Linn County
Department of Health Services
P.O. Box 100, Albany, OR 97321

"Working together to promote the health and well-being of all Linn County residents."

February 27, 2014

Mr. Jan Kaplan
Office of Community Liaison
Oregon Department of Human Services
800 NE Oregon Street, Suite 930
Portland, OR 97232

Dear Mr. Kaplan:

Enclosed is Linn County's 2014-2015 Local Public Health Authority Plan. Attached to this letter please find the following documents:

- Linn County Health Department budget (hyperlink to Linn County on-line information)
- Linn County 2012 Community Health Assessment
- Linn County 2012 Community Health Improvement Plan
- Linn County 2012-2015 Strategic Plan
- Linn County Public Health Organizational chart
- Minimum Standards checklist

The signed minimum standard statement will be signed by our Board of Commissioners and forwarded when done.

I hope you find these materials satisfactory. Please contact me if your office requires further information or details.

Sincerely,

Frank Moore, Administrator

Linn County Health Services

Community Health Assessment 2012

Linn County, Oregon

Linn County Public Health Community Health Status Assessment

2012

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Executive Summary

The community Health Assessment (CHA) is an inclusive look at the health of Linn County. The CHA is comprised of four individual sections: Community Health Status Report, Local Public Health System Assessment, Key Informant interviews and The Quality of Life Survey. The information collected in this Assessment is the evidence used to support priority areas included in Linn County's Community Health Improvement Plan (CHIP).

The *Community Health Status Report* investigates indices that are commonly measured and compares them to overall rates for Oregon. The data was collected from a variety of surveillance databases, including the Centers for Disease Control and Prevention's (CDC) National Health and Nutrition Examination Survey (NHANES) and Behavioral Risk Factor Surveillance System (BRFSS), Oregon Health Authority's Oregon State Cancer Registry (OSCaR) as well as state epidemiology databases for mandatory reportable diseases.

Linn County ranks 28th out of 33 counties in measures of overall health. That figure mostly reflects poor metrics related to mortality, premature death and risk behaviors. Areas of particular concern for Linn County are high tobacco rates, low childhood immunization rates, higher rates of chronic diseases and lower rates of preventative screenings. The Community Health Status Report contains metrics across 11 categories of indicators: Demographics, Socioeconomics, Health Resource Availability, Quality of Life, Behavioral Risk Factors, Environmental Risk Factors, Social and Mental Health, Maternal and Child Health, Mortality and Morbidity, Reportable Diseases (communicable and infectious), and Sentinel (preventable) Events.

The Local Public Health System Assessment looked at how the entire public health system worked together to ensure the ten essential services of public health. The assessment was completed using the National Public Health Performance Standards Program (NPHPSP) Local Public Health System Performance Assessment Instrument version 2.0. The Mobilizing for Action through Planning and Partnerships (MAPP) committee as well as other agencies, partners, and community members met six times over the course of two months to complete the instrument. Questions were voted on using a remote voting system and a consensus was agreed upon on how to rate each item. At the completion of the assessment instrument, the answers were uploaded onto the NPHPSP's website and a report was generated. Results of the Local Public Health System Assessment were valuable to inform the MAPP committee about issues faced with building strong partnerships and mobilizing the community to act on health concerns.

Key Informant Interviews were conducted on 30 individuals throughout the county for firsthand, personal accounts of health issues and concerns in Linn communities. Interviewees were selected by the MAPP committee based on their connection to the community, their education, job, and the level of influence they had in their community. Key Informants in general were described as highly informed individuals that could provide our assessment efforts with quality information.

The Key Informant interviews allowed the MAPP committee to identify broad topical areas of concern, both in specific communities and county wide. Key Informants were invaluable in investigating social determinants (factors such as education, income, living conditions, peer group) as important health concerns. Key Informant interviews were critical to informing the priority areas of substance abuse and access to care in the Community Health Improvement Plan.

The Quality of Life Survey was developed by the MAPP committee in order find out how the community felt about where they lived as it pertained to their health. The survey was seven single-sided pages and contained 40 questions, including detailed demographic questions. After elimination of incomplete surveys, Linn County had data from 836 respondents and representation from almost all zip codes. Demographics of the survey closely matched census demographics for Linn County, with the exception of more females answering then males, and a higher level of low income individuals answering. The quality of life surveys were key to informing the MAPP committee about perceived health threats in the community and collecting information on issues with access to care.

By collecting detailed demographics, the MAPP committee was able to collect information on health inequity as it applies to socioeconomic status and ethnicity. The survey also asked questions about rental housing, investigating the rate in which repairs are not completed and the quality of available housing.

LINN COUNTY
OREGON

Community Health Status Report

1.1 Demographics ◊ 1.2 Socioeconomic Characteristics ◊ 1.3 Health Resource Availability ◊ 1.4 Maternal and Childhood Health Indicators ◊ 1.5 Health Outcomes ◊ 1.6 Modifiable Behavioral Risk Factors ◊ 1.7 Communicable Disease ◊ 1.8 Quality of Life

1.1 Introduction

Linn county Public Health completed this community health status assessment as a part of their overall Community Health Assessment (CHA) for 2012. The community health status assessment reports on health indices that are commonly measured and compares them to overall rates for Oregon. The data was collected from a variety of surveillance databases, including the Centers for Disease Control and Prevention's (CDC) National Health and Nutrition Examination Survey (NHANES) and Behavioral Risk Factor Surveillance System (BRFSS), Oregon Health Authority's Oregon State Cancer Registry (OSCaR) as well as state epidemiology databases for mandatory reportable diseases.

Linn County ranks 28th out of 33 counties in measures of overall health. That figure mostly reflects poor metrics related to mortality, premature death and risk behaviors. Areas of particular concern for Linn County are tobacco rates, childhood immunization rates, higher rates of chronic diseases and lower rates of preventative screenings.

This assessment contains metrics across 11 categories of indicators: Demographics, Socioeconomics, Health Resource Availability, Quality of Life, Behavioral Risk Factors, Environmental Risk Factors, Social and Mental Health, Maternal and Child Health, Mortality and Morbidity, Reportable Diseases (communicable and infectious), and Sentinel (preventable) Events.

This information is intended to be used in conjunction with other portions of the Community Health Assessment to help identify key areas of focus for public health planning and prevention as well as the creation of Linn County's Community Health Improvement Plan (CHIP). When applicable, measures have been compared to Healthy People 2020 target goals. Healthy People 2020 goals are target measures for the entire nation to achieve and typically represent a 10 percent improvement from the current measure. For example, a Healthy People 2020 goal would be a 10% reduction in the number of adult smokers from the 2010 rate. In some measures, Linn County is already at or better than the goal, and in some areas there is work to do to achieve the goal. Healthy People 2020 goals will be the targets for areas prioritized in Linn County's CHIP.

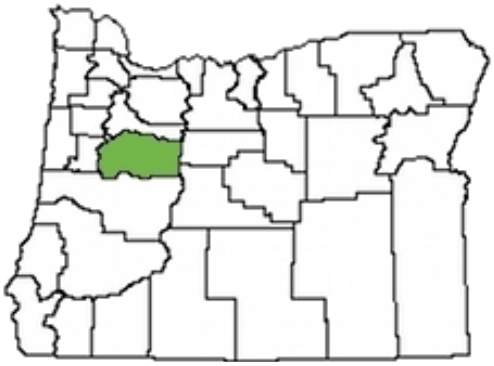


Figure ~ Linn County in Oregon.

Linn County Department of Health
315 4th Avenue SW
Albany, OR 97321
http://www.co.linn.or.us/health/
Telephone: 541-967-3888
Toll free: 1-800-304-7468
FAX: 541-967-3837
TTY/TTD: 1-800-735-2900

Continue to Demographics
► ► ►

1.2 Demographics

LINN COUNTY is located in the center of Oregon's Willamette Valley. The county is 2,310 square miles and spans from its western boundary, the Willamette River, across to the top of the Cascade Mountain range. The climate and soils in Linn County create ideal agricultural conditions; the county produces a variety of specialty crops and is the nation's leader in grass seed production.

Population

Since 2000, Linn County has experienced a 13.2% population increase[1]. According to the 2010 US Census, the population of Linn County is 116,672[2]. Albany is the seat of Linn County and with a population of 50,158; it is the County's largest city. Other incorporated cities in the county include Gates, Brownsville, Halsey, Harrisburg, Idanha, Mill City, Millersburg, Lyons, Lebanon, Scio, Sodaville, Sweet Home, Tangent and Waterloo. The County is also home to the unincorporated communities of Cascadia, Crawsfordville, Crabtree, Marion Forks, Shedd and South Lebanon.

The population density in Linn County is 51 people per square mile[3]. Because the county is an agriculturally driven community, there are proportionately more people living in rural areas compared to the state in general. It is estimated that 37% of Linn County's population resides in a rural location while only 21% of Oregon lives in a rural setting[4], factoring in the Portland Metropolitan area.

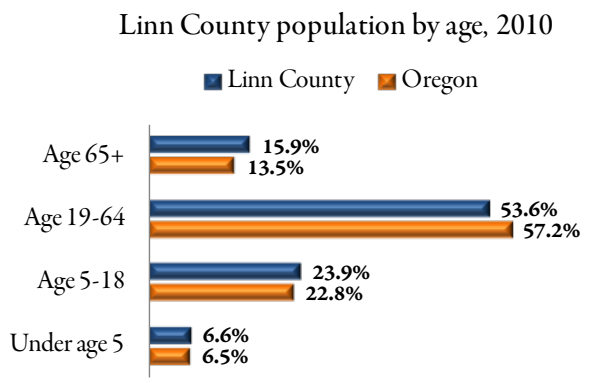
Table 1 ~ Population

2010	Linn County	Oregon
Population	116,672	3,831,074
Population change, 2000 to 2010	+13.2%	+12.0%
Land Area	2,292 square miles	95,997 square miles
Population density	51 people per square mile	40 people per square mile
*Percent of population living in a rural location	37%	21%

Source: US Census Bureau-State and County QuickFacts: Linn County, Oregon, 2010

*County Health Rankings- Linn County, 2011

Chart 1



Source: US Census Bureau-State and County QuickFacts: Linn County, Oregon, 2010

Linn County has a greater percentage of its population over age 65 compared to the total population of Oregon. In Linn County 15.9% of the population is over 65 compared to 13.5%[5] for the state. The percent of Linn County between the ages of 19-64 is 53.6%, this is a little lower than Oregon at 57.2%[6]. About 6.6% of the County is under age 5 and 22.8% of the population is between the ages of 5-18; these numbers are right in line with Oregon's[7].

Race/Ethnicity

In Linn County the majority of the population is White. According to the 2010 US Census, Linn County is 90.6% White, 7.8% Hispanic/Latino, 1.3% American Indian or Alaskan Native, 1.0% Asian, 0.5% Black, and 0.1% Hawaiian or Pacific Islander[8]. In Oregon the majority of the population is also White. The Oregon Population is 81.6% White, 11.4% is Hispanic or Latino origin, 3.6% Asian, 1.8% Black, 1.4% American Indian or Alaskan Native, and 0.3% Native Hawaiian or Pacific Islander.

See Chart 2 next page.

Continue to **Socioeconomics**

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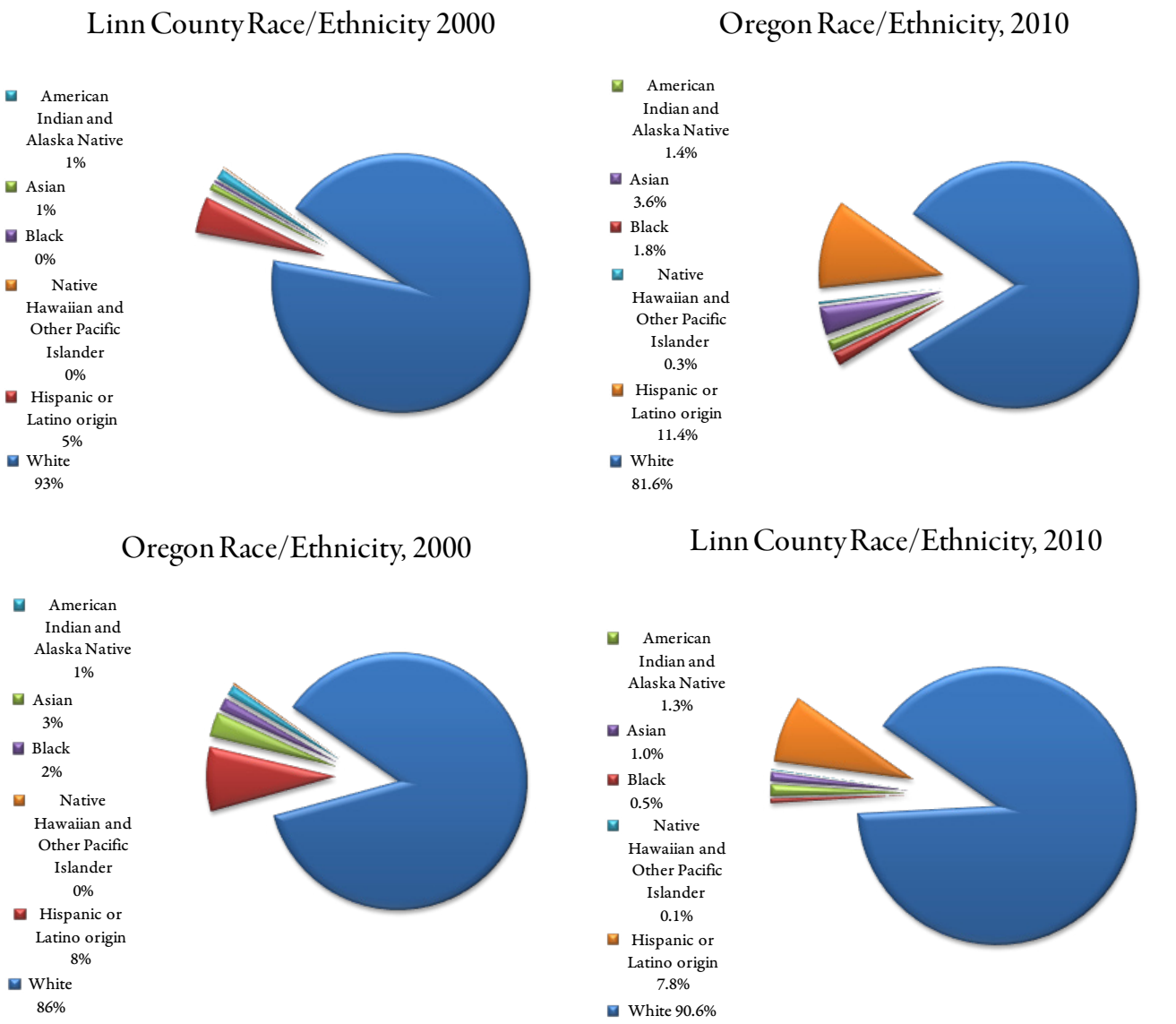
Chart 2



Source: US Census Bureau-State and County QuickFacts: Linn County, Oregon, 2010

Table 2 ~ Race	2000		2010	
Race	Linn County	Oregon	Linn County	Oregon
White	93.2%	86.6%	90.6%	83.6%
Hispanic or Latino origin	4.4%	8.0%	7.8%	11.7%
Asian	0.8%	3.0%	1.0%	3.7%
Black	0.3%	1.6%	0.5%	1.8%
American Indian and Alaska Native	1.3%	1.3%	1.3%	1.4%
Native Hawaiian and Other Pacific Islander	0.1%	0.2%	0.1%	0.3%

Source: US Census Bureau-State and County QuickFacts: Linn County, Oregon, 2010

1.3 Socioeconomic Characteristics

LINN COUNTY has fewer residents in the labor force when compared to Oregon. Approximately 53,509 or 60.4%[9] of the population is in the labor force compared to 64.7% for the state. This could partially be explained by the higher portion of residents aged 65 and older living in Linn County. The median household income for Linn County is $46,717[10]. This sits below Oregon's median household income of $48,325[11].

The average home value in Linn County is $173,000 compared to $244,200[12] for the state. The average household size in Linn County is 2.56 people and the average family size is 3.05 people[13]. Linn County is 32% single parent families compared to 29% for the state[14].

The unemployment rate in Linn County is higher than the overall rate in Oregon. According to the Oregon Employment Department, 11.9% of Linn County was unemployed in August 2011[15]. The unemployment level in Oregon during August 2011 was 9.6%[16].

The number of people in Linn County living at or below poverty level is similar to Oregon. Approximately 14.9% of Linn County lives at or below poverty level and an estimated 19.7% of individuals under the age of 18 live at or below the poverty level[17]. In Oregon 14.3% of the population lives at or below poverty level as well as 19.4% of the population under the age of 18[18].

Linn County reports 60,408 registered voters, 20,539 Democrats and 23,743 Republican as the two major parties. This number represents approximately 86% of the eligible population is registered to vote. There are approximately 69,600 residents of voting age in Linn County.

Educational Attainment

In Linn County the high school graduation rate is 70% while the Oregon high school graduation rate is 74%[19]. Graduation rate is considered the number of ninth graders in public schools who graduate from high school in four years. Linn County has fewer residents over the age of 25 with a high school diploma and college degree compared to the rest of Oregon. In Linn County, 86.2% of the population over age 25 have received a high school diploma; in Oregon 88.3% of the population have received high school diplomas[20].

Linn County is significantly lower than Oregon in obtaining college degrees. Only a combined 15.6% of Linn County residents over age 25 have received a bachelor's degree or higher compared to 28.3% of Oregon[21].

Language

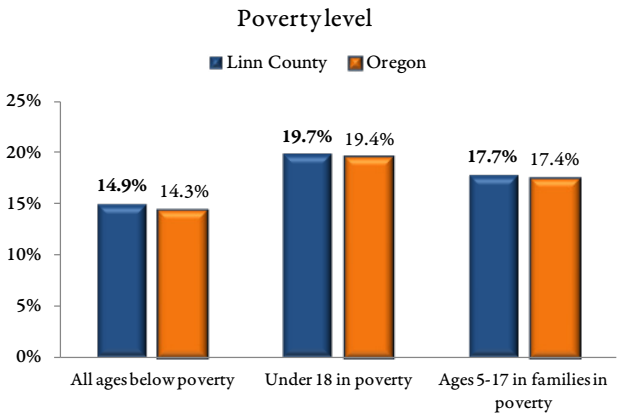
According to the 2005-2009 US Census Bureau data, 6.8% of Linn County residents speak a language other than English in their home. That is divided up as 4.3%

Table 3~ Income and Employment	Linn	Oregon
Median household Income, 2010	$46,717	$48,325
Average household size, 2010	2.56	2.6
Average family size, 2010	3.05	3.05
Single parent families, 2010	32%	29%
Unemployment Rates, August 2011	11.9%	9.6%
Percent population in labor force	60.4%	64.7%
Median home value	$173,00	$244,200

Source: US Census Bureau: *State and County QuickFacts: Linn County, Oregon, 2010*

Oregon Unemployment Department: *Current Unemployment Rates*

Chart 3



Source: U.S. Census Bureau -*Small Area Income and Poverty estimates- Linn County*

Table 4 ~ School Districts

Linn County School District 2010-2011	Student Population
Central Linn School District	721
Greater Albany Public Schools	9169
Harrisburg School District	922
Lebanon Community School District	4333
Santiam Canyon School District	595
Scio School District	3257
Sweet Home School District	2347

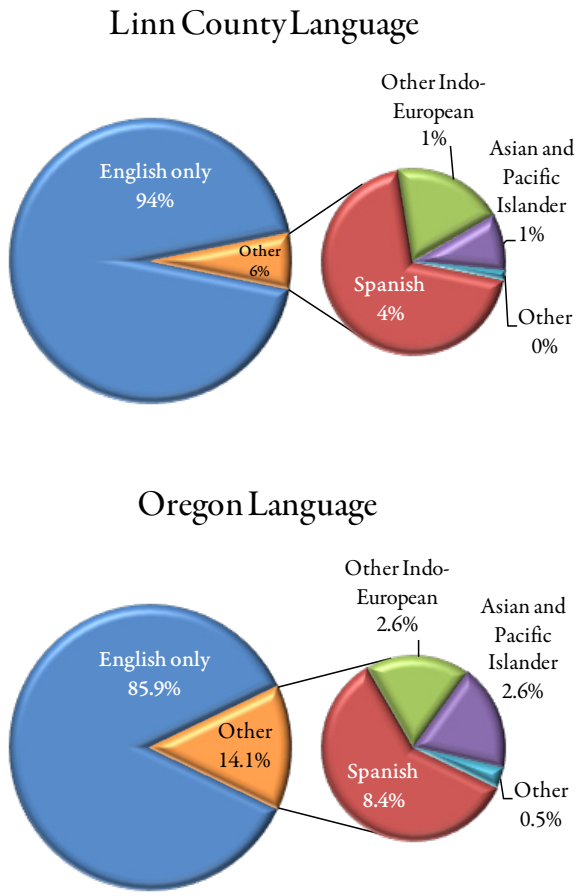
Source: Oregon Department of Education School Directory 2010-2011

Table 5 ~ Education Attainment

Education level for people 25 and older , 2005-2009	Linn County	Oregon
*High School Graduation Rate	70%	74%
Less than high school degree, no diploma	13.8%	11.8%
High school graduate (or equivalency)	33.1%	26.0%
Some college, no degree	29.1%	26.1%
Associate's degree	8.4%	8.0%
Bachelor's degree	10.9%	18.1%
Graduate or professional degree	4.8%	10.2%

Source: US Census Bureau-*State and County QuickFacts: Linn County, Oregon, 2010*

Chart 4



Source: US Census Bureau- *Selected Social Characteristics: 2005-2009*

speaking Spanish, 1.2% speaking a form of indo-European language, 0.6% speaking Asian or Pacific Island language, and 0.1% speaking other languages[22].

Food Security

Food security for a household means access by all members at all times to enough food for an active, healthy life. Food security includes at a minimum (1) the ready availability of nutritionally adequate and safe foods, and (2) an assured ability to acquire acceptable foods in socially acceptable ways (that is, without resorting to emergency food supplies, scavenging, stealing, or other coping strategies)[23].

According to Feeding America's Meal Gap study, Linn County is one of the most food-insecure counties in Oregon at 19.2% or 21,770 individuals, exceeding both national and state ratings[24]. Nearly 1 in 5 Linn County residents use Supplemental Nutrition Assistance Program (SNAP) benefits.[25] Linn-Benton Food Share, the regional food bank, distributed nearly 5,000,000 pounds of food to Linn and Benton County residents in need in 2010. In that same year, food pantries distributed 42,366 emergency food boxes to 145,997 individuals and 261,118 meals were served at free-meal sites in Linn and Benton counties.

The United States Department of Agriculture (USDA) defines food deserts as low-income communities without ready access to healthy and affordable food. According to the USDA Food Desert Locator, three census tracts in Linn County qualify as Food Deserts[23], two in Lebanon and one in south Albany.

Continue to **Health Resource Availability**

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1.4 Health Resource Availability

Health insurance coverage remains an area of concern in Oregon and Linn County. Approximately 10.8%[26] of Linn County children are not insured and 19%[27] of adults are uninsured. The percent of children in Oregon who do not have insurance is 10.6%[28] as well as 21%[29] of adults.

Table 6 ~ Insurance	Linn	Oregon
Uninsured children, 2010	10.8%	10.6%
*Uninsured Adults, 2010	19%	21%

Source: Oregon Department of Human Services: Children First For Oregon, 2010. *County Health Rankings: Linn County, 2010

In Linn County there are two hospitals and a total of 88 short-term general hospital beds [30]. There are approximately 69.8 primary care physicians and 30.9 dentists per 100,000 population[31]. About 83.4% of adults have someone they consider their own personal doctor; in Oregon only 79.6% of adults have a personal doctor[32].

There are no school based health clinics in Linn County or anything comparable. Throughout Oregon, there are a total 53 certified health clinics operating within schools[33]. There are three urgent care clinics in the county, plus an additional clinic in North Albany on the Benton County side of the Willamette River. Linn County has one Federally Qualified Health Center, operated by Benton County, in Lebanon. Samaritan Health Services operates a low income health clinic once a week out of the Linn County Public Health office in Albany. Lebanon has a low income clinic run by the non-profit group Community Outreach.

The largest provider of mental health in the County is the Health Department. Linn County Mental Health services staffs and contracts with 82 providers to administer mental health care in the county. One immediate drawback is that Linn County is primarily a Medicaid provider, meaning they offer mental health services to those only under Oregon Health Plan. While low economic status individuals are the primary consumers of mental health services, that leaves approximately 80% of Linn County population underserved for services.

Oral health is an issue particularly among low socioeconomic status individuals. Reports from Samaritan Health Services indicate that in 2011, 554 people accessed the emergency room at Albany Samaritan Hospital for dental services, and 625 individuals used the Lebanon Samaritan Hospital for their oral care. There is a new low income dental clinic organized by the United Way, Samaritan Albany General Hospital Foundation, Boys & Girls Club of Albany and several local dentists.

Geographic location creates problems with access to care. Some towns in Linn County, such as Harrisburg, do not have a family practice doctor or clinic there. Medicaid patients in particular must travel up to Albany for care. Depending on where you live, that distance can be 40 miles or more one way. Needing to travel a significant distance to seek medical care can be a barrier to access, particularly among individuals of low socioeconomic status.

1.5 Maternal and Childhood Health Indicators

A high percentage of women in Linn County seek early prenatal care. Approximately 96.2% of pregnant women obtained prenatal care by the 1st trimester, which compares well with the Oregon rate of 94.7%[34].

While the number of pregnant women receiving prenatal care is high, childhood health has some areas of concern in Linn County.

The teen pregnancy rate in Linn County for girls ages 15-17 is 21.4 per 1,000 live births; slightly higher than Oregon's teen pregnancy rate of 20.8 per 1,000 live births[35], though not appreciably different.

Approximately 32% of children in Linn County live in single parent households, compared to the overall Oregon Rate of 29%[36].

The infant mortality rate in Linn County was nearly twice as high as Oregon's this past year. In 2010, the Linn County infant mortality rate was 8.4 deaths per 1,000 live births[37]. In Oregon, the rate was 4.8 per 1000 live births. In Oregon and Linn County approximately 6% of babies have a low birth weight (less than 2,500 grams) [38]. Infant mortality is a rare occurrence and it is possible that one or two extra deaths can significantly skew the data. Because of this reason, low birth weight is a superior measure of maternal health. Long term trends show Linn is not considerably different than the state in infant mortality, and equal in low birth weight.

The largest difference in childhood health are immunization rates. In Linn County only 57.8% of 2 year olds were up to date with their immunization series in 2010[39]. Oregon's immunization rate was higher at 70.3%[40]. Several factors can contribute to that low number, including a period effect of vaccine shortage as well as an adjustment of the vaccination schedule that also effected Oregon numbers. Even considering that however, Linn County is significantly lower than Oregon, and immunizations should remain an area of focus.

In Linn County there are almost twice as many child abuse and neglect victims reported in a year compared to the state. In 2010, the rate of abuse and neglect in Linn County among children under the age of 17 is 12.3 per 1000 children[41]. In Oregon, only 7.3 per 1,000 children are reported to be victims of abuse and neglect[42]. It is mindful to remember that many cases of child abuse and neglect go unreported and figures could vary considerable depending on the loation.

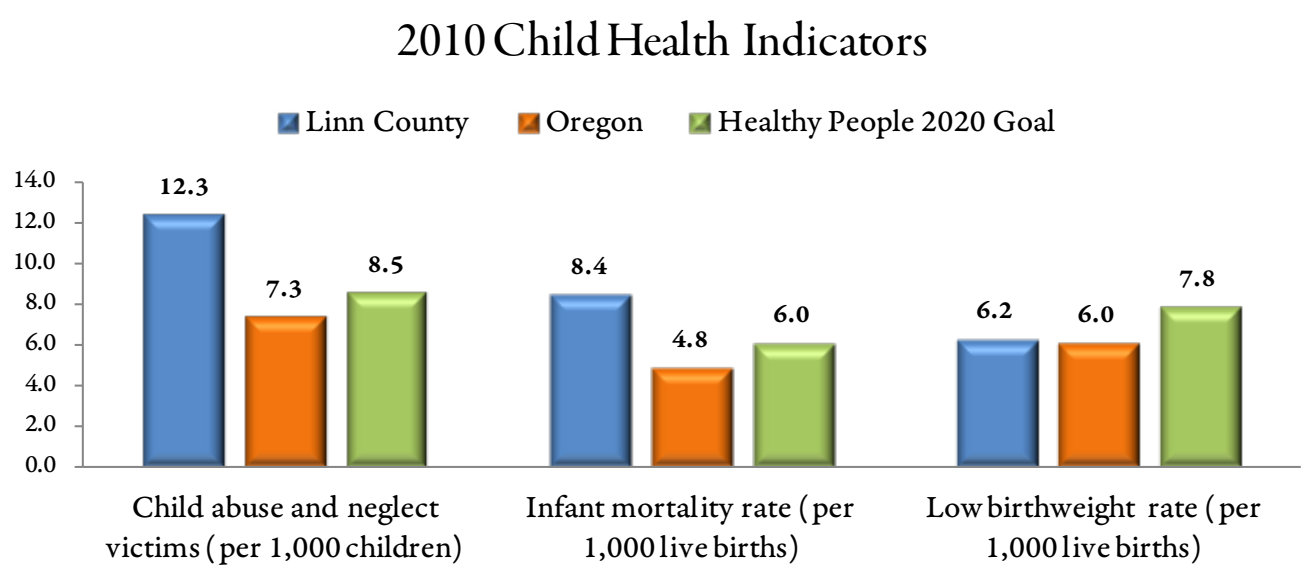
In Linn County public schools, 52.3% of public school kids are eligible for either free or reduced lunches[43]. That comes to 12,769 children every day. 54.1% of public school children in Oregon were eligible to receive free/reduced price lunches during the school year. On average, 292,857 children ate free or reduced price lunches on a given day. Children that rely on school lunches for their primary meals are at risk for poor nutrition. School

Table 7 ~ Child Health Indicators	Linn County	Oregon
Entrance into prenatal care by 1st trimester, 2010	96.2%	94.7%
Teen pregnancy per 1,000 girls (ages 15-17), 2010	21.4	20.8
Infant mortality per 1000 live births, 2010	8.4	4.8
*Children living in single parent households, 2005-2009	32%	29%
*Low birthweight, 2001-2007	6.2%	6.0%
Percent of 2 year olds up to date with immunizations	57.8%	70.3%
Child Obesity rate	27.4%	26.8%
Abuse and neglect victims (per 1,000 ages 0-17), 2010	12.3	7.3

Source: Oregon Department of Human Services: Children First For Oregon, 2010

*County Health Rankings: Linn County, 2010

Chart 5



Source: Oregon Department of Human Services: Children First For Oregon, 2010

lunches are poorly monitored and regulated and vary greatly from school to school. Poorer districts are more likely to have less healthy food options due to limited budgets. Unfortunately, schools in poorer districts have a higher percentage of free and reduced lunch consumers, and more children are reliant on school lunches for their food.

In Linn County, 27.4% of children under the age of 18 are considered obese, slightly higher than the state average of 26.8%[44]. According to past Healthy Community assessment efforts done by Linn County Public Health, schools in the county rated poorly in the ability to ensure all students received a minimum amount of physical education and activity during the week. The same assessment also showed schools do a poor job of ensuring snacks and vending items are healthy choices within the schools.

1.6 Health Outcomes

Every year County Health Rankings obtains data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) and the CDC's National Vital Statistic System[45]. *County Health Rankings* are a key component of the Mobilizing Action Towards Community Health (MATCH) project. MATCH is a collaborative effort between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute[46].

The most recent data from County Health Rankings published in 2011 ranks Linn County 28th out of 33 Oregon Counties in overall health outcomes[47]. Health outcomes are measured on factors of mortality and morbidiy.

Mortality

Linn County is ranked 23rd out of 33 Oregon counties for mortality measures[48]. Mortality is measured by a rate of premature death, factored with the common statistical measurement of years of potential life loss, or YPLL-75. YPLL-75 is used to factor the frequency and distribution of death before the age of 75, which is considered to be a premature death. YPLL-75 is calculated by adding up all the years before 75 death occurred for every death in the County, then dividing it by the population to get a rate. Linn County has a premature death rate of 7,952 per 100,000, compared to Oregon's rate of 6,478[49]. The interpretation of this measure is that for every 100,000 persons, Linn County losses about 1500 more total years of life than does the state of Oregon on average does.

Causes of Death

In 2008 the leading causes of death in Linn County were Heart Disease (23.2%), Cancer (22.8%), Respiratory Disease (6.5%), Cerebrovascular Disease (6.3%), Unintentional Injuries (4.4%), and Diabetes (2.6%)[50]. Other causes of death are reported among the county and state[51].

In Linn County the rate of death from Cancer and Heart Disease is concerning. Heart Disease is the leading cause of death in Linn County and the second leading cause of death in Oregon. In 2008, the rate of death from Heart Disease in Linn County was 236.9 per 100,000 population; In Oregon the rate of death from Heart Disease was 171.9 per 100,000[52]. The rate of cancer in Linn County is 233.2 per 100,000 and in Oregon it is 197.4 per 100,000[53].

Morbidity

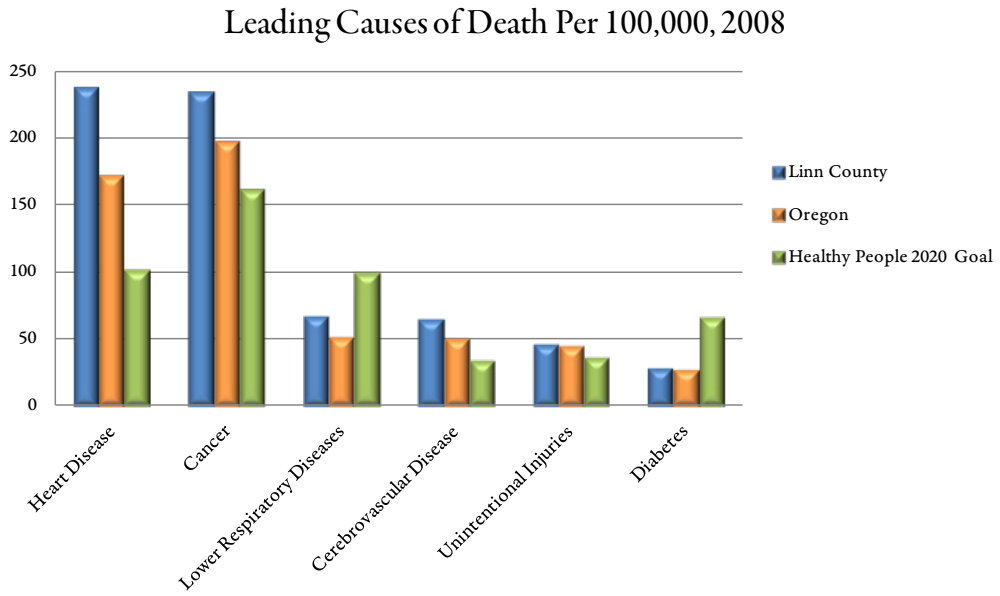
In terms of morbidity, Linn County ranks 29th out of 33 Oregon counties[54]. Morbidity attempts to explain the quality of health experienced by the living population. County Health Rankings specifically reports on measures pertaining to physical, mental, and overall health. Approximately 18% of Linn County residents report living in poor to fair health and17% report inadequate social support[55]. Another 8% have had at least one major depressive episode over the last 30 days[56]. Linn County residents report living an average of 4.5 days a month in poor physical health, and an average of 4.0 days in poor mental health[57].

This is in contrast to 14% of Oregon adults who report living in poor to fair health and only experience 3.6 days a month in poor physical health and 3.3 days a month in poor mental state[58].

Table 8 ~ Morbidity	Linn County	Oregon
Premature Death	7,755	6,537
Living in Poor Health	18%	14%
Days in poor Physical Health	4.5	3.6
Days in Poor Mental Health	4.0	3.3

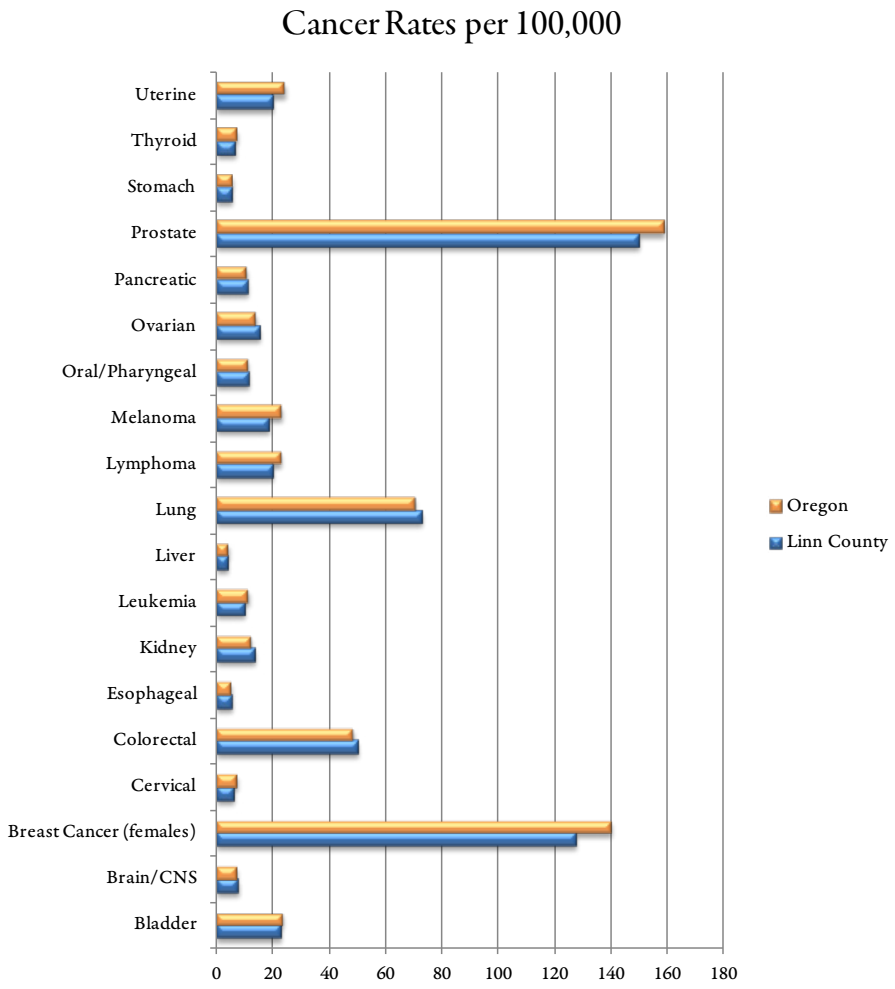
Source: County Health Rankings: Linn County, 2010

Chart 6



Source: Oregon Health Authority, *Leading causes of death by county of residence, 2008*

Chart 7



Source: Oregon State Cancer Registry Cancer in Oregon, 2006.

Chronic Disease

The rate of chronic disease in Linn County exceeds Oregon's average rates. Arthritis, high blood pressure, and high cholesterol are the highest incidence markers for chronic disease in Linn County. In Linn County, 29.5% of county residents are living with arthritis in comparison to the average state rate of 25.6%[59]. Approximately 27.7% of the county has high blood pressure and 29.6% have high cholesterol compared to state rates of 25.8% and 33% respectively[60]. Approximately 10.5% of the population has asthma[61], 7.9% of Linn County residents have diabetes and the rate of heart attack, coronary heart disease, and stroke in the county is 5.4%, 5%, and 4% respectively[62].

All measures are age-adjusted to control for Linn County's higher proportion of residents over the age of 65. This means the higher rate of chronic disease is not explained by a higher number of older residents, but rather by lifestyle choices such as poor diet, lack of exercise and tobaco use.

Cancer Rates

The cancer rate in Linn County is slightly lower than the overall cancer rate in Oregon. **See Chart 9, pg. 9.**

Linn County has a cancer rate of 461 per 100,000 individuals and the state rate is 481.5[63]. Prostate cancer in males and breast cancer in females are the two forms of cancer with the highest prevalence in Linn County and in Oregon. The prostate cancer rate of 149.9 per 100,000 population and breast cancer rate of 127.9 per 100,000 population in Linn County are slightly lower than the state rates[64]. Colorectal and lung cancer are two other forms of cancer with high prevalence rates in Linn County. The county lung cancer rate of 73.5 and colorectal cancer rate of 50 per 100,000 population is slightly higher than the state rate of 70.3 and 48.5, respectively[65]. Linn County has lower cancer rates than Oregon per 100,000 population for bladder cancer (22.8), uterine cancer (20.3), lymphoma (20.2), melanoma (18.7), leukemia (10.1), thyroid cancer (6.8), cervical cancer (6.3), and liver cancer (4.3) [66]. The rate of brain cancer (7.5), esophageal cancer (5.6), oral/pharyngeal cancer (11.3), pancreatic cancer (10.8), and stomach (5.8) are fairly in line with the state averages[67]. Kidney cancer rates (13.5) and ovarian cancer rates (15.2) per 100,000 are slightly higher than state rates of 12.2 and 14.1 per 100,000, respectively[68].

1.7 Modifiable Behavioral Risk Factors

Prevention is a core value in public health. The majority of prevention and health promotion programs and models are adopted and implemented to prevent chronic disease. Tobacco use, alcohol consumption, obesity, lack of proper physical activity, and poor dietary habits contribute to the onset of chronic disease.

Physical Health and Nutrition

Perhaps the most profound data is related to fruit and vegetable consumption. In Linn County only 15.8% of adults report eating five servings of fruits and vegetables a day[69].

