sexually transmitted diseases, unintended pregnancy, children born with fetal alcohol spectrum disorders, liver disease, neurological damage, sexual dysfunction and poor control of diabetes (Centers for Disease Control and Prevention).

* See note on page 12.

**STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS**

*Community Survey
Top Concerns
Ranking*:
6*



Target:
8.5% **
Healthy People
2020
**Target set for high school youth

Sources: Oregon Healthy Teens Survey, 2007-2008; Youth Behavioral Risk Factor Surveillance Survey, 2007-2008 (National data for 8th grade binge drinking are unavailable)

The National Institute on Alcohol Abuse and Alcoholism defines binge drinking as a pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 grams percent or above. The **teen binge drinking** measure reflects the percent of students that reports 5 or more drinks of alcohol in a row within a couple of hours at least once during the past 30 days.

Binge drinking is a risk factor for a number of adverse health outcomes such as unintentional injuries, intentional injuries, alcohol poisoning, high blood pressure, stroke and other cardiovascular diseases, sexually transmitted diseases, unintended pregnancy, children born with fetal alcohol spectrum disorders, liver disease, neurological damage, sexual dysfunction and poor control of diabetes (Centers for Disease Control and Prevention).

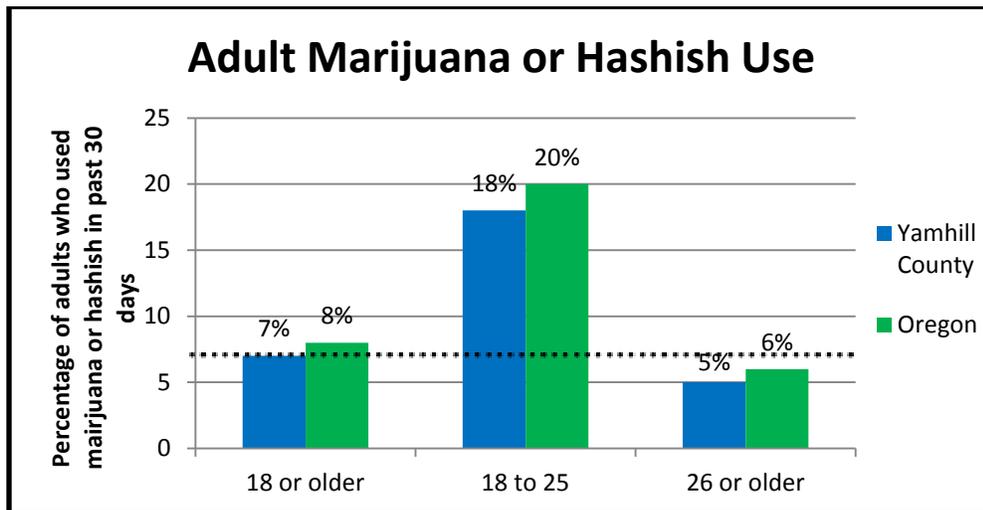


* See note on page 12.

**STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS**

*Community Survey
Top Concerns
Ranking*:*

7

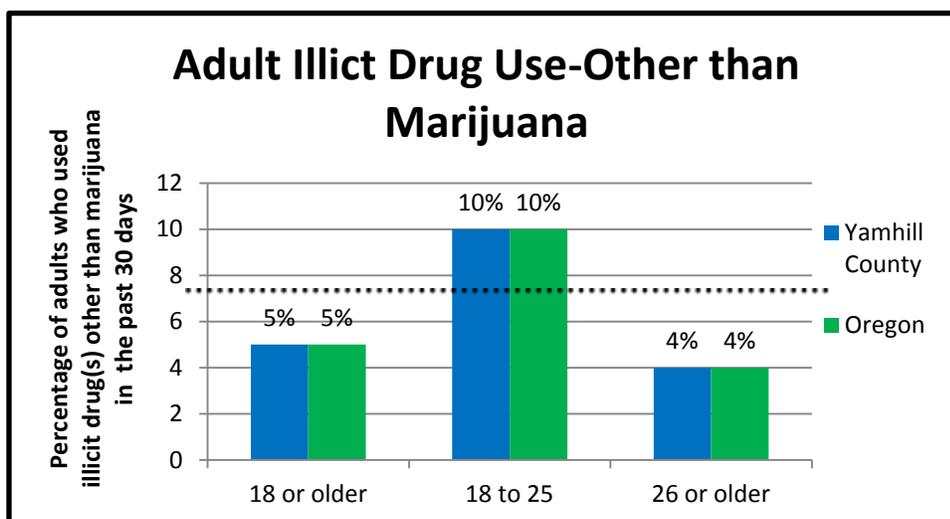


Target:
7%
Healthy People
2020

Source: National Survey on Drug Use and Health, 2006-2008

Illicit drug use by adults is defined as using at least one of the following substances in the past 30 days: Top graph: marijuana or hashish. Bottom graph: cocaine (including "crack"), inhalants, hallucinogens (including PCP and LSD), heroin, or any nonmedical use of analgesics, tranquilizers, stimulants, or sedatives.

Illicit drug use has a major impact on individuals, families, and communities. The effects of illicit drug use are cumulative, significantly contributing to costly social, physical, mental, and public health problems. Substance abuse impacts a number of negative health outcomes such as cardiovascular conditions, pregnancy complications, HIV/AIDS, teen pregnancy, sexually transmitted diseases, domestic violence, child abuse, motor vehicle crashes, homicide and suicide (Healthy People 2020).



Target:
7%
Healthy People
2020

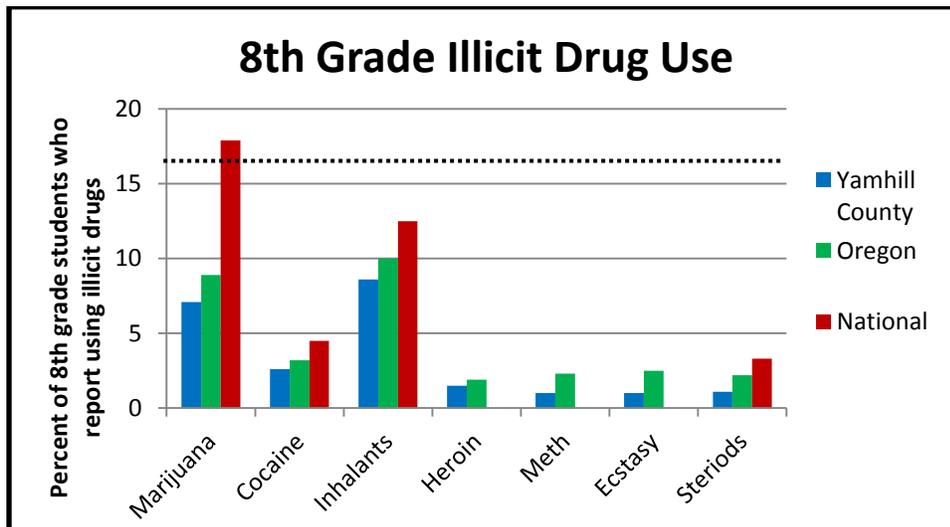
Source: National Survey on Drug Use and Health, 2006-2008

* See note on page 12.

**STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS**

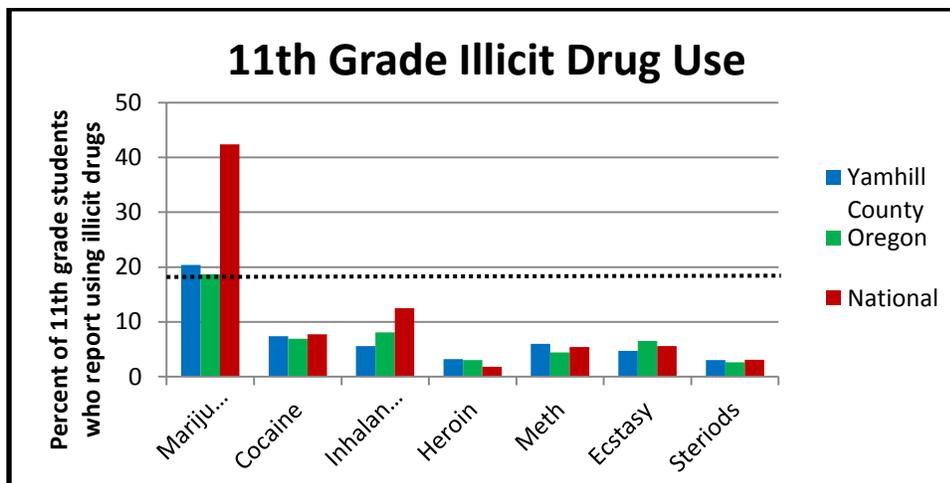
*Community Survey
Top Concerns
Ranking*:*

7



Target:
16.5%
Healthy People
2020

Sources: Oregon Healthy Teens Survey, 2007-2008; Youth Behavioral Risk Factor Surveillance Survey, 2007-2008



Target:
16.5%
Healthy People
2020

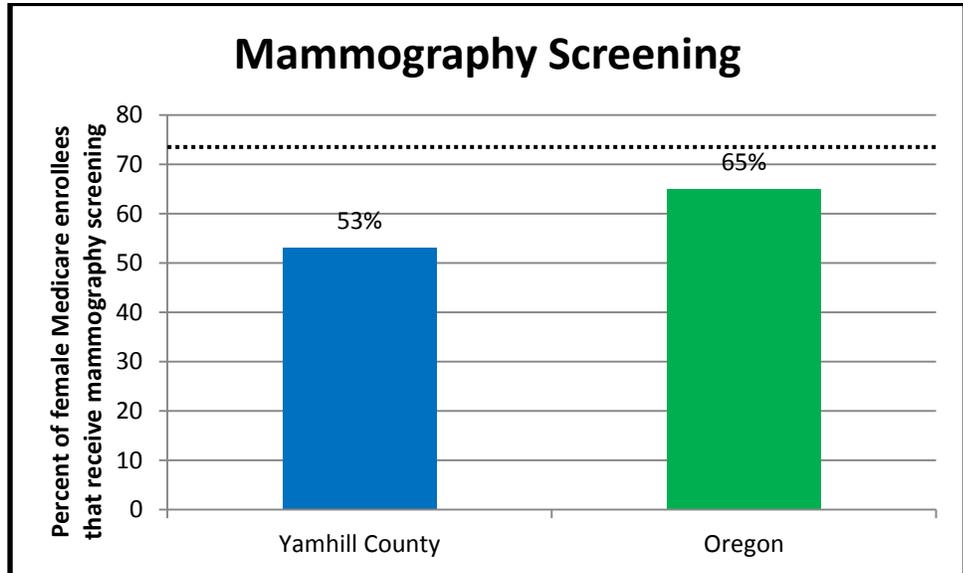
Sources: Oregon Healthy Teens Survey, 2007-2008; Youth Behavioral Risk Factor Surveillance Survey, 2007-2008

Illicit drug use by youth measures the percent of the 8th and 11th grade population that reported on illicit drug usage in their lifetime.

Illicit drug use has a major impact on individuals, families, and communities. The effects of illicit drug use are cumulative, significantly contributing to costly social, physical, mental, and public health problems.

* See note on page 12.

**STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS**



Target:
74%
2006-2007
County Health Rankings

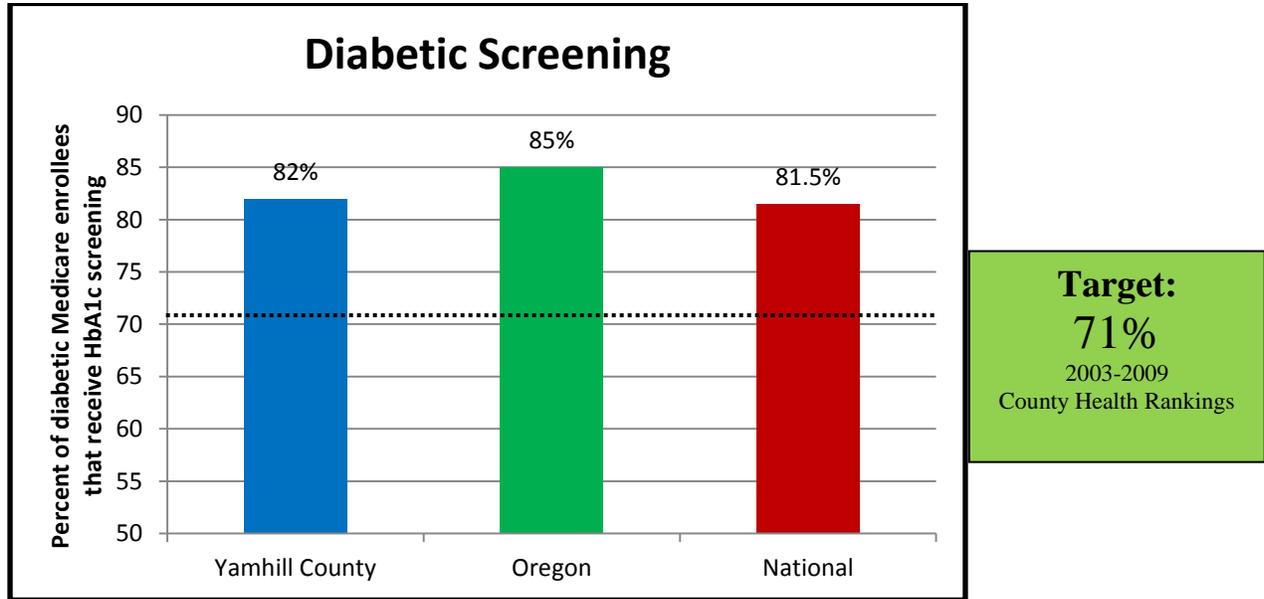
Source: Dartmouth Atlas for Health Care, 2006-2007



Mammography screening represents the percentage of female Medicare enrollees ages 67-69 that had at least one mammogram over a two-year period. At the time of publication, national data was not available.

Evidence suggests that mammography screening reduces breast cancer mortality, especially among women over the age of 50. A physician’s recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain breast cancer screenings.

STRENGTHS AND RISKS
BEHAVIORAL RISK FACTORS



Source: Dartmouth Atlas of Health Care, 2006-2007

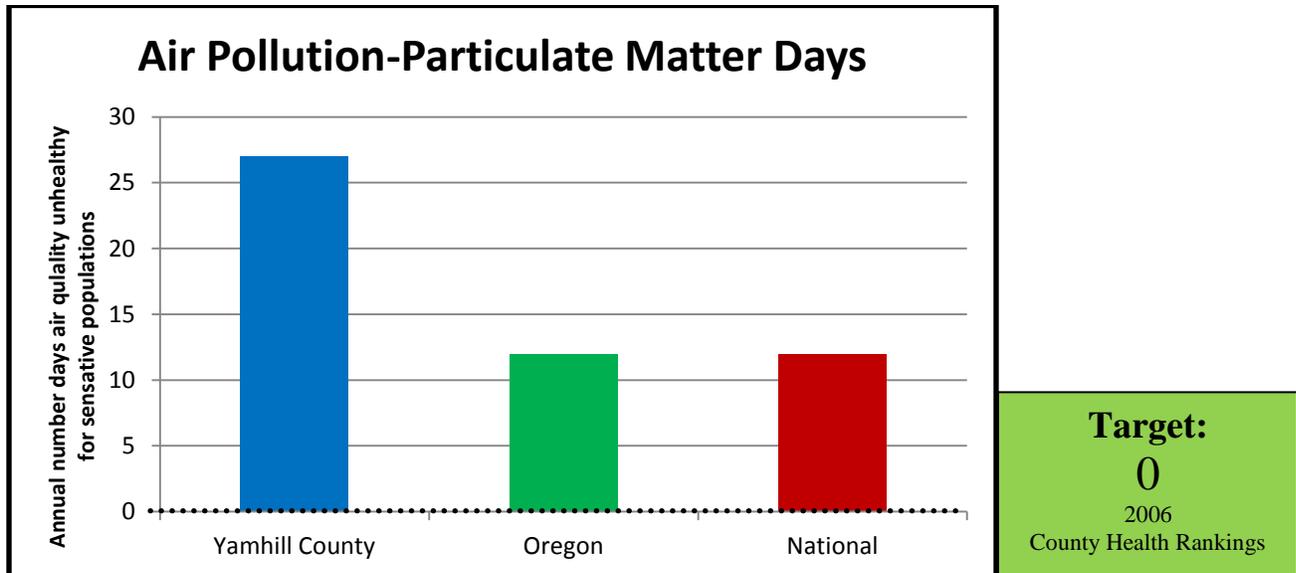
Diabetic screening is calculated as the percent of diabetic Medicare patients whose blood sugar control was screened in the past year using a test of their glycated hemoglobin (HbA1c) levels.