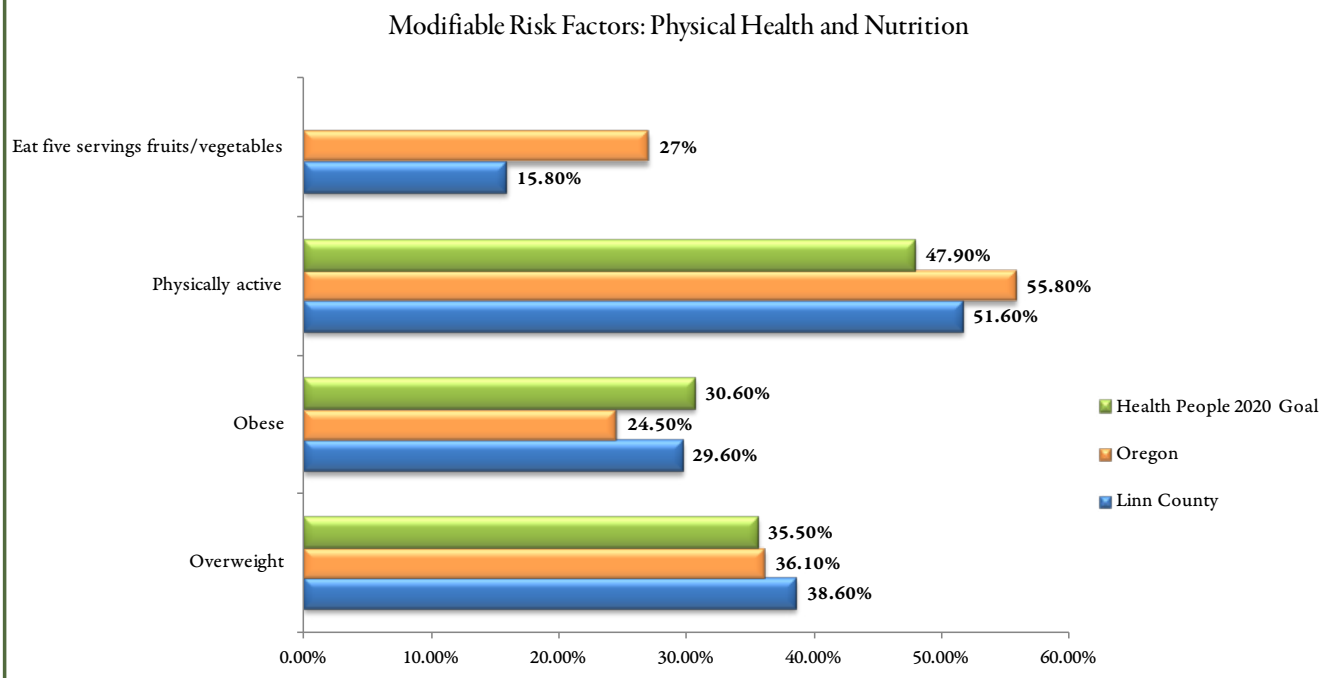
In Linn County, about 29.6% of Linn County adults are considered obese and 38.4% of adults are considered overweight[70]. That means nearly 10% of all individuals that are overweight in Linn County are considered obese. In Oregon about 24.5% of the adult population is considered obese and 36.1% overweight[71]. Only 51.6% of adults in the county meet the CDC recommendations for physical activity compared to nearly 56% of Oregon adults[72].

Tobacco

Tobacco use is a problem in Linn County. The Tobacco Prevention and Education Program (TPEP) releases information about tobacco use in each Oregon County. According to the 2010 tobacco fact sheet, 21% of Linn County smokes tobacco, compared to the statewide average of 19%. Around 9% of county 8th graders and 23% of 11th graders smoke cigarettes[73]. In Oregon, 9% of 8th graders and only 16% of 11th graders report smoking cigarettes[74].

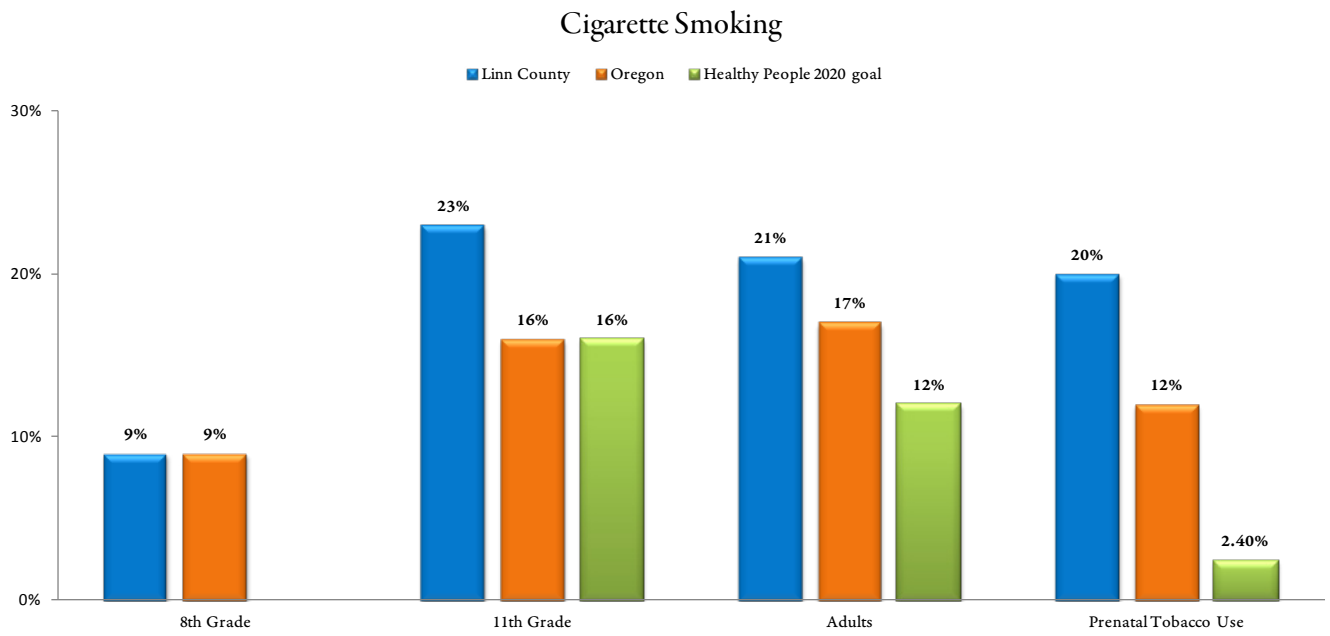
Since 1996 the percent of infants born to mothers in Oregon who use tobacco has decreased 34%[75]. Despite this significant decrease there are an astonishing number of infants born to mothers who smoke in Linn County. Approximately 20% of pregnant women use tobacco while pregnant; this number is much greater than the overall Oregon averge of 12%[76].

Chart 8



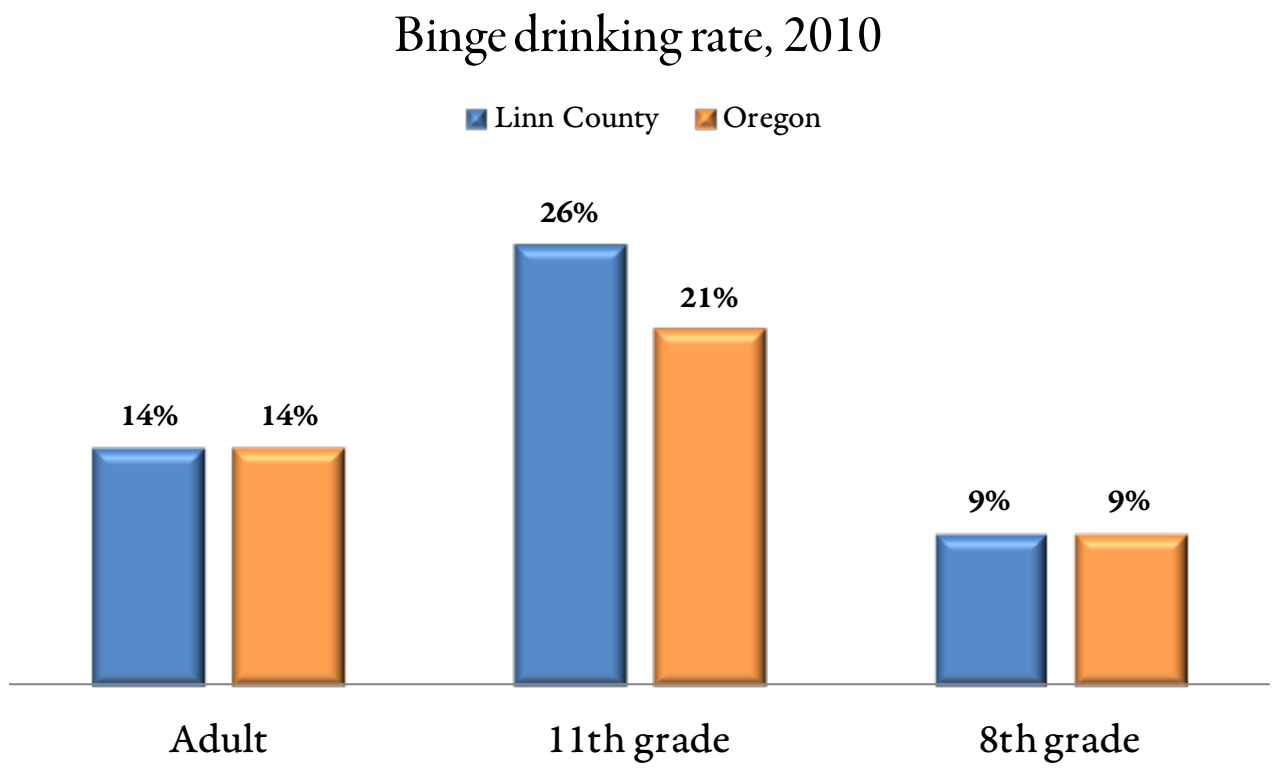
Oregon Health Authority-*Age-adjusted and unadjusted prevalence of modifiable risk factors among adults, by county, 2006-2009*

Chart 9



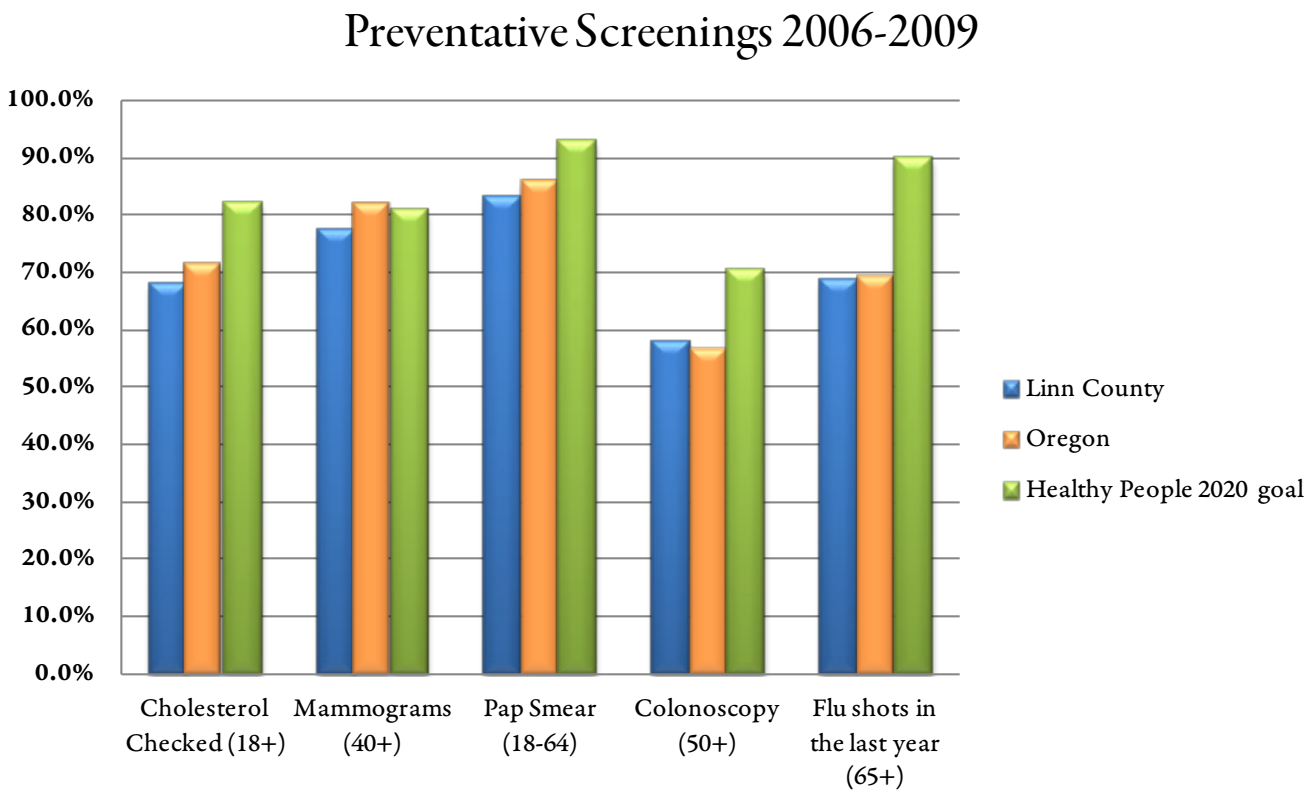
Source: Oregon Department of Human Services *Linn County Tobacco Fact Sheet, 2011*

Chart 10



Source: Oregon Health Authority-*Linn County's Epidemiological Data on Alcohol, Drugs and Mental health, 2000-2010*

Chart 11



Source: Oregon Health Authority-*Linn County's Epidemiological Data on Alcohol, Drugs and Mental health, 2000-2010*

Motor Vehicle Accidents

In Linn County the death rate from motor vehicle accidents is almost double the state rate. In 2010, the county had a motor vehicle death crash rate of 21.1 crashes per 100,000 population[77]. In Oregon, the motor vehicle crash death rate was 14 crashes per 100,000 individuals[78]. Only 30% of Linn County crash fatalities involved alcohol while 37% of vehicle fatalities in Oregon involve alcohol[79].

Table 9 ~ Motor Accidents	Linn County	Oregon
Motor vehicle crash death rate (per 100,000):	21	4
Motor vehicle fatalities involving alcohol:	30%	37%

Source: Oregon Health Authority-Linn County's Epidemiological Data on Alcohol, Drugs and Mental health, 2000-2010.

Alcohol

The negative effects of chronic alcohol abuse are well documented. It is linked to certain types of cancer and is the leading cause of chronic liver disease.

Alcohol use, especially binge drinking, results in negative health consequences and contributes to motor vehicle crashes, birth defects, and a number of other chronic and acute conditions[80]. Binge drinking is considered five or more drinks by men or four or more drinks by women in a short time span. 14% of Linn County adults and are considered binge drinkers, which is the same as the overall rate in Oregon[81].

Unfortunately, young people who consume alcohol are more likely to binge drink than adults[82]. Young binge drinkers are much more likely to engage in risky behaviors such as drug use, unsafe sexual behavior, and aggressive antisocial behavior. In 2010, approximately 9% of 8th graders in Linn County and Oregon reported binge drinking[83]. During the same year 26% of Linn County 11th graders reported binge drinking; this is higher than 21% of 11th graders throughout the state[84].

Drug Use

An important area of focus in public health revolves around substance use. Drug use impacts families, schools, workplaces, and the community. Using drugs can lead to long term health problems and premature death. It may also contribute to injuries, abuse and violence.

In Linn County the rate of drug-induced death is 12 people per 100,000 population[85]. The state rate is slightly higher; approximately 14 people per 100,000 population die from drug related causes[86].

Marijuana

Marijuana use is common in Linn County and throughout the state of Oregon. The use of marijuana can be addicting and cause adverse physical, mental, emotional, and behavioral changes. Adverse health effects include respiratory illnesses, memory impairment, and weakening of the immune system[87].

Marijuana use is highest among individuals between the ages of 18 to 25. According to the 2006-2008 Nation Survey on Drug Use and Health, about 18% of Linn County and 20% Oregon residents from ages 18 to 25 use marijuana[88]. In Linn County 7% of adolescents between ages 12 to17 use marijuana as well as 5% of adult residents over age 26[89]. Approximately 8% of Oregon youth between 12 and 17 years of age and 6% of Oregonians over the age of 26 are marijuana users[90].

The most current information regarding youth marijuana use is from 2010. According to information gathered from the Oregon Healthy Teens Survey and the Oregon Student Wellness survey, 10% of Linn County 8th graders and 12% of Oregon 8th graders reported using marijuana in the past 30 days[91]. A higher portion of youth in 11th grade reported using marijuana. In Linn County over 1 in 4 students in 11th grade used marijuana[92] and nearly 26% of 11th grade students used marijuana one or more times in the last 30 days[93]. In Oregon 24% of the 11th grade population used marijuana[94].

Preventative Screening and Services

Preventative screening rates in Linn County are in line with state rates. In Linn County 68.1% of the population has had their blood cholesterol checked within the past 5 years; this rate is slightly lower than 71.3% of the state[95]. About 77.4% of women ages 50-75 in Linn County have had a mammogram in the past 2 years; the state mammogram screening rate is 82%[96]. Women in Linn County between the ages of 18-65 who went in for a PAP smear within the past 3 years is 83.3%[97]. This is slightly lower than the state rate for PAP smears, which is 85.8%[98]. Colon cancer screening rates in Linn County are slightly higher than the state rate. About 58% of Linn County is screened for colon cancer and around 56.8% of Oregon[99]. Approximately 68% of Linn County residents over the age of 65 received a flu shot; the average number of Oregonians accessing this preventative service is 69.2%[100].

1.8 Communicable Disease

An increased incidence of sexually transmitted infections is a concern in Linn County. The number of Chlamydia cases has steadily increased over the past 5 years. In 2005 the county reported 194 Chlamydia cases; by 2010 the annual number of Chlamydia cases in Linn County reached 359[101]. The rate of Gonorrhea has also increased in the county. In 2005, 24 cases of gonorrhea were reported compared to thirty-five reported cases in 2010[102]. Linn County has 58 residents with HIV in the County. The state of Oregon has 5001 total known cases of HIV. HIV rate is 49.7 per 100,000 compared to a state rate of 130.7 per 100,000[103]

◊ Reportable infections

Linn County rates of reportable infections are generally in line with or below the rates for Oregon. Some notable exceptions are an increased rate of Cryptosporidiosis (a water-borne parasite infection) of 13.71 compared to state rate of 5.69 per 100,000. Linn County experiences four times the outbreaks of E.Coli that the state does, 12.00 per 100,000 compared to 3.08 for the state. Linn County also experiences a slightly higher rate of Gonorrhea (29.14 versus 28.11) and acute Hepatitis B (2.57 versus 1.15). A rate to take careful note of is Pertussis in Linn County. Pertussis is also known as Whopping Cough and is a mandatory childhood vaccinated disease. The rate of Pertussis in Linn County is 10.29 cases per 100,000 in 2010, compared to 7.44 for the state. This might possibly reflect the earlier reported lower rate of childhood vaccinations in Linn County as compared to the state. It should be noted that when dealing with rare diseases and small count numbers there is chance for great variability in the rates.

See Tables 10 and 11 next page.

Continue to **Quality of Life.**

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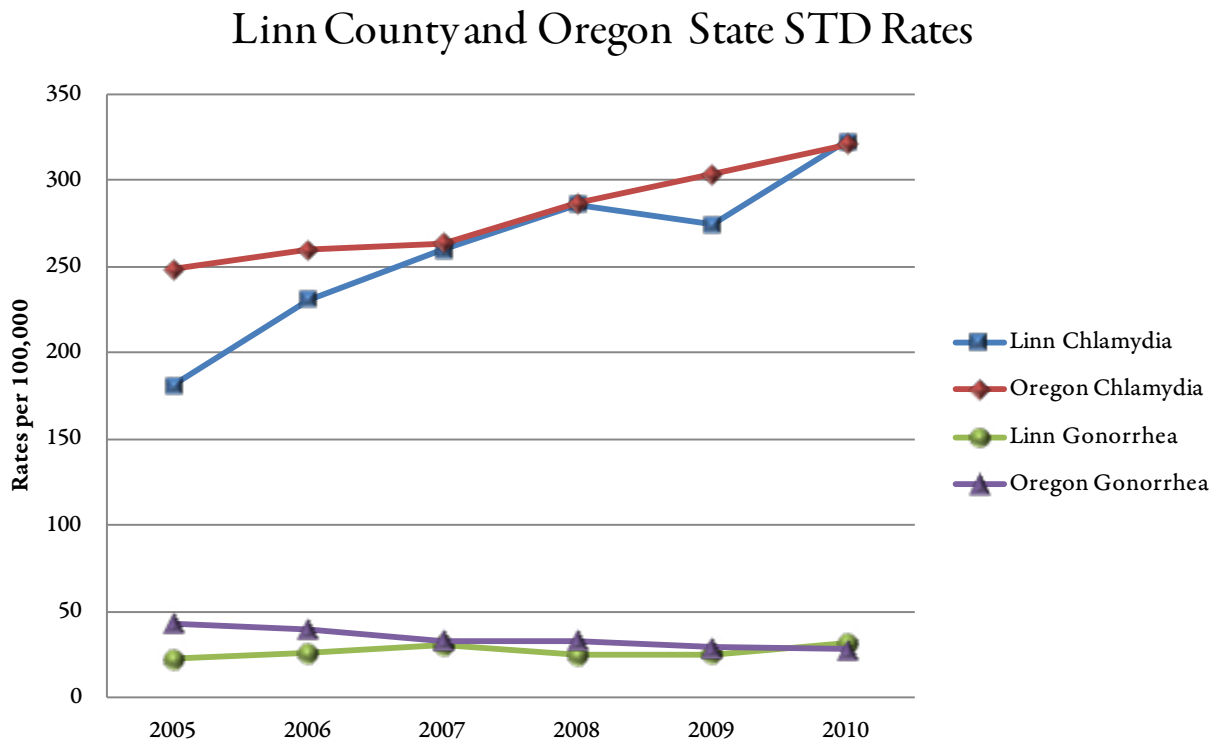
Chart 12



Source: Oregon Health Authority: Oregon STD statistics

Table 10 ~ Linn County sexually transmitted disease total counts

Disease	2005	2006	2007	2008	2009	2010
Chlamydia	194	250	278	315	316	359
Gonorrhea	24	28	29	27	29	35
Syphilis	0	2	1	0	0	0

Source: Oregon Health Authority: Oregon STD statistics

Table 11 ~ Reportable Infections

Disease	Linn Counts	Linn Rate	Oregon Counts	Oregon Rates
AIDS/HIV living	60	51.43	5226	136.41
Campylobacteriosis	25	21.43	862	22.50
Chlamydiosis	358	306.84	12337	322.02
Cryptosporidiosis	16	13.71	218	5.69
E. Coli	14	12.00	118	3.08
Giardiasis	9	7.71	482	12.58
Gonorrhea	34	29.14	1077	28.11
Haemophilus influenzae	2	1.71	68	1.77
Hepatitis A	0	0.00	17	0.44
Hepatitis B (acute)	3	2.57	44	1.15
Hepatitis B (chronic)	6	5.14	414	10.81
Hepatitis C (acute)	0	0.00	22	0.57
Lyme Disease	2	1.71	40	1.04
Malaria	0	0.00	16	0.42
Meningococcal Disease	1	0.86	32	0.84
Pertussis	12	10.29	285	7.44
Rabies	0	0.00	14	0.37
Salmonellosis	10	8.57	512	13.36
Shigellosis	0	0.00	59	1.54
Early Syphillis	0	0.00	107	2.79
Taeniasis	0	0.00	3	0.08
Tuberculosis	1	0.86	87	2.27

Source: Oregon Health Authority: Oregon STD statistics

1.8 Quality of Life

Every year the Oregon Law Enforcement Agency compiles a report of criminal offenses and arrests of Crimes Against Persons, Crimes Against Property and Behavioral Crimes.

Criminal Offenses and Arrests

Crimes Against Persons are criminal offenses where the victim is present and the act is violent, threatening or has the potential of being physically harmful. Examples of crimes against persons include willful murder, negligent homicide, forcible rape, other sex crimes, kidnapping, robbery, aggravated assault, and simple assault. In 2009, Linn County had the 11th highest rate in Oregon for crimes against people, a total of 1,130; this equates to a county rate of 101.9 per 10,000 population[104]. This is slightly higher than the average rate in Oregon, which sits at 95.4 crimes per 10,000 population[105].

Crimes Against Property are criminal offenses that involve taking something of value by theft, deception or the destruction of property[106]. Examples of property crimes include burglary, larceny, motor vehicle theft, arson, forgery, fraud, embezzlement, stolen property offenses, or vandalism. Linn County reported 5,234 crimes against property in 2009. This is the 7th highest rate in Oregon at a rate of 472.1 crimes per 10,000 population. The average rate in Oregon is 460 per 10,000 population[107].

In 2009, Linn County had the 2nd highest behavior crime rate in Oregon[108] with a reported 8,777 crimes. This is an annual rate of 791.7 crimes per 10,000 population[109]. The state average is 400.1 crimes per 10,000 population. Behavioral Crimes are crimes that represent society's prohibitions on engaging in certain types of activity, such as criminal offenses that violate laws relating to personal conduct, responsibility, and public order[110]. Behavioral Crimes may not necessarily be violent or property offenses in themselves; however, they may often contribute to other criminal acts.

Table 12 ~ Crime	Linn County	Oregon
Crimes against persons	101.9	95.5
Crimes against property	472.1	460
Behavioral crimes	791.1	400.1

Source: Oregon Uniform Crime Reporting- State of Oregon report of criminal offenses and arrests, 2009.

Mental and Social Health

The Centers for Disease Control and Prevention continually survey for measures of quality of life and health outcomes. Results of their Behavior Risk Factor Surveillance Survey show Linn County has a lower rate of individuals with major depressive episodes than the state of Oregon. Between 2004-2006 8% of Linn County residents reported a major depressive episode in the past 30 days; the average rate in Oregon was 9%[111]. 4% of Linn Country residents report living in poor mental health, with the state showing similar results at 3.3%. 18% of Linn County residents report living in poor physical health, compared to 14% for the state. The suicide rate in Linn County is the same as for Oregon at 15 suicides per 100,000.

More information on quality of life and mental health will be reported in Linn County's Quality of Life survey report. Included will be data assessing citizens' views on the state of their community, the care and livability of it.

Continue to Part 2

Local Public Health System Performance Assessment Report of Results

2.1 Introduction ◊ 2.2 About This Report ◊ 2.3 Tips for Interpreting and Using NPHPSP Assessment Results ◊ 2.4 Final Remarks ◊ 2.5 Performance Assessment Instrument Results ◊ 2.6 Resources for Next Steps

2.1 Introduction

The national Public Health Performance Standards Program (NPHPSP) assessments are intended to help users answer questions such as "What are the activities and capacities of our public health system?" and "How well are we providing the Essential Public Health Services in our jurisdiction?" The dialogue that occurs in answering these questions can help to identify strengths and weaknesses and determine opportunities for improvement.

The NPHPSP is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPSP assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, responding sites consider the activities of all public health system partners, thus addressing the activities of all public, private and voluntary entities that contribute to public health within the community.

Three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems or boards of health. These instruments are the:

- State Public Health System Performance Assessment Instrument,
- Local Public Health System Performance Assessment Instrument, and
- Local Public Health Governance Performance Assessment Instrument.

The NPHPSP is a collaborative effort of seven national partners:

- Centers for Disease Control and Prevention, Office of Chief of Public Health Practice (CDC/OCPHP)
- American Public Health Association (APHA)
- Association of State and Territorial Health Officials (ASTHO)
- National Association of County and City Health Officials (NACCHO)
- National Association of Local Boards of Health (NALBOH)
- National Network of Public Health Institutes (NNPHI)
- Public Health Foundation (PHF)

This report provides a summary of results from the NPHPSP Local Public Health System Assessment (OMB Control number 0920-0555, expiration date: August 31, 2013). The report, including the charts, graphs, and scores, are intended to help sites gain a good understanding of their performance and move on to the next step in strengthening their public system.

Continue to **About This Report**

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2.2 About This Report

The NPHPSP assessment instruments are constructed using the Essential Public Health Services (EPHS) as a framework. Within the Local Instrument, each EPHS includes between 2-4 model standards that describe the key aspects of an optimally performing public health system. Each model standard is followed by assessment questions that serve as measures of performance. Each site's responses to these questions should indicate how well the model standard - which portrays the highest level of performance or "gold standard" - is being met.

Calculating the Scores

Sites responded to assessment questions using the following response options below. These same categories are used in this report to characterize levels of activity for Essential Services and model standards.

- NO ACTIVITY: 0% or absolutely no activity.
- MINIMAL ACTIVITY: Greater than zero, but no more than 25% of the activity described within the question is met.
- MODERATE ACTIVITY: Greater than 25%, but no more than 50% of the activity described within the question is met.
- SIGNIFICANT ACTIVITY: Greater than 50%, but no more than 75% of the activity described within the question is met.
- OPTIMAL ACTIVITY: Greater than 75% of the activity described within the question is met.

Using the responses to all of the assessment questions, a scoring process generates scores for each first-tier or "stem" question, model standard, Essential Service, and one overall score. The scoring methodology is available from CDC or can be accessed on-line at http://www.cdc.gov/nphpsp/conducting.html.

Understanding Data Limitations

Respondents to the self-assessment should understand what the performance scores represent and potential data limitations. All performance scores are a composite; stem question scores represent a composite of the stem question and subquestion responses; model standard scores are a composite of the question scores within that area, and so on. The responses to the questions within the assessment are based upon processes that utilize input from diverse system participants with different experiences and perspectives. The gathering of these inputs and the development of a response for each question incorporates an element of subjectivity, which can be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes can differ among sites. The assessment methods are not fully standardized and these differences in administration of the self-assessment may introduce an element of measurement error. In addition, there are differences in knowledge about the public health system among assessment participants. This may lead to some interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

Because of the limitations noted, the results and recommendations associated with these reported data should be used for quality improvement purposes. More specifically, results should be utilized for guiding an overall public health infrastructure and performance improvement process for the public health system. These data represent the collective performance of all organizational participants in the assessment of the local public health system. The data and results should not be interpreted to reflect the capacity or performance of any single agency or organization.

Presentation of Results

The NPHPSP has attempted to present results - through a variety of figures and tables - in a user-friendly and clear manner. Results are presented in a Microsoft Word document, which allows users to easily copy and paste or edit the report for their own customized purposes. Original responses to all questions are also available.

For ease of use, many figures in tables use short titles to refer to Essential Services, model standards, and questions. If in doubt of the meaning, please refer to the full text in the assessment instruments.

Sites may choose to complete two optional questionnaires - one which asks about priority of each model standard and the second which assesses the local health department's contribution to achieving the model standard. Sites that submit responses for these questionnaires will see the results included as an additional component of their reports. Recipients of the priority results section may find that the scatter plot figures include data points that overlap. This is unavoidable when presenting results that represent similar data; in these cases, sites may find that the table listing of results will more clearly show the results found in each quadrant.

2.3 Tips for Interpreting and Using NPHPSP Assessment Results

THE USE of these results by respondents to strengthen the public health system is the most important part of the performance improvement process that the NPHPSP is intended to promote. Report data may be used to identify strengths and weaknesses within the local public health system and pinpoint areas of performance that need improvement. The NPHPSP User Guide describes steps for using these results to develop and implement public health system performance improvement plans. Implementation of these plans is critical to achieving a higher performing public health system. Suggested steps in developing such improvement plans are:

1. Organize Participation for Performance Improvement
2. Prioritize Areas for Action
3. Explore "Root Causes" of Performance Problems
4. Develop and Implement Improvement Plans
5. Regularly Monitor and Report Progress

Refer to the User Guide section, "After We Complete the Assessment, What Next?" for details on the above steps.

Assessment results represent the collective performance of all entities in the local public health system and not any one organization. Therefore, system partners should be involved in the discussion of results and improvement strategies to assure that this information is appropriately used. The assessment results can drive improvement planning within each organization as well as system-wide. In addition, coordinated use of the Local Instrument with the Governance Instrument or state-wide use of the Local Instrument can lead to more successful and comprehensive improvement plans to address more systemic statewide issues.

Although respondents will ultimately want to review these results with stakeholders in the context of their overall performance improvement process, they may initially find it helpful to review the results either individually or in a small group. The following tips may be helpful when initially reviewing the results, or preparing to present the results to performance improvement stakeholders.

◊ Examine Performance Scores

First, sites should take a look at the overall or composite performance scores for Essential Services and model standards. These scores are presented visually in order by Essential Service (Figure1) and in ascending order (Figfure 2). Additionally, Figure 3 uses color designations to indicate performance level categories. Examination of these scores can immediately give a sense of the local public health system's greatest strengths and weaknesses.

◊ Review the Range of Scores within Each Essential Service and Model Standard

The Essential Service score is an average of the model standard scores within that service, and, in turn, the model standard scores represent the average of stem question scores for that standard. If there is great range or difference in scores, focusing attention on the model standard(s) or questions with the lower scores will help to identify where performance inconsistency or weakness may be. Some figures, such as the bar charts in Figure 4, provide "range bars" which indicate the variation in scores. Looking for long range bars will help to easily identify these opportunities.

Also, refer back to the original question responses to determine where weaknesses or inconsistencies in performance may be occurring. By examining the assessment questions, including the subquestions and discussion toolbox items, participants will be reminded of particular areas of concern that may most need attention.

◊ Consider the Context

The NPHPSP User Guide and other technical assistance resources strongly encourage responding jurisdictions to gather and record qualitative input from participants throughout the assessment process. Such

information can include insights that shaped group responses, gaps that were uncovered, solutions to identified problems, and impressions or early ideas for improving system performance. This information should have emerged from the general discussion of the model standards and assessment questions, as well as the responses to discussion toolbox topics.

The results viewed in this report should be considered within the context of this qualitative information, as well as with other information. The assessment report, by itself, is not intended to be the sole "roadmap" to answer the question of what a local public health system's performance improvement priorities should be. The original purpose of the assessment, current issues being addressed by the community, and the needs and interests for all stakeholders should be considered.

Some sites have used a process such as Mobilizing for Action through Planning and Partnerships (MAPP) to address their NPHPSP data within the context of other community issues. In the MAPP process, local users consider the NPHPSP results in addition to three other assessments - community health status, community themes and strengths, and forces of change - before determining strategic issues, setting priorities, and developing action plans. See "Resources for Next Steps" for more about MAPP.

◊ Use the optional priority rating and agency contribution questionnaire results

Sites may choose to complete two optional questionnaires - one which asks about priority of each model standard and the second which assesses the local health department's contribution to achieving of the model standard. The supplemental priority questionnaire, which asks about the priority of each model standard to the public health system, should guide sites in considering their performance scores in relationship to their own system's priorities. The use of this questionnaire can guide sites in targeting their limited attention and resources to areas of high priority but low performance. This information should serve to catalyze or strengthen the performance improvement activities resulting from the assessment process.

The second questionnaire, which asks about the contribution of the public health agency to each model standard, can assist sites in considering the role of the agency in performance improvement efforts. Sites that use this component will see a list of questions to consider regarding the agency role and as it relates to the results for each model standard. These results may assist the local health department in its own strategic planning and quality improvement activities.

2.4 Final Remarks

THE CHALLENGE of preventing illness and improving health is ongoing and complex. The ability to meet this challenge rests on the capacity and performance of public health systems. Through well equipped, high-performing public health systems, this challenge can be addressed. Public health performance standards are intended to guide the development of stronger public health systems capable of improving the health of populations. The development of high-performing public health systems will increase the likelihood that all citizens have access to a defined optimal level of public health services. Through periodic assessment guided by model performance standards, public health leaders can improve collaboration and integration among the many components of a public health system, and more effectively and efficiently use resources while improving health intervention services.

Continue to **Performance Assessment Instrument Results**

▸ ▸ ▸

2.5 Performance Assessment Instrument Results

◊ How well did the system perform the ten Essential Public Health Services (EPHS)?

Table 1 ~ Summary of performance scores by Essential Public Health Service (EPHS)

EPHS	Title	Score
1	Monitor Health Status To Identify Community Health Problems	47
2	Diagnose And Investigate Health Problems and Health Hazards	82
3	Inform, Educate, And Empower People about Health Issues	51
4	Mobilize Community Partnerships to Identify and Solve Health Problems	31
5	Develop Policies and Plans that Support Individual and Community Health Efforts	51
6	Enforce Laws and Regulations that Protect Health and Ensure Safety	70
7	Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	44
8	Assure a Competent Public and Personal Health Care Workforce	44
9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	55
10	Research for New Insights and Innovative Solutions to Health Problems	57
	Overall Performance Score:	53

Table 2.1 provides a quick overview of the system's performance in each of the 10 Essential Public Health Services (EPHS). Each EPHS score is a composite value determined by the scores given to those activities that contribute to each Essential Service. These scores range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum of 100% (all activities associated with the standards are performed at optimal levels).

Figure 1 ~ Summary of EPHS performance scores and overall score (with range)

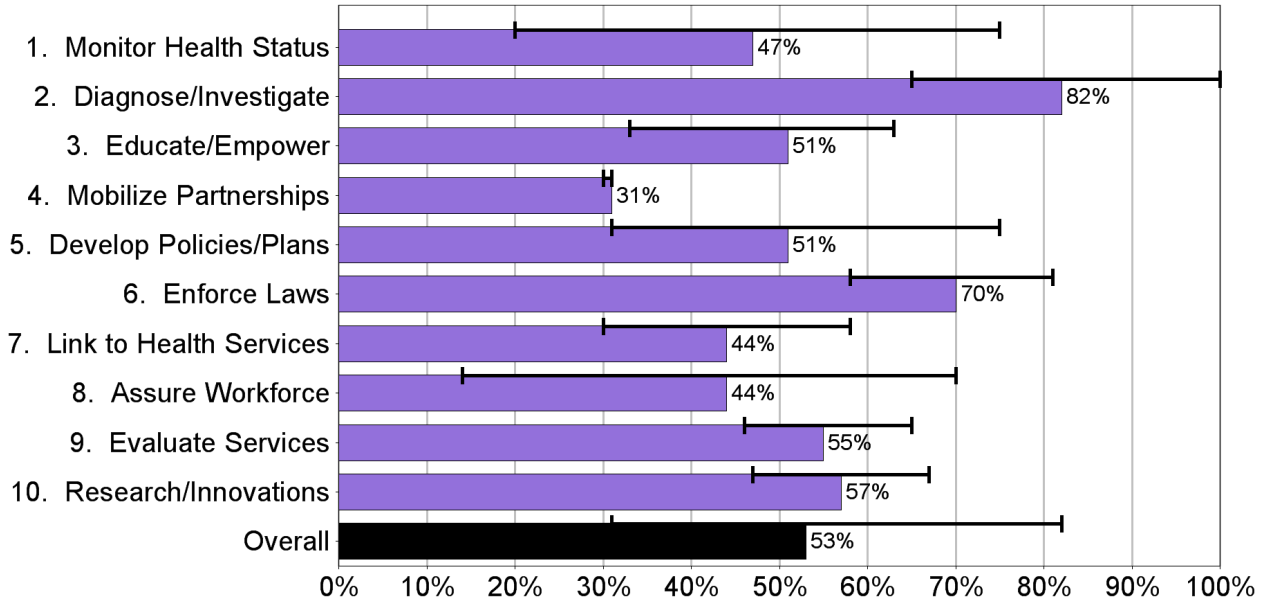


Chart 2.1 displays performance scores for each Essential Service along with an overall score that indicates the average performance level across all 10 Essential Services. The range bars show the minimum and maximum values of responses within the Essential Service and an overall score. Areas of wide range may warrant a closer look in **Figure 4** or the raw data.

Figure 2 ~ Rank ordered performance scores for each Essential Service

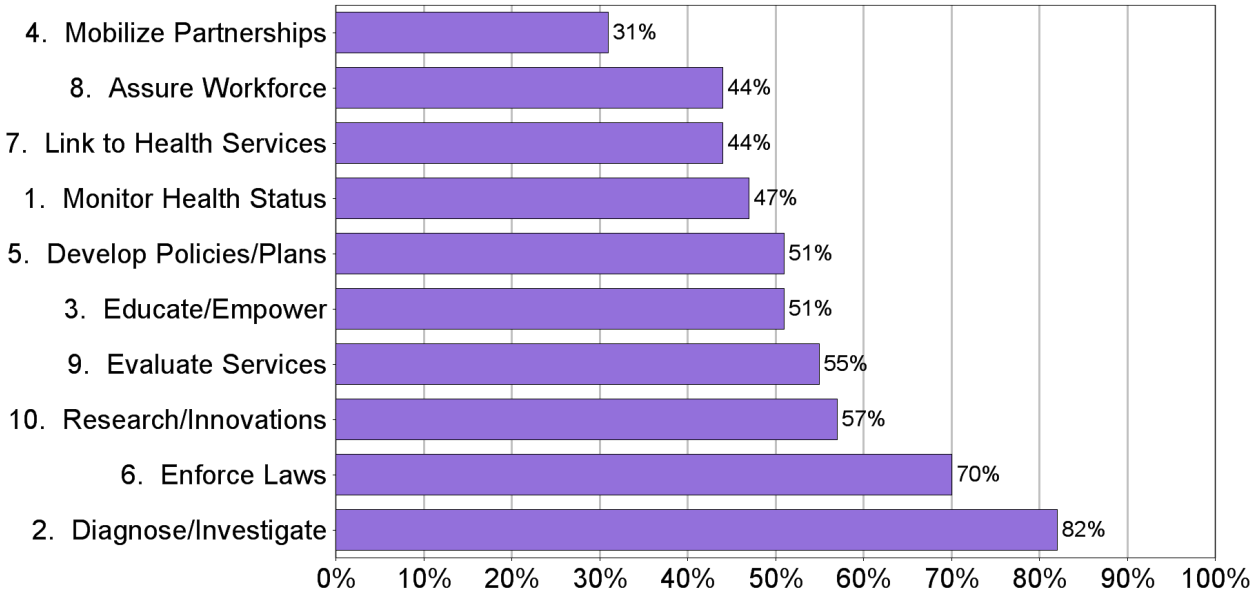


Figure 2 (above) displays each composite score from low to high, allowing easy identification of service domains where performance is relatively strong or weak.

Figure 3 ~ Rank ordered performance scores for each Essential Service, by level of activity

☐ No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal

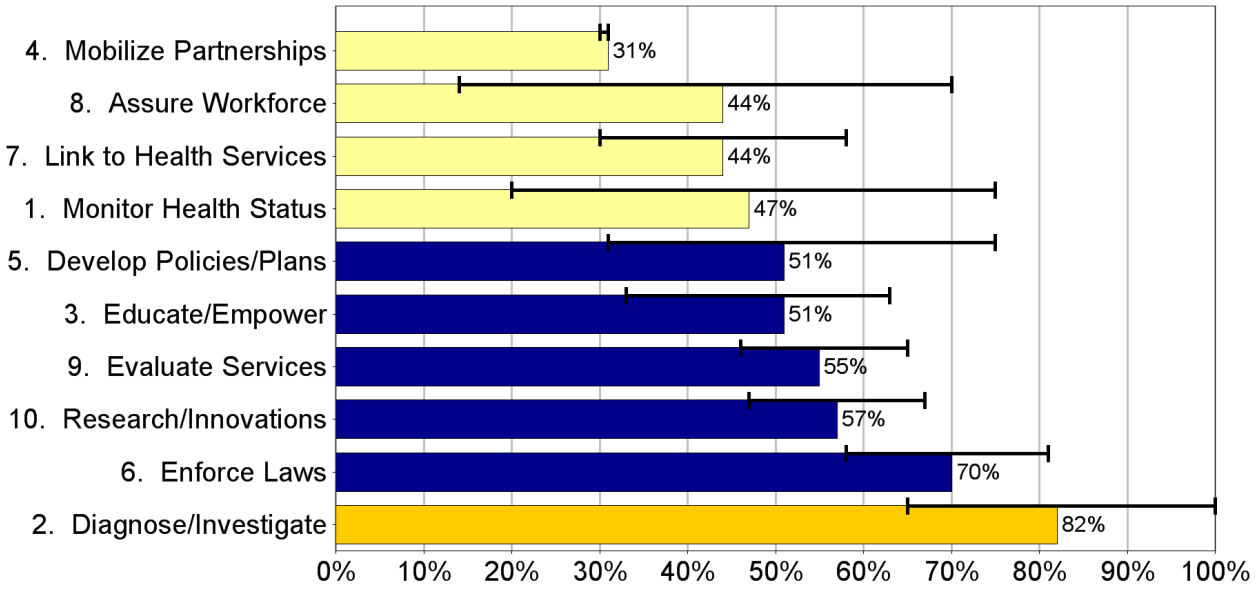


Figure 3 (above) provides a composite picture of the previous two graphs. The range lines show the range of responses within an Essential Service. The color coded bars make it easier to identify which of the Essential Services fall in the five categories of performance activity.