Regular HbA1c screening among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed and controlled, complications from diabetes can be delayed or prevented.



STRENGTHS AND RISKS

ENVIRONMENTAL HEALTH INDICATORS



Sources: Public Health Air Surveillance Evaluation, 2006; Environmental Protection Agency, 2006

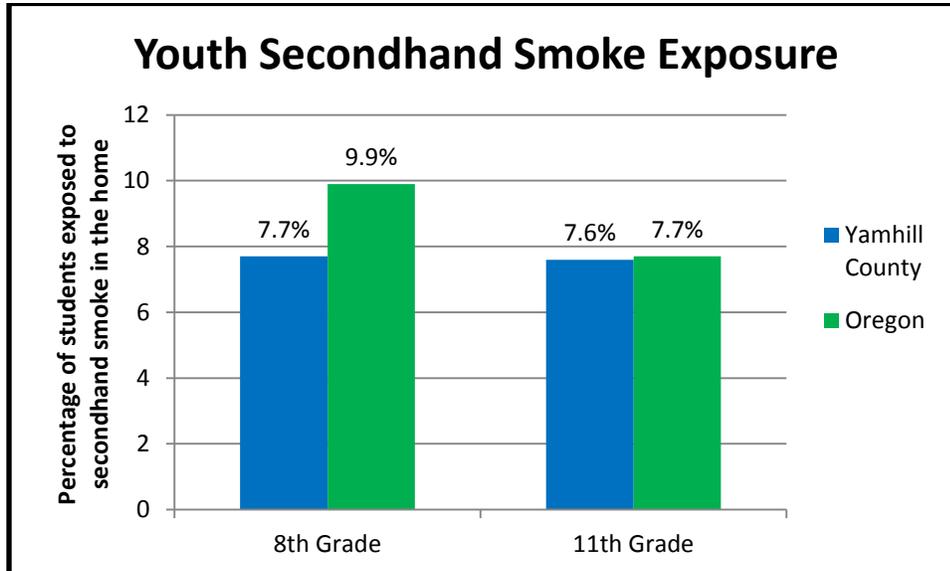
The **air pollution-particulate matter** measure represents the annual number of days that air quality was unhealthy for sensitive populations due to fine particulate matter (FPM, <math><2.5\ \mu\text{m}</math> in diameter) which often comes from fuel combustion, power plants and diesel buses and trucks.

A strong relationship exists between elevated air pollution—particularly fine particulate matter and ozone—and compromised health. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects (Environmental Protection Agency).



**STRENGTHS AND RISKS
ENVIRONMENTAL HEALTH INDICATORS**

*Community Survey
Top Concerns
Ranking*:
8*



**Target:
10%
Improvement
Healthy People
2020**

Source: Oregon Healthy Teens Survey, 2007-2008

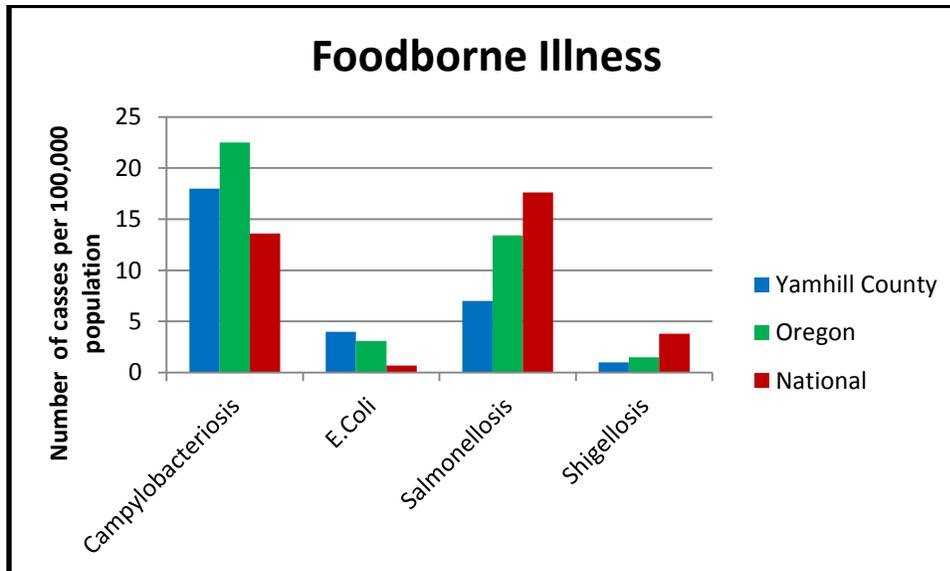
Youth secondhand smoke exposure measures the percent of 8th and 11th grade youth who reported that someone (other than themselves) smokes cigarettes inside the house.

According to the United States Department of Health and Human Services 2006 Surgeon General’s Report, there is no safe level of second-hand smoke exposure. Children and youth are especially vulnerable to second-hand smoke exposure. There is firm evidence that it causes middle-ear disease, respiratory symptoms such as coughing and wheezing, impaired lung function, sudden infant death syndrome, and lower respiratory illness, including infections. There is suggestive evidence that it might lead to some cancers, and asthma.

* See note on page 12.