◊ How well did the system perform on specific model standards?

Figure 4: Performance scores for each model standard, by Essential Service

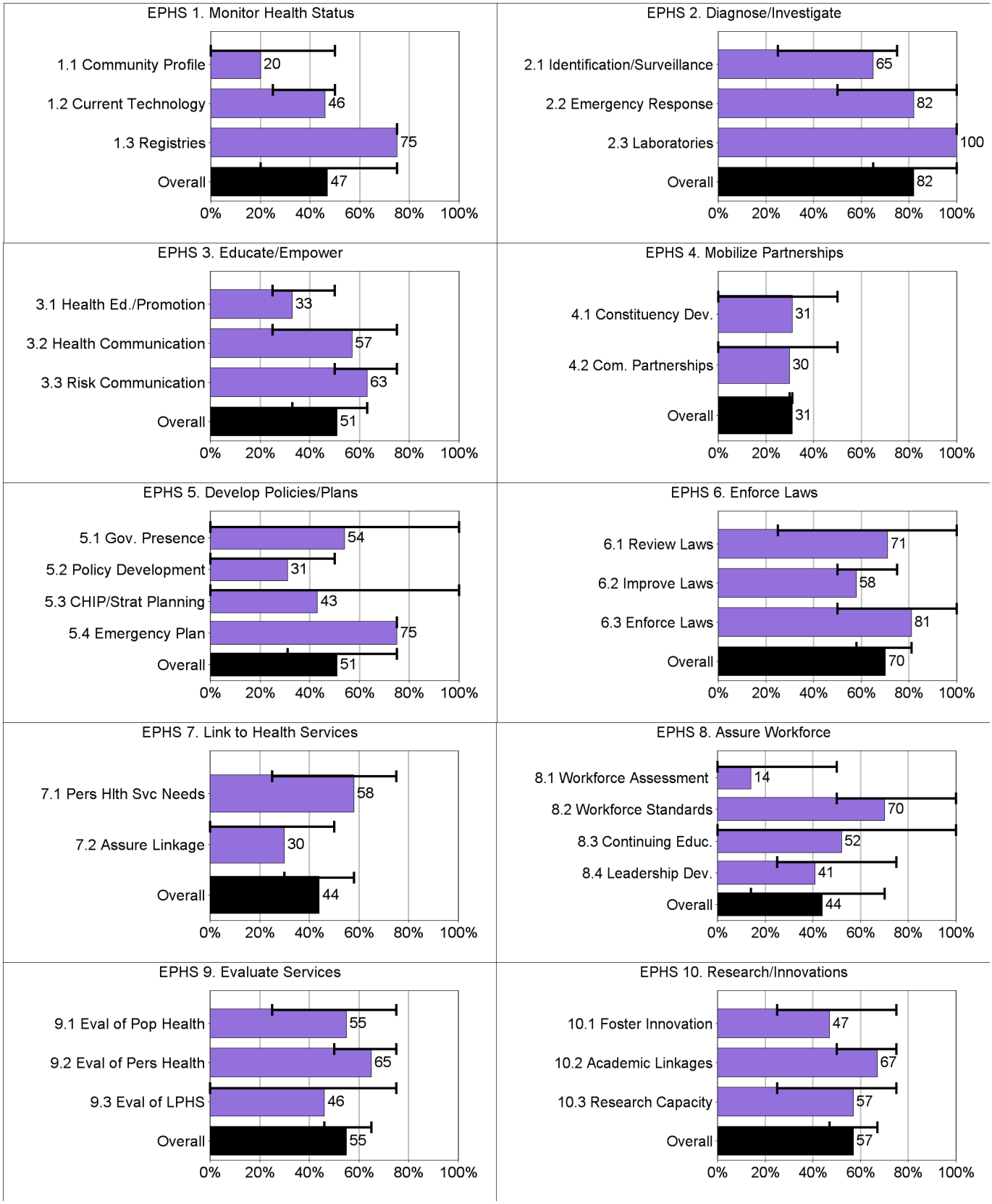


Figure 4 (next page) shows scores for each model standard. Sites can use these graphs to pinpoint specific activities within the Essential Service that may need a closer look. Note these scores also have range bars, showing sub-areas that comprise the model standard.

Table 2 ~ Summary of performance scores by Essential Public Health Service (EPHS) and model standard

Essential Public Health Service	Score
EPHS 4. Mobilize Community Partnerships to Identify and Solve Health Problems	31
4.1 Constituency Development	31
4.1.1 Identification of key constituents or stakeholders	31
4.1.2 Participation of constituents in improving community health	50
4.1.3 Directory of organizations that comprise the LPHS	13
4.1.4 Communications strategies to build awareness of public health	31
4.2 Community Partnerships	30
4.2.1 Partnerships for public health improvement activities	50
4.2.2 Community health improvement committee	25
4.2.3 Review of community partnerships and strategic alliances	15
EPHS 5. Develop Policies and Plans that Support Individual and Community Health Efforts	51
5.1 Government Presence at the Local Level	54
5.1.1 Governmental local public health presence	88
5.1.2 Resources for the local health department	38
5.1.3 Local board of health or other governing entity (not scored)	0
5.1.4 LHD work with the state public health agency and other state partners	38
5.2 Public Health Policy Development	31
5.2.1 Contribution to development of public health policies	46
5.2.2 Alert policymakers/public of public health impacts from policies	25
5.2.3 Review of public health policies	21
5.3 Community Health Improvement Process	43
5.3.1 Community health improvement process	67
5.3.2 Strategies to address community health objectives	13
5.3.3 Local health department (LHD) strategic planning process	50
5.4 Plan for Public Health Emergencies	75
5.4.1 Community task force or coalition for emergency preparedness and response plans	75
5.4.2 All-hazards emergency preparedness and response plan	75
5.4.3 Review and revision of the all-hazards plan	75
EPHS 6. Enforce Laws and Regulations that Protect Health and Ensure Safety	70
6.1 Review and Evaluate Laws, Regulations, and Ordinances	71
6.1.1 Identification of public health issues to be addressed through laws, regulations, and ordinances	50
6.1.2 Knowledge of laws, regulations, and ordinances	75
6.1.3 Review of laws, regulations, and ordinances	59
6.1.4 Access to legal counsel	100
6.2 Involvement in the Improvement of Laws, Regulations, and Ordinances	58
6.2.1 Identification of public health issues not addressed through existing laws	50
6.2.2 Development or modification of laws for public health issues	75
6.2.3 Technical assistance for drafting proposed legislation, regulations, or ordinances	50
6.3 Enforce Laws, Regulations and Ordinances	81
6.3.1 Authority to enforce laws, regulation, ordinances	94
6.3.2 Public health emergency powers	100
6.3.3 Enforcement in accordance with applicable laws, regulations, and ordinances	75
6.3.4 Provision of information about compliance	75
6.3.5 Assessment of compliance	63

Essential Public Health Service	Score
EPHS 7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	44
7.1 Identification of Populations with Barriers to Personal Health Services	58
7.1.1 Identification of populations who experience barriers to care	75
7.1.2 Identification of personal health service needs of populations	75
7.1.3 Assessment of personal health services available to populations who experience barriers to care	25
7.2 Assuring the Linkage of People to Personal Health Services	30
7.2.1 Link populations to needed personal health services	50
7.2.2 Assistance to vulnerable populations in accessing needed health services	25
7.2.3 Initiatives for enrolling eligible individuals in public benefit programs	25
7.2.4 Coordination of personal health and social services	19
EPHS 8. Assure a Competent Public and Personal Health Care Workforce	44
8.1 Workforce Assessment Planning, and Development	14
8.1.1 Assessment of the LPHS workforce	0
8.1.2 Identification of shortfalls and/or gaps within the LPHS workforce	43
8.1.3 Dissemination of results of the workforce assessment / gap analysis	0
8.2 Public Health Workforce Standards	70
8.2.1 Awareness of guidelines and/or licensure/certification requirements	75
8.2.2 Written job standards and/or position descriptions	75
8.2.3 Annual performance evaluations	75
8.2.4 LHD written job standards and/or position descriptions	75
8.2.5 LHD performance evaluations	50
8.3 Life-Long Learning Through Continuing Education, Training, and Mentoring	52
8.3.1 Identification of education and training needs for workforce development	75
8.3.2 Opportunities for developing core public health competencies	21
8.3.3 Educational and training incentives	63
8.3.4 Interaction between personnel from LPHS and academic organizations	50
8.4 Public Health Leadership Development	41
8.4.1 Development of leadership skills	53
8.4.2 Collaborative leadership	38
8.4.3 Leadership opportunities for individuals and/or organizations	50
8.4.4 Recruitment and retention of new and diverse leaders	25
EPHS 9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	55
9.1 Evaluation of Population-based Health Services	55
9.1.1 Evaluation of population-based health services	75
9.1.2 Assessment of community satisfaction with population-based health services	47
9.1.3 Identification of gaps in the provision of population-based health services	50
9.1.4 Use of population-based health services evaluation	50
9.2 Evaluation of Personal Health Care Services	65
9.2.1.In Personal health services evaluation	54
9.2.2 Evaluation of personal health services against established standards	75
9.2.3 Assessment of client satisfaction with personal health services	50
9.2.4 Information technology to assure quality of personal health services	69
9.2.5 Use of personal health services evaluation	75

Essential Public Health Service	Score
9.3 Evaluation of the Local Public Health System	46
9.3.1 Identification of community organizations or entities that contribute to the EPHS	75
9.3.2 Periodic evaluation of LPHS	29
9.3.3 Evaluation of partnership within the LPHS	25
9.3.4 Use of LPHS evaluation to guide community health improvements	53
EPHS 10. Research for New Insights and Innovative Solutions to Health Problems	57
10.1 Fostering Innovation	47
10.1.1 Encouragement of new solutions to health problems	63
10.1.2 Proposal of public health issues for inclusion in research agenda	25
10.1.3 Identification and monitoring of best practices	75
10.1.4 Encouragement of community participation in research	25
10.2 Linkage with Institutions of Higher Learning and/or Research	67
10.2.1 Relationships with institutions of higher learning and/or research organizations	75
10.2.2 Partnerships to conduct research	50
10.2.3 Collaboration between the academic and practice communities	75
10.3 Capacity to Initiate or Participate in Research	57
10.3.1 Access to researchers	75
10.3.2 Access to resources to facilitate research	75
10.3.3 Dissemination of research findings	50
10.3.4 Evaluation of research activities	28

◊ Overall, how well is the system achieving optimal activity levels?

Figure 5: Percentage of Essential Services scored in each level of activity

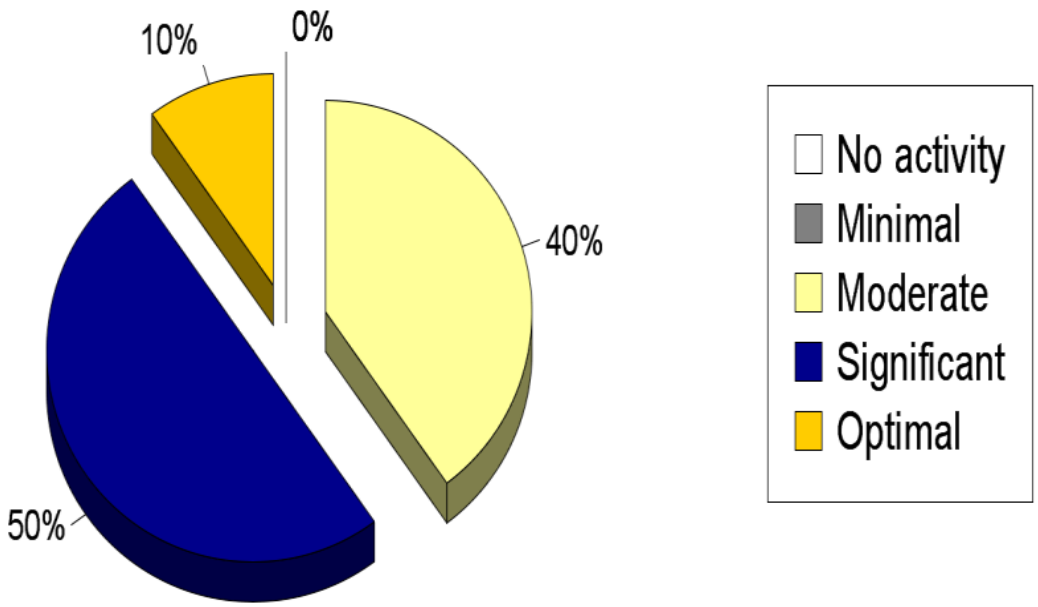


Figure 5 displays the percentage of the system's Essential Services scores that fall within the five activity categories. This chart provides the site with a high level snapshot of the information found in **Figure 3**.

Figure 6: Percentage of model standards scored in each level of activity

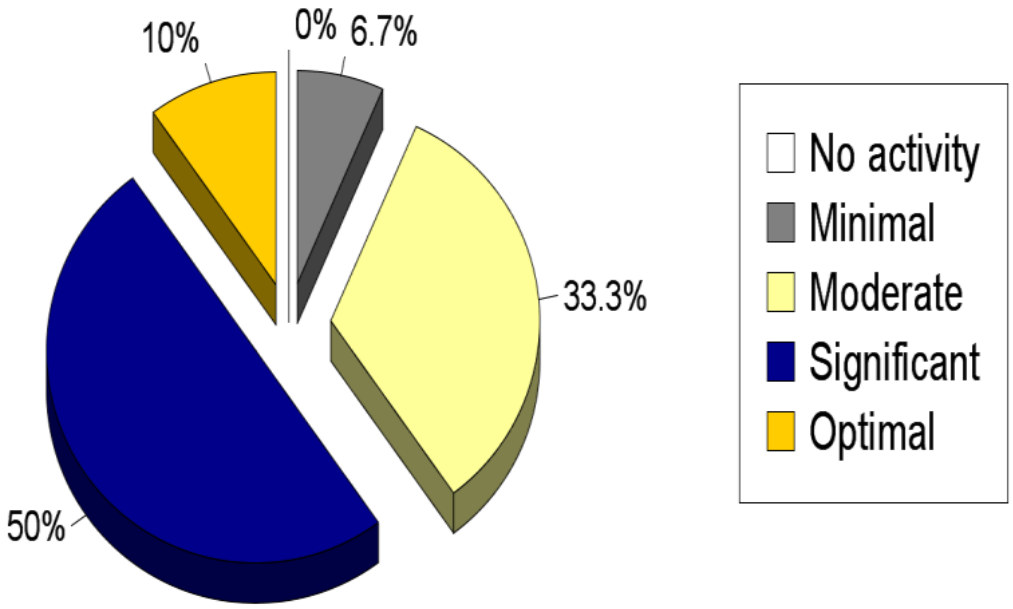


Figure 6 displays the percentage of the system's model standard scores that fall within the five activity categories.

Figure 7: Percentage of all questions scored in each level of activity

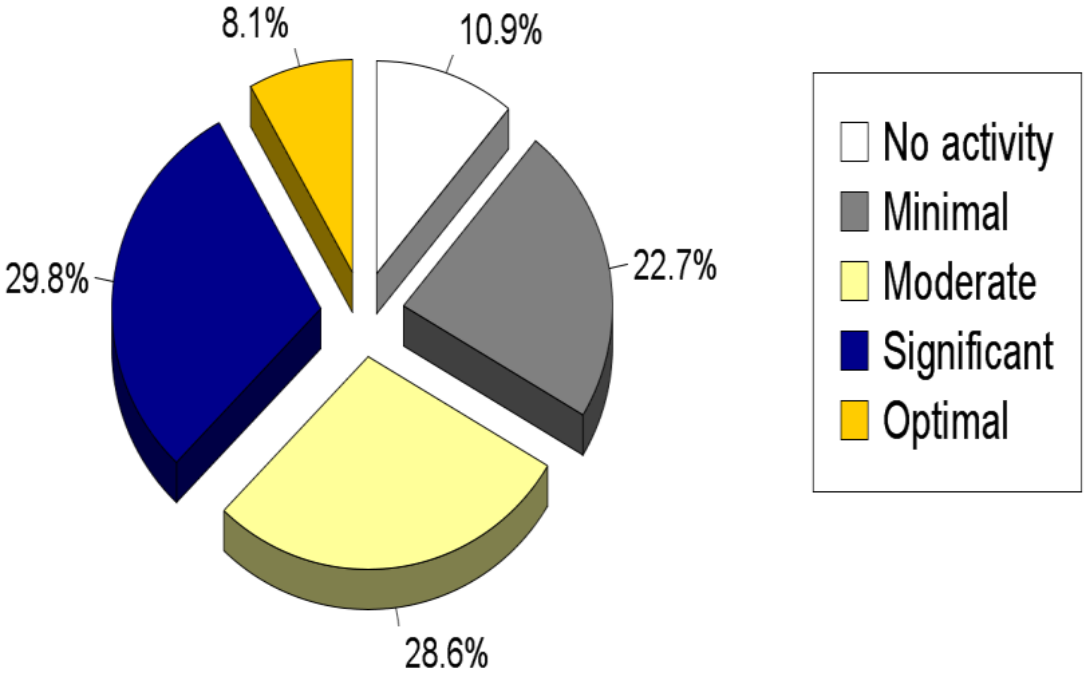


Figure 7 displays the percentage of all scored questions that fall within the five activity categories. This breakdown provides a closer snapshot of the system's performance, showing variation that may be masked by the scores in **Figures 5** and **6**.

2.6 Resources for Next Steps

THE NPHPSP offers a variety of information, technical assistance, and training resources to assist in quality improvement activities. Descriptions of these resources are provided below. Other resources and websites that may be of particular interest to NPHPSP users are also noted below.

- **Technical Assistance and Consultation** - NPHPSP partners are available for phone and email consultation to state and localities as they plan for and conduct NPHPSP assessment and performance improvement activities. Contact 1-800-747-7649 or phpsp@cdc.gov.
- **NPHPSP User Guide** - The NPHPSP User Guide section, "After We Complete the Assessment, What Next?" describes five essential steps in a performance improvement process following the use of the NPHPSP assessment instruments. The NPHPSP User Guide may be found on the NPHPSP website (http://www.cdc.gov/NPHPSP/PDF/User-Guide.pdf).
- **NPHPSP Online Tool Kit** - Additional resources that may be found on, or are linked to, the NPHPSP website (http://www.cdc.gov/NPHPSP/generalResources.html) under the "Post Assessment/ Performance Improvement" link include sample performance improvement plans, quality improvement and priority-setting tools, and other technical assistance documents and links.
- **NPHPSP Online Resource Center** - Designed specifically for NPHPSP users, the Public Health Foundation's online resource center (www.phf.org/nphpsp) for public health systems performance improvement allows users to search for State, Local, and Governance resources by model standards, essential public health service, and keyword.;
- **NPHPSP Monthly User Calls** - These calls feature speakers and dialogue on topic of interest to users. They also provide an opportunity for people from around the country to learn from each other about various approaches to the NPHPSP assessment and performance improvement process. Calls occur on the third Tuesday of each month, 2:00 - 3:00 ET. Contact phpsp@cdc.gov to be added to the email notification list for the call.
- **Annual Training Workshop** - Individuals responsible for coordinating performance assessment and improvement activities may attend an annual two-day workshop held in the spring of each year. Visit the NPHPSP website (http://www.cdc.gov/nphpsp/annualTrainingWorkshop.html) for more information.
- **Public Health Improvement Resource Center at the Public Health Foundation** - This website (www.phf.org/improvement) provides resources and tools for evaluating and building the capacity of public health systems. More than 100 accessible resources organized here support the initiation and continuation of quality improvement efforts. These resources promote performance management and quality improvement, community health information and data systems, accreditation preparation, and workforce development.
- **Mobilizing for Action through Planning and Partnerships (MAPP)** - MAPP has proven to be a particularly helpful tool for sites engaged in community-based health improvement planning. Systems that have just completed the NPHPSP may consider using the MAPP process as a way to launch their performance improvement efforts. Go to www.naccho.org/topics/infrastructure/MAPP to link directly to the MAPP website.

Continue to Part 3.

Key Informant Interviews Linn County Public Health

3.1 Introduction ◊ 3.2 Linn County ◊ 3.3 Rural Health ◊ 3.4 Seniors ◊ 3.5 Hispanic Population ◊ 3.6 Homeless Population ◊ Child Health ◊ Quantative Analysis of Key Informants

3.1 Introduction

Key informant interviews are a way of collecting qualitative information from individuals. Linn County Public Health used Key Informant interviews to collect information on health and quality of life issues affecting communities throughout the County. Linn County Public Health performed 30 interviews from individuals all over the county. These people included doctors, government leaders, business owners, school leaders, community advocates and other people in the unique position of knowing priority issues in their community.

The following is a narrative of the issues uncovered during these interviews. This report attempts to deliver a picture of the status of the county from the viewpoint of those interviewed. In addition, there is a brief quantification of the questions and their answers.

Key Informant Interviews

Linn County conducted key informant interviews to collect qualitative first-person information on the state of health and quality of life in various communities and sub-populations in our County. These interviews gave Linn County Public Health valuable first hand testimony on issues that communities face, from the perspective of people living in those communities

Questions:

- Health Problem
- Contributing Factors
- People at Risk.
- Significant Barriers
- Community Assests

3.2 Linn County

When we look county wide, nearly all key informants agreed that health has been declining. This is primarily due to the current nationwide recession that has been going on since 2008. Unemployment has resulted in loss of not only income but health insurance as well. Period effects are a difficult subject to untangle from other health problems. Public health has a limited capacity to affect fundamental issues such as loss of income, resources and health insurance. With that said, there is still much to offer in terms of referral networks to community organizations, health promotion, education and prevention. Most key informants have commented on the stretched capacity of social services and community services.

Based on the questions asked, informants were able to point to factors that are not based on the economy. Education is a pervasive issue among those at risk for poor health. Overall, Linn County has poor education rates as compared to the state, with a 70% high school graduation rate and a 15% college graduation rate. Poverty, in particular generational poverty, are key determinants of poor health according to many informants. The impoverished in our communities often adopt lifestyles that represent risk behaviors. Poor eating habits, smoking, drinking, drug use and lack of exercise all have significantly higher rates among the poor. Generational poverty, learned poverty, and lifestyle of poverty are all terms key

informants used to describe how families pass down coping strategies and risk behaviors from generation to generation. Being raised in a poor family is a social determinant that has the potential to affect health outcomes. Children learn that eating a bowl of cereal for dinner is normal and boxed meals are an everyday diet. Eating a diet of processed foods and cheap sugary cereals conditions our bodies to desire salty, sweet and fatty foods and it makes the introduction of whole foods, vegetables and fruits difficult later in life.

◊ Supplemental Nutrition Assistance Program (SNAP)

Many informants have lamented the lack of education that accompanies SNAP benefits for the low income. Unlike Women in Crisis (WIC), there is no required check up or education tied to the benefit, and regulations on what types of food you can buy are quite loose in comparison. As mentioned above, individuals that have never known a different way, continue to shop towards their tastes and palates, despite having extra financial assistance for food. Individuals with SNAP benefits tend to stock up on soda pop, chips, and boxed dinners in the absence of knowing how to prepare fruits, vegetables, and whole grains.

◊ Physical Activity

Another county wide trend is a general lack of physical activity and exercise. Both informant views and collected statistics confirm that the county has a problem with obesity and the average citizen does not get enough exercise. Linn County is fortunate to have many County maintained parks, as well as city parks and outdoor areas. Lebanon is very active in attempting to improve their parks and build extensive trails and bike paths throughout their city. Work still needs to be done to improve outdoor conditions in low socioeconomic areas throughout Linn County. Having a park in disrepair, inadequate traffic control, or lack of paved areas are barriers to children and adults getting outside to walk, run, or ride a bike.

◊ Albany

Albany faces unique challenges as the population center for the county. Its location on the freeway, coupled with the busy rail yard makes it a transit city for the homeless. Homeless health concerns will be covered later in this report, but at a population level Albany faces a significant burden. The city has been forced to implement ordinances and take enforcement measures to combat many issues that arise due to homelessness. Highly correlated with homelessness are mental health issues. Linn County has no inpatient treatment centers for mental health disorders and patients must seek care in either Salem or Corvallis for any inpatient needs. For therapy, counseling and outpatient care, Linn County Mental Health is the area's largest provider. There are limited private therapists and counselors operating in the county and the ones that do tend to have a family/marriage focus.

3.3 Rural Health

Linn county spoke with community leaders in several rural and small towns in the county. Transportation is on health issue that is shared by all of these communities. As the Medicaid provider for a number of services, clients are required to travel to Albany, or Lebanon for certain services. For low socioeconomic individuals, a 60 mile round trip from Harrisburg, or an 85 mile round trip from Mill City can be a serious hardship. Many people in need of Oregon Health Plan treatments do not have a car, or cannot afford to spend the extra gas. These small communities also do not offer a robust or reliable public transportation system either.

Related to the inability to access transportation, services in the community or brought to the community are very limited. Harrisburg, for example does not have any practicing doctors in the community. Mill City has a single clinic that must provide services to the entire Santiam Canyon area, including Lyons and Gates. Brownsville and Halsey only benefit from a part-time clinician on certain days of the week. A key informant speaking on behalf of Mill City also stated the lack of county services brought to the town. Mental health was a large cited need, and it was noted that Mill City does not have access to any County practitioners. The County's inability to send a therapist to Mill City means that troubled, and very low socioeconomic individuals with mental health problems must find transportation to come to Albany for treatment or help. The Mill City informant noted that they had requested that Linn County Mental Health send a worker to Mill City a few times a month, but was told that was not possible because the roads are not safe in the winter.

Access to Healthy food is an issue. Harrisburg does not have a grocery store that stocks fruits and vegetables. Most all small towns in the community are serviced by smaller scale markets with very limited healthy food options.

These places are in prime locations for seasonal foods from area farms, but eating healthy in the off seasons can be difficult.

Education and cultural norms are a bigger issue in rural Linn County than in Albany or even Lebanon. Smoking and smokeless tobacco are more acceptable. It was noted that in many rural areas, it is viewed as a normal and acceptable thing to buy a six pack every night after work. Generational poverty is more of a problem as well. Children grow up poor, in households that have adopted coping mechanisms to deal with years of living in poverty. They learn to eat unhealthy, they do not know how to budget, education is not a priority, and they are more likely to engage in risk behaviors. Harrisburg, Mill City and the Brownsville/Halsey area all commented that they have a high proportion of single mothers living in poverty. These women have difficulties with access to health care, with housing and with acquiring healthy food for themselves and their families.

Small and rural communities also have unique community assets. Smaller towns tend to be closer knit, and have a more cohesive and willing to help community than larger towns. Community organizations may be few and far between, but they are very specific and tailored to the needs in that area. Churches are a more dominate community organization than in larger towns, and much of the community leans on them for support services. Many operate as emergency shelters and food banks. Linn County's smaller communities are supportive of activism and usually eager to help make a difference.

3.4 Seniors

Several interviews were specific to the special needs of seniors within Linn County. More unique to seniors than other demographics is the rate of prescription drug abuse, which is usually coupled with long term disablement and chronic diseases. Many seniors have behavioral health issues and untreated mental health issues that compound chronic disease problem they may have. It is common to mistake behavior issues with normal and common aging. Forgetfulness and irritability are frequent markers of larger mental health issues that are commonly attributed to aging.

The demographics of the boomer population make this a growing and increasingly vulnerable population. Nationwide 10,000 people turn 65 every day. Additionally, we are all living longer, there is a greater proportion of individuals over 85+ than ever before in history. With current economic conditions, increased unemployment, reduced pensions and decreased stock values, there are is an increasing number of incoming poor seniors. Work opportunities can be very hard to come by for seniors, particularly those with physical limitations or disablement. A person entering 65 in poverty is very likely to stay that way.

We do not have a strong focus on prevention in Linn County, not to mention the already strained safety net and social programs. Treatment for multiple chronic conditions is costly, and a large percentage of seniors are on Medicare. A focus on chronic disease prevention, as opposed to expanding treatment options needs to take center stage.

3.5 Hispanic Population

Three key informant interviews were conducted with individuals that work with the Hispanic and Latino population in Linn County. Across all three interviews, Obesity, Diabetes and Hypertension were pervasive health issues. Poverty, education and language barrier issues were often cited as contributing causes to these health issues. Poverty contributes to obesity by not being able to purchase healthy, whole foods and a creating a reliance on high fat, high sodium process foods and boxed meals. Transportation issues compound this problem. Many Hispanic individuals do not have a driver's license, or access to a vehicle. With limited house availability, much of the grocery shopping happens at convenience and corner stores as opposed to grocery stores. This limits access to fruits and vegetables, as well as options for whole grain baked good, butcher services or even the availability of low fat milk. Language barrier issue means gaining access to support services can be difficult, as well as ability to receive education. Language barriers at health clinics create issues with access to care. Many times individuals with low English skills will simply avoid asking questions or seeking help because of the frustrations of trying to communicate.

The above mentioned language barrier was the most commonly cited contributing factor to the declining status of the health in the Hispanic and Latino population. Lack of bilingual services is a barrier in Linn County.

Farm laborer health was a commonly cited concern. Several factors contribute to health concerns in this group. Some workers may be undocumented or in the country illegally, thus preventing them from seeking health care

for fear of being discovered. Farm workers may have exposures to chemicals, pesticides or herbicides that the average citizen does not. The nature of much migrate farm work is long working days under intense physical conditions for a short harvesting season. Heatstroke and dehydration are issues that often go unreported. Long term, consistent dehydration can lead to chronic kidney disease as well as affect the function of many other organ systems.

Related to the following homeless section, a key informant feels that the homeless population among Hispanics is greatly underestimated. This is a factor of dense living arrangements; couch surfing and communal living in excess of what is safe or healthy.

3.6 Homeless Population

It goes without saying that the homeless face a mountain of health concerns and issues that the average citizen in Linn County does not. However, like with all sub-populations, there are unique aspects to the homeless population in Linn County that might not be the same state wide or nationwide.

One of the biggest issues faced by the homeless in Linn County is the availability of psychotropic medication they need to function. Our key informant estimates that over half the homeless in Linn County have or need a prescription for a mental health problem and most of them do not have access to maintain that prescription. Many homeless get trapped in a cycle of becoming mentally unstable to the point they break a society law. Law enforcement takes them to jail, where they are referred to an area mental health hospital and receive treatment. After a few weeks of stabilizing, they are discharged with only a few weeks worth of medicine. The cycle then continues. Our key informant stresses the need to expand programs to provide these vital medications so many of the chronically homeless can stabilize their lives, and contribute back to society.

Local programs in Linn County have made great progress in improving the health of the homeless population. Linn County's active TB screening program has helped all but eliminate TB among homeless in the area. Samaritan and Parish Nurses extend triage care to area shelters, offering basic health services, advice and screenings to this vulnerable population.

3.7 Child Health

Linn county faces several issues pertaining to child health. Like most places across the nation, childhood obesity is on the rise, currently we sit at about 27.4% of our kids being obese. Food security and school nutrition policies are major contributing factors. Children in low socioeconomic home are much more likely to eat meals consisting of highly process, carbohydrate intensive, high fat and high sodium foods. Macaroni and cheese or Hamburger Helper style meals come very cheap, but have poor nutritional value. Many children are not receiving adequate information about the potential harm of sugar-sweetened beverages. Schools often have vending machines full of soda and sports drinks that contain high calorie loads. Kids drink too many of these beverages not knowing the potential harmful effects, and policies in many schools do not adequately limit consumption.

There is also great inequity across school meals and policies. Some area schools have stronger policies than others regarding fruit and vegetable servings, chocolate milk availability, and serving sizes. Additionally, schools do not have equal policy or strength in enforcing physical education requirements, or encouraging children to be active during play and recess times.

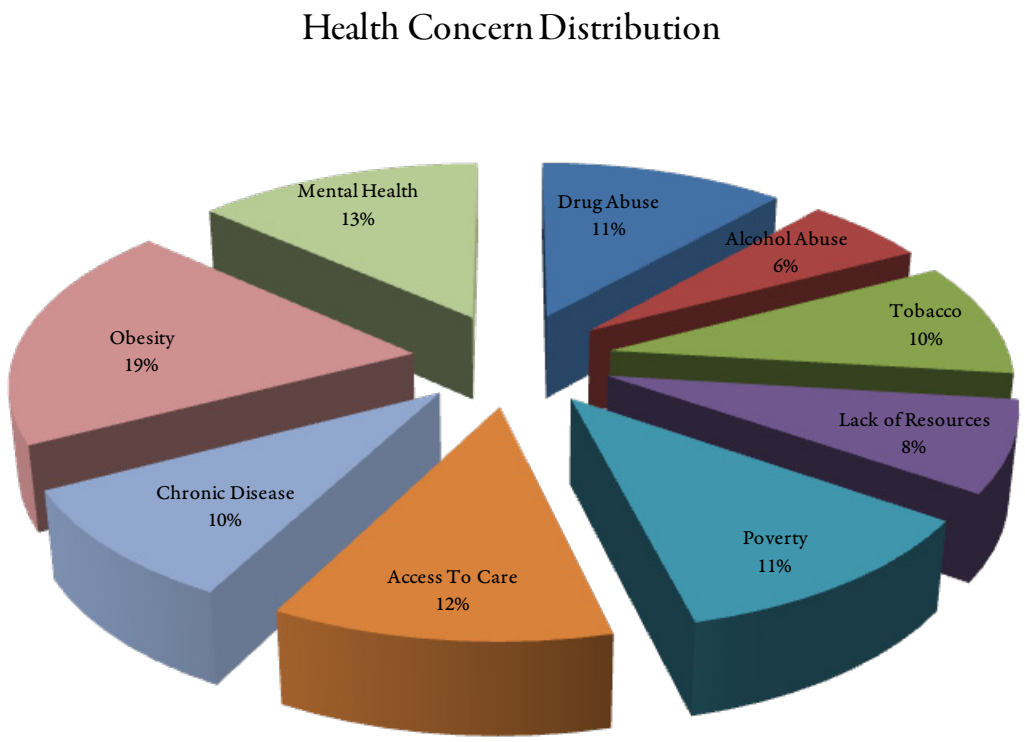
Beyond policy, an often commented issue is the deterioration of "life skills" education. With shrinking budgets and larger class sizes, health promotion educations, home economic and cooking classes and sexual education classes have been cut. Teachers at one time handled much of this subject matter, but now are becoming more and more reliant on third parties to deliver content, and those third parties are stretched for resources as well.

3.8 Quantitative Analysis of Key Informant Responses

The primary focus of the Key Informant interview is for planners and investigators to get firsthand accounts of issues and perspectives from highly informed individuals. However, trends and common themes tend to emerge that are relevant to a total population perspective. This analysis looks at themed responses across all the interviews, and sums common categories in order to establish a snap shot of the county. The following is a quantification of responses and a distribution of them. Results are given by question, with a methods description describing how answers were categorized.

◊ Question 1: "What would you say are the top one or two health problems in your community?"

Chart 3.1



▷ Methods

Responses to question one were summarized and coded into a collection of logical topic areas. Answers that occurred more than once are graphed above:

Obesity: Reponses that spoke of lack of exercise, excessive eating, junk food and other related topics.

Access to Health Care: Issues with the ability to receive care were categorized here. Not having a doctor in the city, long distances needed to travel, no Public Health presence are examples of Access issues.

Substance Abuse: any response, not including tobacco, involving abuse of an illegal drug, or abuse of prescription drugs.

Poverty: Any response that included an individual's ability to pay, either for health care, or food, or a safe housing or any other basic need. Answers dealing with culture of poverty and generational poverty were common and also included here as was the issue of homelessness, unless specifically qualified with mental health issues.

Chronic Disease: A response that included directly stating chronic diseases, or long term health issues, disablement, or a specific chronic condition, such as diabetes or arthritis.

Resources: Responses that indicated an infrastructure issue, such as inability to maintain city parks, build walking trails. Unique answers such as the need to maintain soda and junk food vending machines for a revenue stream is included here, as the need for resources control that health decision.

Mental Health: A response that indicated a problem with access to, treatment, affordability of prescriptions or housing of individuals with Mental Health issues.

Tobacco: Any response having to do with smoking or chewing, and the culture surrounding those issues.

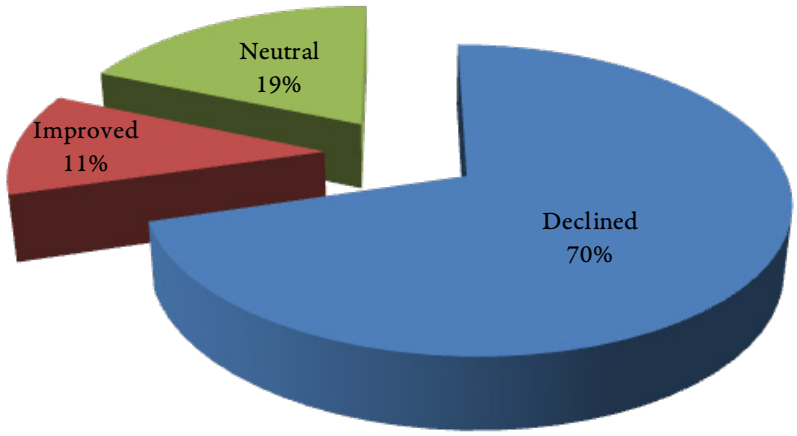
Alcohol Abuse: Any response dealing with alcohol consumption and social beliefs around it.

◊ Question 2: "Do you think, on average, the health of the people in your community has improved, stayed the same, or declined in the past 3-5 years?"

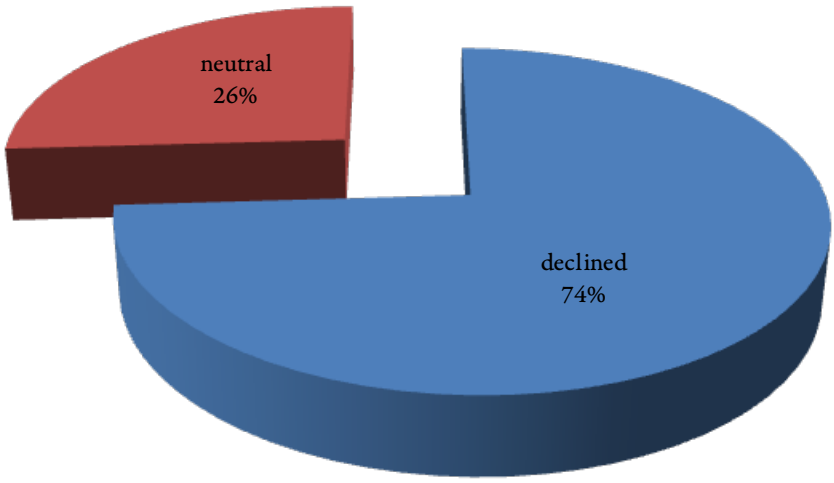
◊ Question 3: "Do you think, on average, the quality of life of the people in your community has improved, stayed the same or declined in the past 3-5 years?

Chart 3.2

Health Status in your Community?



Quality of Life Status in your Community?

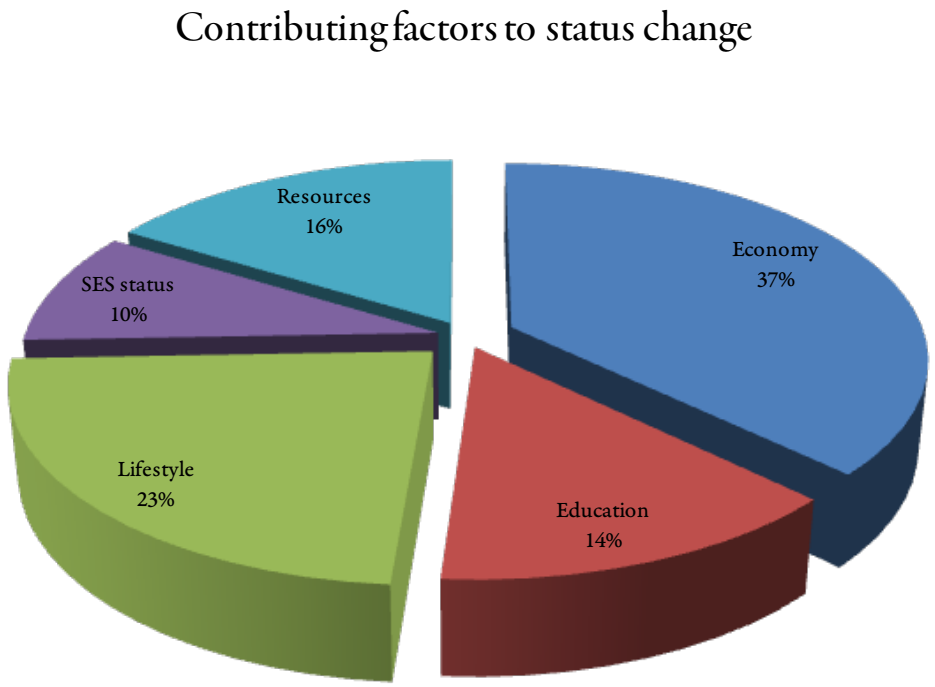


▷ Methods

Interviewees were asked to characterize the change in health and quality of life status as either improved, declined or stayed the same.

◊ Question 4: "What do you see as the major contributing factor or factors to the improvement, decline or neutral status of the health and quality of life in your community?"

Chart 3.3



▷ Methods

Resources: Any response that cited a lack of an ability to maintain a program or upkeep infrastructure.

Economy: Any response that specifically stated the economy, the recession, unemployment, lack of jobs, loss of insurance to layoffs or job loss.

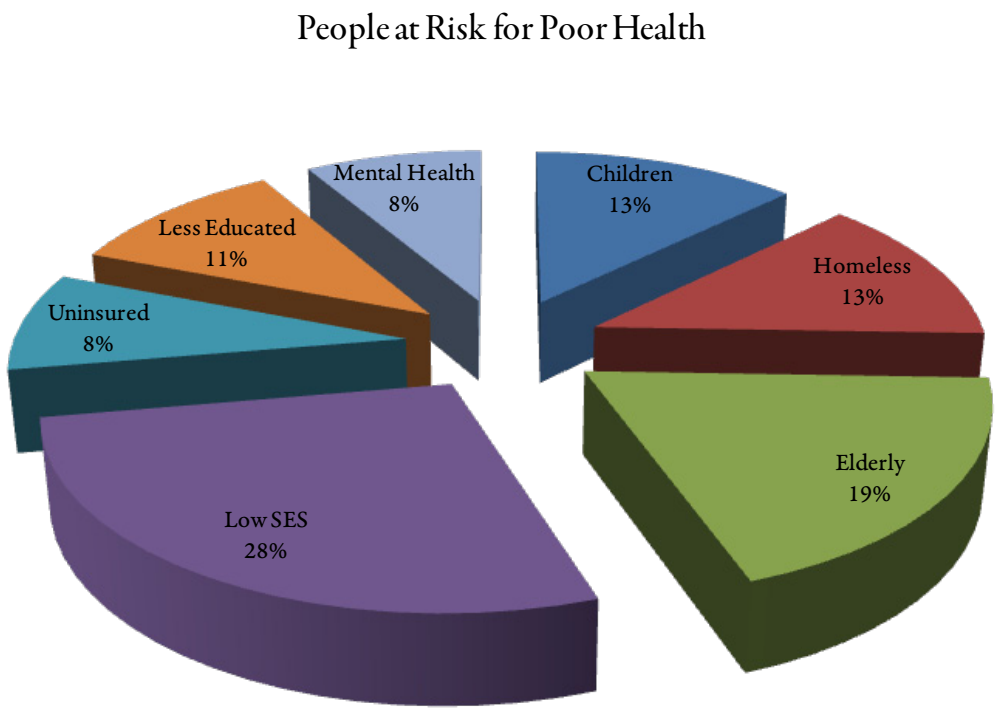
Education: Any response that cited a lack of knowledge about consequences of a risk behavior, lack of knowledge about prevention. Any response that cited a need for health communication or school based education or programs

Lifestyle: Any response that stated social norms of engaging in harmful risk behaviors. Smoking, drinking, lack of exercise, poor nutrition habits and items similar are captured here.

SES status: Any response citing socioeconomic status or the culture of poverty. These did not include recession related status, but existing societal norms around being poor and the behaviors associated with that status.

Question 5: "What people or groups of people in your community do you view as having poor health and why?

Chart 3.4



Methods

Mental Health: Any response indicating a person with mental health issues or needs.

Children: Any response indicating a child, or children of, or youth.

Elderly: Any response indicating Elderly, the Elderly, Seniors, older people.

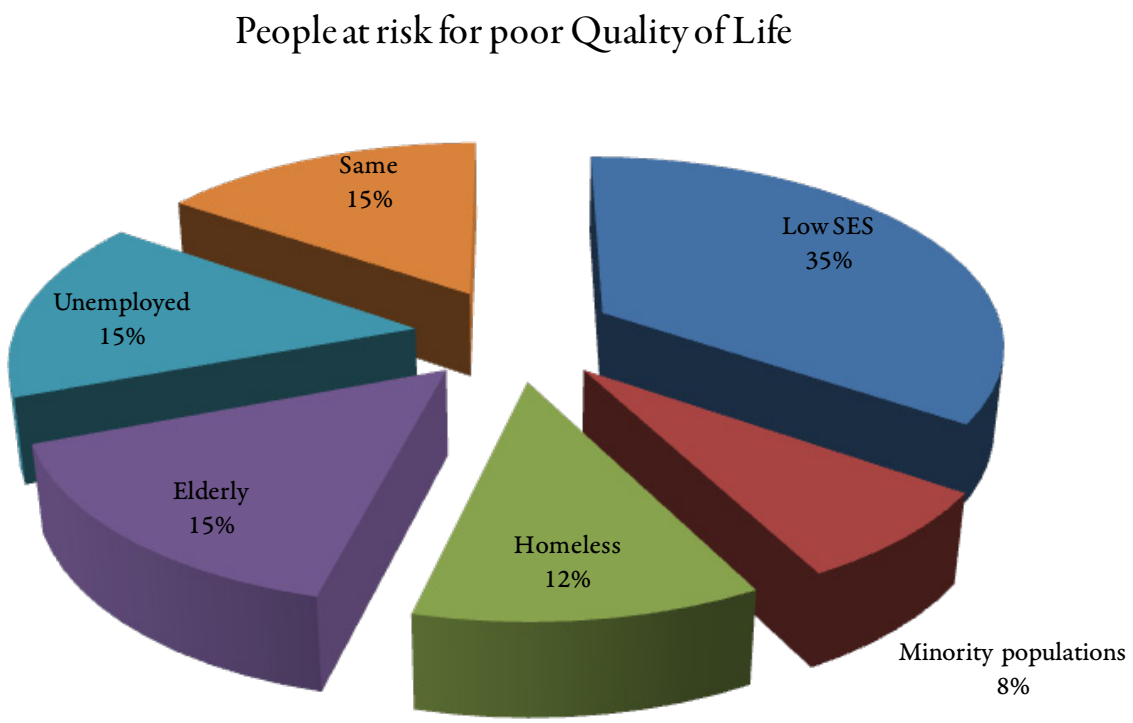
Low SES: Any response indicating low income, poor, poverty, or similar.

Uninsured: Any response indicating no insurance, a loss of insurance or similar.

Less Educated: Any response indicating a lack of education, high school dropout, low education, low literacy or similar.

◊ Question 6: "What people or group of people in your community do you view as having a poor quality of life and why?"

Chart 3.5



▷ Methods

Same: Any response indicating that the same groups of people at risk for poor health were at risk for poor quality of life.

Low SES: Any response indicating low income, poor, poverty, or similar.

Minority Populations: Any response indicating a minority population, Hispanic or Latino populations, immigrants or similar.

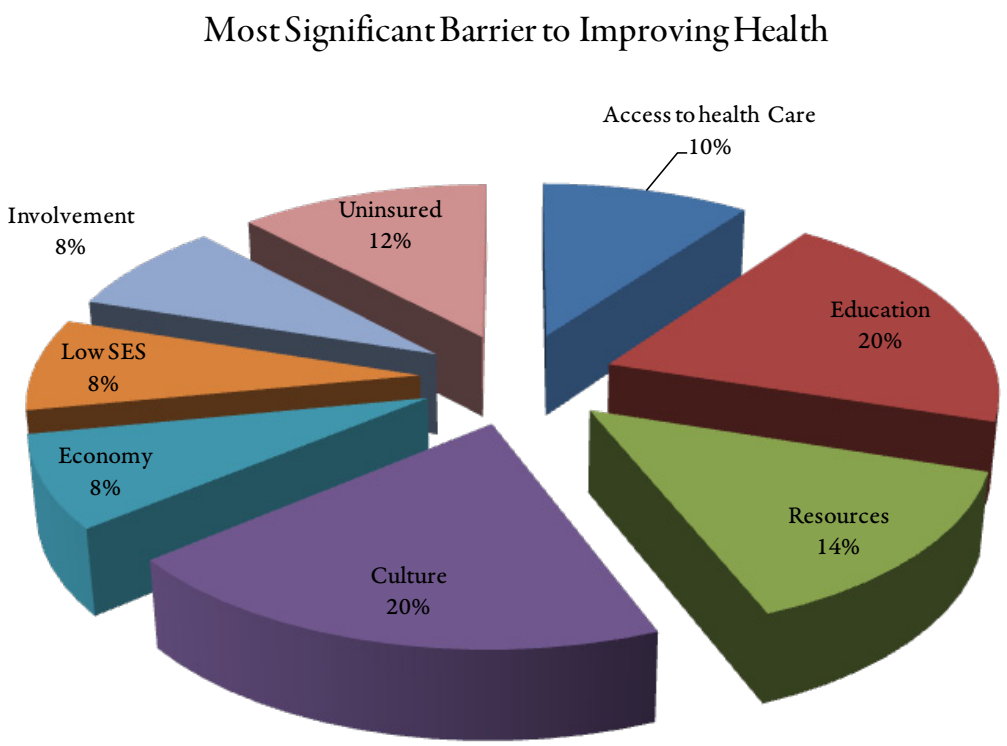
Homeless: Any response indicating a homeless or transient person

Elderly: Any response indicating Elderly, the Elderly, Seniors, older people.

Unemployed: Any response indicating a loss of work, being unemployed, chronically unemployed or under employed.

Question 7: "What do you view as the most significant barrier or barriers to improving health in your community?"

Chart 3.6



Methods

Uninsured: Any response indicating a lack of insurance, or health coverage

Access to health care: Any response indicating a lack of ability to access a service, acquire transportation to or have ready access to. This includes access to mental health services as well

Education: Any response involving education level, literacy level, or drop out rate

Resources: Any response involving financial limitation, funding issues, or ability to pay for a program or intervention or ability to sustain a program

Culture: Any response about the accepted or perceived acceptance of living a certain lifestyle, engaging in risk behaviors, or the idea that they are okay behaviors.

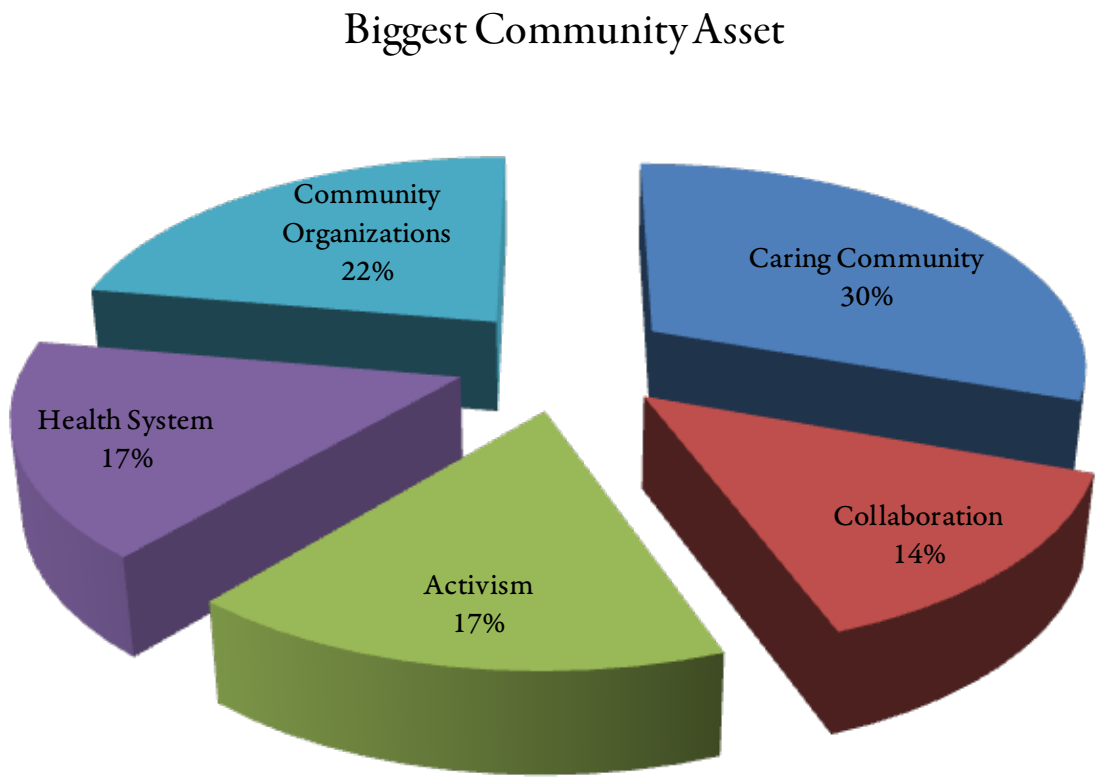
Economy: Any response involving the recession, availability of jobs or closures due to the recession

Low SES: Any response involving the challenge faced by individuals of low socioeconomic status, individual's ability to pay and the culture of poverty.

Involvement: Any response involving the ability to mobilize the community to effect change.

◊ Question 8: What do you view as the most important strength or asset for improving health in your community?

Chart 3.7



▷ Methods

Community Organizations: Any response that cited a specific organization doing work in the community, non-profits, churches, senior centers or other community based organizations

Caring Community: Any response citing community caring about the one another, willingness to help a friend in need, willingness to effect change, or desire to see improvement

Collaboration: Any response citing partnerships, public and private working together, organizations coming together or any other mention of a collaborative effort.

Activism: Any response citing a strong leader or person working towards change. People or groups of people engaged in policy or awareness activities, or attempts at passing legislation or policy.

Health System: Any response citing a component of the health system, such as Samaritan Health Services, Linn County Public Health, a local clinic, a free clinic or local doctors office.

◊ Question 9: "If you could do just one thing to improve the health of your community what would it be?"

The following are individual statements of what an Informant would do to improve the health of their community

"I would have a 100% ban on all tobacco products."

"I would require complete integration of behavioral and physical medicine."

"I would increase education in the community."

"I would open a free clinic with comprehensive mental and physical services including sobering and detox facilities."

"I would bring a doctor here."

"I would study the possibilities for broad based funding for insurance. Single payer?"

"I would start Universal Health Insurance."

"I would reform social programs such as food stamps and welfare to help more people that need it, and remove people that do not."

"I would increase smoking bans."

"I would help parents get back to work."

"I would make sure everybody has shelter and good food."

"I would increase education on budgeting, cooking healthy and life skills."

"I would expand the services of In-Reach clinic, have services more than once a week, and make sure people that use the clinic have access to the prescriptions they need."

"I would change and improve the high school graduation rate, and college education rates. I would have better college prep in High Schools."

"I would make drastic changes to the food service for schools"

"I would open OHP so they had more funds to cover, and drop barriers to accessing health care and medications."

"I would improve facilities for outdoor activities, bike paths, river walks, access, green places and open parks."

"I would have a healthcare navigator to help patients and provide bottom up support from frontline workers."

"I would increase education regarding prevention."

"I would be at the table at the planning department for city ordinances."

"I would have more educational events on food and diet and how it relates to health and expand it to all, not just those who are interested."

"I would have an average of 30% weight loss for most people."

"I would break the cycle of poverty, increase high school graduation rates."

"I would bring drug and alcohol programs here."

"We desperately need a dental health initiative in East Linn County."

"I would improve city transportation."

"If I could do one thing to improve the health in East Linn County I would increase the availability for East Linn children to receive regular and consistent dental, vision and health screenings and access to treatment when diagnosed with a problem."

"Linn County should expand services similar to Lane County- where there are family doctors open to all ages all weeks."

"We must have bilingual clerks at local clinics including urgent care and the emergency rooms."

"The Hispanic community is growing and still being ignored. They must be recognized and the community should be a little more culturally sensitive or aware of differences and beliefs"

"We need to advocate for Spanish speaking doctors and staff in community."

"Expand low cost dental maintenance work (fillings, teeth cleaning, check-ups) with payment plan options."

"Help more Hispanic individuals get driver's licenses."

Continue to Part 4

Quality of Life Survey

4.1 Introduction ◊ 4.2 Community ◊ 4.3 Self-Percieved Health ◊ 4.4 Access to Health Care ◊ 4.5 Healthy Communities ◊ 4.6 Quality of Rental Property ◊ 4.7 Discrimination ◊ Appendecies

4.1 Introduction

Quality of life and well-being is an important determinant of a health[112, 113]. Quality of life, however, is a complicated, multidisciplinary term encompassing the following dimensions: physical, psychological, and social[114]. Each dimension is defined by an individual's own self-perception. Since quality of life is subjective, it may not mirror what decision makers deem important. In an effort to determine if the residents of Linn County enjoy a high quality of life and identify perceived health needs, the Department of Health Services completed a Quality of Life survey. The responses allowed for in depth analysis, establishing baseline measures throughout the county and revealed important health trends, areas for improvement, and needed plans for the future.

The department encouraged all residents to fill out the survey, making available paper and digital versions in both English and Spanish. A total of 836 residents completed the survey.

4.2 Community

Evaluating how Linn County residents view their community, questions one to seven provide statements about the community and residents selected how strongly they either agree or disagree. With the exception of question 5, the responses are similar. On average, residents have positive feelings about their community.

All referred Tables for Part 4 are located in Appendixes A through F.

◊ I am Proud of My Community

As seen in Figure 1, the majority of county residents (55.5%) are proud of the community they live in. Less than 12% of residents are not proud of their community.

Table 1.1shows the results by zip code. In every zip code, most of the residents positively agreed with the statement. Interestingly, when the results are broken by total household annual income, certain trends appear. According to Table 1.2, only 42.2% of respondents in the lowest income group are proud of their community (selecting either "Agree" or "Disagree"). That is in contrast to all other income levels, which have proud response rates between 54% and 67%.

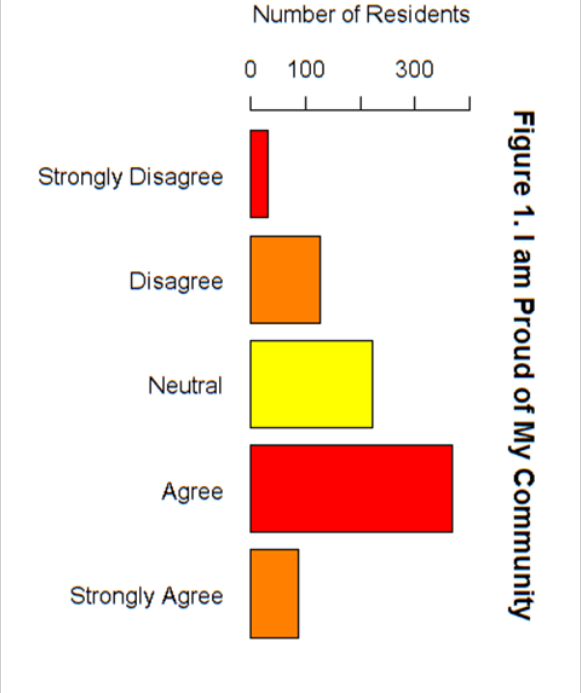
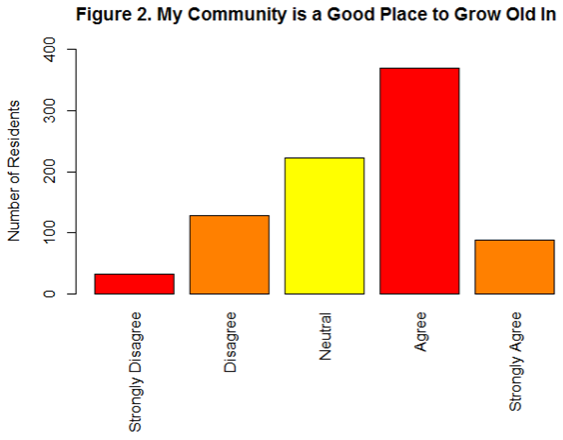


Figure 1. I am Proud of My Community

My community is a good place to grow old in

As seen in Figure 2, almost half of the residents (43.9%) "Agree" that their community is a good place to grow old in. Less than 12% of residents are not proud of their community.

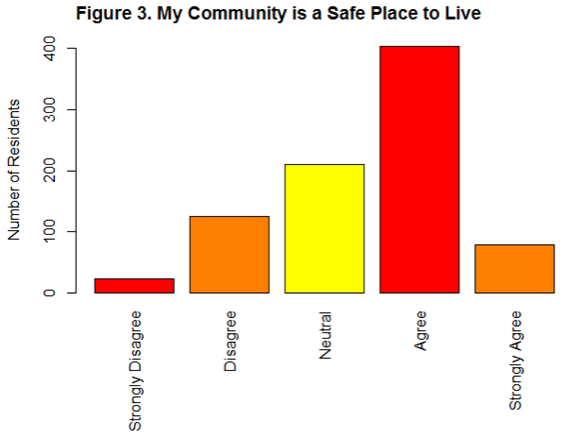
Similar to the previous statement, Table 1.3 shows that the results by zip code reflect the county percentages. In every zip code, the majority of residents positively agreed that their community was a good place to grow old in. When the results were broken down by total household income, as seen in Table 1.4, the highest levels of agreement are between the income categories $20,000 and $99,000. Interestingly, the lowest and highest income categories had the highest levels of disagreement (24.5% and 22.7% respectively).



My community is a safe place to live

Figure 3 shows that 57% of residents either "Agree" or "Strongly Agree" that their community is a safe place to live. Whereas, only 17.3% of residents feel that their community is not a safe place to live.

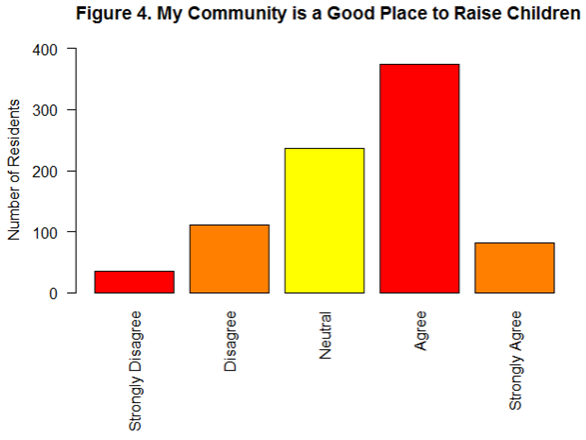
As seen in Table 1.5, the majority of zip codes reflect the county data. However, 97327 more residents (33.3%) that "Strongly Agree" their community is a safe place to live, it is over three times the county average. Table 1.6 shows the data separated by total household income. Most of income groups are similar to the county rates. It should be noted, that the two highest income categories reported the safest communities.



My community is a good place to raise-children

Figure 4, the majority of residents (54.4%) feel that their community is a good place to raise children.

Table 1.7 shows the results by zip code; all but a few zip codes reflect the county responses. Over 29% of residents in 97327 "Strongly Agree" that their community is a good place to raise children, three times the county rate. According to Table 1.8, there is an unfortunate pattern. The lower the income level group, the higher the percentage of residents reporting that the community is not a good place to raise children.

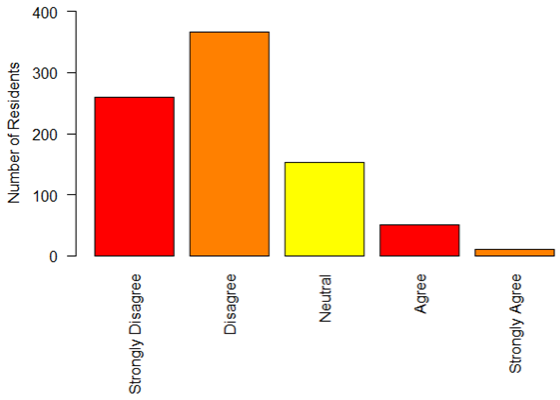


◊ There are enough job opportunities in my community

Unlike the previous questions, the county residents overwhelming felt that there are not enough jobs. As seen in Figure 5, 74% of those who reported either selected "Disagree" or "Strongly Disagree" with the statement above.

As seen in Table 1.9, all zip codes felt that there are not enough jobs in the community. Unlike previous questions, Table 1.10 shows that all income levels match the county data. Less than 10% of all residents felt that there are enough jobs in their community.

Figure 5. There Are Enough Job Opportunities in My Community

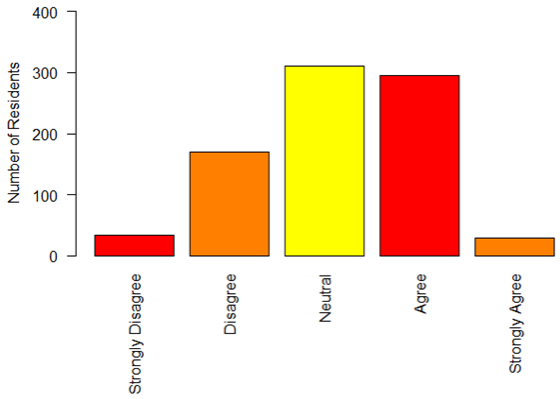


◊ My community is well cared for

As Figure 6 reveals, when asked about the care of their community, residents' most popular single response was "Neutral" (37.2%). More people, however, did report that the community is well cared for (38.5%) than those who feel it is not (24.4%).

Table 1.11 shows the responses by zip code, the responses follow the county data, with most residents selecting "Neutral" or "Agree". When looking at the response by total household income, as seen in Table 1.12, the higher income categories had higher agreement that their community was properly maintained.

Figure 6. My Community is Well Cared For

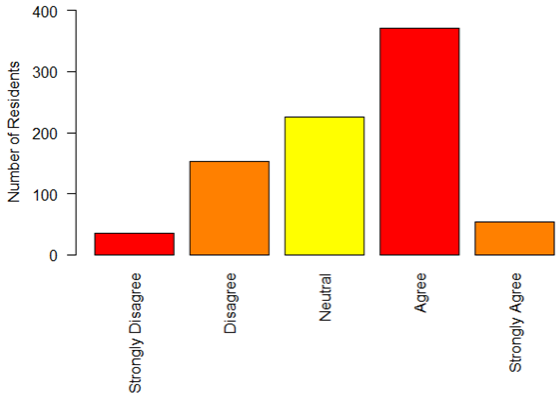


◊ I am happy with the quality of life in my community

The overall satisfaction of quality of life follows the pattern of pervious questions. Figure 7 shows 50% of residents are happy with the quality of life in their community.

Table 1.13 shows the results by zip code. Again, zip code 97327 had a much higher satisfaction rate (29.2%) than all other zip codes. As seen in Table 1.14, the percentage answering "Strongly Disagree" lowers as total household income increases. Not surprisingly, the rates of "Agree" and "Strongly Agree" tend to increase as total household income increases.

Figure 7. I am happy with the quality of life in my community



4.3 Self-Percieved Health

Understanding an individual's perception of their health is an important because quality of life and well-being is subjective. The following two questions asked the residents to rate their perceived physical and mental health.

All referred Tables for Section 2 are located in Appendix B.

Self-Reported Physical Health

As seen in Figure 8, the majority of residents (75.2%) rated their overall self-perceived physical health "Good", "Very Good", or "Excellent". Only 4.7% of residents considered their health "Poor".

When the results are broken down by zip code, as seen in Table 2.1, the results match the county with the majority of all zip codes reporting that their health as "Good". Table 2.2 shows the data organized by total household income. There is a pattern, the higher the income level, the higher the perceived physical health. Finally, Table 2.3 shows the difference in self-perceived health rating between those with and without a regular doctor. Interestingly, the results are relatively the same.

Self-Reported Mental Health

Residents felt that their mental health was better than their physical health. As seen in Figure 9, the most common response of self-reported mental health was "Very Good" (32.5%).

Table 2.4 shows the data by zip code. With the exception of 97335, the zip codes reflect the county percentages. Zip code 97355 has more residents reporting "Good" (33.1%) rather than "Very Good" 28.3%). According to Table 2.5, the higher a resident's income, the more likely a resident will have a positive self-perceived mental health status. Finally, Table 2.6 shows the difference in self-reported mental health between those with and without a regular doctor. Compared to not having a regular doctor, residents with a regular doctor have higher percentages of "Very Good" (30.2% and 33% respectively) and "Excellent" (17.2% and 20.7% respectively).

Figure 8. Self-Reported Physical Health

Figure 9. Self-Reported Mental Health

4.4 Access to Health Care

Evaluating access to health care is difficult because there are so many individual components. In an effort to understand who has adequate resources and who needs greater attention, residents were asked questions about their social relationships, doctors, and insurance status.

All referred Tables for Section 3 are located in Appendix C.

Relationships and Resources for Health Care

Social support can affect perceived mental health, especially during times of sadness and depression. Ninety one percent of residents reported that they have someone to talk to during times of sadness or depression. According to Table 3.1, residents who had someone to talk to during times of sadness or depression were less likely to have report low levels of mental health. Similarly, Table 3.2 shows that perceived mental health is higher if a resident knows of a place to go for professional help during times of sadness or depression. Unfortunately, the majority of residents (85.8%) do not know where to go to get help with sadness or depression.

Regular Doctor

Amongst all residents who responded to the survey, 77% had a regular doctor. As seen in Table 3.3, the majority of the zip codes follow reflect the county data. In 97374, over 82% percent of respondents said they had a regular doctor. Table 3.4 shows that the higher the income, the more likely a resident had a regular doctor. Similarly, as seen in Table 3.5, the higher a resident's education level, the more likely a resident had a regular doctor.

Access to Needed Health Care

Over 25% of all county residents have been unable to get needed health care at least once. While the majority of zip codes follow the county data, as seen in Table 3.6, 97360 and 97346 both have substantially higher rates of no access (44.4% and 100%, respectively). Table 3.7 shows that the higher the total household income, the better the access to needed health care. Fewer than 10% of residents with a total household income above $75,000 could not get needed health care. Similarly, Table 3.8 shows that the lower a resident's education level, the more likely they are to not have access to health care.

4.5 Healthy Communities

People have varying ideas of what is a healthy and safe community. The following two questions were asked to help identify what Linn County residents feel are qualities of healthy and safe communities.

All tables for Section 4 are located in the Appendix D.

Most Important Things Needed to Make a Healthy Community

Residents were given a list of 11 aspects of a healthy community and asked to select the three most important to them. In addition, the residents could write in an aspect not listed under "Other". Figure 9 shows the top 6 most important attribute to a healthy community; they were the only categories to have more than 100 selections. Safe neighborhoods and available jobs were the top selections with 541 and 496 residents selecting them, respectively. Table 4.1 shows the data by zip code. Safe neighborhoods, available jobs, and quality schools were the top three aspects across all zip codes. The pattern is similar when looking at the aspects by total household income, as seen in Table 4.2

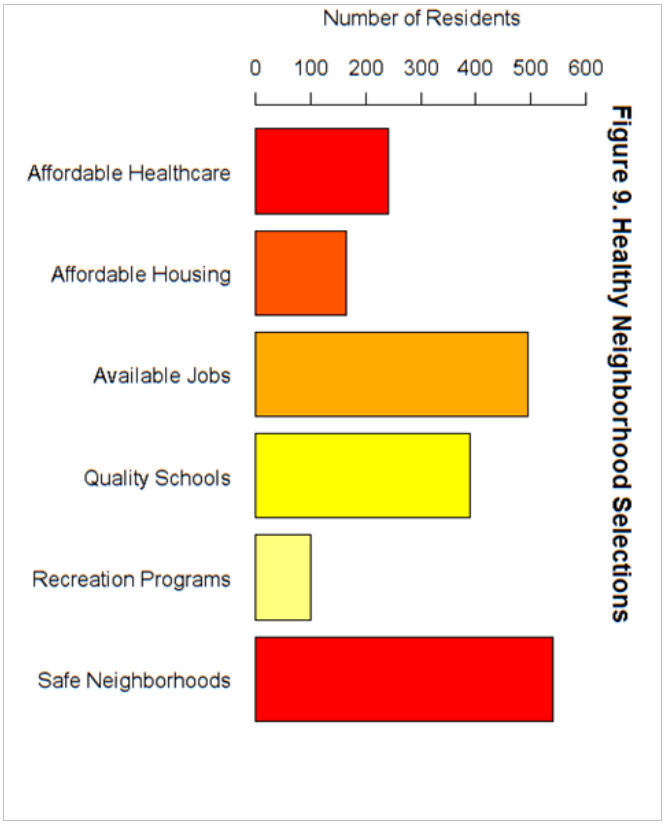


Figure 9. Healthy Neighborhood Selections

Top Health Problems in the Community

Residents were given a list of 22 health problems and asked to select the three most relevant to their community. In addition, the residents could write in a problem not listed under "Other". Figure 10 lists the top 5 resident reported health problems in the county, over 100 residents selected each problem. The top health problems in the county are drug abuse and unemployment, with 582 and 431 residents, respectively. Table 4.3 shows the results by zip code, drug abuse was the most frequently cited health problem across all zip codes, over 23% of county residents selected it. Interestingly, Table 4.4 shows that drug abuse is also the top problem across all income categories.

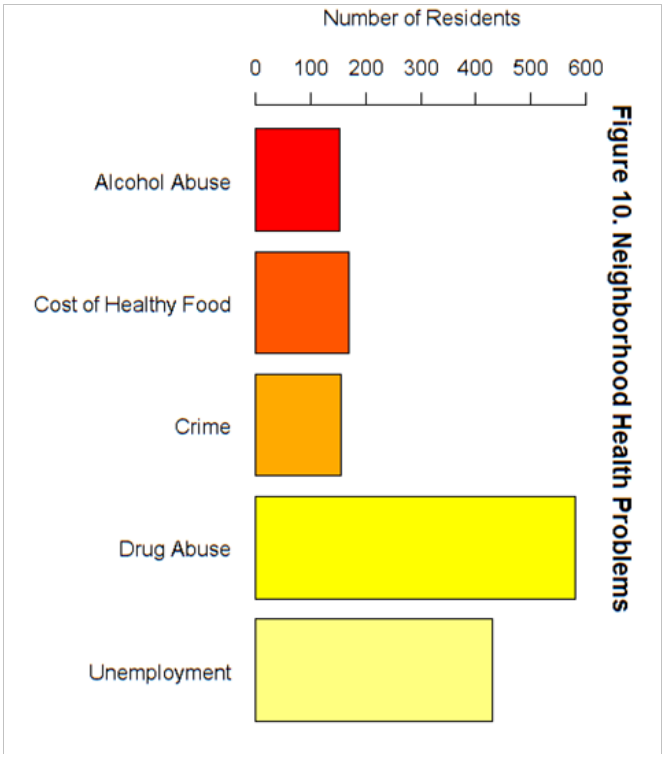


Figure 10. Neighborhood Health Problems

4.6 Quality of Rental Property

In an effort to assess the quality of renter property and landlords within Linn County, the survey asked a series of questions specifically to renters. Of the county residents that responded to the survey, almost half (42%) are renters.

All referred Tables for Section 5 are located in Appendix E.

Able to Find Timely Repairs

Of the renters, approximately 26% had a problem getting timely repairs. According to Table 5.1, the majority of zip codes followed the county percentages, with the exception of 97346 (66.7%) and 97386 (41.2%). When looking at total household income, as seen in Table 5.2, tenants making more than $75,000 per year had no problems getting timely repairs.

Able to Find Affordable Rental Home

Over 58% of renters reported finding an affordable place to live. Table 5.3 shows that some zip codes had substantially higher rates of affordable places, such as 97356 (66.7%) and 97355 (73%). Table 5.4 shows total household income, residents within $20,000 to $29,999 had the highest levels of finding an affordable place to live (71.4%). Those in the highest income categories, however, had the highest rates of dissatisfaction in the county's rent prices.

Able to Find Safe Home

The renters generally feel that their homes are safe. Over 68% of respondents felt their rented home was safe. As seen in Table 5.5, the majority of zip codes follow the county pattern. There were two zip codes whose percentages were higher than the county average: 97322 (70.4%) and 97355 (81.8%). Table 5.6 shows a worrying pattern, as total household income increases, there is a decline in feeling that one's home is safe.

Able to Find Nice Rental Home

Similar to the previous questions, renters generally felt that they were able to find a nice home (68.3%). Table 5.7, however, shows that some zip codes are more dissatisfied with the niceness of their home, especially 97386 (57.6%) and 97389 (57.1%). Following the pattern of the previous question, Table 5.8 shows that as total household income increases, the perception of a home's likability decreases.

4.7 Discrimination

Discrimination can occur at many different settings. To find out if discrimination is a problem in the county, residents were asked how they were treated in different setting. There are also numerous types of discrimination. This survey explores discrimination by education level, income level, race, and ethnicity.

All referred Tables for Section 5 are located in Appendix F.

◊ Treated with less courtesy

The majority of residents have not often been treated with less courtesy (84.6%). However, as Table 6.1 shows, less educated people were more often treated with less courtesy than those with more education. Similarly, Table 6.2 shows that the higher the total household income, the less likely a resident is to be treated with less courtesy. Table 6.3 shows that rates are relatively equal across race, but Table 6.4 suggests that Latinos are treated with less courtesy than non-Latinos.

◊ Respect

In the county, 87% of residents were not treated with less respect. Table 6.5 shows that residents with a "Less than High School" education level have the highest percentage of being treated often with less respect (25.4%). Table 6.6 reports that residents in higher income levels receive more respect than those in lower income levels. As seen in Table 6.7, African Americans and Native Alaskans are the most likely to be treated with less respect. Finally, Table 6.8 shows that 7.5% of Latinos report being treated "Very Often".

◊ Poorer Service at Restaurants & Stores

Very few residents reported often receiving poorer service at restaurants and stores (7.5%). As seen in Table 6.9 and Table 6.10, this general pattern is seen across both education level and total household income. However, higher education levels and higher income levels report better service. In addition, there is little different between race and ethnicity groups, as seen in Table 6.11 and Table 6.12.

◊ Poorer Service at Healthcare Providers

While the majority of residents did not report receiving poorer service (73.5%), over 25% did perceive receiving poorer service than others. Table 6.13 shows that less educated residents reported higher levels of mistreatment than those with higher education, especially those holding a Bachelor or Graduate degree. Similarly, Table 6.14 shows that residents earning more than $50,000 per year had very low rates of poor service. Table 6.15 and Table 6.16 show rates by race and ethnicity, it should be noted that 4.5% of Hispanics reported being treated with poorer service, which is almost two times the county average (2.3%).

◊ People Act as if they are Afraid of You

Very few county residents believe that people act as if they are afraid of them; only 4.1% reported "Very Often" or "Fairly Often". Table 6.17 shows that when examined by education level, the pattern does not differ substantially from the county pattern. Once a person has some college education, however, there is a sizable jump in the percentage in "Never". Total household income, as seen in Table 6.18, is similar to education level. Table 6.19 illustrates that Caucasians have the highest report of "Never" perceiving someone as being afraid of them (63.4%). Finally, as seen in Table 6.20, there are no sizable differences between ethnicity.

◊ People Act as if they are Better than You

This final category of discrimination had 20.7% of county residents report "Very Often" or "Fair Often". When looked at by education, as seen in Table 6.21, a similar pattern occurs, those with more education report less people act as if they are better than them. This pattern is more apparent when the results are examined by total household income. Table 6.22 shows that 36.5% of residents earning less than $20,000 reported being mistreated "Very Often" or "Fairly Often". Table 6.23 shows that African Americans (23.1%) and Native American/ Pacific Islander report high levels of being mistreated "Very Often" (33.3%). Finally, Table 6.24 illustrates that Hispanics report a higher percentage compared to non-Hispanics of people acting as if they are better than them.