STRENGTHS AND RISKS

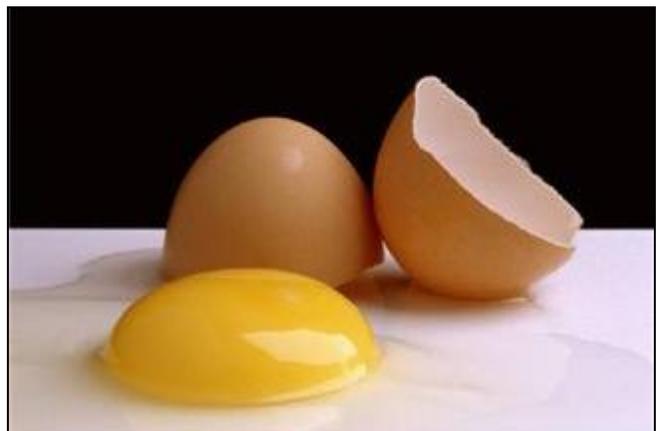
ENVIRONMENTAL HEALTH INDICATORS



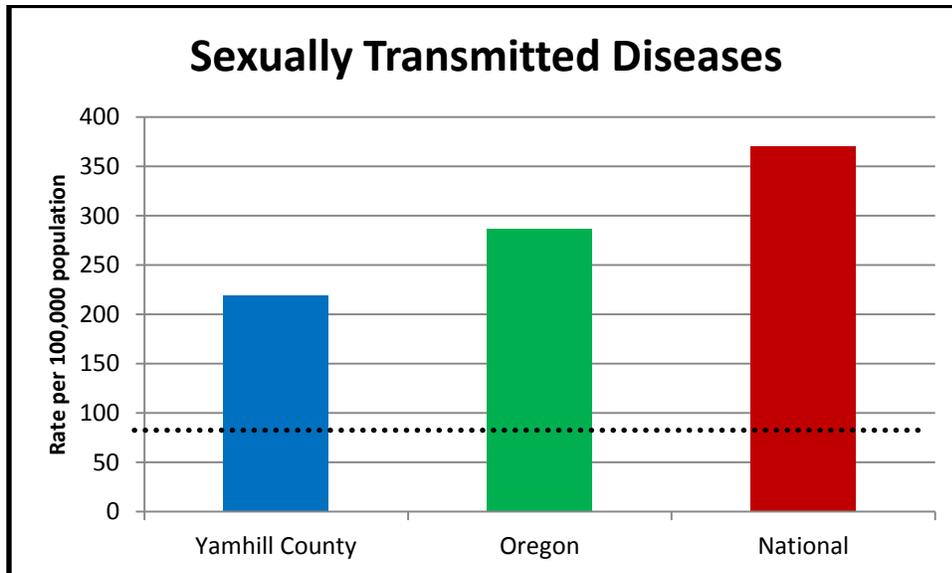
Sources: Food NET 2010; Selected Reportable Communicable Disease Summary: Oregon 2010

A **foodborne outbreak** occurs when two or more cases of a similar illness result from eating the same food. Figures show the number of cases per 100,000 populations.

Foodborne illness is a preventable and underreported public health problem. It presents a major challenge to both general and at-risk populations. Each year, millions of illnesses in the United States can be attributed to contaminated foods. Foodborne illnesses are a burden on public health and contribute significantly to the cost of health care. In 2006, the Centers for Disease Control and Prevention received reports of a total of 1,270 foodborne disease outbreaks, which resulted in 27,634 cases of illness and 11 deaths.



**STRENGTHS AND RISKS
COMMUNICABLE DISEASE**



Target:
83
2008
County Health Rankings

Source: Center for Disease Control and Prevention’s National Center for Hepatitis, Human Immunodeficiency Virus, Sexually Transmitted Disease, and Tuberculosis Prevention, 2008.

The **Sexually Transmitted Disease (STD)** rate is measured as chlamydia incidence (the number of new cases reported) per 100,000 population.

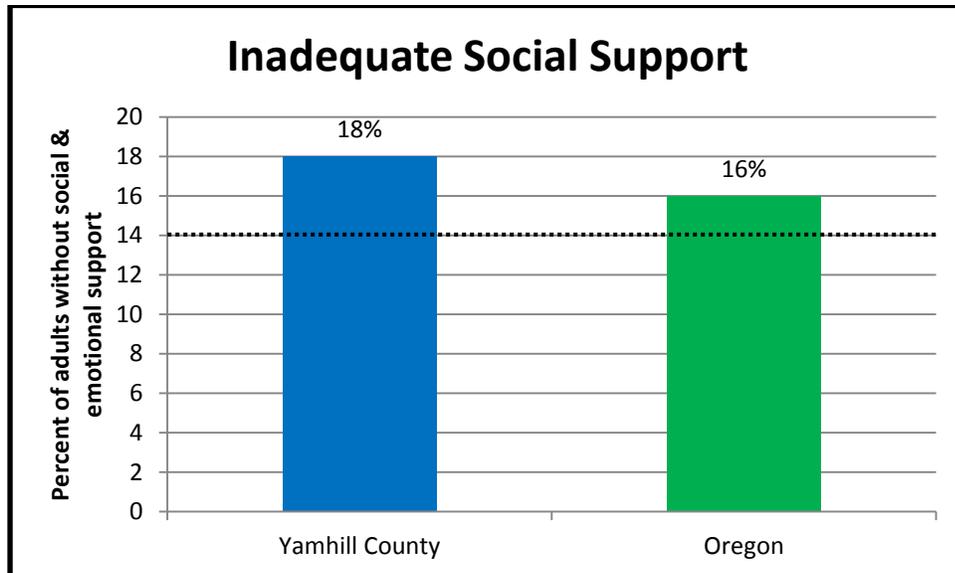
Chlamydia is the most common bacterial STD in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain.



STDs in general are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, involuntary infertility, and premature death. However, increases in reported Chlamydia infections may reflect the expansion of Chlamydia screening, use of increasingly sensitive diagnostic tests, an increased emphasis on case reporting from providers and laboratories, improvements in the information systems for reporting, as well as true increases in disease.

OUR HEALTH STATUS
SOCIAL & MENTAL HEALTH

*Community Survey
Top Concerns
Ranking*:*
10



Target:
14%
2005-2009
County Health Rankings

Sources: National Center for Health Statistics, 2005-2009; Behavioral Risk Factor Surveillance System, 2005-2009 (National data is unavailable)

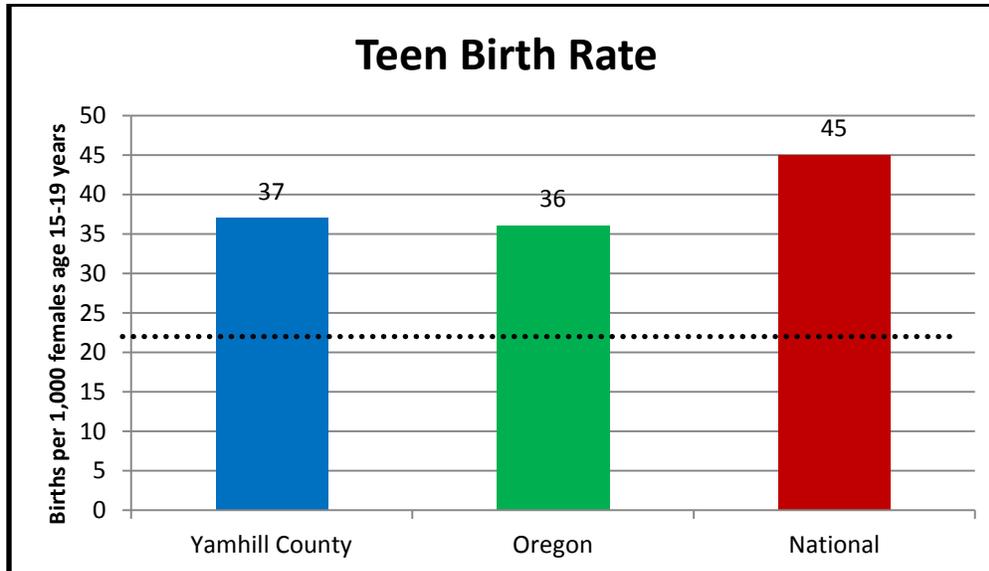
The **social and emotional support** measure is based on responses to the question: “How often do you get the social and emotional support you need?” The County Health Rankings reports the percent of the adult population that responds that they “never,” “rarely,” or “sometimes” get the support they need.

Poor family support, minimal contact with others, and limited involvement in community life are associated with increased morbidity and early mortality. Furthermore social support networks have been identified as powerful predictors of health behaviors, suggesting that individuals without a strong social network are less likely to participate in healthy lifestyle choices (County Health Rankings).

* See note on page 12.