Appendix A

Table 1.1 I Am Proud of My Community by Zip Code (Percentage)

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97321	West Albany	8 (3.3)	20 (8.1)	95 (38.9)	105 (43)	16 (6.5)	244
97322	East Albany	13 (4.4)	23 (7.8)	105 (35.6)	128 (43.4)	26 (8.8)	295
97327	Brownsville	0 (0)	2 (8.3)	1 (4.2)	8 (33.3)	13 (54.2)	24
97335	Crabtree	0 (0)	0 (0)	0 (0)	0 (0)	1 (100)	1
97336	Crawfordsville	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97346	Gates	0 (0)	0 (0)	2 (50)	2 (50)	0 (0)	4
97348	Hasley	0 (0)	2 (18.1)	0 (0)	9 (81.9)	0 (0)	11
97352	Jefferson	0 (0)	0 (0)	1 (100)	0 (0)	0 (0)	1
97355	Lebanon	3 (2.4)	11 (8.7)	39 (30.7)	57 (44.9)	17 (13.4)	127
97358	Lyons	0 (0)	0 (0)	1 (20)	3 (60)	1 (20)	5
97360	Mill City	0 (0)	2 (22.2)	2 (22.2)	5 (55.6)	0 (0)	9
97374	Scio	1 (5.9)	1 (5.9)	2 (11.8)	11 (64.7)	2 (11.8)	17
97377	Shed	0 (0)	1 (25)	0 (0)	2 (50)	1 (25)	4
97386	Sweet Home	5 (8.2)	5 (8.2)	17 (27.9)	29 (47.6)	5 (8.2)	61
97389	Tangent	0 (0)	0 (0)	6 (33.3)	12 (66.7)	0 (0)	18
97446	Harrisburg	0 (0)	0 (0)	2 (25)	5 (62.5)	1 (12.5)	8
Total		**30 (3.6)**	**67 (8.1)**	**273 (32.8)**	**378 (45.5)**	**83 (10.0)**	**831**

Table 1.2 I Am Proud of My Community by Annual Household Income (Percentage)

Income	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Less than$20,000	12 (4.3)	21 (7.5)	127 (45.8)	104 (37.5)	13 (4.7)	277
$20,000-$29,999	6 (5.4)	8 (7.3)	35 (31.8)	48 (43.6)	13 (11.8)	110
$30,000-$49,999	4 (2.6)	18 (11.8)	42 (27.6)	69 (45.4)	19 (12.5)	152
$50,000-$74,999	4 (2.5)	13 (8.2)	36 (22.8)	88 (55.7)	17 (10.8)	158
$75,000-$99,999	2 (2.3)	5 (5.8)	21 (24.4)	45 (52.3)	13 (15.1)	86
Over $100,000	2 (3.8)	2 (3.8)	13 (24.5)	28 (52.8)	8 (15.1)	53
Total	**30 (3.6)**	**67 (8.1)**	**273 (32.8)**	**378 (45.5)**	**83 (10.0)**	**836**

Table 1.3 My Community is a Good Place to Grow Old In by Zip Code (Percentage)

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97321	West Albany	8 (3.3)	39 (16.0)	77 (31.6)	104 (42.6)	16 (6.6)	244
97322	East Albany	14 (4.7)	51 (17.3)	82 (27.8)	116 (39.3)	32 (10.8)	295
97327	Brownsville	2 (8.3)	3 (12.5)	4 (16.7)	11 (45.8)	4 (16.7)	24
97335	Crabtree	0 (0)	0 (0)	0 (0)	0 (0)	1 (100)	1

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97336	Crawfordsville	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97346	Gates	0 (0)	0 (0)	2 (50)	1 (25)	1 (25)	4
97348	Hasley	1 (9.1)	1 (9.1)	2 (18.2)	7 (63.6)	0 (0)	11
97352	Jefferson	0 (0)	0 (0)	1 (100)	0 (0)	0 (0)	1
97355	Lebanon	2 (1.6)	21 (16.5)	33 (26)	55 (43.3)	16 (12.6)	127
97358	Lyons	0 (0)	0 (0)	1 (20)	3 (60)	1 (20)	5
97360	Mill City	0 (0)	2 (22.2)	3 (33.3)	3 (33.3)	1 (11.1)	9
97374	Scio	1 (5.9)	2 (11.8)	3 (17.6)	9 (52.9)	2 (11.8)	17
97377	Shed	0 (0)	1 (25)	0 (0)	2 (50)	1 (25)	4
97386	Sweet Home	4 (6.6)	4 (6.6)	10 (16.4)	37 (60.7)	6 (9.8)	61
97389	Tangent	0 (0)	2 (11.1)	2 (16.7)	12 (66.7)	1 (5.6)	18
97446	Harrisburg	0 (0)	1 (12.5)	1 (12.5)	3 (37.5)	3 (37.5)	8
Total		**32 (3.9)**	**127 (15.3)**	**222 (26.7)**	**365 (43.9)**	**85 (10.2)**	**831**

Table 1.4 My Community is a Good Place to Grow Old In by Annual Household Income (Percentage)

Income	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Less than$20,000	10 (3.6)	58 (20.9)	99 (35.7)	94 (33.9)	16 (5.8)	277
$20,000-$29,999	9 (8.2)	15 (13.6)	28 (25.5)	52 (47.3)	6 (5.5)	110
$30,000-$49,999	4 (2.6)	30 (13.2)	27 (17.8)	81 (53.3)	20 (13.2)	152
$50,000-$74,999	5 (3.2)	15 (9.5)	39 (24.7)	74 (46.8)	25 (15.8)	158
$75,000-$99,999	3 (3.5)	8 (9.3)	19 (22.1)	45 (52.3)	11 (12.8)	86
Over $100,000	1 (1.9)	11 (20.8)	10 (18.9)	23 (43.4)	8 (15.1)	53
Total	**32 (3.8)**	**127 (15.2)**	**222 (26.6)**	**369 (44.1)**	**86 (10.3)**	**836**

Table 1.5 My Community is a Safe Place to Live by Zip Code (Percentage)

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97321	West Albany	5 (2)	37 (15.2)	80 (32.8)	105 (43)	17 (7)	244
97322	East Albany	9 (3.1)	50 (16.9)	70 (23.7)	146 (49.5)	20 (6.8)	295
97327	Brownsville	1 (4.2)	2 (8.3)	2 (8.3)	11 (45.8)	8 (33.3)	24
97335	Crabtree	0 (0)	0 (0)	0 (0)	0 (0)	1 (100)	1
97336	Crawfordsville	0 (0)	0 (0)	1 (100)	0 (0)	0 (0)	1
97346	Gates	0 (0)	1 (25)	1 (25)	2 (50)	0 (0)	4
97348	Hasley	1 (9.1)	0 (0)	2 (18.2)	6 (54.5)	2 (18.2)	11
97352	Jefferson	0 (0)	0 (0)	1 (100)	0 (0)	0 (0)	1
97355	Lebanon	2 (1.6)	18 (14.2)	34 (26.8)	63 (49.6)	10 (7.9)	127
97358	Lyons	0 (0)	0 (0)	2 (40)	2 (40)	1 (20)	5

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97360	Mill City	0 (0)	1 (11.1)	2 (22.2)	5 (55.6)	1 (11.1)	9
97374	Scio	1 (5.9)	2 (11.8)	1 (11.8)	10 (58.8)	2 (11.8)	17
97377	Shed	0 (0)	2 (50)	0 (0)	1 (25)	1 (25)	4
97386	Sweet Home	3 (4.9)	11 (18)	12 (19.7)	27 (44.3)	8 13.1)	61
97389	Tangent	0 (0)	1 (5.6)	0 (0)	14 (77.8)	3 (16.7)	18
97446	Harrisburg	0 (0)	0 (0)	1 (12.5)	5 (62.5)	2 (25)	8
Total		**22 (2.7)**	**125 (15.0)**	**210 (25.3)**	**398 (47.9)**	**76 (9.1)**	**831**

Table 1.6 My Community is a Safe Place to Live by Annual Household Income (Percentage)

Income	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Less than$20,000	10 (3.6)	57 (20.6)	90 (32.5)	103 (37.2)	17 (6.1)	277
$20,000-$29,999	6 (5.5)	15 (13.6)	28 (25.5)	52 (47.3)	6 (5.5)	110
$30,000-$49,999	3 (2)	24 (15.8)	32 (21.1)	77 (50.7)	16 (10.5)	152
$50,000-$74,999	2 (1.3)	17 (10.8)	35 (22.2)	89 (56.3)	15 (9.5)	158
$75,000-$99,999	1 (1.2)	7 (8.1)	18 (20.9)	49 (57)	11 (12.8)	86
Over $100,000	0 (0)	5 (9.4)	10 (18.9)	28 (52.8)	10 (18.9)	53
Total	**22 (2.6)**	**125 (15.0)**	**210 (25.1)**	**401 (48.0)**	**78 (9.3)**	**836**

Table 1.7 My Community is a Good Place to Raise Children by Zip Code (Percentage)

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97321	West Albany	8 (3.3)	37 (15.2)	78 (32)	100 (41)	21 (8.6)	244
97322	East Albany	15 (5.1)	40 (13.6)	86 (29.2)	132 (44.7)	22 (7.5)	295
97327	Brownsville	1 (4.2)	2 (8.3)	1 (4.2)	13 (54.2)	7 (29.2)	24
97335	Crabtree	0 (0)	0 (0)	0 (0)	0 (0)	1 (100)	1
97336	Crawfordsville	0 (0)	0 (0)	0 (0)	0 (0)	1 (100)	1
97346	Gates	0 (0)	0 (0)	2 (50)	2 (50)	0 (0)	4
97348	Hasley	0 (0)	0 (0)	3 (27.3)	7 (63.6)	1 (91.)	11
97352	Jefferson	0 (0)	1 (100)	0 (0)	0 (0)	0 (0)	1
97355	Lebanon	4 (3.1)	19 (15)	37 (29.1)	57 (44.9)	10 (7.9)	127
97358	Lyons	0 (0)	1 (20)	1 (20)	2 (40)	1 (20)	5
97360	Mill City	0 (0)	2 (22.2)	3 (33.3)	2 (22.2)	2 (22.2)	9
97374	Scio	1 (5.9)	1 (5.9)	2 (11.8)	12 (70.6)	1 (5.9)	17
97377	Shed	0 (0)	1 (25)	1 (25)	1 (25)	1 (25)	4
97386	Sweet Home	5 (8.2)	6 (9.8)	15 (24.6)	27 (44.3)	8 (13.1)	61
97389	Tangent	0 (0)	0 (0)	4 (22.2)	13 (72.2)	1 (5.6)	18
97446	Harrisburg	0 (0)	0 (0)	2 (25)	3 (37.5)	3 (37.5)	8
Total		**34 (4.1)**	**110 (13.2)**	**235 (28.3)**	**372 (44.8)**	**80 (9.6)**	**831**

Table 1.8 My Community is a Good Place to Raise Children by Annual Household Income (Percentage)

Income	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Less than$20,000	16 (5.8)	52 (18.8)	96 (34.7)	93 (33.6)	20 (7.2)	277
$20,000-$29,999	7 (6.4)	12 (10.9)	32 (29.1)	51 (46.4)	8 (7.3)	110
$30,000-$49,999	5 (3.3)	18 (11.8)	33 (21.7)	81 (53.3)	15 (9.9)	152
$50,000-$74,999	2 (1.3)	16 (10.1)	48 (30.4)	77 (48.7)	15 (9.5)	158
$75,000-$99,999	3 (3.5)	7 (8.1)	17 (19.8)	44 (51.2)	15 (17.4)	86
Over $100,000	2 (3.8)	5 (9.4)	10 (18.9)	27 (50.9)	9 (17)	53
Total	35 (4.2)	110 (13.2)	236 (28.2)	373 (44.6)	82 (9.8)	836

Table 1.9 There Are Enough Job Opportunities in My Community by Zip Code (Percentage)

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97321	West Albany	68 (27.9)	115 (47.1)	44 (18)	15 (6.1)	2 (0.8)	244
97322	East Albany	88 (29.8)	125 (42.4)	57 (19.3)	23 (7.8)	2 (0.7)	295
97327	Brownsville	6 (25)	13 (42.4)	5 (20.8)	0 (0)	0 (0)	24
97335	Crabtree	0 (0)	1 (100)	0 (0)	0 (0)	0 (0)	1
97336	Crawfordsville	0 (0)	1 (100)	0 (0)	0 (0)	0 (0)	1
97346	Gates	1 (25)	1 (25)	2 (50)	0 (0)	0 (0)	4
97348	Hasley	4 (36.4)	4 (36.4)	2 (18.2)	0 (0)	1 (9.1)	11
97352	Jefferson	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97355	Lebanon	36 (28.3)	54 (42.5)	30 (23.6)	5 (3.9)	2 (1.6)	127
97358	Lyons	4 (80)	1 (20)	0 (0)	0 (0)	0 (0)	5
97360	Mill City	5 (55.6)	2 (22.2)	0 (0)	1 (11.1)	1 (11.1)	9
97374	Scio	5 (29.4)	11 (64.7)	0 (0)	1 (5.9)	0 (0)	17
97377	Shed	0 (0)	2 (50)	0 (0)	2 (50)	0 (0)	4
97386	Sweet Home	34 (55.7)	19 (31.1)	5 (8.2)	1 (1.6)	2 (3.3)	61
97389	Tangent	3 (16.7)	9 (50)	6 (33.3)	0 (0)	0 (0)	18
97446	Harrisburg	1 (12.5)	6 (75)	15 1 (12.5)	0 (0)	0 (0)	8
Total		**255 (30.7)**	**365 (43.9)**	**152 (18.3)**	**49 (5.9)**	**10 (1.2)**	**831**

Table 1.10 There Are Enough Job Opportunities in My Community by Annual Household Income (Percentage)

Income	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Less than$20,000	100 (36.1)	101 (36.5)	58 (20.9)	15 (5.4)	3 (1.1)	277
$20,000-$29,999	32 (29.1)	50 (45.5)	19 (17.3)	8 (7.3)	1 (0.9)	110
$30,000-$49,999	54 (35.5)	67 (44.1)	19 (12.5)	9 (5.9)	3 (2)	152
$50,000-$74,999	38 (24.1)	85 (53.8)	24 (15.2)	10 (6.3)	1 (0.6)	158
$75,000-$99,999	20 (23.3)	41 (47.7)	19 (22.1)	5 (5.8)	1 (1.2)	86
Over $100,000	13 (24.5)	22 (41.5)	14 (26.4)	3 (5.7)	1 (1.9)	53
Total	**257 (30.7)**	**366 (43.8)**	**153 (18.3)**	**50 (6.0)**	**10 (1.2)**	**836**

Table 1.11 My Community is Well Cared For by Zip Code (Percentage)

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97321	West Albany	10 (4.1)	51 (20.9)	101 (41.4)	79 (32.4)	3 (1.2)	244
97322	East Albany	12 (4.1)	60 (20.3)	107 (36.3)	103 (34.9)	13 (4.4)	295
97327	Brownsville	1 (4.2)	3 (12.5)	5 (20.8)	11 (45.8)	4 (16.7)	24
97335	Crabtree	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97336	Crawfordsville	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97346	Gates	1 (25)	0 (0)	1 (25)	2 (50)	0 (0)	4
97348	Hasley	0 (0)	4 (36.4)	3 (27.3)	4 (36.4)	0 (0)	11
97352	Jefferson	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97355	Lebanon	2 (1.6)	21 (16.5)	48 (37.8)	50 (39.4)	6 (4.7)	127
97358	Lyons	0 (0)	2 (40)	2 (40)	1 (20)	0 (0)	5
97360	Mill City	2 (22.2)	4 (44.4)	2 (22.2)	0 (0)	1 (11.1)	9
97374	Scio	1 (5.9)	3 (17.6)	6 (35.3)	7 (41.2)	0 (0)	17
97377	Shed	0 (0)	1 (25)	2 (50)	1 (25)	0 (0)	4
97386	Sweet Home	3 (4.9)	16 (26.3)	21 (34.4)	19 (31.1)	2 (3.3)	61
97389	Tangent	0 (0)	3 (16.7)	8 (44.4)	7 (38.9)	0 (0)	18
97446	Harrisburg	0 (0)	2 (25)	3 (37.5)	3 (37.5)	0 (0)	8
Total		**32 (3.9)**	**170 (20.5)**	**309 (37.2)**	**291 (35.0)**	**29 (3.5)**	**831**

Table 1.12 My Community is Well Cared For by Annual Household Income (Percentage)

Income	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Less than$20,000	16 (5.8)	50 (18.1)	121 (43.7)	82 (29.6)	8 (2.9)	277
$20,000-$29,999	6 (5.5)	20 (18.2)	36 (32.7)	45 (40.9)	3 (2.7)	110
$30,000-$49,999	3 (2)	43 (28.3)	52 (34.3)	46 (30.3)	8 (5.3)	152
$50,000-$74,999	3 (1.9)	34 (21.5)	56 (35.4)	60 (38)	5 (3.2)	158
$75,000-$99,999	4 (4.7)	12 (14)	28 (32.6)	40 (46.5)	2 (2.3)	86
Over $100,000	0 (0)	11 (20.8)	18 (34)	21 (39.6)	3 (5.7)	53
Total	**32 (3.8)**	**170 (20.3)**	**311 (37.2)**	**294 (35.2)**	**29 (34.7)**	**836**

Table 1.13 I am Happy with the Quality of Life in My Community by Zip Code (Percentage)

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97321	West Albany	7 (2.9)	56 (23)	66 (27)	106 (43.4)	9 (3.7)	244
97322	East Albany	14 (4.7)	53 (18)	89 (30.2)	122 (41.4)	17 (5.8)	295
97327	Brownsville	1 (4.2)	0 (0)	3 (12.5)	13 (54.2)	7 (29.2)	24
97335	Crabtree	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97336	Crawfordsville	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97346	Gates	0 (0)	1 (25)	1 (25)	2 (50)	0 (0)	4
97348	Hasley	0 (0)	2 (18.2)	5 (45.5)	4 (36.4)	0 (0)	11

Zip Code	City	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
97352	Jefferson	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97355	Lebanon	4 (3.1)	19 (15)	35 (27.6)	59 (46.5)	10 (7.9)	127
97358	Lyons	0 (0)	1 (20)	2 (40)	2 (40)	0 (0)	5
97360	Mill City	0 (0)	1 (11.1)	3 (33.3)	4 (44.4)	1 (11.1)	9
97374	Scio	2 (11.8)	2 (11.8)	3 (17.6)	8 (47.1)	2 (11.8)	17
97377	Shed	0 (0)	1 (25)	0 (0)	2 (50)	1 (25)	4
97386	Sweet Home	5 (8.2)	14 (23)	13 (21.3)	25 (41)	4 (6.6)	61
97389	Tangent	1 (5.6)	3 (16.7)	4 (22.2)	9 (50)	1 (5.6)	18
97446	Harrisburg	0 (0)	0 (0)	1 (12.5)	7 (87.5)	0 (0)	8
Total		**34 (4.1)**	**153 (18.4)**	**225 (27.1)**	**367 (44.2)**	**52 (6.3)**	**831**

Table 1.14 I am Happy with the Quality of Life in My Community by Annual Household Income (Percentage)

Income	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Less than $20,000	18 (6.5)	67 (24.2)	99 (35.7)	85 (30.7)	8 (2.9)	277
$20,000-$29,999	6 (5.5)	24 (21.8)	30 (27.3)	44 (40)	6 (5.5)	110
$30,000-$49,999	5 (3.3)	24 (15.8)	39 (25.7)	67 (44.1)	17 (11)	152
$50,000-$74,999	4 (2.5)	21 (13.3)	34 (21.5)	90 (57)	9 (5.7)	158
$75,000-$99,999	1 (1.2)	8 (9.3)	15 (17.4)	54 (62.8)	8 (9.3)	86
Over $100,000	0 (0)	9 (17)	9 (17)	30 (56.6)	5 (9.4)	53
Total	**34 (4.1)**	**153 (18.3)**	**226 (27.0)**	**370 (44.3)**	**53 (6.3)**	**836**

Appendix B

Table 2.1 Self-Rated Physical Health by Zip Code (Percentage)

Zip Code	City	Poor	Fair	Good	Very Good	Excellent	Total
97321	West Albany	5 (2)	47 (19.3)	103 (42.2)	59 (24.2)	30 (12.3)	244
97322	East Albany	18 (6.1)	62 (21)	112 (38)	82 (27.8)	21 (7.1)	295
97327	Brownsville	1 (4.2)	1 (4.2)	11 (45.8)	7 (29.2)	4 (16.7)	24
97335	Crabtree	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97336	Crawfordsville	0 (0)	1 (100)	0 (0)	0 (0)	0 (0)	1
97346	Gates	1 (25)	2 (50)	1 (25)	0 (0)	0 (0)	4
97348	Hasley	0 (0)	2 (18.2)	4 (36.4)	3 (27.3)	2 (18.2)	11
97352	Jefferson	0 (0)	0 (0)	1 (100)	0 (0)	0 (0)	1
97355	Lebanon	6 (4.7)	25 (19.7)	53 (41.7)	31 (24.4)	12 (9.4)	127
97358	Lyons	0 (0)	1 (20)	3 (60)	1 (20)	0 (0)	5
97360	Mill City	0 (0)	2 (22.2)	3 (33.3)	3 (33.3)	1 (11.1)	9
97374	Scio	1 (5.9)	8 (47.1)	5 (29.4)	3 (17.6)	0 (0)	17
97377	Shed	0 (0)	0 (0)	2 (50)	1 (25)	1 (25)	4
97386	Sweet Home	5 (8.2)	12 (19.7)	26 (42.6)	25 (41)	3 (4.9)	61
97389	Tangent	2 (11.1)	3 (16.7)	6 (33.3)	6 (33.3)	1 (5.6)	18
97446	Harrisburg	0 (0)	1 (12.5)	3 (37.5)	3 (37.5)	1 (12.5)	8
Total		**39 (4.7)**	**167 (20.1)**	**334 (40.2)**	**215 (25.9)**	**76 (9.1)**	**831**

Table 2.2 Self-Rated Physical Health by Annual Household Income (Percentage)

Income	Poor	Fair	Good	Very Good	Excellent	Total
Less than$20,000	25 (9)	90 (32.5)	109 (39.4)	38 (13.7)	15 (5.4)	277
$20,000-$29,999	7 (6.4)	21 (19.1)	45 (40.9)	28 (25.5)	9 (8.2)	110
$30,000-$49,999	4 (2.6)	27 (17.8)	60 (39.5)	48 (31.6)	13 (8.6)	152
$50,000-$74,999	3 (1.9)	18 (11.4)	71 (44.9)	49 (31)	17 (10.8)	158
$75,000-$99,999	0 (0)	9 (10.5)	32 (37.2)	34 (39.5)	11 (12.8)	86
Over $100,000	0 (0)	2 (3.8)	19 (35.8)	20 (37.7)	12 (22.6)	53
Total	**39 (4.7)**	**167 (20)**	**336 (40.2)**	**217 (26)**	**77 (9.1)**	**836**

Table 2.3 Self-Rated Physical Health by Regular Doctor (Percentage)

Doctor	Poor	Fair	Good	Very Good	Excellent	Total
Regular Doctor	31 (4.8)	122 (18.9)	259 (40.1)	175 (27.1)	59 (9.1)	646
No Regular Doctor	8 (4.2)	45 (23.4)	79 (41.1)	42 (21.9)	18 (9.4)	192
Total	**39 (4.7)**	**167 (19.9)**	**338 (40.3)**	**217 (25.9)**	**77 (9.2)**	**838**

Table 2.4 Self-Rated Mental Health by Zip Code (Percentage)

Zip Code	City	Poor	Fair	Good	Very Good	Excellent	Total
97321	West Albany	12 (4.9)	41 (16.8)	62 (25.4)	80 (32.8)	49 (20.1)	244
97322	East Albany	7 (2.4)	41 (13.9)	87 (29.5)	105 (35.6)	55 (18.6)	295
97327	Brownsville	1 (4.2)	1 (4.2)	5 (20.8)	9 (37.5)	8 (33.3)	24
97335	Crabtree	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)	1
97336	Crawfordsville	0 (0)	1 (100)	0 (0)	0 (0)	0 (0)	1
97346	Gates	1 (25)	2 (50)	0 (0)	1 (25)	0 (0)	4
97348	Hasley	0 (0)	1 (9.1)	4 (36.4)	3 (27.3)	3 (27.3)	11
97352	Jefferson	0 (0)	0 (0)	1 (100)	0 (0)	0 (0)	1
97355	Lebanon	6 (4.7)	19 (15)	42 (33.1)	36 (28.3)	24 (18.9)	127
97358	Lyons	0 (0)	0 (0)	1 (20)	3 (60)	1 (20)	5
97360	Mill City	0 (0)	2 (22.2)	4 (44.4)	1 (11.1)	2 (22.2)	9
97374	Scio	1 (5.9)	3 (17.6)	5 (29.4)	7 (41.2)	1 (5.9)	17
97377	Shed	0 (0)	0 (0)	1 (25)	2 (50)	1 (25)	4
97386	Sweet Home	9 (14.8)	3 (4.9)	21 (34.4)	12 (19.7)	16 (26.2)	61
97389	Tangent	1 (5.6)	3 (16.7)	6 (33.3)	5 (27.8)	3 (16.7)	18
97446	Harrisburg	0 (0)	1 (12.5)	2 (25)	3 (37.5)	2 (25)	8
Total		**38 (4.6)**	**118 (14.2)**	**241 (28.8)**	**269 (32.5)**	**165 (19.9)**	**831**

Table 2.5 Self-Rated Mental Health by Annual Household Income (Percentage)

Income	Poor	Fair	Good	Very Good	Excellent	Total
Less than$20,000	32 (11.6)	72 (26)	81 (29.2)	64 (23.1)	28 (10.1)	277
$20,000-$29,999	3 (2.7)	15 (13.6)	40 (36.4)	29 (26.4)	23 (20.9)	110
$30,000-$49,999	3 (2)	15 (9.9)	49 (32.2)	54 (35.5)	31 (20.4)	152
$50,000-$74,999	0 (0)	11 (7)	45 (28.5)	64 (40.5)	38 (24.1)	158
$75,000-$99,999	0 (0)	6 (7)	15 (17.4)	41 (47.7)	24 (27.9)	86
Over $100,000	0 (0)	0 (0)	11 (20.8)	19 (35.8)	23 (43.4)	53
Total	**38 (4.5)**	**119 (14.3)**	**241 (28.8)**	**271 (32.4)**	**167 (20)**	**836**

Table 2.6 Self-Rated Mental Health by Regular Doctor (Percentage)

Doctor	Poor	Fair	Good	Very Good	Excellent	Total
Regular Doctor	29 (4.2)	89 (13.8)	181 (28)	213 (33)	134 (20.7)	646
No Regular Doctor	9 (4.7)	30 (15.6)	62 (32.3)	58 (30.2)	33 (17.2)	192
Total	**38 (4.5)**	**119 (14.2)**	**243 (29.9)**	**271 (32.4)**	**167 (19.9)**	**838**

Appendix C

Table 3.1 I have People I can Talk to if I am Depressed or Sad by Self-Reported Mental Health (Percentage)

Contact	Poor	Fair	Good	Very Good	Excellent	Total
Person to Talk to	22 (2.9)	97 (12.7)	223 (29.1)	262 (34.5)	162 (21.1)	766
No Person to Talk to	16 (22.2)	22 (30.6)	20 (27.8)	9 (12.5)	5 (6.9)	72
Total	**38 (4.5)**	**119 (14.2)**	**243 (29)**	**271 (32.3)**	**167 (20)**	**838**

Table 3.2 I Know of Places to Go for Help if I am Depressed or Sad by Self-Reported Mental Health (Percentage)

Help	Poor	Fair	Good	Very Good	Excellent	Total
Place to Get Help	27 (3.8)	89 (12.4)	203 (28.2)	244 (33.9)	156 (21.7)	119
No Place to Get Help	11 (9.2)	30 (25.2)	40 (33.6)	27 (22.7)	11 (9.2)	719
Total	**38 (4.5)**	**119 (14.2)**	**243 (29)**	**271 (32.3)**	**167 (20)**	**838**

Table 3.3 Do You Have A Regular Doctor by Zip Code (Percentage)

Zip Code	City	Yes	No	Total
97321	West Albany	173 (70.9)	71 (29.1)	244
97322	East Albany	222 (75.3)	73 (24.7)	295
97327	Brownsville	21 (87.5)	3 (12.5)	24
97335	Crabtree	1 (100)	0 (0)	1
97336	Crawfordsville	1 (100)	0 (0)	1
97346	Gates	1 (25)	3 (75)	4
97348	Hasley	11 (100)	0 (0)	11
97352	Jefferson	1 (100)	0 (0)	1
97355	Lebanon	108 (85)	19 (15)	127
97358	Lyons	4 (80)	1 (20)	5
97360	Mill City	7 (77.8)	2 (22.2)	9
97374	Scio	14 (82.4)	3 (17.6)	17
97377	Shed	3 (75)	1 (25)	4
97386	Sweet Home	48 (78.7)	13 (21.3)	61
97389	Tangent	17 (94.4)	1 (5.6)	18
97446	Harrisburg	7 (87.5)	1 (12.5)	8
Total		**640 (77)**	**191 (23)**	**831**

Table 3.4 Do You Have a Regular Doctor by Annual Household Income (Percentage)

Income	Yes	No	Total
Less than$20,000	175 (63.2)	102 (36.8)	277
$20,000-$29,999	64 (58.2)	46 (41.8)	110
$30,000-$49,999	131 (86.2)	21 (13.8)	152
$50,000-$74,999	140 (88.6)	18 (11.4)	158

Income	Yes	No	Total
$75,000-$99,999	82 (95.3)	4 (4.7)	86
Over $100,000	52 (98.1)	1 (1.9)	53
Total	**644 (77)**	**192 (23)**	**836**

Table 3.5 Do You Have a Regular Doctor by Education (Percentage)

	Yes	No	Total
Less than high school	33 (49.3)	34 (50.7)	67
High School Diploma or GED	96 (63.2)	56 (36.8)	152
Some College	192 (78)	54 (22)	246
Associate/Trade Degree	108 (84.4)	20 (15.6)	128
Bachelor Degree	136 (88.9)	17 (11.1)	153
Graduate Degree	79 (87.8)	11 (12.2)	90
Total	**644 (77)**	**192 (23)**	**836**

Table 3.6 Needed Health Care but Did Not Get It by Zip Code (Percentage)

Zip Code	City	Yes	No	Total
97321	West Albany	75 (30.7)	169 (69.3)	244
97322	East Albany	62 (21)	233 (79)	295
97327	Brownsville	5 (20.8)	19 (79.2)	24
97335	Crabtree	0 (0)	1 (100)	1
97336	Crawfordsville	0 (0)	1 (100)	1
97346	Gates	4 (100)	0 (0)	4
97348	Hasley	2 (18.2)	9 (81.8)	11
97352	Jefferson	0 (0)	1 (100)	1
97355	Lebanon	31 (24.4)	96 (75.6)	127
97358	Lyons	1 (20)	4 (80)	5
97360	Mill City	4 (44.4)	5 (55.6)	9
97374	Scio	2 (11.8)	15 (88.2)	17
97377	Shed	1 (25)	3 (75)	4
97386	Sweet Home	18 (29.5)	43 (70.5)	61
97389	Tangent	2 (11.1)	16 (88.9)	18
97446	Harrisburg	3 (37.5)	5 (62.5)	8
Total		**210 (25.3)**	**621 (74.7)**	**831**

Table 3.7 Needed Health Care but Did Not Get It by Annual Household Income (Percentage)

Income	Yes	No	Total
Less than$20,000	108 (39)	169 (61)	277
$20,000-$29,999	34 (30.9)	76 (69.1)	110
$30,000-$49,999	35 (23)	117 (77)	152
$50,000-$74,999	24 (15.2)	134 (84.8)	158
$75,000-$99,999	5 (5.8)	81 (94.2)	86
Over $100,000	5 (9.4)	48 (90.6)	53
Total	**211 (25.2)**	**625 (74.8)**	**836**

Table 3.8 Needed Health Care but Did Not Get It by Education (Percentage)

Education	Yes	No	Total
Less than high school	25 (37.3)	42 (62.7)	67
High School Diploma or GED	45 (29.6)	107 (70.4)	152
Some College	69 (28)	177 (72)	246
Associate/Trade Degree	35 (27.3)	93 (72.7)	128
Bachelor Degree	21 (13.7)	132 (86.3)	153
Graduate Degree	16 (17.8)	74 (82.2)	90
Total	**211 (25.2)**	**625 (74.8)**	**836**

Appendix D

Zip Code Reference

Zip Code	Major City
97321	West Albany
97322	East Albany
97327	Brownsville
97335	Crabtree
97336	Crawfordsville
97346	Gates
97348	Hasley
97352	Jefferson
97355	Lebanon
97358	Lyons
97360	Mill City
97374	Scio
97377	Shed
97386	Sweet Home
97389	Tangent
97446	Harrisburg

Table 4.1 Most Important Things Needed to Have a Health Community by Zip Code (Percentage)*

	Affordable childcare	Affordable dental care	Affordable healthcare	Affordable housing	Available jobs	Cleanliness	Drug prevention programs	Quality schools	Recreation programs	Safe neighborhoods	Tobacco free areas	Other	Total
97321	1 (0.2)	10 (1.8)	81 (14.2)	44 (7.7)	108 (18.9)	20 (3.5)	8 (1.4)	107 (18.7)	31 (5.4)	147 (25.7)	7 (1.2)	7 (1.2)	571
97322	5 (0.7)	10 (1.3)	67 (8.9)	51 (6.8)	198 (26.4)	16 (2.1)	5 (0.7)	134 (17.8)	39 (5.2)	207 (27.6)	15 (2)	4 (0.5)	751
97327	0 (0)	1 (1.7)	10 (16.7)	3 (5)	11 (18.3)	3 (5)	0 (0)	14 (23.3)	2 (3.3)	15 (25)	0 (0)	1 (1.7)	60
97335	0 (0)	0 (0)	1 (33.3)	0 (0)	1 (33.3)	0 (0)	0 (0)	1 (33.3)	0 (0)	0 (0)	0 (0)	0 (0)	3
97336	0 (0)	0 (0)	0 (0)	1 (25)	1 (25)	0 (0)	0 (0)	1 (25)	0 (0)	1 (25)	0 (0)	0 (0)	4
97346	0 (0)	0 (0)	4 (44.4)	0 (0)	2 (22.2)	0 (0)	0 (0)	1 (11.1)	0 (0)	2 (22.2)	0 (0)	0 (0)	9
97347	0 (0)	0 (0)	0 (0)	0 (0)	1 (33.3)	0 (0)	0 (0)	1 (33.3)	0 (0)	1 (33.3)	0 (0)	0 (0)	3
97348	0 (0)	0 (0)	7 (22.6)	2 (6.5)	6 (19.4)	1 (3.2)	0 (0)	5 (16.1)	3 (9.7)	6 (19.4)	1 (3.2)	0 (0)	31
97352	0 (0)	0 (0)	1 (20)	1 (20)	0 (0)	0 (0)	1 (20)	1 (20)	0 (0)	1 (20)	0 (0)	0 (0)	5
97355	1 (0.3)	1 (0.3)	37 (10.8)	37 (10.8)	87 (25.4)	10 (2.9)	0 (0)	74 (21.6)	10 (2.9)	84 (24.6)	1 (0.3)	0 (0)	342
97358	0 (0)	0 (0)	2 (20)	0 (0)	4 (40)	1 (10)	0 (0)	1 (10)	0 (0)	2 (20)	0 (0)	0 (0)	10
97360	0 (0)	0 (0)	2 (8.7)	3 (13)	6 (26.1)	1 (4.3)	0 (0)	3 (13)	4 (17.4)	4 (17.4)	0 (0)	0 (0)	23
97374	0 (0)	0 (0)	6 (15)	6 (15)	8 (20)	1 (2.5)	0 (0)	8 (20)	1 (2.5)	10 (25)	0 (0)	0 (0)	40
97377	0 (0)	0 (0)	1 (10)	0 (0)	3 (30)	0 (0)	0 (0)	2 (20)	0 (0)	3 (30)	1 (10)	0 (0)	10
97386	1 (0.6)	2 (1.3)	13 (8.4)	10 (6.5)	45 (29.2)	3 (1.9)	0 (0)	28 (18.2)	7 (4.5)	42 (27.3)	1 (0.6)	2 (1.3)	154
97389	0 (0)	0 (0)	6 (14.6)	5 (12.2)	13 (31.7)	1 (2.4)	1 (2.4)	5 (12.2)	1 (2.4)	9 (22)	0 (0)	0 (0)	41
97446	0 (0)	0 (0)	4 (19)	1 (4.8)	2 (9.5)	0 (0)	0 (0)	4 (19)	2 (9.5)	7 (33.3)	1 (4.8)	0 (0)	21
Total	8 (0.4)	24 (1.2)	242 (11.6)	164 (7.9)	496 (23.9)	57 (2.7)	15 (0.7)	390 (18.8)	100 (4.8)	541 (26)	27 (1.3)	14 (0.7)	2078

*Totals may be greater than sample because residents were allowed to select up to three categories

Table 4.2 Most Important Things Needed to Have a Health Community by Annual Household Income (Percentage)*

	Affordable childcare	Affordable dental care	Affordable healthcare	Affordable housing	Available jobs	Cleanliness	Drug prevention programs	Quality schools	Recreation programs	Safe neighborhoods	Tobacco free areas	Other	Total
Less than$20,000	27 (3.1)	33 (3.8)	96 (11.1)	133 (15.3)	186 (21.5)	32 (3.7)	34 (3.9)	89 (10.3)	45 (5.2)	180 (20.8)	7 (0.8)	5 (0.6)	867
$20,000- $29,999	4 (1.2)	10 (3)	47 (14.1)	34 (10.2)	73 (21.9)	11 (3.3)	15 (4.5)	55 (16.5)	14 (4.2)	65 (19.5)	5 (1.5)	0 (0)	333
$30,000- $49,999	10 (2.2)	14 (3.1)	68 (14.9)	48 (10.5)	89 (19.5)	16 (3.5)	18 (3.9)	70 (15.3)	15 (3.3)	100 (21.9)	5 (1.1)	4 (0.9)	457
$50,000- $74,999	4 (0.9)	14 (3.1)	56 (12.3)	18 (4)	105 (23.1)	22 (4.8)	9 (2)	92 (20.2)	18 (4)	105 (23.1)	5 (1.1)	7 (1.5)	455
$75,000- $99,999	2 (0.8)	7 (2.7)	29 (11.4)	21 (8.2)	60 (23.5)	9 (3.5)	4 (1.6)	55 (21.6)	5 (2)	58 (22.7)	1 (0.4)	4 (1.6)	255
Over $100,000	0 (0)	0 (0)	19 (12)	15 (9.5)	38 (24.1)	5 (3.2)	5 (3.2)	33 (20.9)	3 (1.9)	36 (22.8)	2 (1.3)	2 (1.3)	158
Total	47 (1.9)	78 (3.1)	315 (12.5)	269 (10.7)	551 (21.8)	95 (3.8)	85 (3.4)	394 (15.6)	100 (4)	544 (21.5)	25 (1)	22 (0.9)	2525

* Totals may be greater than sample because residents were allowed to select up to three categories

Table 4.3 Top Health Problems in Community by Zip Code (Percentage)*

	97321	97322	97327	97335	97336	97346	97347	97348	97352	97355	97358	97360	97374	97377	97386	97389	97446	Total
Alcohol abuse	46 (6.3)	46 (5.2)	4 (5.8)	0 (0)	0 (0)	0 (0)	1 (33.3)	3 (8.1)	1 (20)	22 (5.6)	2 (14.3)	0 (0)	2 (4.3)	4 (20)	13 (7)	4 (7.4)	3 (13)	151 (6)
Cancer	6 (0.8)	4 (0.4)	3 (4.3)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	3 (0.8)	1 (7.1)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	17 (0.7)
Careless driving	9 (1.2)	14 (1.6)	1 (1.4)	0 (0)	0 (0)	0 (0)	0 (0)	1 (2.7)	0 (0)	4 (1)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	2 (3.7)	0 (0)	31 (1.2)
Child abuse & neglect	45 (6.1)	49 (5.5)	3 (4.3)	1 (33.3)	0 (0)	0 (0)	0 (0)	3 (8.1)	0 (0)	22 (5.6)	1 (7.1)	1 (3.8)	1 (2.2)	9 (45)	14 (7.6)	3 (5.6)	0 (0)	152 (6)
Cost of dental care	39 (5.3)	37 (4.1)	0 (0)	0 (0)	0 (0)	1 (8.3)	0 (0)	0 (0)	0 (0)	10 (2.6)	0 (0)	0 (0)	2 (4.3)	0 (0)	1 (0.5)	2 (3.7)	1 (4.3)	93 (3.7)
Cost of health care	29 (4)	75 (8.4)	13 (18.8)	0 (0)	0 (0)	2 (16.7)	0 (0)	4 (10.8)	0 (0)	24 (6.1)	0 (0)	2 (7.7)	3 (6.5)	0 (0)	9 (4.9)	3 (5.6)	3 (13)	167 (6.6)
Cost of healthy food	31 (4.2)	46 (5.2)	6 (8.7)	0 (0)	0 (0)	2 (16.7)	0 (0)	7 (18.9)	0 (0)	33 (8.4)	0 (0)	2 (7.7)	5 (10.9)	1 (5)	28 (15.1)	5 (9.3)	3 (13)	169 (6.7)
Crime	54 (7.4)	56 (6.3)	3 (4.3)	0 (0)	1 (25)	1 (8.3)	0 (0)	1 (2.7)	1 (20)	25 (6.4)	1 (7.1)	2 (7.7)	2 (4.3)	0 (0)	5 (2.7)	2 (3.7)	0 (0)	154 (6.1)
Domestic Violence	17 (2.3)	33 (3.7)	0 (0)	0 (0)	1 (25)	0 (0)	0 (0)	0 (0)	0 (0)	16 (4.1)	2 (14.3)	0 (0)	1 (2.2)	0 (0)	4 (2.2)	2 (3.7)	0 (0)	76 (3)
Drug Abuse	177 (24.1)	199 (22.3)	14 (20.3)	0 (0)	1 (25)	2 (16.7)	0 (0)	5 (13.5)	1 (20)	95 (24.2)	4 (28.6)	7 (26.9)	10 (21.7)	3 (15)	46 (24.9)	14 (25.9)	4 (17.4)	582 (23.1)
Heart Problems	6 (0.8)	2 (0.2)	2 (2.9)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (0.3)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	11 (0.4)
HIV/AIDS	2 (0.3)	2 (0.2)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	4 (0.2)
Mental Health	35 (4.8)	32 (3.6)	2 (2.9)	0 (0)	1 (25)	0 (0)	0 (0)	0 (0)	0 (0)	19 (4.8)	0 (0)	1 (3.8)	1 (2.2)	0 (0)	8 (4.3)	1 (1.9)	1 (4.3)	101 (4)
Obesity	42 (5.7)	44 (4.9)	5 (7.2)	1 (33.3)	0 (0)	1 (8.3)	1 (33.3)	5 (13.5)	1 (20)	28 (7.1)	0 (0)	1 (3.8)	2 (4.3)	1 (5)	10 (5.4)	6 (11.1)	2 (8.7)	150 (6)
Pollution	6 (0.8)	10 (1.1)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (2.7)	0 (0)	1 (0.3)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	18 (0.7)
Seasonal flu	5 (0.7)	6 (0.7)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (0.5)	0 (0)	0 (0)	12 (0.5)
Sexual Assault	6 (0.8)	9 (1)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	2 (0.5)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	17 (0.7)
STD	5 (0.7)	4 (0.4)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	2 (0.5)	0 (0)	0 (0)	0 (0)	0 (0)	1 (0.5)	0 (0)	0 (0)	12 (0.5)
Suicide	0 (0)	1 (0.1)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (0)
Teen pregnancy	15 (2)	25 (2.8)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	7 (1.8)	0 (0)	3 (11.5)	1 (2.2)	0 (0)	8 (4.3)	0 (0)	0 (0)	59 (2.3)
Tobacco use	16 (2.2)	37 (4.1)	2 (2.9)	1 (33.3)	0 (0)	1 (8.3)	1 (33.3)	3 (8.1)	1 (20)	6 (1.5)	0 (0)	1 (3.8)	1 (2.2)	1 (5)	5 (2.7)	2 (3.7)	1 (4.3)	79 (3.1)
Unemployment	125 (17.1)	152 (17)	10 (14.5)	0 (0)	0 (0)	2 (16.7)	0 (0)	4 (10.8)	0 (0)	70 (17.9)	3 (21.4)	6 (23.1)	14 (30.4)	1 (5)	31 (16.8)	8 (14.8)	5 (21.7)	431 (17.1)
Other	17 (2.3)	10 (1.1)	1 (1.4)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	2 (0.5)	0 (0)	0 (0)	1 (2.2)	0 (0)	1 (0.5)	0 (0)	0 (0)	32 (1.3)
Total	733	893	69	3	4	12	3	37	5	392	14	26	46	20	185	54	23	2519

* Totals may be greater than sample because residents were allowed to select up to three categories

Table 4.4 Top Health Problems in Community by Annual Household Income*

	Less than$20,000	$20,000-$29,999	$30,000-$49,999	$50,000-$74,999	$75,000-$99,999	Over $100,000	Total
Alcohol abuse	53 (6.3)	23 (6.8)	26 (5.9)	27 (5.7)	18 (7.2)	7 (4.6)	154 (6.1)
Cancer	7 (0.8)	1 (0.3)	2 (0.5)	4 (0.8)	3 (1.2)	0 (0)	17 (0.7)
Careless driving	9 (1.1)	2 (0.6)	7 (1.6)	7 (1.5)	4 (1.6)	0 (0)	29 (1.2)
Child abuse & neglect	46 (5.5)	11 (3.2)	28 (6.3)	29 (6.1)	22 (8.8)	10 (6.6)	146 (5.8)
Cost of dental care	25 (3)	15 (4.4)	12 (2.7)	10 (2.1)	5 (2)	0 (0)	67 (2.7)
Cost of health care	56 (6.6)	37 (10.9)	38 (8.6)	45 (9.4)	24 (9.6)	12 (7.9)	212 (8.5)
Cost of healthy food	44 (5.2)	23 (6.8)	17 (3.8)	28 (5.9)	9 (3.6)	6 (4)	127 (5.1)
Crime	81 (9.6)	19 (5.6)	26 (5.9)	21 (4.4)	9 (3.6)	6 (4)	162 (6.5)
Domestic Violence	34 (4)	10 (2.9)	10 (2.3)	16 (3.4)	2 (0.8)	4 (2.6)	76 (3)
Drug Abuse	192 (22.7)	73 (21.5)	107 (24.2)	119 (24.9)	57 (22.8)	37 (24.5)	585 (23.4)
Heart Problems	3 (0.4)	1 (0.3)	3 (0.7)	1 (0.2)	1 (0.4)	1 (0.7)	10 (0.4)
HIV/AIDS	1 (0.1)	0 (0)	0 (0)	1 (0.2)	0 (0)	0 (0)	2 (0.1)
Mental Health	33 (3.9)	9 (2.6)	18 (4.1)	22 (4.6)	10 (4)	9 (6)	101 (4)
Obesity	30 (3.6)	11 (3.2)	35 (7.9)	29 (6.1)	32 (12.8)	18 (11.9)	155 (6.2)
Pollution	11 (1.3)	3 (0.9)	2 (0.5)	3 (0.6)	0 (0)	0 (0)	19 (0.8)
Seasonal flu	5 (0.6)	2 (0.6)	3 (0.7)	3 (0.6)	1 (0.4)	0 (0)	14 (0.6)
Sexual Assualt	14 (1.7)	3 (0.9)	0 (0)	0 (0)	0 (0)	0 (0)	17 (0.7)
STD	7 (0.8)	1 (0.3)	2 (0.5)	1 (0.2)	1 (0.4)	0 (0)	12 (0.5)
Suicide	0 (0)	0 (0)	0 (0)	0 (0)	1 (0.4)	0 (0)	1 (0)
Teen pregnancy	26 (3.1)	9 (2.6)	13 (2.9)	6 (1.3)	1 (0.4)	6 (4)	61 (2.4)
Tobacco use	27 (3.2)	12 (3.5)	15 (3.4)	11 (2.3)	11 (4.4)	5 (3.3)	81 (3.2)
Unemployment	134 (15.9)	74 (21.8)	75 (16.9)	88 (18.4)	35 (14)	28 (18.5)	434 (17.3)
Other	6 (0.7)	1 (0.3)	4 (0.9)	6 (1.3)	4 (1.6)	2 (1.3)	23 (0.9)
Total	844	340	443	477	250	151	2505

* Totals may be greater than sample because residents were allowed to select up to three categories

Appendix E

Table 5.1 My Rental has Not Received Timely Repairs by Zip Code (Percentages)