OUR HEALTH STATUS
MATERNAL & CHILD HEALTH

*Community Survey
 Top Concerns
 Ranking*:*
9



Target:
22
 2001-2007
 County Health Rankings

Sources: National Vital Statistics System and American Community Survey population estimates for 2001-2007

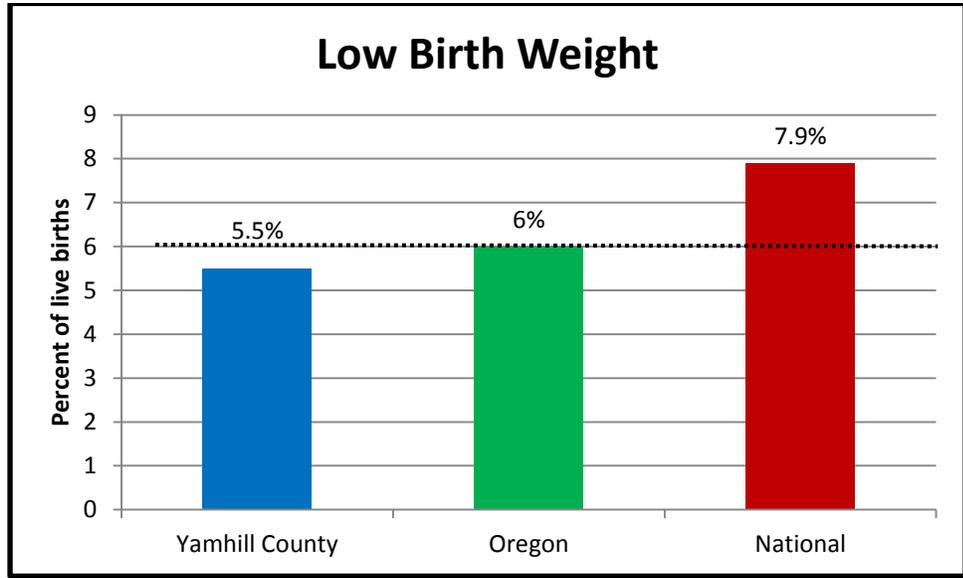
Teen births are reported as the number of births per 1,000 female population, ages 15-19.



Teen pregnancy is associated with poor prenatal care and pre-term delivery. Pregnant teens are more likely than older women to receive late or no prenatal care, have gestational hypertension and anemia, and achieve poor maternal weight gain. They are also more likely to have a pre-term delivery and low birth weight child, increasing the risk of developmental delay, illness, and mortality (County Health Rankings).

* See note on page 12.

OUR HEALTH STATUS
MATERNAL & CHILD HEALTH



Target:
6%
 2001-2007
 County Health Rankings

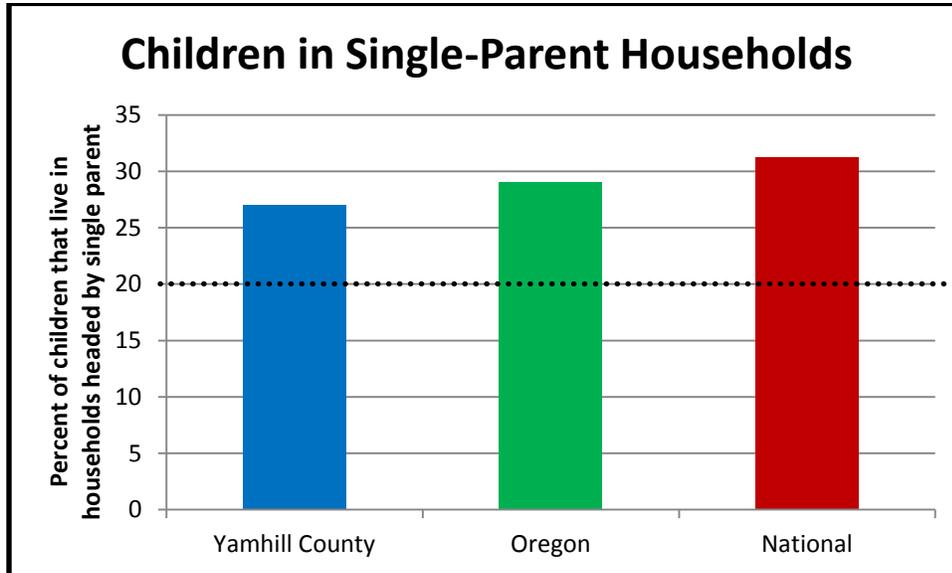
Source: Health Indicator Warehouse, 2001-2007

Low birth weight is the percent of live births for which the infant weighed less than 2,500 grams (approximately 5lbs., 8oz.).



Low birth weight is representative of maternal exposure to health risks and an infant’s current and future risk of disease, as well as premature death risk. The health consequences of low birth weight are many (County Health Rankings).

OUR HEALTH STATUS
MATERNAL & CHILD HEALTH

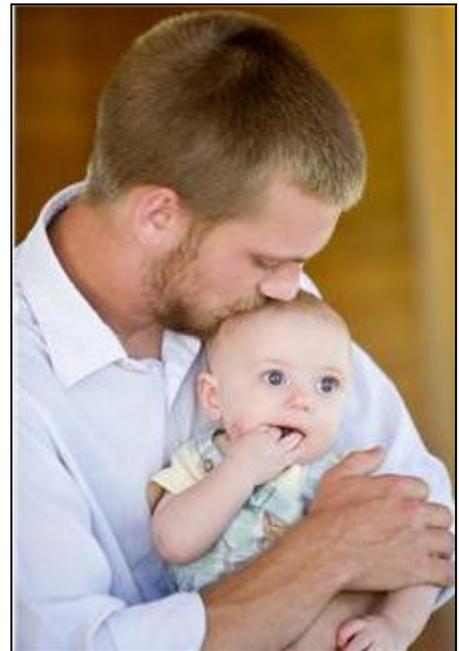


Target:
20%
 2005-2009
 County Health Rankings

Source: American Community Survey, 2005-2009

The **single-parent household** measure is the percent of all children in family households that live in a household headed by a single parent (male or female householder with no spouse present)

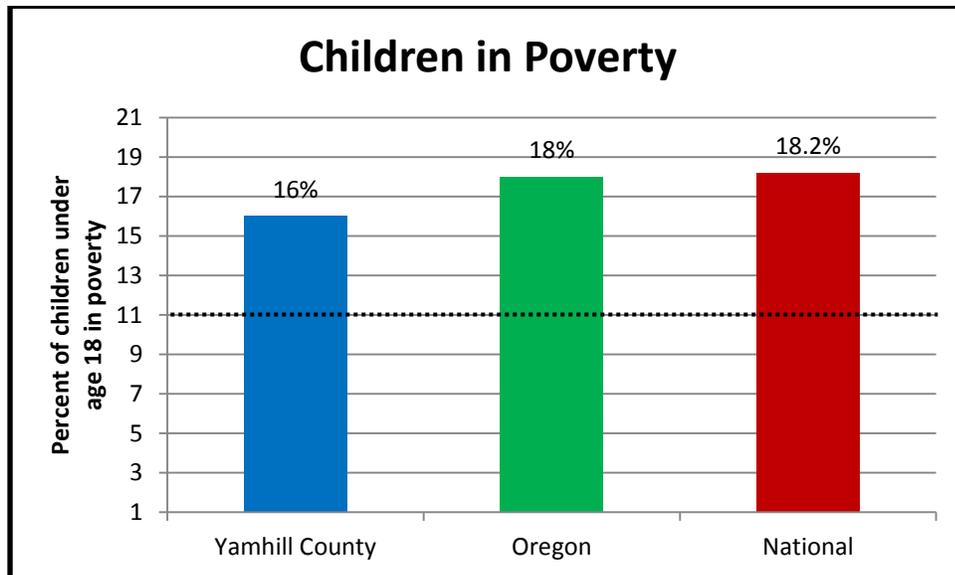
Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use (County Health Rankings).