Zip Code	City	Yes	No	Total
97321	West Albany	32 (29.1)	78 (70.9)	110
97322	East Albany	34 (21.8)	122 (78.2)	156
97327	Brownsville	1 (25)	3 (75)	4
97335	Crabtree	0 (0)	0 (0)	0
97336	Crawfordsville	0 (0)	1 (100)	1
97346	Gates	2 (66.7)	1 (33.3)	3
97348	Hasley	0 (0)	2 (100)	2
97352	Jefferson	0 (0)	0 (0)	0
97355	Lebanon	12 (31.6)	26 (68.4)	38
97358	Lyons	1 (50)	1 (50)	2
97360	Mill City	3 (60)	2 (40)	5
97374	Scio	1 (25)	3 (75)	4
97377	Shed	0 (0)	1 (100)	1
97386	Sweet Home	7 (41.2)	10 (58.8)	17
97389	Tangent	0 (0)	7 (100)	7
97446	Harrisburg	0 (0)	1 (100)	1
Total		**93 (26.5)**	**258 (73.5)**	**351**

Table 5.2 My Rental has Not Received Timely Repairs by Annual Household Income (Percentage)

Income	Yes	No	Total
Less than$20,000	55 (29.4)	132 (70.6)	187
$20,000-$29,999	19 (28.4)	48 (71.6)	67
$30,000-$49,999	14 (26.9)	38 (73.1)	52
$50,000-$74,999	5 (13.9)	31 (86.1)	36
$75,000-$99,999	0 (0)	7 (100)	7
Over $100,000	0 (0)	4 (100)	4
Total	**93 (26.3)**	**260 (73.65)**	**353**

Table 5.3 I was Able to Find an Affordable Place to Rent by Zip Code (Percentages)

Zip Code	City	Yes	No	Total
97321	West Albany	60 (55.6)	48 (44.4)	108
97322	East Albany	91 (58.3)	65 (41.7)	156
97327	Brownsville	4 (100)	0 (0)	4
97335	Crabtree	0 (0)	0 (0)	0
97336	Crawfordsville	1 (100)	0 (0)	1
97346	Gates	2 (66.7)	1 (33.3)	3

Zip Code	City	Yes	No	Total
97348	Hasley	1 (100)	0 (0)	1
97352	Jefferson	0 (0)	0 (0)	0
97355	Lebanon	27 (73)	10 (27)	37
97358	Lyons	1 (50)	1 (50)	2
97360	Mill City	1 (25)	3 (75)	4
97374	Scio	1 (25)	3 (75)	4
97377	Shed	0 (0)	1 (100)	1
97386	Sweet Home	8 (47.1)	9 (52.9)	17
97389	Tangent	4 (57.1)	3 (42.9)	7
97446	Harrisburg	1 (100)	0 (0)	1
Total		**202 (58.4)**	**144 (41.6)**	**346**

Table 5.4 I was Able to Find an Affordable Place to Rent by Annual Household Income (Percentage)

Income	Yes	No	Total
Less than$20,000	103 (55.7)	82 (44.3)	185
$20,000-$29,999	50 (71.4)	20 (28.6)	70
$30,000-$49,999	32 (64)	18 (36)	50
$50,000-$74,999	17 (51.5)	16 (48.5)	33
$75,000-$99,999	0 (0)	6 (100)	6
Over $100,000	1 (33.3)	2 (66.7)	3
Total	**203 (58.5)**	**144 (41.5)**	**347**

Table 5.5 I was Able to Rent a Safe Home by Zip Code (Percentages)

Zip Code	City	Yes	No	Total
97321	West Albany	73 (66.4)	37 (33.6)	110
97322	East Albany	107 (70.4)	45 (29.6)	152
97327	Brownsville	4 (100)	0 (0)	4
97335	Crabtree	0 (0)	0 (0)	0
97336	Crawfordsville	1 (100)	0 (0)	1
97346	Gates	2 (66.7)	1 (33.3)	3
97348	Hasley	1 (100)	0 (0)	1
97352	Jefferson	0 (0)	0 (0)	0
97355	Lebanon	27 (81.8)	6 (18.2)	33
97358	Lyons	1 (50)	1 (50)	2
97360	Mill City	2 (40)	3 (60)	5

Zip Code	City	Yes	No	Total
97374	Scio	2 (50)	2 (50)	4
97377	Shed	1 (100)	0 (0)	1
97386	Sweet Home	8 (50)	8 (50)	16
97389	Tangent	4 (57.1)	3 (42.9)	7
97446	Harrisburg	1 (100)	0 (0)	1
Total		**234 (68.8)**	**106 (31.2)**	**340**

Table 5.6 I was Able to Rent a Safe Home by Annual Household Income (Percentage)

Income	Yes	No	Total
Less than$20,000	118 (64.8)	64 (35.2)	182
$20,000-$29,999	55 (79.7)	14 (20.3)	69
$30,000-$49,999	39 (79.6)	10 (20.4)	49
$50,000-$74,999	21 (65.6)	11 (34.4)	32
$75,000-$99,999	1 (16.7)	5 (83.3)	6
Over $100,000	1 (33.3)	2 (66.7)	3
Total	**235 (68.9)**	**106 (31.1)**	**341**

Table 5.7 I was Able to Rent a Nice Home by Zip Code (Percentages)

Zip Code	City	Yes	No	Total
97321	West Albany	68 (60.7)	44 (39.3)	112
97322	East Albany	96 (62.3)	58 (37.7)	154
97327	Brownsville	4 (100)	0 (0)	4
97335	Crabtree	0 (0)	0 (0)	0
97336	Crawfordsville	1 (100)	0 (0)	1
97346	Gates	1 (33.3)	2 (66.7)	3
97348	Hasley	1 (100)	0 (0)	1
97352	Jefferson	0 (0)	0 (0)	0
97355	Lebanon	27 (81.8)	6 (18.2)	33
97358	Lyons	1 (50)	1 (50)	2
97360	Mill City	2 (40)	3 (60)	5
97374	Scio	2 (50)	2 (50)	4
97377	Shed	1 (100)	0 (0)	1
97386	Sweet Home	8 (42.1)	11 (57.9)	19
97389	Tangent	3 (42.9)	4 (57.1)	7
97446	Harrisburg	1 (100)	0 (0)	1
Total		**216 (62.3)**	**131 (37.7)**	**347**

Table 5.8 I was Able to Rent a Nice Home by Annual Household Income (Percentage)

Income	Yes	No	Total
Less than$20,000	105 (56.8)	80 (43.2)	182
$20,000-$29,999	52 (74.3)	18 (25.7)	69
$30,000-$49,999	38 (76)	12 (24)	49
$50,000-$74,999	20 (58.8)	14 (41.2)	32
$75,000-$99,999	1 (16.7)	5 (83.3)	6
Over $100,000	1 (33.3)	2 (66.7)	3
Total	**217 (62.4)**	**131 (37.6)**	**348**

Appendix F

Table 6.1You Were Treated With Less Courtesy Than Others by Education Level (Percentage)

Education	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than high school	6 (9)	12 (17.9)	23 (34.3)	10 (14.9)	16 (23.9)	67
High School Diploma or GED	7 (4.6)	23 (15.1)	60 (39.5)	42 (27.6)	20 (13.2)	152
Some College	7 (2.8)	35 (14.2)	80 (32.5)	86 (35)	38 (15.4)	246
Associate/Trade Degree	3 (2.3)	21 (16.4)	30 (23.4)	56 (43.8)	18 (14.1)	128
Bachelor Degree	3 (2)	5 (3.3)	47 (30.7)	75 (49)	23 (15)	153
Graduate Degree	1 (1.1)	6 (6.7)	28 (31.1)	41 (45.6)	14 (15.6)	90
Total	**27 (3.2)**	**102 (12.2)**	**268 (32.1)**	**310 (37.1)**	**129 (15.4)**	**836**

Table 6.3 You Were Treated With Less Courtesy Than Others by Race (Percentage)

Race	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
African American	2 (15.4)	3 (23.1)	5 (38.5)	1 (7.7)	2 (15.4)	13
Asian	0 (0)	0 (0)	3 (60)	2 (40)	0 (0)	5
Native American/Pacific Islander	0 (0)	1 (33.3)	2 (66.7)	0 (0)	0 (0)	3
Native American/Native Alaskan	1 (6.2)	3 (18.8)	6 (37.5)	5 (31.2)	1 (6.2)	16
Caucasian	22 (2.8)	93 (11.9)	245 (31.3)	300 (38.4)	122 (15.6)	782
Biracial	0 (0)	1 (10)	5 (50)	1 (10)	3 (30)	10
No Response	2 (28.6)	1 (14.3)	2 (28.6)	1 (14.3)	1 (14.3)	7
Total	**27 (3.2)**	**102 (12.2)**	**268 (32.1)**	**310 (37.1)**	**129 (15.4)**	**836**

Table 6.2 You Were Treated With Less Courtesy Than Others by Annual Household Income (Percentage)

Income	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than$20,000	17 (6.1)	58 (20.9)	104 (37.5)	57 (20.6)	41 (14.8)	277
$20,000-$29,999	4 (3.6)	13 (11.8)	41 (37.3)	33 (30)	19 (17.3)	110
$30,000-$49,999	3 (2)	13 (8.6)	41 (27)	71 (46.7)	24 (15.8)	152
$50,000-$74,999	3 (1.9)	14 (8.9)	46 (29.1)	72 (45.6)	23 (14.6)	158
$75,000-$99,999	0 (0)	3 (3.5)	20 (23.3)	52 (60.5)	11 (12.8)	86
Over $100,000	0 (0)	1 (1.9)	16 (30.2)	25 (47.2)	11 (20.8)	53
Total	**27 (3.2)**	**102 (12.2)**	**268 (32.1)**	**310 (37.1)**	**129 (15.4)**	**836**

Table 6.4 You Were Treated With Less Courtesy Than Others by Ethnicity (Percentage)

Ethnicity	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Hispanic/Latino	5 (7.5)	11 (16.4)	23 (34.3)	16 (23.9)	12 (17.9)	67
Not Hispanic/Latino	22 (2.9)	91 (11.8)	245 (31.9)	294 (38.2)	117 (15.2)	769
Total	**27 (3.2)**	**102 (12.2)**	**268 (32.1)**	**310 (37.1)**	**129 (15.4)**	**836**

Table 6.5 Treated With Less Respect Than Others by Education Level(Percentage)

Education	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than high school	6 (9)	11 (16.4)	27 (40.3)	8 (11.9)	15 (22.4)	67
High School Diploma or GED	9 (5.9)	19 (12.5)	62 (40.8)	40 (26.3)	22 (14.5)	152
Some College	5 (2)	27 (11)	49 (32.1)	91 (37)	44 (17.9)	246
Associate/Trade Degree	3 (2.3)	19 (14.8)	31 (24.2)	54 (42.2)	21 (16.4)	128
Bachelor Degree	2 (1.3)	3 (2)	43 (28.1)	77 (50.3)	28 (18.3)	153
Graduate Degree	1 (1.1)	4 (4.4)	22 (24.4)	47 (52.2)	16 (17.8)	90
Total	**26 (3.1)**	**83 (9.9)**	**264 (31.6)**	**317 (37.9)**	**146 (17.5)**	**836**

Table 6.6 Treated With Less Respect Than Others by Annual Household Income (Percentage)

Income	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than$20,000	18 (6.5)	49 (17.7)	109 (39.4)	54 (19.5)	47 (17)	277
$20,000-$29,999	4 (3.6)	10 (9.1)	41 (37.3)	36 (32.7)	19 (17.3)	110
$30,000-$49,999	2 (1.3)	10 (6.6)	35 (23)	78 (51.3)	27 (17.8)	152
$50,000-$74,999	2 (1.3)	12 (7.6)	41 (25.9)	77 (48.7)	26 (16.5)	158
$75,000-$99,999	0 (0)	1 (1.2)	22 (25.6)	46 (53.5)	17 (19.8)	86
Over $100,000	0 (0)	1 (1.9)	16 (30.2)	26 (49.1)	10 (18.9)	53
Total	**26 (3.1)**	**83 (9.9)**	**264 (31.6)**	**317 (37.9)**	**146 (17.5)**	**836**

Table 6.7 Treated With Less Respect Than Others by Race (Percentage)

Race	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
African American	1 (7.7)	2 (15.4)	7 (53.8)	1 (7.7)	2 (15.4)	13
Asian	0 (0)	0 (0)	3 (60)	2 (40)	0 (0)	5
Native American/Pacific Islander	0 (0)	1 (33.3)	2 (66.7)	0 (0)	0 (0)	3
Native American/Native Alaskan	1 (6.2)	3 (18.8)	5 (31.2)	6 (37.5)	1 (6.2)	16
Caucasian	22 (2.8)	75 (9.6)	239 (30.6)	307 (39.3)	139 (17.8)	782
Biracial	0 (0)	1 (10)	5 (50)	1 (10)	3 (30)	10
No Response	2 (28.6)	1 (14.3)	3 (42.9)	0 (0)	1 (14.3)	7
Total	**26 (3.1)**	**83 (9.9)**	**264 (31.6)**	**317 (37.9)**	**146 (17.5)**	**836**

Table 6.8 Treated With Less Respect Than Others by Ethnicity (Percentage)

Ethnicity	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Hispanic/Latino	5 (7.5)	10 (14.9)	22 (32.8)	16 (23.9)	14 (20.9)	67
Not Hispanic/Latino	21 (2.7)	73 (9.5)	242 (31.5)	301 (39.1)	132 (17.2)	769
Total	**26 (3.1)**	**83 (9.9)**	**264 (31.6)**	**317 (37.9)**	**146 (17.5)**	**836**

Table 6.9 You Received Poorer Service at Restaurants and Stores by Education Level (Percentage)

Education	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than high school	3 (4.5)	7 (10.4)	18 (26.9)	19 (28.4)	20 (29.9)	67
High School Diploma or GED	6 (3.9)	8 (5.3)	60 (39.5)	44 (28.9)	34 (22.4)	152
Some College	5 (2)	16 (6.5)	64 (26)	86 (35)	75 (30.5)	246
Associate/Trade Degree	2 (1.6)	6 (4.7)	30 (23.4)	58 (45.3)	32 (25)	128
Bachelor Degree	0 (0)	7 (4.6)	22 (14.4)	82 (53.6)	42 (27.5)	153
Graduate Degree	1 (1.1)	2 (2.2)	16 (17.8)	37 (41.1)	34 (37.8)	90
Total	**17 (2)**	**46 (5.5)**	**210 (25.1)**	**326 (39)**	**237 (38.4)**	**836**

Table 6.10 You Received Poorer Service at Restaurants and Stores by Annual Household Income (Percentage)

Income	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than$20,000	15 (5.4)	24 (8.7)	94 (33.9)	84 (30.3)	60 (21.7)	277
$20,000-$29,999	2 (1.8)	7 (6.4)	31 (28.2)	41 (37.3)	29 (26.4)	110
$30,000-$49,999	0 (0)	5 (3.3)	33 (21.7)	71 (46.7)	43 (28.3)	152
$50,000-$74,999	0 (0)	8 (5.1)	32 (20.3)	68 (43)	50 (31.6)	158
$75,000-$99,999	0 (0)	2 (2.3)	14 (16.3)	34 (39.5)	36 (41.9)	86
Over $100,000	0 (0)	0 (1.9)	6 (11.3)	28 (52.8)	19 (35.8)	53
Total	**17 (2)**	**46 (5.5)**	**210 (25.1)**	**326 (39)**	**237 (38.4)**	**836**

Table 6.11 You Received Poorer Service at Restaurants and Stores by Race (Percentage)

Race	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
African American	0 (0)	3 (23.1)	7 (53.8)	1 (7.7)	2 (15.4)	13
Asian	0 (0)	0 (0)	1 (20)	4 (80)	0 (0)	5
Native American/Pacific Islander	1 (33.3)	0 (0)	1 (33.3)	1 (33.3)	0 (0)	3
Native American/Native Alaskan	0 (0)	1 (6.2)	5 (31.2)	6 (37.5)	4 (25)	16
Caucasian	15 (1.9)	40 (5.1)	188 (24)	313 (40)	226 (28.9)	782
Biracial	0 (0)	0 (0)	6 (60)	1 (10)	3 (30)	10
No Response	1 (14.3)	2 (28.6)	2 (28.6)	0 (0)	2 (28.6)	7
Total	**17 (2)**	**46 (5.5)**	**210 (25.1)**	**326 (39)**	**237 (38.4)**	**836**

Table 6.12 You Received Poorer Service at Restaurants and Stores by Ethnicity (Percentage)

Ethnicity	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Hispanic/Latino	2 (3)	7 (10.4)	20 (29.9)	20 (29.9)	18 (26.9)	67
Not Hispanic/Latino	15 (2)	39 (5.1)	190 (24.7)	306 (39.8)	219 (28.5)	769
Total	**17 (2)**	**46 (5.5)**	**210 (25.1)**	**326 (39)**	**237 (38.4)**	**836**

Table 6.13 You Received Poorer Service at Healthcare Providers by Zip Code (Percentage)

Education	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than high school	5 (7.5)	10 (14.9)	13 (19.4)	12 (17.9)	27 (40.3)	67
High School Diploma or GED	3 (2)	12 (7.9)	45 (29.6)	39 (25.7)	53 (34.9)	152
Some College	7 (2.8)	13 (5.3)	46 (18.7)	67 (27.2)	113 (45.9)	246

Education	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Associate/Trade Degree	3 (2.3)	9 (7)	22 (17.2)	37 (28.9)	57 (44.5)	128
Bachelor Degree	0 (0)	3 (2)	16 (10.5)	53 (34.6)	81 (52.9)	153
Graduate Degree	1 (1.1)	1 (1.1)	13 (14.4)	19 (21.1)	56 (62.2)	90
Total	**19 (2.3)**	**48 (5.7)**	**155 (18.5)**	**227 (27.2)**	**387 (46.3)**	**836**

Table 6.14 You Received Poorer Service at Healthcare Providers by Annual Household Income (Percentage)

	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than$20,000	18 (6.5)	33 (11.9)	73 (26.4)	61 (22)	92 (33.2)	277
$20,000-$29,999	1 (0.9)	3 (2.7)	25 (22.7)	35 (31.8)	46 (41.8)	110
$30,000-$49,999	0 (0)	7 (4.6)	25 (16.4)	48 (31.6)	72 (47.4)	152
$50,000-$74,999	0 (0)	3 (1.9)	19 (12)	44 (27.8)	92 (58.2)	158
$75,000-$99,999	0 (0)	2 (2.3)	8 (9.3)	19 (22.1)	57 (66.3)	86
Over $100,000	0 (0)	0 (0)	5 (9.4)	20 (37.7)	28 (52.8)	53
Total	**19 (2.3)**	**48 (5.7)**	**155 (18.5)**	**227 (27.2)**	**387 (46.3)**	**836**

Table 6.15 You Received Poorer Service at Healthcare Providers by Race (Percentage)

Race	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
African American	0 (0)	0 (0)	6 (46.2)	3 (23.1)	4 (30.8)	13
Asian	0 (0)	0 (0)	0 (0)	2 (40)	3 (60)	5
Native American/Pacific Islander	0 (0)	1 (33.3)	2 (66.7)	0 (0)	0 (0)	3
Native American/Native Alaskan	0 (0)	0 (0)	5 (31.2)	8 (50)	3 (18.8)	16
Caucasian	18 (2.3)	46 (5.9)	136 (17.4)	211 (27)	371 (47.4)	782
Biracial	0 (0)	1 (10)	3 (30)	2 (20)	3 (40)	10
No Response	1 (14.3)	0 (0)	3 (42.9)	1 (14.3)	2 (28.6)	7
Total	**19 (2.3)**	**48 (5.7)**	**155 (18.5)**	**227 (27.2)**	**387 (46.3)**	**836**

Table 6.16 You Received Poorer Service at Healthcare Providers by Ethnicity (Percentage)

Ethnicity	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Hispanic/Latino	3 (4.5)	3 (4.5)	14 (20.9)	18 (26.9)	29 (43.3)	67
Not Hispanic/Latino	16 (2.1)	45 (5.9)	141 (18.3)	209 (27.2)	358 (46.6)	769
Total	**19 (2.3)**	**48 (5.7)**	**155 (18.5)**	**227 (27.2)**	**387 (46.3)**	**836**

Table 6.17 Other People Act as if they are Afraid of You by Zip Code (Percentage)

Education	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than high school	1 (1.5)	5 (7.5)	15 (22.4)	15 (22.4)	31 (46.3)	67
High School Diploma or GED	3 (2)	8 (5.3)	32 (21.1)	39 (25.7)	70 (46.1)	152
Some College	0 (0)	10 (4.1)	29 (11.8)	44 (17.9)	163 (66.3)	246
Associate/Trade Degree	0 (0)	1 (0.8)	12 (9.4)	28 (21.9)	87 (68)	128
Bachelor Degree	1 (0.7)	1 (0.7)	13 (8.5)	34 (22.2)	104 (68)	153
Graduate Degree	3 (1.1)	1 (1.1)	6 (6.7)	15 (16.7)	65 (72)	90
Total	**8 (1)**	**26 (3.1)**	**107 (12.8)**	**175 (20.9)**	**520 (62.2)**	**836**

Table 6.18 Other People Act as if they are Afraid of You by Annual Household Income (Percentage)

Income	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than$20,000	4 (1.4)	16 (5.8)	63 (22.7)	56 (20.2)	138 (49.8)	277
$20,000-$29,999	0 (0)	4 (3.6)	14 (12.7)	31 (28.2)	61 (55.5)	110
$30,000-$49,999	0 (0)	2 (1.3)	11 (7.2)	32 (21.1)	107 (70.4)	152
$50,000-$74,999	3 (1.9)	3 (1.9)	11 (7)	33 (20.9)	108 (68.4)	158
$75,000-$99,999	0 (0)	1 (1.2)	5 (5.8)	11 (12.8)	69 (80.2)	86
Over $100,000	1 (1.9)	0 (0)	3 (5.7)	12 (22.6)	37 (69.8)	53
Total	**8 (1)**	**26 (3.1)**	**107 (12.8)**	**175 (20.9)**	**520 (62.2)**	**836**

Table 6.19 Other People Act as if they are Afraid of You by Race (Percentage)

Race	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
African American	2 (15.4)	1 (7.7)	4 (30.8)	2 (15.4)	4 (30.8)	13
Asian	0 (0)	0 (0)	2 (40)	0 (0)	3 (60)	5
Native American/Pacific Islander	0 (0)	0 (0)	2 (66.7)	0 (0)	1 (33.3)	3
Native American/Native Alaskan	0 (0)	1 (6.2)	3 (18.8)	6 (37.5)	6 (37.5)	16
Caucasian	6 (0.8)	22 (2.8)	93 (11.9)	165 (21.1)	496 (63.4)	782
Biracial	0 (0)	0 (0)	2 (20)	0 (0)	8 (80)	10
No Response	0 (0)	2 (28.6)	1 (14.3)	2 (28.6)	2 (28.6)	7
Total	**8 (1)**	**26 (3.1)**	**107 (12.8)**	**175 (20.9)**	**520 (62.2)**	**836**

Table 6.20 Other People Act as if they are Afraid of You by Ethnicity (Percentage)

Ethnicity	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Hispanic/Latino	0 (0)	3 (4.5)	8 (11.9)	16 (23.9)	40 (59.7)	67
Not Hispanic/Latino	8 (1)	23 (3)	99 (12.9)	159 (20.7)	480 (62.4)	769
Total	**8 (1)**	**26 (3.1)**	**107 (12.8)**	**175 (20.9)**	**520 (62.2)**	**836**

Table 6.21 Other People Act As if They Are Better Than You by Zip Code (Percentage)

	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than high school	9 (13.4)	16 (23.9)	20 (29.9)	6 (9)	16 (23.9)	67
High School Diploma or GED	21 (13.8)	21 (13.8)	52 (34.2)	35 (23)	23 (15.1)	152
Some College	19 (7.7)	35 (14.2)	75 (30.5)	71 (28.9)	46 (18.7)	246
Associate/Trade Degree	8 (6.2)	19 (14.8)	32 (25)	50 (39.1)	19 (14.8)	128
Bachelor Degree	6 (3.9)	3 (2)	49 (32)	71 (46.4)	24 (15.7)	153
Graduate Degree	4 (4.4)	12 (13.3)	23 (25.6)	35 (38.9)	16 (17.8)	90
Total	**67 (8)**	**106 (12.7)**	**251 (30)**	**268 (32.1)**	**144 (17.2)**	**836**

Table 6.22 Other People Act As if They Are Better Than You by Annual Household Income (Percentage)

Income	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Less than$20,000	46 (16.6)	55 (19.9)	88 (31.8)	48 (30.3)	40 (14.4)	277
$20,000-$29,999	7 (6.4)	16 (14.5)	39 (35.5)	28 (37.3)	20 (18.2)	110
$30,000-$49,999	4 (2.6)	12 (7.9)	51 (33.6)	62 (40.8)	23 (15.1)	152
$50,000-$74,999	7 (4.4)	15 (9.5)	45 (28.5)	68 (40.5)	27 (17.1)	158
$75,000-$99,999	2 (2.3)	5 (5.8)	21 (24.4)	34 (38.4)	25 (29.1)	86
Over $100,000	1 (1.9)	3 (5.7)	7 (13.2)	28 (62.3)	9 (17)	53
Total	**67 (8)**	**106 (12.7)**	**251 (30)**	**268 (32.1)**	**144 (17.2)**	**836**

Table 6.23 Other People Act As if They Are Better Than You by Race (Percentage)

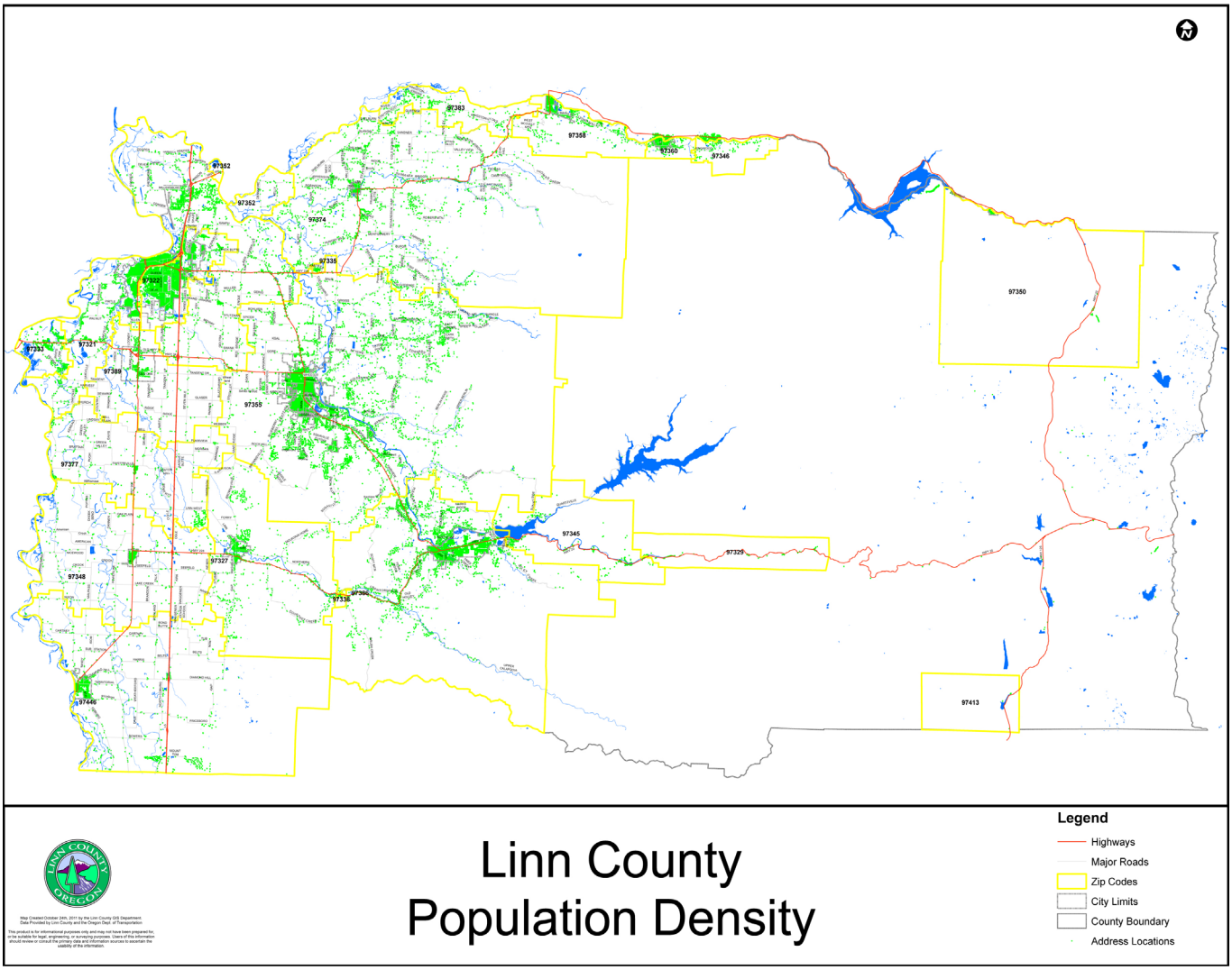
Race	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
African American	3 (23.1)	5 (7.7)	1 (7.7)	3 (7.7)	3 (23.1)	13
Asian	0 (0)	0 (20)	4 (80)	0 (80)	0 (0)	5
Native American/Pacific Islander	1 (33.3)	1 (33.3)	0 (0)	0 (33.3)	0 (0)	3
Native American/Native Alaskan	0 (0)	2 (62.5)	2 (12.5)	2 (37.5)	2 (12.5)	16

Race	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Caucasian	62 (7.9)	93 (29.9)	258 (33)	135 (40)	135 (17.3)	782
Biracial	0 (0)	2 (20)	3 (30)	3 (10)	3 (30)	10
No Response	1 (14.3)	3 (42.9)	0 (0)	1 (0)	1 (14.3)	7
Total	**67 (8)**	**106 (12.7)**	**251 (30)**	**268 (32.1)**	**144 (17.2)**	836

Table 6.24 Other People Act As if They Are Better Than You by Ethnicity (Percentage)

Ethnicity	Very Often	Fairly Often	Not Too Often	Hardly Ever	Never	Total
Hispanic/Latino	9 (13.4)	12 (17.9)	19 (28.4)	14 (20.9)	13 (19.4)	67
Not Hispanic/Latino	58 (7.5)	94 (12.2)	232 (30.2)	254 (33)	131 (17)	769
Total	67 (8)	106 (12.7)	251 (30)	268 (32.1)	144 (17.2)	836

Appendix G



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End of **Community Health Status Report 2012**

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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 _**X**_ No ___ A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.

2. Yes _**X**__ No ___ The Local Health Authority meets at least annually to address public health concerns.

3. Yes _**X**__ 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 _**X**__ No ___ Current local health department policies and procedures exist which are reviewed at least annually.

5. Yes _**X**__ No ___ Ongoing community assessment is performed to analyze and evaluate community data.

6. Yes _**X**__ No ___ Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.

7. Yes _**X**__ No ___ Local health officials develop and manage an annual operating budget.

8. Yes _**X**__ No ___ Generally accepted public accounting practices are used for managing funds.

9. Yes _**X**_ No ___ All revenues generated from public health services are allocated to public health programs.

10. Yes_**X**_ No ___ Written personnel policies and procedures are in compliance with federal and state laws and regulations.

11. Yes _**X**__ No ___ Personnel policies and procedures are available for all employees.

12. Yes _**X**__ No ___ All positions have written job descriptions, including minimum qualifications.

13. Yes **_X__** No ___ Written performance evaluations are done annually**. (County policy that after 5.5 years, evaluations are every two years.)**

14. Yes **_X_** No ___ Evidence of staff development activities exists.

15. Yes **_X__** No ___ Personnel records for all terminated employees are retained consistently with State Archives rules.

16. Yes **_X_** No ___ Records include minimum information required by each program.

17. Yes ___ No **_X__** A records manual of all forms used is reviewed annually. (**Each program has their own. No formal manual)**

18. Yes **_X__** No ___ There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.

19. Yes **_X__** No ___ Filing and retrieval of health records follow written procedures.

20. Yes **_X__** No ___ Retention and destruction of records follow written procedures and are consistent with State Archives rules.

21. Yes **_X__** No ___ Local health department telephone numbers and facilities' addresses are publicized.

22. Yes **_X__** No ___ Health information and referral services are available during regular business hours.

23. Yes **_X__** 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 **_X__** 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 **_X__** No ___ To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.

26. Yes **_X__** No ___ Certified copies of registered birth and death certificates are issued within one working day of request.

27. Yes **_X__** No ___ Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.

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

29. Yes **_X__** 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 **_X__** No ___ Health department administration and county medical examiner review collaborative efforts at least annually.

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

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

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

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

35. Yes **_X__** 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 **_X__** 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 **_X__** No ___ There is a mechanism for reporting communicable disease cases to the health department.

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

40. Yes **_X__** 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 **__X_** 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 **__X_** No ___ There is a mechanism for reporting and following up on zoonotic diseases to the local health department.

43. Yes **_X__** No ___ A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.

44. Yes **_X__** 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 **_X__** No ___ Immunizations for human target populations are available within the local health department jurisdiction.

46. Yes **_X_** No ___ Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

47. Yes **_X__** No ___ Food service facilities are licensed and inspected as required by Chapter 333 Division 12.

48. Yes **_X__** No ___ Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.

49. Yes **_X__** No ___ Training in first aid for choking is available for food service workers.

50. Yes **_X__** No ___ Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.

51. Yes **_X__** No ___ Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.

52. Yes **_X__** No ___ Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

53. Yes _**X**__ No ___ Compliance assistance is provided to public water systems that violate requirements.

54. Yes _**X**_ No ___ All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.

55. Yes _**X**__ No ___ A written plan exists for responding to emergencies involving public water systems.

56. Yes _**X**__ No ___ Information for developing a safe water supply is available to people using on-site individual wells and springs.

57. Yes _**X**__ No ___ A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.

58. Yes _**X**__ No ___ Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.

59. Yes _**X**__ No ___ School and public facilities food service operations are inspected for health and safety risks.

60. Yes _**X**__ 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 _**X**__ No ___ A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.

62. Yes _**X**__ No ___ Indoor clean air complaints in licensed facilities are investigated. (with our TPEP Program)

63. Yes _**X**__ No ___ Environmental contamination potentially impacting public health or the environment is investigated.

64. Yes _**X**__ No ___ The health and safety of the public is being protected through hazardous incidence investigation and response.

65. Yes _**X**__ 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 _**X**__ No ___ All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

Health Education and Health Promotion

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

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

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

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

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

72. Yes **_X__** No ___ All health department facilities are smoke free. **(We follow the indoor clean air act and 10' rule.)**

Nutrition

73. Yes _X__ 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 **_X__** No ___ WIC
b. Yes **_X__** No ___ Family Planning
c. Yes **_X__** No ___ Parent and Child Health
d. Yes ___ No **__NA_** Older Adult Health
e. Yes ___ No **__NA_** Corrections Health **(not through health department)**

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

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

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

Older Adult Health

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

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

80. Yes **_X__** 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 **_X__** 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 **_X__** No ___ Perinatal care is provided directly or by referral.

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

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

85. Yes **_X__** 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 **_X__** No ___ Child abuse prevention and treatment services are provided directly or by referral.

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

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

89. Yes **_X__** No ___ There is a system in place to follow up on all reported SIDS deaths. **(Limited)**

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

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

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

Primary Health Care

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

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

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

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

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

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

Cultural Competency

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

100. Yes **_X__** 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 **_X__** No ___ The local health department assures that advisory groups reflect the population to be served. **(Trying to recruit vacant positions)**

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

Health Department Personnel Qualifications

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

Answer the following questions:
Administrator name: ____**Frank Moore**_____
Does the Administrator have a Bachelor degree? Yes _**X**__ No ___
Does the Administrator have at least 3 years experience in Yes _**X**__ No ___
public health or a related field?
Has the Administrator taken a graduate level course in Yes ___ No _**X**__
biostatistics?
Has the Administrator taken a graduate level course in Yes ___ No _**X**__
epidemiology?
Has the Administrator taken a graduate level course Yes ___ No _**X**__
in environmental health?
Has the Administrator taken a graduate level course Yes _**X**__ No ___
in health services administration?
Has the Administrator taken a graduate level course in Yes _**X**__ No ___
social and behavioral sciences relevant to public health problems?
a. Yes ___ No _X__ 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. (Health Administrator continues to look into graduate level courses)

b. Yes _X__ 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 _X__ No ___ The local health department Environmental Health Supervisor meets minimum qualifications:
Registration as a sanitarian 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 _X__ No____ The local health department Health Officer meets minimum qualifications:

Licensed in the State of Oregon as M.D. or D.O. Two years of practice as licensed physician (two years after internship and/or residency). Training and/or experience in epidemiology and public health.
If the answer is "No", submit an attachment that describes your plan to meet the minimum qualifications.

Agencies are **required** to include with the submitted Annual Plan:
The local public health authority is submitting the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431.375–431.385 and ORS 431.416, are performed.

_____ _____ _____
Local Public Health Authority County 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.

Local Public Health Authority	County	Date
Roger Nyquist, Chair Board of Health	Linn	4.16.2014

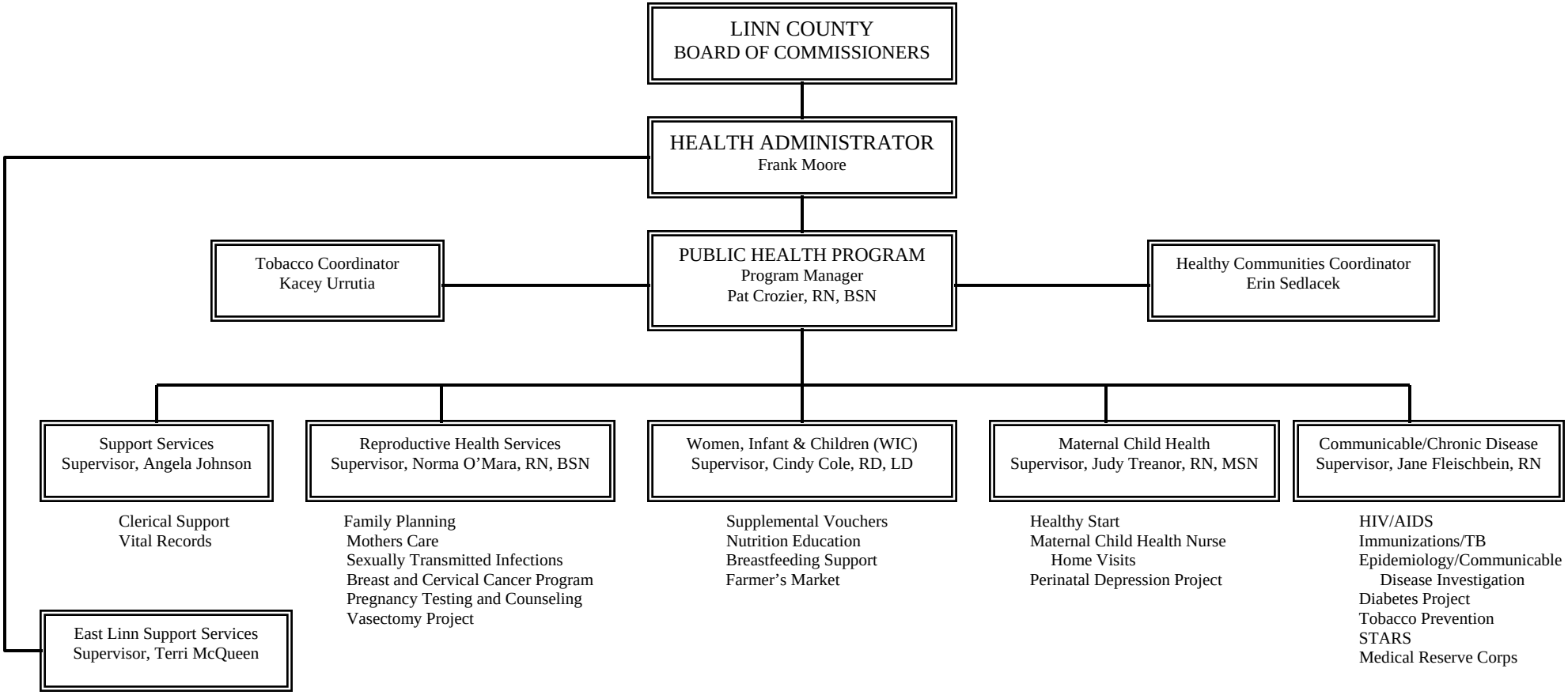
Budget:

Brandi Ashton is the keeper of our budget information. She can be reached at (541) 967-3888 Ext. 2035 and bashton@co.linn.or.us .

Our address is P.O. Box 100, Albany, Or. 97321

Please go to www.co.linn.or.us for a complete financial report.

LINN COUNTY
PUBLIC HEALTH PROGRAM



2012

Linn County Community Health Improvement Plan

Linn County Mobilizing Action through Planning and Partnerships Committee

8/08/2012

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Executive Summary

The Linn County Community Health Improvement Plan (CHIP) represents a year of work in which the County and its partners utilized the Mobilizing Action through Planning and Partnerships (MAPP) framework to assess the health status of the county and build a plan to improve priority areas.

Four key topic areas were prioritized by the MAPP committee based on collected health statistics, survey data, and key informant interviews. That collected information comprised the Linn County Community Health Assessment which was the guiding document in the creation of this plan. The Linn County Community Health Assessment can be viewed here or found on the Linn County website at www.co.linn.or.us.

The topic areas comprising this document are: Access to Health Care, Tobacco Use, Chronic Diseases, and Substance Abuse. Under each topic is a list of goals and general strategies to help achieve those goals. It is important to note that the Community Health Improvement Plan is a living document that may be updated or revised as new resources become available, new technologies are introduced, new research happens, or events shift the community priorities. This document has shared ownership across all partners of Linn County Public Health and has shared responsibility in achieving goals. Funding for completion of this Community Health Improvement Plan and Linn County's Community Health Assessment was provided by the Oregon Public Health Division's Performance Management Program accreditation readiness grant.

The MAPP process

Mobilizing Action through Planning and Partnerships is a community-wide strategic planning process for improving public health. It is a method to help communities prioritize public health issues and to identify resources for addressing them.

In August of 2011, Linn County Public Health formed a coalition of community members and partners to begin the MAPP process. Over the next 10 months, Linn County Public Health and the MAPP committee set out to assess the health of the community, identify strategic issues, and formulate goals and strategies to address key issues.

The Assessments

Assessing the health status of the entire county was a challenging task. Linn County has a population of 116,672 as of the 2010 census, with a diverse mix of both urban and rural areas (see Table 1).