**OUR HEALTH STATUS
MATERNAL & CHILD HEALTH**

*Community Survey
Top Concerns
Ranking*:*

13



Target:
11%
2008
County Health Rankings

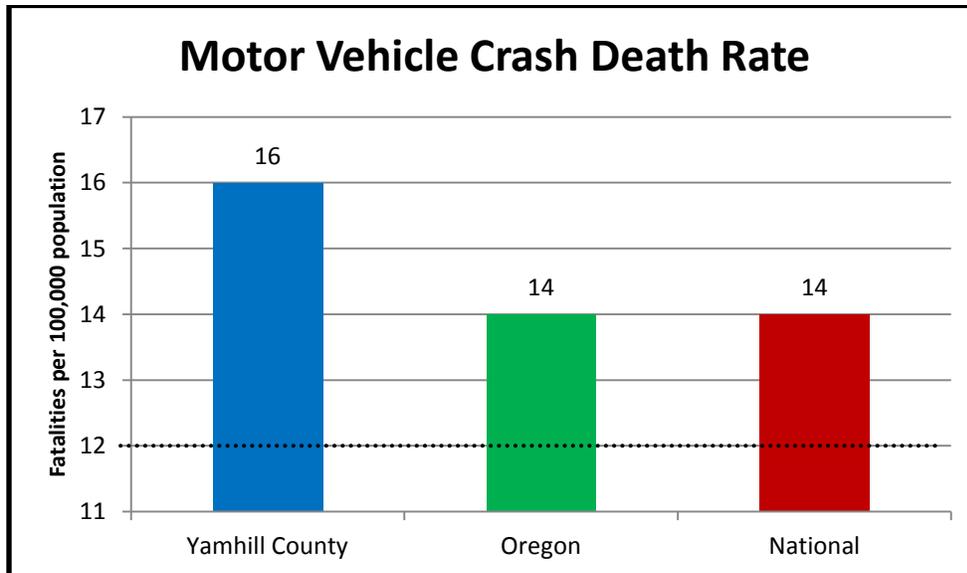
Source: Small Area Income and Poverty Estimates, 2008

The indicator, **Children in poverty**, measures the percentage of children under age 18 living below the Federal Poverty Line.

Poverty can result in negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. While negative health effects resulting from poverty are present at all ages, children in poverty have a greater morbidity and mortality due to an increased risk of accidental injury and lack of health care access. Children’s risk from poor health and premature mortality may also be increased due to the poor educational achievement associated with poverty. The children in poverty measure are highly correlated with overall poverty rates (County Health Rankings).

* See note on page 12.

OUR HEALTH STATUS
DEATH, ILLNESS & INJURY



Target:
12
 2001-2007
 County Health Rankings

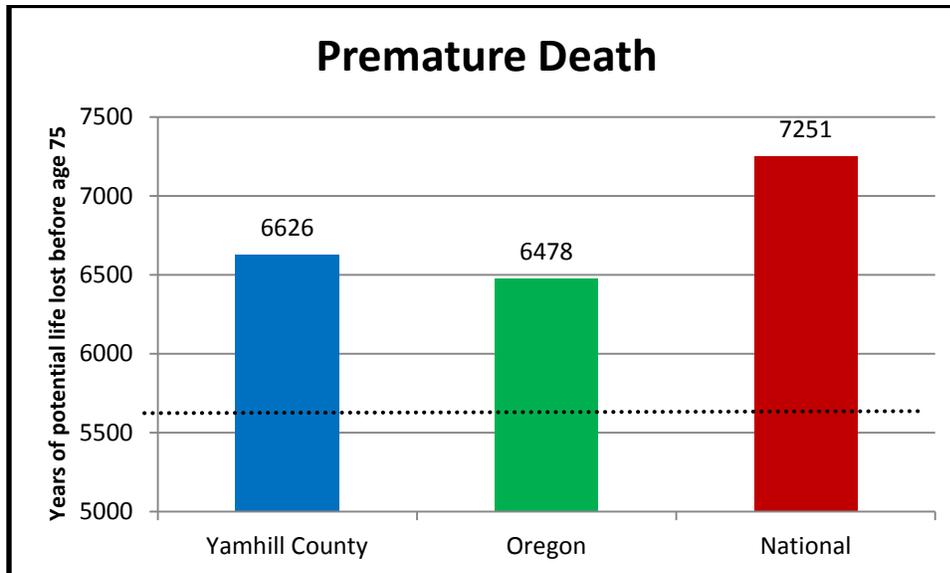
Sources: National Vital Statistics System, 2001-2007; Fatality Analysis Reporting System, 2000-2007

Motor vehicle crash deaths are measured as the crude mortality rate per 100,000 populations due to on- or off-road accidents involving a motor vehicle. Motor vehicle deaths includes traffic and non-traffic accidents involving motorcycles and 3-wheel motor vehicles; cars; vans; trucks; buses; street cars; all-terrain vehicles; industrial, agricultural, and construction vehicles; and bikes & pedestrians when colliding with any of the vehicles mentioned. Deaths due to boating accidents and airline crashes are not included in this measure.



According to the Centers for Disease Control and Prevention (CDC), motor vehicle crashes are a leading cause of death in the United States. Injuries from motor vehicle accidents are also burdening our emergency departments where more than 2.3 million adult drivers and passengers were treated for injuries in 2009 (CDC).

OUR HEALTH STATUS
DEATH, ILLNESS & INJURY



Target:
5564
 2005-2007
 County Health Rankings

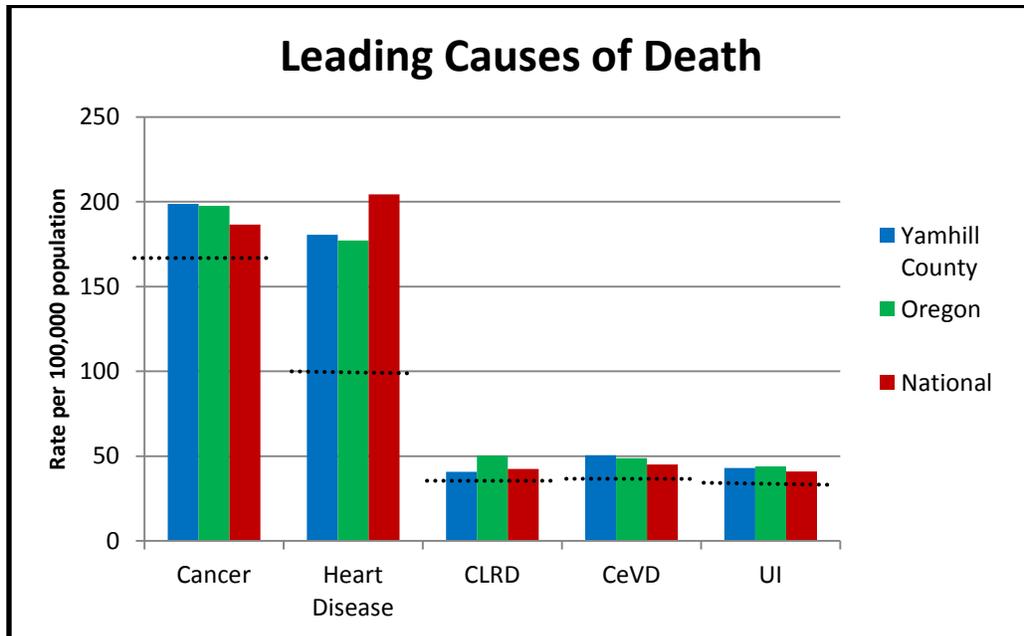
Sources: National Vital Statistics System, 2005-2007; National Center for Health Statistics, 2005-2006

Premature death is represented by Years of Potential Life Lost (YPLL) before age 75. Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a county’s YPLL. The YPLL measure is presented as a rate per 100,000 populations and is age-adjusted to the 2000 US population.

Age-adjusted years of potential life lost before age 75 (YPLL-75) rates are commonly used to represent the frequency and distribution of premature deaths. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of death (County Health Rankings).



OUR HEALTH STATUS
DEATH, ILLNESS & INJURY



Sources: Oregon Vital Statistics, 2007; National Vital Statistics System, 2007

Targets (Healthy People 2020):

Cancer – 160.6

Heart Disease – 100.8

Chronic Lower Respiratory Diseases (CLRD) – 38.2

Cerebrovascular Disease (CeVD) – 38.8

Unintentional Injury (UI) - 36

This measure looks at the **leading causes of death** per 100,000 population.