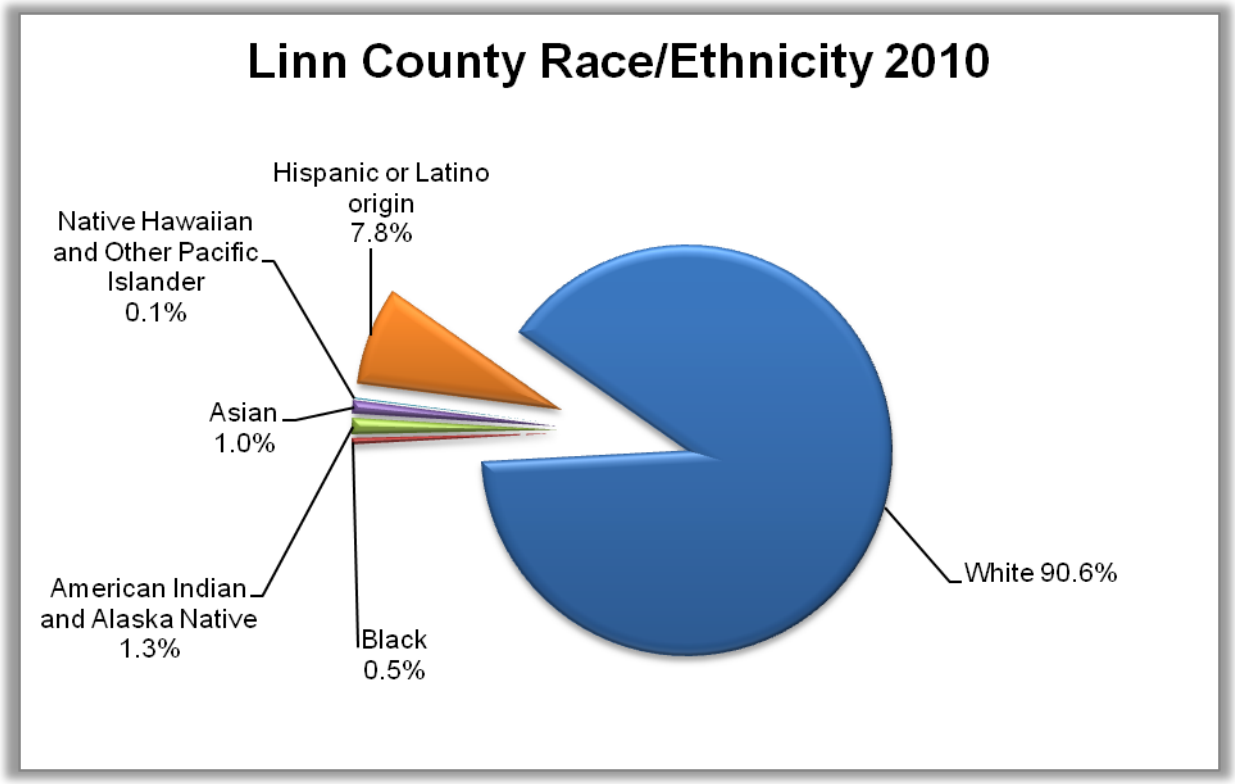
Table 1: Linn County demographics from the 2010 census

2010	Linn County	Oregon
Population	**116,672**	3,831,074
Population change, 2000 to 2010	**+13.2%**	+12.0%
Land Area	**2,292 square miles**	95,997 square miles
Population density	**51 people per square mile**	40 people per square mile
***Percent of population living in a rural location**	**37%**	21%

Source: US Census Bureau-*State and County QuickFacts: Linn County, Oregon, 2010*

The MAPP committee put special attention into assessing vulnerable populations. Linn County is predominately White; however, it is home to an increasing population of Hispanics/Latinos (see Figure 1). The proportion of Hispanic/Latinos in the community has increased 3.4 percent since 2000, increasing from approximately 4,664 in 2000 to approximately 9,330 individuals today.

Figure 1: Linn county Race/Ethnicity as of the 2010 census



The Community Health Assessment was completed using the MAPP process framework. The framework calls for assessing the health of the community across several topical areas. Those assessments include the following:

Community Themes and Strengths was the first assessment topic area, and the area of the majority of focus and resources. Community Themes and Strengths is a way to identify what health issues are important to the members of the community, to gain insight into the quality of life in the community and to find what assets the community has to help improve health. The MAPP committee chose to create a survey to assess the quality of life of the community and to conduct key informant interviews to gather qualitative information on the health status, quality of life, and community strengths and weaknesses throughout the County.

Quality of Life Survey was developed by the MAPP committee in order to find out how the community felt about where they lived as it pertained to their health. The survey

consisted of seven single-sided pages and contained 40 questions, including detailed demographic questions. After eliminating incomplete surveys, Linn County had data from 836 respondents and representation from almost all zip codes. Demographics of the survey closely matched census demographics for Linn County, with the exception of more females and low income individuals answering. The Quality of Life Surveys were key to informing the MAPP committee about perceived health threats in the community, and directly lead to the inclusion of substance abuse as a topic area. The Quality of Life Survey also informed the MAPP committee about issues with access to care and health inequalities that exist in the county. For instance, Hispanics face much greater challenges with access to health care than non-Hispanics. Transportation, insurance, and language barriers were also identified as issues that increase barriers to care.

Key Informant Interviews were conducted on thirty individuals throughout the county for firsthand, personal accounts of health issues and concerns in county communities. Interviewees were selected by the MAPP committee based on their connection to the community, their education, job, and the level of influence they had in their community. Key Informants in general were described as highly informed individuals who could provide our assessment efforts with quality information.

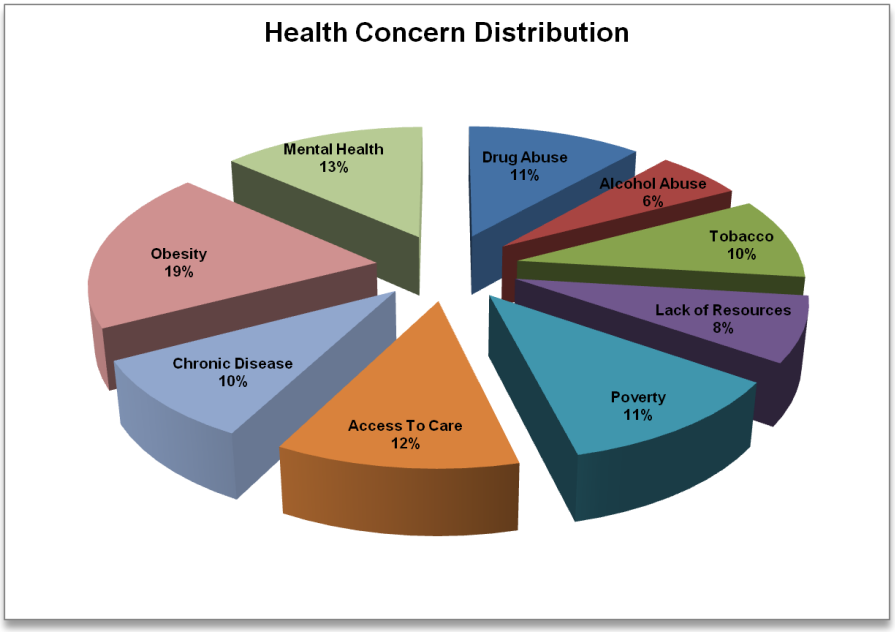


Figure 2: Heath Concerns as reported by Key Informant interviews

The key informant interviews allowed the MAPP committee to identify numerous areas of concern, both in specific communities and countywide. Figure 2 is a countywide look at the top reported health concerns across all 30 interviews. Key Informants were allowed to cite multiple health concerns but it is important to note that the majority of Key Informants cited social determinants (factors such as education, income, living conditions, and peer group) as important health concerns. Key Informant interviews were a terrific resource in identifying the priority areas of substance abuse and access to care in the Community Health Improvement Plan.

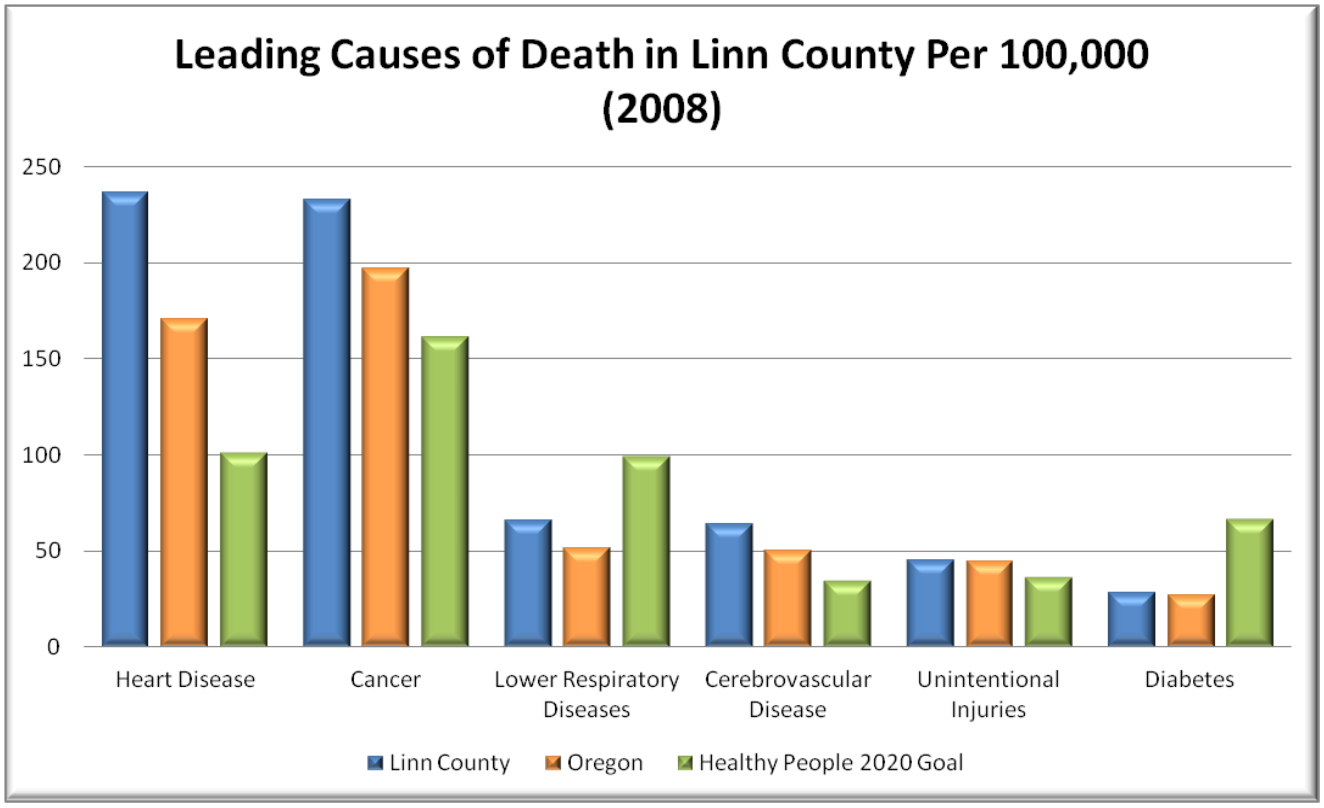


Figure 3: Mortality rates as reported in the Linn County Community Health Assessment

The Community Health Status Report was the second assessment area. Data was reviewed on 11 key subjects: Demographics, Socioeconomic Characteristics, Health Resource Availability, Quality of Life, Behavioral Risk Factors, Environmental Health Indicators, Mental and Social Health, Maternal Health, Mortality and Morbidity, Communicable Diseases, and Preventable Events. Data was collected using a variety of databases and surveillance systems, most notably the Centers for Disease Control and Prevention's (CDC) *National Health and Nutrition Examination Survey* (*NHANES*), the CDC's *Behavioral Risk Factor Surveillance System* (*BRFSS)*, Linn County's mandatory reportable disease information, Children First for Oregon, and Oregon Health Authority's various epidemiological databases. Shown in Figure 3 are the leading causes of death for Linn County and is an example of the information collected for the Community Health Status Report. Please review the Community Health Assessment for complete statistics reported in the Community Health Status Report.

The Local Public Health System Assessment looked at how the entire public health system worked together to ensure the ten essential services of public health. The **Ten Essential Public Health Services** (see table 2) provide the fundamental framework for the Local Public Health System Assessment by describing the public health activities that should be undertaken in all communities.

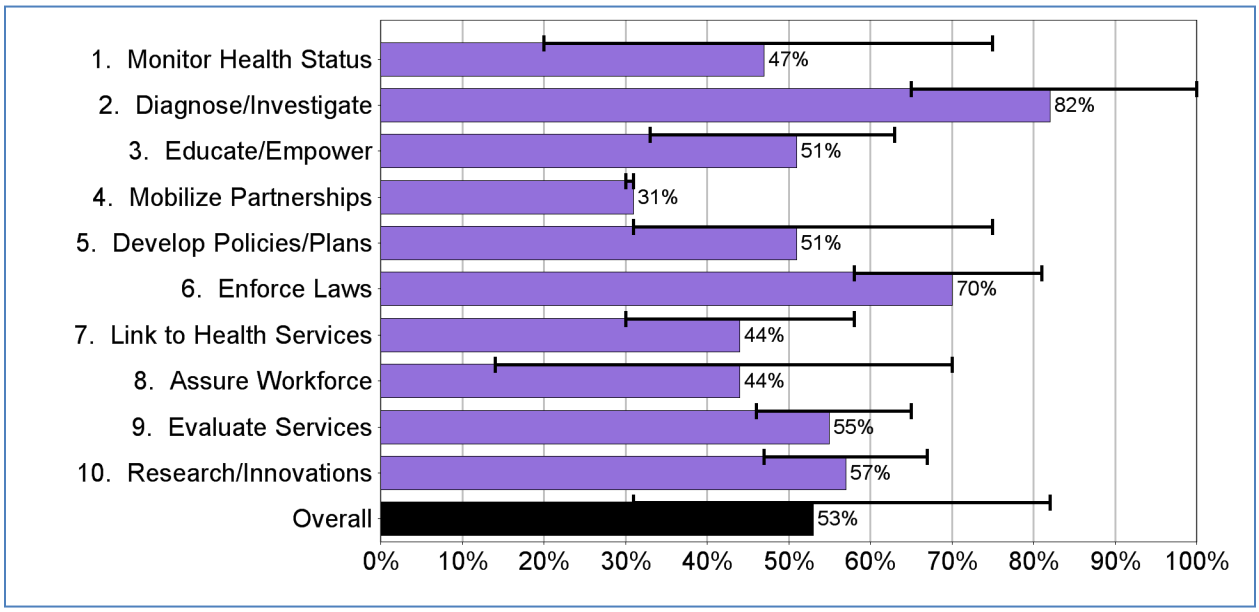
The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. This steering committee included representatives from US Public Health Service agencies and other major public health organizations. The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

Table 2: the Ten Essential Services of Public Health

The Ten Essential Services of Public Health
Monitor health status to identify and solve community health problems.
Diagnose and investigate health problems and health hazards in the community.
Inform, educate, and empower people about health issues.
Mobilize community partnerships and action to identify and solve health problems.
Develop policies and plans that support individual and community health efforts.
Enforce laws and regulations that protect health and ensure safety.
Link people to needed personal health services and assure the provision of health care.
Assure competent public and personal health care workforce.
Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
Research for new insights and innovative solutions to health problems.

The assessment was completed using the National Public Health Performance Standards Program (NPHPSP) Local Public Health System Performance Assessment Instrument version 2.0. The MAPP committee, as well as other agencies, partners, and community members, met six times over the course of two months to complete the instrument. Questions were voted on using a remote voting system and a consensus was met upon how to rate each item. At the completion of the assessment instrument, the answers were uploaded onto the NPHPSP's website and a report was generated. Results of the Local Public Health System Assessment (see Figure 4) were used to inform the MAPP committee about issues faced with building strong partnerships and mobilizing the community to act on health concerns. The need to mobilize the community to act on health concerns and collaborate across partners and agencies is an overarching theme reflected across the Community Health Improvement Plan. All goals and strategies will require collaboration and partnership to achieve. This report was included in the Community Health Assessment.

Figure 4: Results of Local Public Health System Assessment



Identifying Key Issues

After reviewing data for the Community Health Assessment, the MAPP committee identified key topic areas. Several reoccurring themes guided the creation of the Community Health Improvement Plan: high adolescent and adult smoking rates, high adult and child obesity rates, high chronic disease rates, inability to access healthcare, high levels of substance abuse, inadequate policy and environmental factors to promote health, inadequate partnerships and communication networks, increasing minority populations, recent economic conditions, and reductions in budgets and resources.

Hundreds of individual statistics and data points were arranged into commonly themed topics. Core issues identified were: Substance Abuse, Tobacco Use, Access to Health Care, Access to Mental Health Care, Risk Behaviors, Chronic Diseases, Access to Healthy Foods, Child and Maternal Health, Resource Availability, Mobilizing Partnerships, Nutrition, Health Communication, and Safe and Affordable Housing. A community meeting was held in which the MAPP committee, community members , and members of the Linn Benton Health Equity Alliance were able to discuss the topics and data that supported those topics, and vote on their top three issues. Chart paper was hung up around the meeting room, each containing the name of the above-mentioned topic areas. Members in attendance were given three sticker dots with which they could use to vote for the top three topics they felt most deserved to be included in the Community Health Improvement Plan.

The voting and discussion resulted in the selection of four topic areas for this CHIP—Chronic Diseases, Access to Care, Tobacco Use, and Substance Abuse—as well as their accompanying goals and strategies. It was decided to combine Access to Health Care and Access to Mental Health into one topic. Additionally, Mobilizing Partnerships was tied with Substance Abuse for the fourth topic. It was decided that Mobilizing Partnerships is a topic that should be reflected in all areas, and achievement of goals in this plan will be a result of increased partnership involvement.

Developing Goals and Strategies

Linn County Public Health and the MAPP committee met to conduct a brief brainstorming session called "Forces of Change." The idea was to come up with a list of potential barriers to change we face in the community, as well as potential allies and strengths. The purpose of this exercise was to help inform the committee and community partners of what strengths Linn County had, and what barriers must be overcome in order to produce healthy changes in the community. The Linn Benton Health Equity Alliance did a similar exercise during a community conversation session they hosted at the Albany Public Library. That information was shared, and several alliance members have continued to support goal and strategy generation. The most popular barriers identified were: lack of funding, lack of resources or employee time, and political forces. Top cited strengths were strong community programs, willingness of the community, and a strong faith and charity network.

Goal formation began by looking to Healthy People 2020 and its established goals. Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. The measures and goals are based on national averages. This was done for two major reasons. First, Healthy People 2020 already has a good set of goals established that closely align with the areas chosen by the MAPP committee; there was no need to spend time establishing new metrics. Second, there has historically been grant funding attached to trying to achieve a Healthy People 2020 goal in your community. It was viewed as a wise decision to align goals to a potential funding source.

After goals were decided upon, strategies were developed to meet those goals. The Forces of Change assessment was instrumental in deciding the direction to take the creation of strategies. As stated above, resources are a significant barrier. Many strategies involve seeking funding to implement an evidence-based program or partnering with multiple agencies to share cost and employee time. Attempts were made to align strategies towards partners' existing goals and functions. For example, tobacco use was an identified priority topic for the Community Health Improvement Plan. It was agreed upon to build from the existing objectives the Linn County Tobacco

Prevention Coordinator developed. The idea was to create strategies that promoted partnerships and supported the lead agency's existing work plans.

Implementation and Ownership

Community Health Improvement Plans provide a direction for the entire public health system to improve health in priority areas. It is the responsibility of all partners involved in the creation of this document to see that the strategies listed are acted upon and progress toward goals is being made. It should also be noted that CHIPs are living documents that are amended as needed and may adapt to necessary changes.

Each topic has a lead agency identified that has key ownership over the strategies and goals. These groups have the responsibility to organize and work toward achieving the goals in that specific area. In terms of overall accountability and leadership, Linn County Public Health places responsibility on itself and its convened partners to update the CHIP when necessary and evaluate progress toward goals. The Linn County Public Health Program Manager has responsibility to maintain and update the CHIP. Linn County Public Health's Program Manager will facilitate a meeting of all Linn County partners four times a year for document review and revision. The MAPP committee will meet once a quarter with the Linn County Health Advisory Council to give status updates and make necessary revisions.

The schedule of updates and revisions is as follows:

Quarter 1	July – September	Progress Checks
Quarter 2	October – December	CHIP Update Meeting
Quarter 3	January – March	Progress Checks
Quarter 4	April – June	CHIP Revisions Meeting

Chronic Diseases

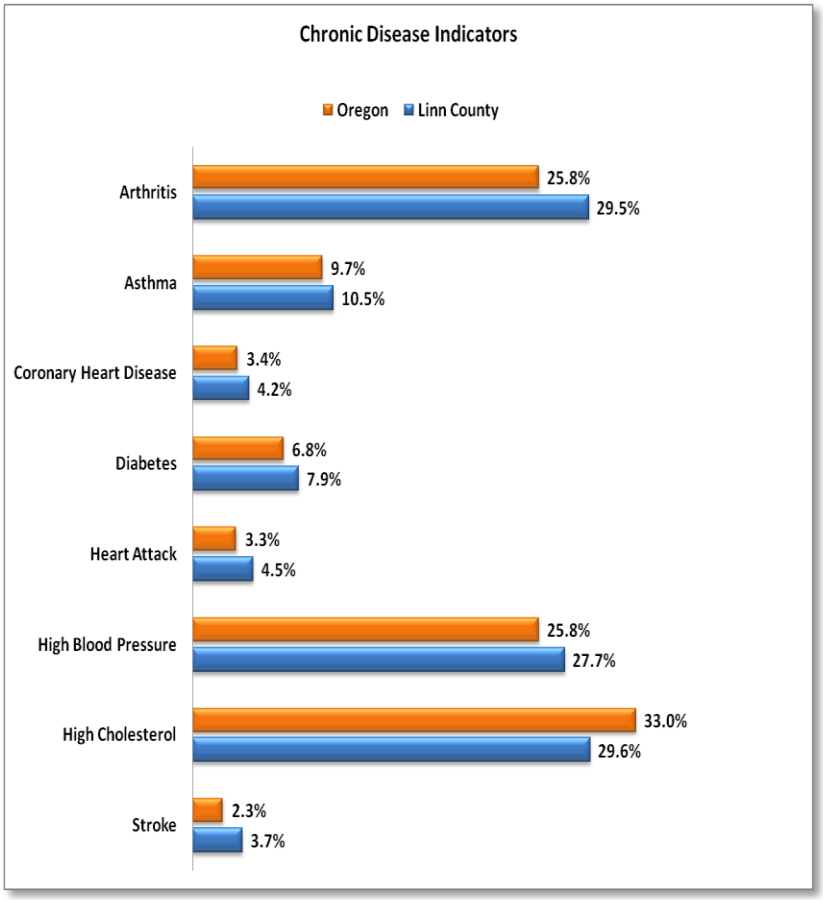


Figure 5: Chronic disease prevalence in Linn County and Oregon

Chronic Disease (Figure 5) was considered a priority area because addressing the burden of chronic diseases means addressing the lifestyle choices and risk behaviors that lead to them. Smoking, diet, and exercise are the primary risk factors that lead to chronic diseases. As the Community Health Assessment showed (Figure 6), Linn County has high rates of obesity and overweight populations among children and adults, as well as low levels of exercise and low levels of fruit and vegetable consumption. In earlier work, Linn County had used the CDC's Community Health Assessment and Group Evaluation (CHANGE) tool to assess the environmental and policy factors that influence nutrition, exercise, and tobacco use in worksites, schools, and community organizations. Generally speaking, Linn County scored low in having strong policy and environmental factors to manage chronic diseases.

Obesity is a primary risk factor for many chronic diseases. Diabetes, cardiovascular disease, many cancers, and arthritis all have increased odds associated with obesity. Obesity is not a problem in just Linn County or Oregon, but is quickly escalating to a nationwide epidemic. Population level reductions in obesity would be reflected in chronic disease rates. Eliminating obesity and smoking as well as improving exercise and diet would have a remarkable impact on the rate of chronic disease in Linn County. By focusing on childhood obesity through education in lifestyle choices, the MAPP committee hopes to create fundamental changes in behavior that will last a lifetime and lead to future reductions in obesity rates.

Eliminating risk factors and promoting a healthy lifestyle is the primary way to prevent chronic disease. That, however, does not help those that are currently living with chronic conditions. Linn County is fortunate to have Samaritan Health Services as an organization that offers many options for those living with chronic conditions. Samaritan helps support Living Well with Chronic Conditions workshops in the area, along with other educational programs and events. Working to expand and promote these events is an important element in the strategy to reduce chronic disease.

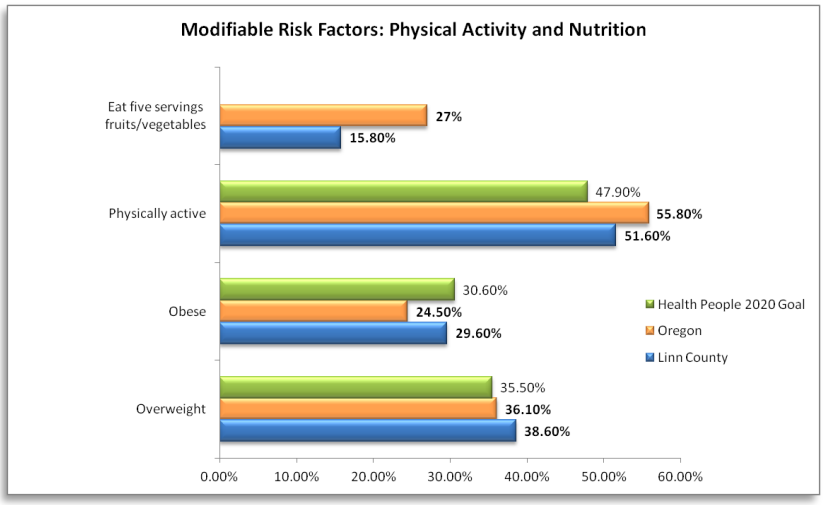


Figure 6: Selected risk factors for chronic disease

Chronic Disease

Strategic Issue Statement:

How do we address the underlying causes of chronic disease, improve prevention efforts, and thereby reduce the burden of chronic disease for everybody in Linn County?

Goal 1: Reduce the rate of childhood obesity by 5 percent from 27.4 percent to 25 percent by August 2016.

Strategies:

A. Implement the Healthy Communities action plan to promote wellness councils in local schools. Through wellness councils, promote food and nutrition policy changes, physical activity, and education. Schools will be engaged to become more active with their wellness councils and take an active role in adopting policy and promoting healthy activities. Facilitation should be rolled into the job duties of Linn County Public Health's Healthy Communities coordinator position.
    - Lead: **All Linn County Partners**
B. Collaborate with Samaritan Health Services Coordinated Approach to Child Health (CATCH) intervention program to help expand influence and support adoption. Engage with schools and look for and encourage fundraising opportunities to purchase CATCH kits ($750). Appeal to Parent-Teacher

Organizations to spend funds to purchase a kit. Investigate potential funding opportunities with the Northwest Health Foundation HEAL grant. Grant opportunities are also available at http://catchinfo.org/apply-for-grants/.

- Lead: **Samaritan Health Services CATCH coordinator**

C. Work to implement Peaceful Playgrounds as another low cost, volunteer-based option. Grant opportunities are available from http://www.peacefulplaygrounds.com/. Use wellness councils in school to promote more engagement from playground monitors to encourage play and activity while at recess.

- Lead: **All Linn County Partners**

Goal 2: Increase usage, awareness, and advertisement of tobacco cessation options.

Strategies:

A. Work with Samaritan Health Services to establish policy for clinicians to display tobacco cessation information, as well as information on health navigation and coaching, in offices. Encourage the hiring of staff behaviorists for immediate one-on-one counseling if a patient indicates a desire to quit tobacco. Look towards the East Linn Health Center as a model for behaviorist usage.

- **Lead: Samaritan Health Services**

B. Work with area clinicians to offer training in evidence-based tobacco cessation.

- **Lead: Linn County Tobacco Prevention Coordinator**

C. Engage with the Coast to Cascade Community Wellness Network to discuss health communication strategies and policies.

- **Lead: All Linn County Partners**

Goal 3: Improve preventative screening rates for everyone. Increase rate of cholesterol checks, mammograms, colonoscopies, and PAP smears at recommended intervals by 10 percent from current baseline by August 2016.

Screening	Current Rate	Goal
Cholesterol test	**68.1%**	**74.9%**
Mammogram	**77.4%**	**85.1%**
PAP smear	**83.3%**	**91.6%**
Colonoscopy	**57.9%**	**63.7%**

Strategies:

A. Promote the use of health fairs and events with opportunities for free screenings and education. Engage with Western University of Health Sciences as well as area pharmacy organizations to build up the number of events and the attendance at such events. Increase interagency promotion and awareness of sponsored events. Look towards engagement with the Global Health Club from Western University of Health Sciences as well as the pharmacy school at Oregon State University.
    - Lead: **All Linn County Partners**
B. Work with area urgent care, emergency rooms, In-Reach clinic, and the East Linn Health Center to strengthen policy on communicating about screenings and promoting their use. Work with Mental Health workers to inform clients about preventative screenings and to promote their use when appropriate.
    - Lead: **Samaritan Health Services**

Goal 4: **Improve Chronic Disease program use. Increase average attendance and use by 25 percent by August 2016 from current baseline numbers.**

Strategies:

A. Work with the CCO development to house programs for sustainable existence and to provide consistent programming.
    - Lead: **Samaritan Health Services**
B. Increase and improve communication to increase utilization. Actively recruit a larger volunteer and community health worker base to help run programs.
    - Lead: **All Linn County Partners**
C. Promote the use of online training programs with individuals in rural locations. Living Well with Chronic Conditions has an online program as well as many others. Compile a comprehensive list of available online resources for those who cannot attend a class.
    - Lead: **Samaritan Health Services**

Access to Health Care

Access to Health Care was chosen as a priority area from firsthand testimony and data. Almost every one of the thirty individuals the MAPP committee interviewed during the key informant interviews discussed difficulties some individuals have accessing care. In July 2012, Linn County's unemployment rate was 10.7 percent and it has been consistently in double digits for the past four years. According to CDC surveillance data, 19 percent of adults do not have insurance, and Linn County's Quality of Life Survey reported the same figure. Data from Linn County's Quality of Life survey also indicate that 25 percent of respondents had a time in the past year where they needed healthcare and could not get it (Figure 7). In addition, 21 percent of all respondents did not have a primary care physician (Figure 8).

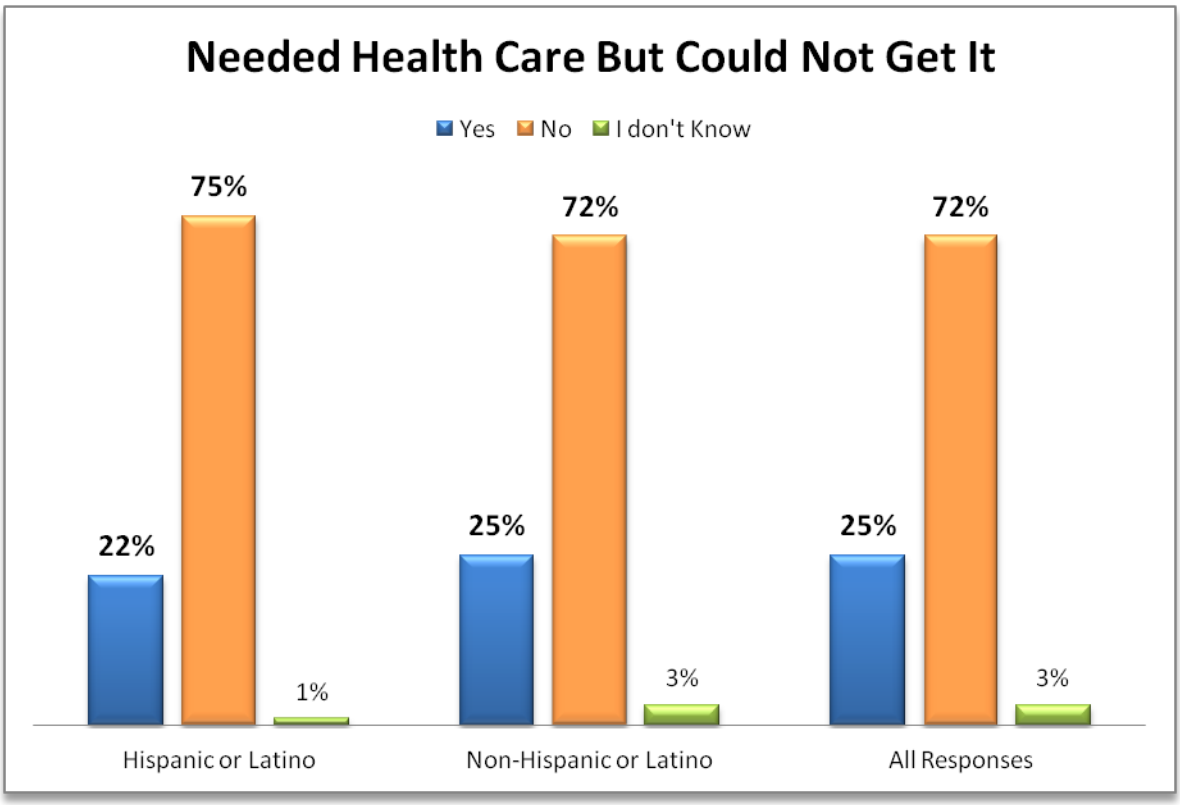


Figure 7: Was there a time in the past year you needed health care but could not get it?

Transportation creates barriers to access to health care. Individuals that utilize the Oregon Health Plan often are required to receive services from their local network health provider. That means a resident of Harrisburg, Mill City, or another rural location has to travel to Albany for many services despite having closer population centers in another county. Knowledge and awareness of available programs and services is a constant battle in the county. The launching of the 2-1-1 information line helps match people with needed services, but in many cases transportation will still be a barrier.

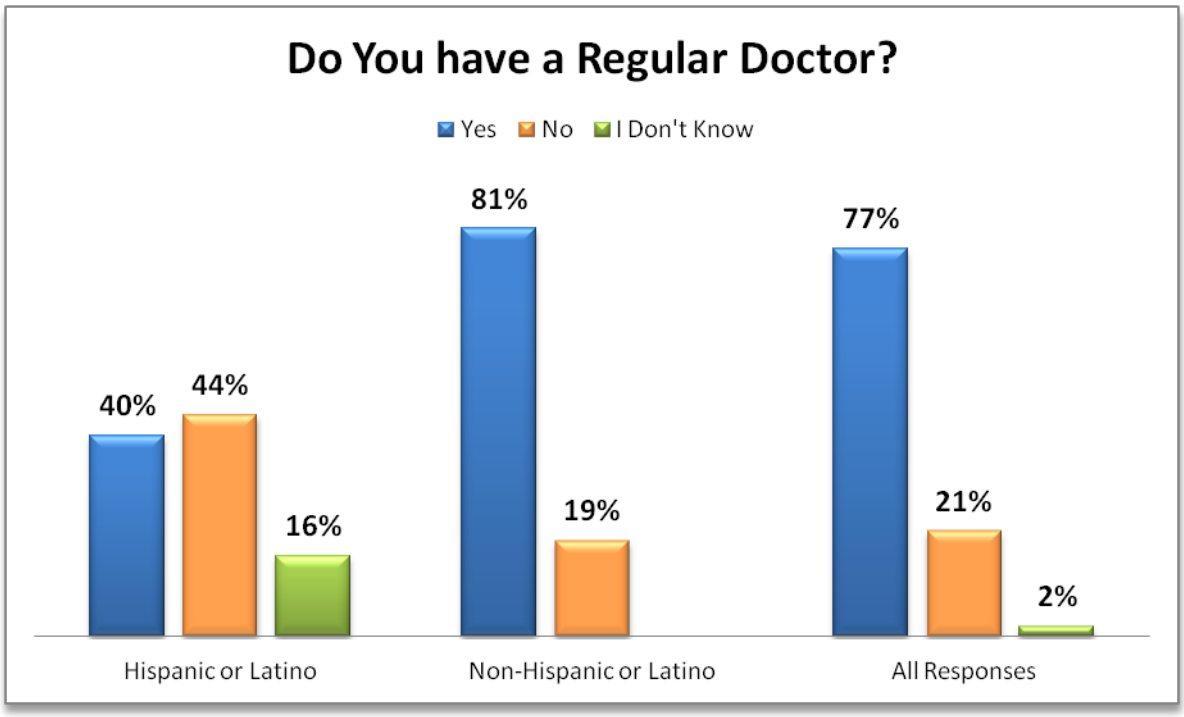


Figure 8: Do you have a regular doctor?

Access to health care also means working with vulnerable populations. Our Quality of Life Survey, as well as key informant interviews, revealed health disparities within the Hispanic population in Linn County. Only 55 percent of Hispanic/Latino respondents on the survey reported having health insurance (Figure 9). Among those Hispanic/Latinos

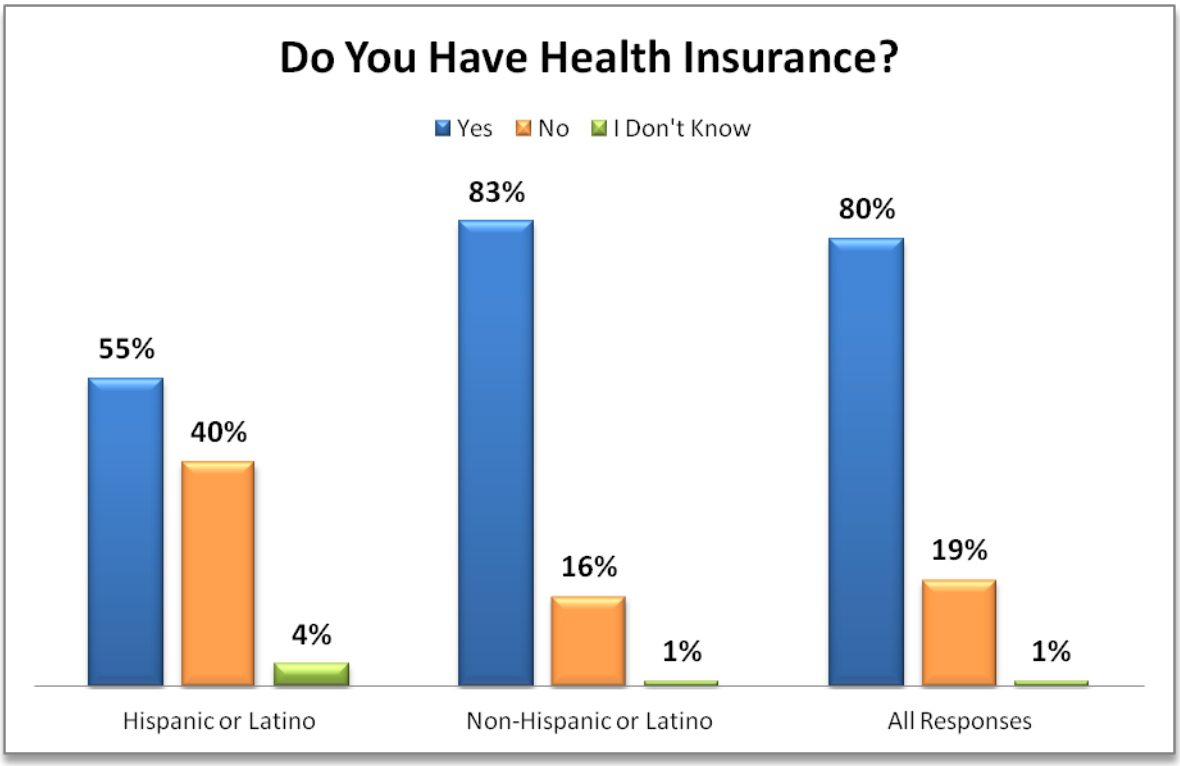


Figure 9: Do you have health insurance?

that have insurance, 23 percent are insured through Medicaid or Medicare, 26 percent are insured through work plans, and the remaining are self-insured or insured through a family member. The significant difference between Hispanics/Latinos and non-Hispanics/Latinos is the proportion of coverage provided by work; 45 percent of non-Hispanics/Latino with insurance have coverage provided by work, nearly twice the rate as Hispanics/ Latinos.

Access to Health Care

Strategic Issue Statement:

How can the residents of Linn County have increased access to physical, behavioral, and dental health?

Goal 1: Reduce the number of individuals that cannot access health care by 5 percent from 21 percent to 18 percent by August 2016.

Strategies:

A. Work to maintain and expand the offerings of safety net clinics in the County.
    - Lead: **All Linn County Partners**
B. Continue to build a strong partnership with Oregon State University, Western University of Health Services College of Osteopathic Medicine Pacific-Northwest, and Samaritan Health Services to identify and promote potential reduced cost services or population-level health programs and interventions. These services would be basic preventative care, immunizations, and check-ups that would give medical school students quality learning opportunities or provide researchers at OSU a location to test pilot programs.
    - Lead: **All Linn County Partners**
C. Actively pursue federal grants that promote improving the health status for vulnerable populations.
    - Lead: **All Linn County Partners**
D. Increase capacity of grassroots organizations and priority populations to identify needs, build leadership capacity, and affect policy change.
    - Lead: **Linn Benton Health Equity Alliance**
E. Better understand transit needs, services, patterns, and gaps in Linn County. Work to install or expand programs that address transportation needs.
    - Lead: **Linn Benton Health Equity Alliance**
F. Increase education and awareness around health equity and social justice among stakeholders and decision makers.
    - Lead: **Linn Benton Health Equity Alliance**

G. Build and strengthen advocacy and leadership for health equity and social justice among Linn County partners.
    - Lead: **Linn Benton Health Equity Alliance**

Goal 2: Improve communication of available services.

Strategies:

A. Continue to promote 2-1-1 information line.
    - Lead: **All Linn County Partners**
B. Work with the Community Services Consortium to obtain, purchase, and distribute their Community Resource Directory among agencies and partners to have on hand in their reception areas and offices as an immediate reference guide.
    - Lead: **Linn County Health Services**
C. Increase utilization of local newspapers and media to celebrate program successes and advertise available programs.
    - Lead: **All Linn County Partners**

Goal 3: Coordinate with CCOs and regional partners for data distribution and planning.