All socioeconomic groups continue acquiring noninfectious diseases related to behavior, including those related to the use of tobacco and alcohol.

Yamhill County Public Health would like to thank each of the individuals and groups who participated in this Community Health Assessment. Next steps are to engage the Community Health Assessment partners in the development of a Community Health Improvement Plan based on the top community health concerns identified in this document.

APPENDIX A- COMMUNITY SURVEY

What are the top three health issues/ concerns you see in your community?

What strengths, resources or assets does our community have that can be used to improve community health?

Key Health IndicatorsDemographic Characteristics

- Age and sex
- Race/ethnic distribution
- Persons with disabilities

Quality of Life

- Poor or fair health days
- Poor physical health days
- Poor mental health days
- Violent crime rate

Health Resource Availability

- Access to healthy foods
- Access to recreation facilities
- Uninsured adults
- Primary care physicians
- Youth immunizations
- Adult immunizations
- Preventable hospital stays
- Medicaid dentist availability

Socioeconomic Characteristics

- High school graduation
- Some college
- Unemployment

Maternal & Child Health

- Teen birth rate
- Child in single-parent household
- Children in poverty
- Low birth weight

Behavioral Risk Factors

- Adult smoking
- Teen smoking
- Adult obesity
- Child obesity
- Excessive drinking
- Mammography screening
- Diabetic screenings

Death, Illness & Injury

- Premature death
- Motor vehicle crash death rate
- Leading cause of death

Environmental Health Indicators

- Air pollution- particulate matter days
- Air pollution- ozone days
- Water quality: boil water days

Social & Mental Health

- Inadequate social support

Communicable Disease

- Sexually Transmitted Infections

Sentinel Events

Are there any Health Indicators missing from this list?

Are there any Health Indicators that you find unnecessary on this list?

What agency, if any, do you represent?

What city do you live in?

APPENDIX B- COMMUNITY ASSETS AND RESOURCES

WHO	LOCATION	WHAT THEY DO
211info	County-wide	Health and social service resource connection
Chehalem Park & Recreation District	Dundee, Newberg	Parks, recreation, open space, natural resources and education
Chehalem Youth and Family Services	County-wide	Residential services, counseling, supervised visitation, trainings for parents, vouchers and other services for children and families
Community Compassion Fund	McMinnville	Resource connection and limited financial assistance
Department of Human Resources	County-wide	Services, self- sufficiency program
Experience Works	County-wide	Employment and training programs
Full-Fill	McMinnville, Newberg	Housing for adults with disabilities
George Fox University	Newberg	Education, behavioral health clinic
Head Start / Early Head Start	Dayton, McMinnville, Newberg, Sheridan	Services, health education for children and families, home visiting
Health Clinics	County-wide	Services and education, reduced fees for those without health insurance
Hope on the Hill	McMinnville	Resources for self-sufficiency
Housing Authority of Yamhill County	County-wide	Affordable housing, Section 8, resource center, Community Connect, 10-year Plan to End Homelessness
Kids on the Block	McMinnville	Tutors and activities for kids
Libraries	McMinnville, Newberg	Information
Linfield College	McMinnville	Education, healthy kids programs
Love in Action	County-wide	Group of front-line service providers
Love INC	Carlton, Dayton, Dundee, Lafayette, Newberg, Yamhill	Free meals, free medical and dental clinics, other health and social services
Lutheran Community Services	McMinnville	Individual/group programs, parenting classes, relief nursery, counseling services
McMinnville Free Clinic	McMinnville	Health services
Meals on Wheels	County-wide	Meals to senior citizens
Mid-Valley Behavioral Care Network	County-wide	Behavioral health managed care
NW Senior & Disability Services	County-wide	Services, Community Health Worker hub

APPENDIX B - COMMUNITY ASSETS AND RESOURCES

WHO	LOCATION	WHAT THEY DO
Office of Vocational Rehabilitation	County-wide	Employment services for persons with disabilities
OSU Extension	County-wide	Variety of health classes
Providence Newberg Medical Center	Newberg	Services, education, and health fairs
School Districts	County-wide	Free/reduced lunch program, Jump Start—Ready Kindergarten, homeless liaisons in schools, community college dual credit or expanded options programs, nutrition specialists, mentors and big/little buddies, health classes
Soup Kitchens and Food Pantries	County-wide	Food access
Service Integration Teams	Amity, Grand Ronde, Willamina	Resource and service connection
Tooth Taxi	County-wide	Dental care and health education
Virginia Garcia Memorial Health Center	McMinnville	Federally Qualified Health Center—services, education and health fairs
Willamette Valley Medical Center	McMinnville	Services, education, and health fairs
Women, Infants, and Children (WIC) Program	County-wide	Nutrition education, nutrition assistance
WorkSource Oregon	County-wide	Business and job-seeker resource
Yamhill Community Action Partnership	County-wide	Food bank, housing assistance
Yamhill County Care Organization	County-wide	Coordinated care for Yamhill County Oregon Health Plan members
Yamhill County Dental Society	County-wide	Services and information
Yamhill County Food Collaborative	County-wide	Food access, healthy corner stores
Yamhill County Gospel Rescue Mission	County-wide	Food and shelter access
Yamhill County Health & Human Services	County-wide	Services and resources
Yamhill County Oral Health Coalition	County-wide	Collective to improve oral health
Youth Opportunity (YOOP)	McMinnville, Newberg	GED services, tutoring
Youth Outreach	Newberg	Opportunities for at-risk youth

APPENDIX C- DATA SOURCES - CONTACT INFORMATION

Behavior Risk Factor Surveillance System

<http://www.cdc.gov/brfss/>

Center for Disease Control and Prevention

<http://www.cdc.gov/>

County Health Rankings

<http://www.countyhealthrankings.org/>

Healthy People 2020

<http://www.healthypeople.gov/2020/default.aspx>

Oregon Health Authority

500 Summer St. NE E-20

Salem, OR 97301-1097

503-947-2340

<http://www.oregon.gov/OHA>

United States Census Bureau

<http://www.census.gov/>

Yamhill County Public Health

412 NE Ford Street

McMinnville, OR 97128

503-434-7525

<http://hhs.co.yamhill.or.us/hhs-ph>

Yamhill County Public Health Community Health Assessment

Available at:

<http://hhs.co.yamhill.or.us/hhs-ph/accreditation-and-assessments>

Local Public Health Authority: Yamhill County Public Health

Date: January 2014

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.

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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.

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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.

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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.

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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.

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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 *We don't operate 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.

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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.

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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.

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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: Silas Halloran-Steiner

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.**

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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.

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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.

Silas Halloran-Steiner, Director
Local Public Health Authority

Yamhill
County

February 28, 2014
Date



ADMINISTRATION
ADULT PROGRAMS
PUBLIC HEALTH PROGRAMS
FAMILY AND YOUTH PROGRAMS
DEVELOPMENTAL DISABILITIES

HEALTH AND HUMAN SERVICES DEPARTMENT

PUBLIC HEALTH

412 NE Ford Street – McMinnville, OR 97128 – Phone 503-434-7525 – Fax 503-472-9731 – TTY 1-800-735-2900

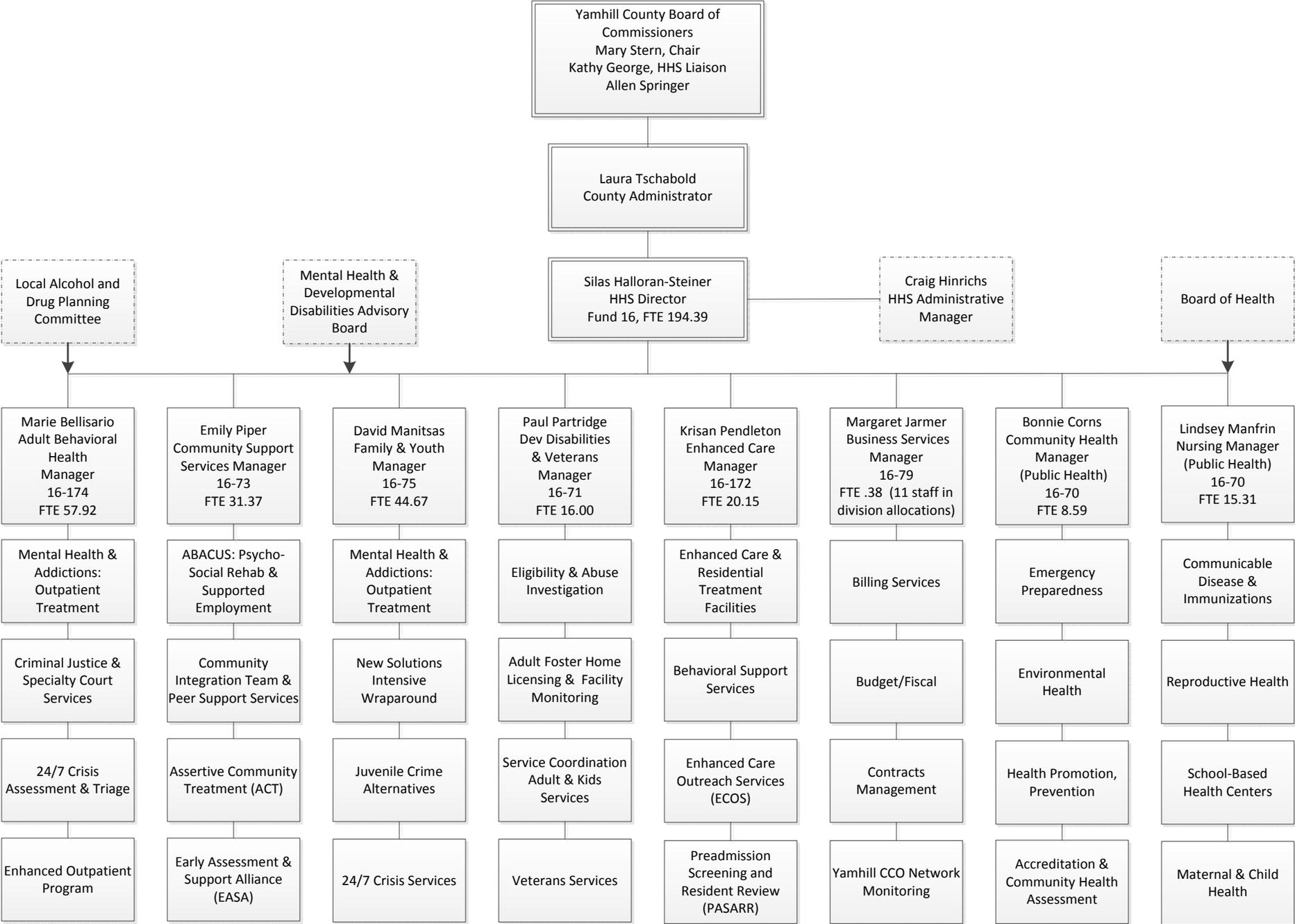
Local Public Health Authority 2014-2015 Plan BUDGET ACCESS INFORMATION

Yamhill County's annual 2013-14 Budget can be found at:

<http://www.co.yamhill.or.us/sites/default/files/yamhill%2013-14%20color.pdf>

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627 NE Evans
McMinnville, OR 97128

Yamhill County Health and Human Services



**REQUIRED REPRODUCTIVE HEALTH ANNUAL PLAN
FY 2015
July 1, 2014 to June 30, 2015**

As a condition of Title X funding, sub-recipient agencies are required to submit an annual plan to the OHA Reproductive Health (RH) Program, as well as a projected budget for the time period of the plan. In order to increase the relevance of the process, we have developed a new required format which more accurately reflects the services – both direct and indirect – that lead to better health outcomes.

The following goals (also located in the drop-down menu of the annual plan form) are derived from OPA Priorities and cover the areas of Clinical Services, Counseling Services, Program Outreach and Health Systems Transformation.

- A.** Assure that delivery of quality family planning and related preventive health services is in accordance with Title X Program requirements and nationally recognized standards of care.
- B.** Assure that delivery of reproductive health services to adolescents is in accordance with Title X Program requirements and nationally recognized standards of care (where they exist).
- C.** Direct services to address reproductive health disparities among your community's high priority and underserved populations.
- D.** Identify strategies for addressing the provision of health care reform and for adapting the delivery of reproductive health services to a changing health care environment.

To complete your annual plan, please choose a minimum of two goals, and then choose one corresponding objectives for each goal from the objectives drop-down list. It is also acceptable to choose two or more objectives for one goal. The objectives reflect National Standards of Care, where available, and best practices. Describe the activities you will conduct to achieve your benchmark and explain how you plan to evaluate your outcomes.

Additional information to help with this process, including suggested activities and program data, can be found at:
http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Documents/TitleX/annual_plan_supporting_information.pdf The new data reports provided here reflect your agency's work in many of these areas during the past fiscal year. The RH program suggests that you review your county's current status for each objective and make your decision based on the needs or issues for your agency.

Our intention is to evaluate your progress by periodically reviewing your agency data when objectives are measurable. For objectives that are not data driven, we will request periodic progress updates

NOTE: We will not be asking for your progress report for FY2014 until after June 30, 2014. You may want to take the opportunity to look at your current plan and evaluate your own progress as you determine your new goals.

If you have any questions, please contact Connie Clark @ (541) 386-3199 x 200 or Linda McCaulley @ (971) 673-0362.

**REQUIRED REPRODUCTIVE HEALTH ANNUAL PLAN
FY 2015
July 1, 2014 to June 30, 2015**

Goal # 1 D. Identify strategies for addressing the provision of health care reform and for adapting the delivery of reproductive health services to a changing health care environment			
Objective	Current Status	Activities	Evaluation timeframe
D1. By June 30, 2015, will initiate (or complete) at least one step toward adoption and/or use of an EHR system in your program	New EHR systems has been identified.	<ol style="list-style-type: none"> 1. Establish new EHR training process and components. 2. Identify superusers 3. Identify type of electronic device to use in clinic. 	<p>New EHR system go live date July 8th for clinic.</p> <p>Evaluation to be ongoing.</p>
Goal # 2 C. Direct services to address reproductive health disparities among your community's priority and underserved populations			
Objective	Current Status	Activities	Evaluation timeframe
D4. By June 30, 2015, will initiate (or complete) at least one activity toward supporting/providing insurance enrollment assistance to clients	HHS has currently assisted 93 people with applications.	<ol style="list-style-type: none"> 1. Develop universal process for asking clients about insurance status. 2. Assure all staff know when application assister is available and that she can be scheduled. 3. Develop a handout notifying people of options to apply for insurance and to let others know what their options for care are once they get insurance. 	<ol style="list-style-type: none"> 1. March 1st have process-evaluate April 1st 2. Send reminder email and announce at all staff meeting March 5th 3. Have handout available March 10th to begin using. 4. All Ccare eligible patients receive an application CCare eligible patients



**REQUIRED REPRODUCTIVE HEALTH ANNUAL PLAN
FY 2015
July 1, 2014 to June 30, 2015**

Goal # 3 C. Direct services to address reproductive health disparities among your community's high priority and underserved populations			
Objective	Current Status	Activities	Evaluation timeframe
C2. By June 30, 2015, complete a plan to reach individuals in Foster Care with reproductive health information and services.	Referral process is not well defined.	1. Develop referral process for Family & Youth. 2. Provide training to F&Y staff so that they are able to provide sexual health information and resources to clients.	1. Have established process developed by August 2014 and implemented by September 2014. 2. Develop training by August 2014 and complete the training September 2014