Strategies:

A. Ensure that the policies, systems, and practices associated with the development and implementation of a regional CCO reflect the input and involvement of key health disparity communities in Linn County.
    - Lead: **All Linn County Partners**
B. Establish clear communication pathways for data sharing. What data is available, what needs to be collected, who owns the data, who is responsible for confidentiality, who analyzes it, when is it appropriate to share with partners?
    - Lead: **All Linn County Partners**
C. Continue to vigilantly assess the health state of the county and engage academic partners. By having a clear set of issues, the county can advocate for becoming a location for future research or intervention development that can benefit both the county and academic institutions.
    - Lead: **Linn County Public Health**
D. Continue to work toward building internal and partnership capacity. Investigate organizational changes to fund sustainable positions that build capacity, such as a full-time grant writer.
    - Lead: **Linn County Public Health**

Tobacco Use

Tobacco is the leading cause of preventable death. In addition to lung cancer and other respiratory diseases, tobacco usage increases the risks for stroke, heart disease, other cancers, and diabetes. Linn County has high rates of tobacco use compared to both the state and the nation. In Linn County 23 percent of 11th graders, 21 percent of adults, and 20 percent of pregnant women smoke (Figure 10). The 11th grade smoking rate has increased by 64 percent in the past 7 years; increasing from 14 percent in 2005 to 23

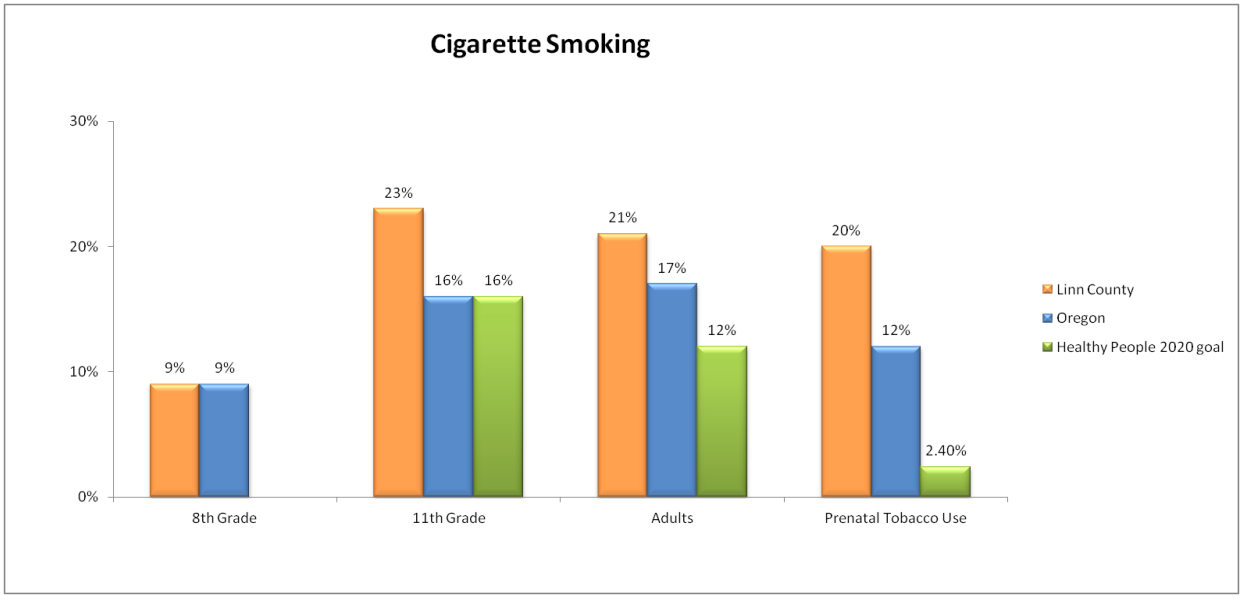


Figure 10: Cigarette smoking rates in Linn County compared to Oregon and to Healthy People 2020 goals

percent today.

Unlike alcohol and drug abuse, the community does not view tobacco use as a significant health issue, despite statistics to the contrary. On the Linn County Quality of Life Survey, tobacco use ranks 10th out of 22 possible health issues. Drug abuse was considered the biggest health issue in the county, and alcohol abuse was tied for third place. This speaks to the level of normalcy that tobacco use has in our community and society in

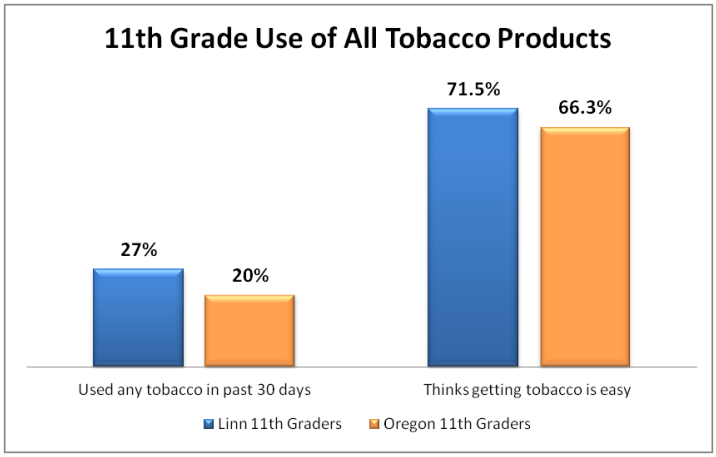


Figure 11: 11th grade tobacco usage and access

general. Despite its high level of use in the county, and its proven negative health consequences, county residents do not consider it a pressing health issue. This creates challenges with moving forward on tobacco policies.

Linn County Alcohol and Drug Prevention Program, in partnership with the state of Oregon, administers the Student Wellness survey to all Linn students in 6th, 8th and 11th grade. The 2010 Student Wellness Survey shows that about 38 percent of Linn County parents do not have conversations with their children about use of tobacco or other substances. The Wellness Survey also reveals that, compared to the state, Linn County has a significantly higher rate of all tobacco use, and more 11th graders feel that accessing tobacco is easy or very easy. Linn County does not require tobacco retailers to be licensed to sell tobacco. Tobacco retailer licensing acts as a mechanism to ensure responsible retailing and compliance with important tobacco laws.

Tobacco goals and strategies are focused on policy measures that aid in prevention of initiation among youth and increase the usage of tobacco cessation services. Additionally, the promotion of tobacco-free outdoor areas is a focus not only within Linn County, but statewide.

Tobacco Use

Strategic Issue Statement

How can we reduce the use of tobacco in Linn County?

Goal 1: Reduce use and initiation of tobacco among children, adolescents, and young adults. Reduce tobacco use in 11th graders by 5 percent from 23 percent to 21 percent by August 2016.

Strategies:

A. Work with municipalities to create zoning regulations for tobacco sales in proximity to schools and youth organizations.
    - Lead: **Linn County Public Health Tobacco Prevention Coordinator**
B. Work with municipalities to create advertising regulations to address tobacco advertisements in proximity to schools and youth organizations and advertising height in stores (tobacco advertisements must be higher than 36 inches).
    - Lead: **Linn County Public Health Tobacco Prevention Coordinator**

Goal 2: Increase health care provider involvement in tobacco cessation. Increase the number of providers using the quit-line referral process by 25 percent by August 2016.

Strategies:

A. Develop referral pathways for patient-centered medical homes.
    - Lead: **Samaritan Health Services**
B. Train medical professionals in 5 A's and motivational interviewing.
    - Lead: **Linn County Public Health Tobacco Prevention Coordinator**

Goal 3: Increase the number of tobacco-free parks and outdoor areas.

Strategies:

A. Conduct an assessment of existing policies and the number of smoke-free outdoor areas in the county.
    - Lead: **Linn County Public Health Tobacco Prevention Coordinator**
B. Work with city councils to adopt policies on smoke-free outdoor areas.
    - Lead: **Linn County Public Health Tobacco Prevention Coordinator**
C. Work with municipalities to adopt countywide policy on smoke-free playgrounds and outdoor areas frequented by children.
    - Lead: **Linn County Public Health Tobacco Prevention Coordinator**

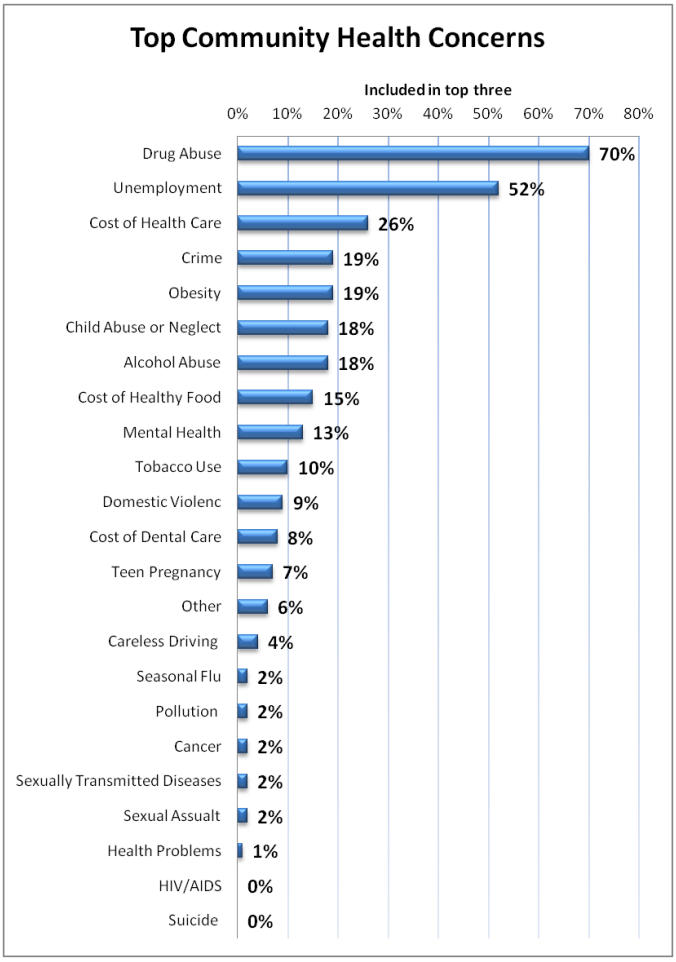
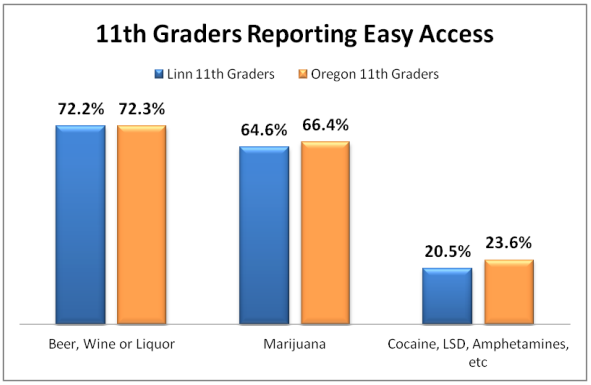


Figure 12: Ordered results from Linn County's Quality of Life Survey

Substance Abuse

Substance Abuse is a focus area based on results from our Quality of Life Survey, our key informant interviews, and our health statistics. 70 percent of respondents on the survey included drug abuse as a top health concern in their community (Figure 12). Repeatedly, Key Informants cited drug abuse, alcohol abuse, and related behaviors as issues in their community. Linn County ranks second in the State for behavioral crimes and fourth in the state for methamphetamine-related incidents according to the Oregon Uniform Crime Reporting, State of Oregon report of criminal offenses and arrests (2011).

The Linn County Alcohol and Drug Abuse Prevention Program is very active in the community with prevention and treatment efforts. They run Life Skills (an evidence-based decision making curriculum) classes in area schools, reaching 1500 students each school year. Additionally, they help lead the Linn County Youth Council STAND (Students Taking Action Not Drinking). STAND is a peer-led group that is active in developing teen-orientated social marketing messages to prevent substance abuse.



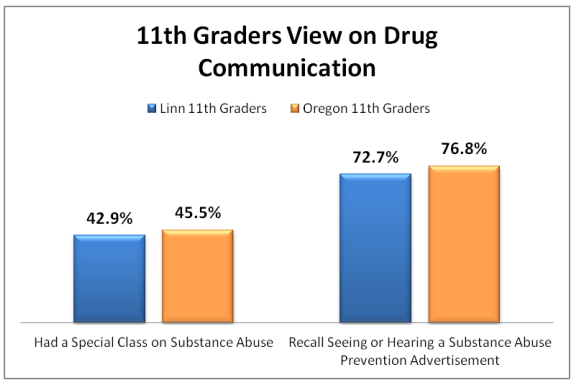


Figure 13: Findings from the 2010 Student Wellness Survey on ease of access and substance abuse prevention

Keys to reducing substance abuse lie with effective interventions that prevent initiation. Early use of alcohol is strongly correlated with future drug use. A focus of Linn County social media messaging is prevention of early alcohol access and involving parents in having a stronger role in monitoring teenage activities. Linn Together is an area partnership of local schools, law enforcement, parents, faith leaders, youth services, local government, students, health care professionals, and business owners that work to launch evidence-based prevention strategies. The focus of Linn Together's messaging this year is to educate parents on laws regarding providing alcohol in the home and policies to prevent teens from gaining alcohol access from parents. Data from the Student Wellness Survey continually show that teens access alcohol through parents, with or without parental knowledge, as well as through older siblings and friends of legal age.

Substance Abuse

Strategic Issue Statement

How can Linn County reduce the burden and prevalence of substance abuse?

Goal 1: Continue work to delay initial onset of youth alcohol use. Reduce the number of 11th graders who report drinking at least one drink of alcohol in the past 30 days by 5 percent from 34.6 percent to 32.8 percent by August 2016.

Strategies:

A. Find ways to maintain and expand the use of Life Skills in Linn County Schools. By September 2013, several funding streams will end and new sources of funding will need to be identified. Lottery funds, Samaritan Health Services, and Juvenile Crime Prevention are potential future sources of grant support or funding.
    - Lead: **Linn County Alcohol and Drug Prevention Program**
B. Linn Together is entering the final year of a support grant to produce social marketing messages and health communication. Future funding sources need to be identified to continue messaging.
    - Lead: **Linn Together**
C. Continue to be active with the Linn County Youth Council to expand membership, partners, and identify sources of funding for implementing peer-led activities, events, and social messages aimed at alcohol prevention.
    - Lead: **Linn County Alcohol and Drug Prevention Program**
D. Expand social marketing campaigns about parental responsibility and social hosting policies and law.
    - Lead: **Linn Together**

Goal 2: Maintain and enhance, with reduced funds, transportation options for access to treatment services.

Strategies:

A. Oregon Department of Transportation funds, which support van purchases and maintenance, are ending. Replacement funding needs to be identified to maintain service routes.
    - Lead: **Linn County Alcohol and Drug Prevention Program**
B. Investigate better interagency sharing of vans (Public Health, Mental Health, Alcohol and Drug) to better serve clients among the agencies and potentially share certain costs across various departments. This has linkages to strategies in the access to care topic.
    - Lead: **Linn County Health Services**

Goal 3: Complete a community health improvement plan for substance abuse prevention and treatment by March 2013, in alignment with the county biennial implementation plan for mental health and substance abuse services and Intercommunity Health Network/Coordinated Care Organization (IHN/CCO) health improvement plans.

Strategies:

A. Review raw student wellness survey information and expand analysis to higher order statistical evaluations. The large amount of variables and sample size available with the student wellness data can allow for logistic analysis that can lend valuable information as it pertains to prevention and interventions.
    - Lead: **Linn County Alcohol and Drug Prevention Program**
B. Continue to advocate for insertion of questions on the student wellness survey that can gain insight to initiation factors so that trends can be quickly identified and prevention strategies launched.
    - Lead: **Linn County Alcohol and Drug Prevention Program**

Goal 4: Expand options for drug free housing for recovering addicts in treatment.

Strategies:

A. Maintain funding streams that provide supportive housing models. Linn County has the most supportive houses per capita in the state.
    - Lead: **Linn County Alcohol and Drug Treatment Program**

B. Expand services for clients transitioning out of treatment to ensure they have the ability to gain employment, afford rent, and have the necessary support to prevent relapse.
    - Lead: **All Linn County Partners**
C. Explore the potential for employment for housing models in Linn County. Work for rent arrangements which provide vocational training and employment experience for recovering addicts and help to offset the cost of providing drug-free housing to recovering addicts.
    - Lead: **Linn County Alcohol and Drug Prevention Program**
D. Work with Community Services Consortium to help identify replacement funds to restore vocational training services that were lost in budget cuts.
    - Lead: **All Linn County Partners**

2012-2015

LINN COUNTY PUBLIC HEALTH STRATEGIC PLAN

March 2012

~ The contents of this document are current as of March 2012~

SHARON N. BLACK CONSULTANTS, LLC

Strategic Planning • "Getting to the Heart of the Matter"

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INTRODUCTORY SUMMARY

Linn County Public Health's (LCPH) Strategic Plan was drafted to guide the Linn County Public Health Programs leadership and staff over the next three years as they work together to deliver quality, county-wide Public Health services to the Linn County community. LCPH's description, programs, department goals and strategies along with measures and timeframes are found below. The Appendices consist of supporting documentation.

LCPH's strategic focus is based on goals found in the following four Strategic Priority Categories:

- Infrastructure
- Financial Sustainability
- Access/Quality of Care
- Community & Partners

Goals with corresponding strategies and measures are found in each Strategic Priority Category.

The Strategic Plan reflects the program's current direction.

ORGANIZATION DESCRIPTION

OVERVIEW

Linn County Public Health focuses on prevention and uses selected interventions to prevent the spread of disease and reduce health risks. Prevention strategies are population based and designed to improve the overall health of communities. Through childhood immunizations and other services, LCPH is striving to make Linn County a safer place for all residents. Public Health is on call 24/7 to respond to any Public Health emergency or disaster that could affect our populations. Public Health prevention measures also save taxpayers the costly expense of future medical treatment.

Linn County Public Health Department provides the basic Public Health services as dictated by Oregon Revised Statutes. These include prevention and control of communicable diseases, parent-child health services including family planning, environmental health services, Public Health emergency preparedness, collection and reporting of health status, health information, and referral to other community agencies and clinical service providers. LCPH is committed to providing services to all residents of Linn County and to assist them to lead healthy and productive lives.

SERVICES

Linn County Public Health Programs include the following areas.

COMMUNICABLE DISEASE AND IMMUNIZATIONS

LCPH provides services to prevent and control communicable disease epidemics and protect the community's health by monitoring and investigating reportable diseases, conditions, or outbreaks. The agency provides case management and medication for Tuberculosis cases in close collaboration with the Health Officer. LCPH also provides health advocacy case management to HIV positive residents.

The Immunization program simultaneously aims to improve the immunization rate of children and adults in Linn County.

WIC Nutrition Program

The WIC Nutrition program provides nutrition counseling, education, and supplemental food vouchers for women, infants, and young children. It also provides referrals to other community programs for pregnant, breastfeeding, or postpartum women.

Reproductive Health

LCPH offers comprehensive reproductive health and family planning services. Services are comprised of multiple programs that include birth control at low or no cost; female physical exams; breast and cervical cancer screenings; STI testing and treatment; pregnancy testing; and vasectomy counseling, among other services.

Maternal-Child Health Programs

Maternal-Child Health programs provide access to services designed to help pregnant women. Children and families obtain care, education, infant assessment, parenting information, and referrals. This includes case management for pregnant women in need of extra support and home visits to families at risk for health and developmental problems.

Vital Statistics

The Vital Statistics program registers births and deaths in Linn County and provides a source of health indicators.

Emergency Preparedness

The Public Health Emergency Preparedness and Response program coordinates the Public Health response to a natural or man-made disaster or emergency in Linn County.

Tobacco Prevention

The focus of the Linn County Tobacco Prevention and Education program is to eliminate and reduce exposure to secondhand smoke and promote quitting. The program also provides information and resources on Tobacco related state and local laws.

Wellness

The Wellness program advocates disease prevention through community health promotion, education, and worksite wellness.

2011 "STATE OF THE AGENCY" PRESENTATION HIGHLIGHTS

The health of a community depends on many factors, including behavioral and environmental influences as well as Public Health services available. LCPH has achieved multiple successes in supporting residents' health while simultaneously facing internal and external challenges.

For the complete State of the Agency presented on December 7, 2011, refer to Appendix B. Highlights from the presentation are found below.

Recent successes include:

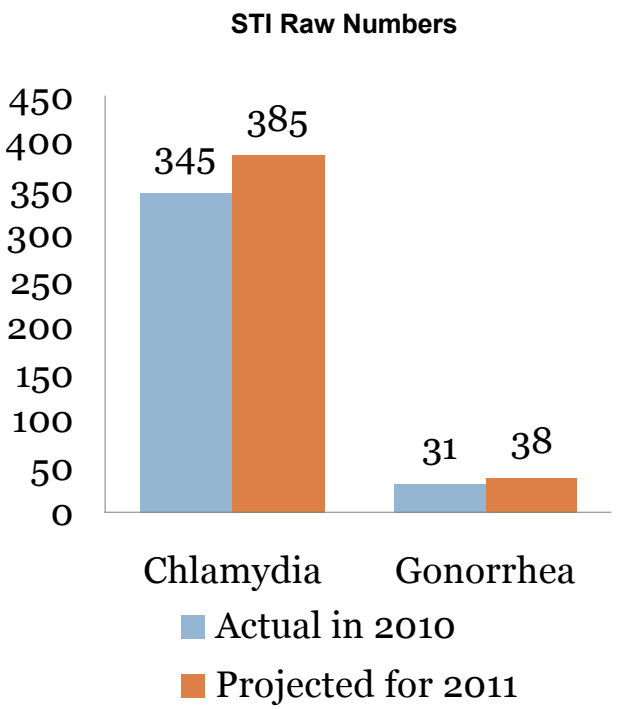
- Follow-up on 705 Communicable disease reports
- 538 TB tests given
- 1300 School Immunization exclusion letters mailed
- 9000 H1N1 shots given in the 2009-2010 flu season
- Good breastfeeding outcomes for WIC
- Care provided to 1945 reproductive health clients
- Oregon Mothers Care provides access to Oregon Health Plan
- Breast and Cervical Cancer Program partners with Soroptimist
- Emergency Preparedness Program staff works with Medical Reserve Corp
- Good outcomes for Maternal Child Health
- Healthy Communities Action Plan has been developed
- Progress toward Public Health Accreditation
- Retention of experienced staff
- County-wide Tobacco Prevention activities in place
- Worksite Wellness Program is initiated

There are many challenges for LCPH such as:

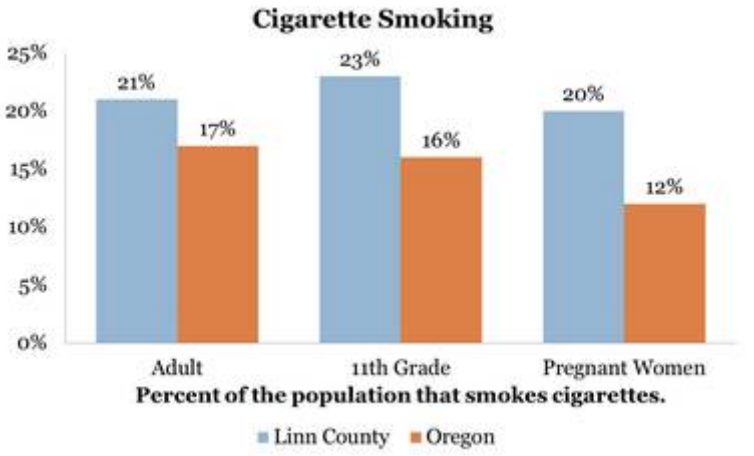
- Lack of awareness of Public Health services
- Health Care Reform
- Need to enhance community partnerships and referrals
- Infrastructure capacity concerns

There are also specific health and environmental concerns for Linn County around the following five areas:

1. High rates of sexually transmitted infection (STI)



2. High tobacco use rates



3. Below average immunization rates

	Linn County	Oregon
Immunization Rate (2 year olds up to date)	**57.8%**	**70.3%**

4. High infant mortality rates

	Linn County	Oregon
Infant Mortality (per 1000 live births)	**8.4**	**4.8**

5. High motor vehicle crash death rates

	Linn County	Oregon
Motor Vehicle Crash Death Rate (per 100,000)	**21**	**14**

Challenges and hopes for the future are addressed in the goals and strategies outlined in this Strategic Plan.

STRATEGIC PLAN OVERVIEW & DEVELOPMENT PROCESS

Preparation for LCPH's December 2011 facilitated strategic planning meeting began in August 2011. Leadership and select staff participated in the planning process via conference calls, an onsite meeting, and ongoing email correspondence. For an attendance list, a planning position sign-up sheet, and meeting agendas, refer to the Strategic Plan attachment documents #1-4.

In addition, LCPH leadership and staff drafted a 22-page "Strategic Planning Background Information" document that included program descriptions, areas of focus, and population demographics. This document was distributed to all staff and community partner invitees approximately 2 weeks before the facilitated session (attachment document #5).

LCPH's Strategic Plan was developed using the creative processes employed at the 7-hour facilitated Strategic Planning session on December 7, 2011. Meeting participants included members of the Linn County community, the Linn County Health Administrator, and the Public Health Program Manager and staff. For an attendance list, refer to attachment document #6.

The following ground rules were used:

- Respect confidentiality
- No texting/lower phone ringtone
- There are no wrong answers
- Respect each other's opinions
- Speak your mind

Prior to the meeting, leadership was given multiple Strategic Priority Categories from which they were asked to choose four. These four categories were to act as the fundamental areas on which to focus during the strategic planning process. The Strategic Priority Categories from which to choose were:

- Financial sustainability
- Organizational Culture
- Access/Quality of Care
- Infrastructure
- Policy
- Community & Partners
- Other

The four Strategic Priority Categories chosen to concentrate on at the strategic planning meeting were:

- Infrastructure
- Financial sustainability
- Access/Quality of Care
- Community & Partners

Meeting participants identified organizational focal points and priorities based on:

- The four Strategic Priority Categories
- A "State of the Agency" presentation by the Public Health Programs Manager and Linn County Health Administrator

- An organization Strengths, Weaknesses, Opportunities, and Threats analysis (SWOT analysis) (Appendix A)
- A review of the Goal, Mission, and Values

Attendees then drafted and presented goals and corresponding strategies to the group.

A writing team of staff and community members was assembled to further refine and prioritize the goals, strategies, measures, and accompanying timelines. The Strategic Plan draft was written in conjunction with an outside consultant and presented to the supervisors and Health Advisory team by the writing team for final approval.

The Goal, Mission, and Values that were reviewed and revised during this process are found below.

PUBLIC HEALTH PROGRAMS GOAL, MISSION, & VALUES

GOAL

Our goal is to provide quality county-wide public health services. Public health is **Prevention** for a better life, **Promotion** for your health, and **Protection** for you, your family, and your community.

MISSION

The Linn County Department of Health Services, Public Health Program, is committed to the health and well-being of all Linn County residents.

VALUES

We Value:

- Respect for each other and our clients
- Providing services that are accessible
- Preventive healthcare
- A supportive atmosphere for our co-workers and clients
- Good communication
- High quality, efficient delivery of services

GOALS & STRATEGIES

LCPH's goals and corresponding strategies have been developed under four Strategic Priority Categories.

LCPH's Strategic Priority Categories:

- Infrastructure
- Financial Sustainability
- Access/Quality of Care
- Community & Partners

The agency's goals, strategies, and measures per Strategic Priority Category are found below.

INFRASTRUCTURE

Goal 1: There are staff and Linn County partnership resources that address emerging Linn County Public Health concerns.	
Strategies	**Completion Date**
A. Support the development and maintenance of systems to regularly review community health demographics and data ☑ Measure: A report of updated demographic information is reviewed by the leadership, staff, and the Health Advisory Council annually.	
Progress Update/Notes:	
B. Adjust programs and staffing to respond to Linn County Public Health concerns such as: • Immunizations • Infant Mortality • Tobacco • Sexually Transmitted Infection • Crash Rates ☑ Measure: Changes in staff focus per annual plan by December 2012.	
Progress Update/Notes:	

Goal 2: A fully developed and implemented external communication plan.	
Strategies	**Completion Date**
A. Assign leadership and staff to develop the communication plan ☑ Measure: An active Quality Improvement Committee will address developing an external communications plan by March 2013.	

Progress Update/Notes:	
B. Implement a client and community partner satisfaction survey regarding external communications ☑ Measure: Survey results are collected annually.	
Progress Update/Notes:	
C. Task an external group to provide Public Health information to the community (issues such as health reform changes) ☑ Measure: An external group is engaged and meeting minutes are available by September 2013.	
Progress Update/Notes:	
D. Work with partners to gain knowledge about their programs and improve coordination and referrals ☑ Measure: Program referral activities are reported quarterly.	
Progress Update/Notes:	
E. Explore Electronic Medical Record interfaces and practices that allow for future collaborations ☑ Measure: Electronic Medical Record interfaces and practices are reported on quarterly.	
Progress Update/Notes:	

F. Improve the organization's ability to communicate with clients and the public. ☑ Measure: Tasks identified as high priority (Strategy B) in the client and community partner satisfaction survey are addressed within one year.	
Progress Update/Notes:	

Goal 3: **A fully developed and implemented internal communication plan.**	
Strategies	**Completion Date**
A. Assign leadership and staff to develop the internal communication plan ☑ Measure: An active Quality Improvement Committee will address developing an internal communication plan by December 2012.	
Progress Update/Notes:	
B. Ensure an internal group communicates Public Health changes to staff (such as health reform and early learning council as they affect programs) ☑ Measure: Public Health updates are routinely on staff meeting agendas monthly. ☑ Measure: Reports are reflected in the staff meeting minutes monthly.	
Progress Update/Notes:	
C. Continue staff training ("Public Health 101") about specific Public Health programs ☑ Measure: All new staff will complete Public Health 101 and an	

annual update will be provided to all staff.	
Progress Update/Notes:	
D. Improve staff awareness and knowledge of existing community programs ☑ Measure: Offer at least two (2) community presentations per year at general staff meetings.	
Progress Update/Notes:	
E. Assure a staff satisfaction survey regarding internal communications ☑ Measure: Survey results are collected annually.	
Progress Update/Notes:	

Goal 4: **A strengthened Linn County Public Health workforce.**	
Strategies	**Completion Date**
A. Assure opportunities and incentives for professional growth ☑ Measure: Based on the results of an annual staff satisfaction survey.	
Progress Update/Notes:	
B. Create programs and incentives for health improvements ☑ Measure: Based on the results of an annual staff satisfaction survey.	

Progress Update/Notes:	
C. Increase opportunities for cultural competency awareness ☑ Measure: At least one (1) cultural awareness training is provided annually. ☑ Measure: Based on the results of an annual staff satisfaction survey.	
Progress Update/Notes:	
D. Develop a process for recruiting and maintaining volunteers ☑ Measure: Volunteer recruitment and retention are reported semi-annually.	
Progress Update/Notes:	

Goal 5: **Improved, fully functional facilities.**	
Strategies	**Completion Date**
A. Establish a routine meeting between Facilities Management and Public Health regarding a facilities improvement plan ☑ Measure: Meetings are scheduled on a recurring, regular basis.	
Progress Update/Notes:	

B. Improve functionality of existing buildings for all users, such as: • Including confidentiality, increased cleanliness of buildings, and improved ventilation of Public Health facilities • Creating a breakroom ☑ Measure: Facility improvements are reviewed annually.	
Progress Update/Notes:	
C. Improve flow for clients and staff • Managed by the Quality Improvement Committee ☑ Measure: Flow problems are identified annually. ☑ Measure: Improved flow as measured by the annual client, community partner and staff satisfaction surveys.	
Progress Update/Notes:	

FINANCIAL SUSTAINABILITY

Goal 1: **Assured financial viability of all Linn County Public Health programs.**	
Strategies	**Completion Date**
A. Continue to inform the Board of Commissioners, Health Advisory Council, and legislature about the value of Public Health ☑ Measure: Board of Commissioners, Health Advisory Council, and legislature activities reported on annually.	
Progress Update/Notes:	
B. Obtain Public Health accreditation ☑ Measure: Accreditation is obtained by December 2014.	

Progress Update/Notes:	
C. Continue to explore grant and other fund sources that address unmet community health needs ☑ Measure: Additional funding resources are obtained to address unmet community needs. ☑ Measure: Grant and other fund sources are reported on quarterly.	
Progress Update/Notes:	

Goal 2: **Linn County Public Health programs are fairly compensated for services provided.**	
Strategies	**Completion Date**
A. Ensure efficient billing systems and procedures ☑ Measure: Increase in general revenue collections, reviewed quarterly.	
Progress Update/Notes:	
B. Maintain and develop insurance partnerships by becoming a preferred provider with appropriate insurers (such as Medicare ODS, OHP, BlueCross) ☑ Measure: Increase in insurance revenue collected, reviewed quarterly.	
Progress Update/Notes:	

C. Ensure fiscal and clinical staff are trained and up to date on current and future billing practices ☑ Measure: Increase in general revenue collections, reviewed quarterly.	
Progress Update/Notes:	
D. Negotiate acceptable payment arrangements in the new health transformation environment ☑ Measure: Payment agreements are negotiated.	
Progress Update/Notes:	

Goal 3: **Linn County Public Health is a successful partner in the local health transformation.**	
Strategies	**Completion Date**
A. Actively participate in Oregon Health Transformation ☑ Measure: Participation in Oregon Health Transformation is reported on quarterly, including reports to all staff.	
Progress Update/Notes:	
B. Market Linn County Public Health's unique expertise and service (such as epidemiology, case management, community health, education, coordination of care, and health promotion) ☑ Measure: Marketing activities are reported on quarterly.	
Progress Update/Notes:	

C. Provide leadership in assessing community health needs ☑ Measure: Leadership activities are reported on quarterly.	
Progress Update/Notes:	

ACCESS/QUALITY OF CARE

Goal 1: **Increased awareness of Public Health services.**	
Strategies	**Completion Date**
A. Survey community attitudes, beliefs, knowledge, and awareness of Public Health services ☑ Measure: Survey is completed and results are collected annually.	
Progress Update/Notes:	
B. Market services through media, social network, print media, radio, open house, Public Service Announcement ☑ Measure: Marketing activities are reported on annually.	
Progress Update/Notes:	
C. Meet with community partners regularly to work on Public Health issues important to the community ☑ Measure: Community partner meeting outcomes are reported on quarterly.	

☑ Measure: One (1) partner meeting is held quarterly.	
Progress Update/Notes:	

Goal 2: **Improved access to Linn County Public Health services.**	
Strategies	**Completion Date**
A. Monitor appropriateness and accessibility of Linn County Public Health services to assure that major Public Health concerns are addressed ☑ Measure: Program accessibility and appropriateness is reviewed annually and is reflected in the annual Strategic Plan update.	
Progress Update/Notes:	
B. Advocate for Linn County Public Health to be a key player in local health transformation ☑ Measure: Linn County Public Health's status as a key player in local health transformation is reviewed quarterly.	
Progress Update/Notes:	
C. Incorporate the Health Navigator concept into the Linn County Public Health Department ☑ Measure: Health Navigators are incorporated into the Linn County team by June 2014.	
Progress Update/Notes:	

D. Improve 2-way communication with internal and external clients ☑ Measure: Based on the results of the annual client, community partner and staff satisfaction surveys.	
Progress Update/Notes:	
E. Determine potential service sites in underserved areas ☑ Measure: One (1) new service site is identified annually as resources allow.	
Progress Update/Notes:	

Goal 3: **Improved active Referral Pathways.**	
Strategies	**Completion Date**
A. Increase staff orientation and training regarding referral resources ☑ Measure: Staff orientation and training regarding referral resources are routinely on staff meeting agendas, quarterly. ☑ Measure: Trainings are reflected in the staff meeting minutes, quarterly.	
Progress Update/Notes:	
B. Ensure Health Navigators maximize referrals (when established) ☑ Measure: Job descriptions and evaluations include the referral expectation.	
Progress Update/Notes:	

C. Expand access to Electronic Medical Records across Linn County Health services ☑ Measure: Progress is measured quarterly on the Electronic Medical Record implementation, beginning in June 2012.	
Progress Update/Notes:	
D. Utilize 211 information and referral services ☑ Measure: Review 211 data to determine client access and referral needs annually.	
Progress Update/Notes:	
E. Improve links (content and technical) on the Linn County Public Health website ☑ Measure: Links are reviewed monthly and improved by the end of each quarter.	
Progress Update/Notes:	

Goal 4: **Expanded access to behavioral health care for Public Health clients.**	
Strategies	**Completion Date**
A. Assign a contact person to the Linn County Public Health Department from Mental Health, Alcohol & Drugs, and Developmental Disability services to facilitate referrals ☑ Measure: Contact position has been assigned by June 2012.	

Progress Update/Notes:	

Goal 5: A fully designed and implemented Quality Improvement (QI) system.	
Strategies	**Completion Date**
A. Design and implement a comprehensive QI program ☑ Measure: QI program is implemented by January 2013.	
Progress Update/Notes:	
B. Use the QI program to monitor and assure the success of the Strategic Plan goals and strategies ☑ Measure: The QI and Strategic Planning processes are aligned and managed over time, reviewed semi-annually.	
Progress Update/Notes:	
C. Coordinate the Community Health Assessment (CHA) and Linn County Community Health Improvement Plan (CHIP) processes with the QI activities and the Strategic Plan goals and strategies ☑ Measure: The annual Strategic Plan review reflects coordination among the three accreditation elements.	
Progress Update/Notes:	

D. Assure adequate staffing for the consistent and ongoing quality improvement activities of the QI committee ☑ Measure: Staffing patterns support QI activities, reviewed annually.	
Progress Update/Notes:	

COMMUNITY & PARTNERS

Goal 1: **Programs are focused on improving community Public Health outcomes.**	
Strategies	**Completion Date**
A. Increase prevention programming (such as nutrition, physical activity, and access to healthy food and improved food security) ☑ Measure: Program accessibility and appropriateness is reviewed annually and is reflected in the annual Strategic Plan update. ☑ Measure: One (1) prevention program is offered annually.	
Progress Update/Notes:	
B. Assure a community health assessment (CHA and Linn County CHIP) that includes chronic diseases, infant mortality, smoking, and obesity rates ☑ Measure: The CHA and CHIP are completed according to the Public Health accreditation requirements.	
Progress Update/Notes:	
C. Participate in focused community efforts to improve health outcomes ☑ Measure: Participation in community efforts reported on quarterly. ☑ Measure: Participation in two (2) community activities semi-annually.	

Progress Update/Notes:	
D. Educate the public regarding immunizations and preventable communicable diseases ☑ Measure: Public education efforts and strategies reported on annually.	
Progress Update/Notes:	
E. Increase immunization rates in order to prevent communicable disease ☑ Measure: Improved community-based immunization rates, reviewed annually.	
Progress Update/Notes:	
F. Provide epidemiological surveillance and disease investigation ☑ Measure: Staffing patterns support epidemiological investigations reported annually.	
Progress Update/Notes:	

Goal 2: **Awareness of and access to comprehensive health care is supported by participating in community efforts.**	
Strategies	**Completion Date**
A. Advocate for appropriate and accessible Public Health services for all Linn County residents ☑ Measure: Legislative activities reported on annually.	
Progress Update/Notes:	
B. Instigate or join in community health care access efforts ☑ Measure: Based on the results of the annual client and community partner satisfaction survey. ☑ Measure: Participation in community health care access efforts reported on quarterly.	
Progress Update/Notes:	
C. Build community relationships that assure Referral Pathways ☑ Measure: Based on the results of the annual client and community partner satisfaction survey.	
Progress Update/Notes:	
D. Strengthen collaboration and coordination with community partners ☑ Measure: Based on the results of the annual client and community partner satisfaction survey.	
Progress Update/Notes:	

E. Expand prevention education regarding risky health behaviors in schools and other youth oriented clubs (such as the Boys and Girls Club and YMCA's) ☑ Measure: Participation in prevention education regarding behavioral health reported on annually.	
Progress Update/Notes:	
F. Support and maintain an active Health Advisory Council ☑ Measure: Health Advisory Council meeting agendas and minutes, reviewed semi-annually.	
Progress Update/Notes:	

Goal 3: **LCPH is prepared for, responds to, and recovers from emerging Public Health threats and emergencies.**	
Strategies	**Completion Date**
A. Maintain a current All Hazard Plan and a coordinated response to a bioterrorism event or communicable disease outbreak ☑ Measure: An All Hazard Plan is reviewed annually. ☑ Measure: Disaster response exercise reported on semi-annually.	
Progress Update/Notes:	
B. Assure that Linn County Public Health is a source of accurate and timely information for Public Health emergencies ☑ Measure: Emergency Preparedness is part of the Internal and External Communication Plans.	

Progress Update/Notes:	
C. Work with community partners to improve emergency preparedness among residents ☑ Measure: Community partner emergency preparedness activities reported on quarterly.	
Progress Update/Notes:	
D. Encourage long-term recovery planning by promoting continuity of operation planning in county and community partner agencies ☑ Measure: An increase in the number of community partners that have a long-term recovery plan, reviewed semi-annually.	
Progress Update/Notes:	

IMPLEMENTATION & TIMELINE

The Strategic Plan is a living and transparent document that plays an active role in the overall management of Linn County Public Health. Goals, strategies, and measures are regularly reviewed throughout the year and guide staff work-plans. Staff work-plan measures are incorporated into staff evaluations. The Strategic Plan and corresponding staff work-plans are consistently updated and maintained.

The Strategic Plan will be presented to staff upon approval by the supervisors and the Health Advisory Council. The Strategic Plan will be integrated into new staff orientation to provide purposeful direction to the daily programmatic work and outreach. The Strategic Plan will also offer focused guidance during budget planning periods. An Executive Summary will be developed, published and available to share with LCPH community partners and other stakeholders.

The Strategic Plan will be aligned with the process and results of the Community Health Assessment. The Strategic Plan will also be incorporated into the Linn County Community Health Improvement Plan (CHIP) process and revised based on the CHIP outcomes.

The Strategic Plan will be coordinated with LCPH's quality improvement efforts and/or managed by the Quality Improvement Committee.

Strategic Planning Document Review:
Leadership and staff will review the Strategic Plan document at least every quarter to gauge the direction and success of the agency and to incorporate any changes or additions to the document. The document will be formally updated annually as needed. A Strategy Measures calendar will be developed and used for regular oversight.

Publication for Community Partners & Other Stakeholders:
An Executive Summary will be developed and regularly updated in accordance with any changes made to the Strategic Plan. The Brief will be available to the public and will be distributed to Community Partners annually.

LCPH PROGRAM MANAGER & APPROVAL TEAM SIGNATURES

Signature designates approval of the strategic direction and goals described in this Strategic Plan.

LCPH Program Manager Signature: _____

Printed Name: _____ Date Signed: _____

LCPH Health Administrator:_____

Printed Name: _____ Date Signed: _____

Approval Team Member Signature:_____

Printed Name: _____ Date Signed: _____

Approval Team Member Signature:_____

Printed Name: _____ Date Signed: _____

Approval Team Member Signature:_____

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Approval Team Member Signature:_____

Printed Name: _____ Date Signed: _____

APPENDIX A: SWOT ANALYSIS

A SWOT Analysis is an evaluation of the Strengths, Weaknesses, Opportunities, & Threats involved in a project or in a business venture.

A SWOT involves specifying the current status of an organization and identifying the internal and external factors that are favorable and unfavorable in order to determine a forward-thinking strategic direction.

Ultimately the goal of conducting an organization SWOT Analysis is to build upon the agency's strengths and opportunities and decrease the impact of its weaknesses and threats.

Internal	*External*
Strength	Opportunity
Weakness	Threat

Strengths

- Amazing dedicated staff/ownership
    - Longevity
- Cross-trained staff
- Co-location East Linn Community Mental Health, Alcohol & Drug, Developmental Disabilities, and Public Health
- Referral Pathways- community outreach education
- Forward thinking
- Large knowledge base
- Management- support/trust
- Bilingual staff and/or interpreter services
- Client success
- Client confidentiality
- Results of case management
    - Higher breast feeding rates
    - Prevent unintended pregnancies
    - Parents reading to kids
    - High immunization rates
    - Tuberculosis
- Accommodating
    - Appointment times
    - Flexibility
    - On time with schedules
- Reaching out to other counties/collaboration
- Proximity to colleges- Oregon State University, Linn Benton Community College, medical school
- Linn County partners work well together
- Support from County Commissioners- budgets
- Focus on cost containment activities

Weaknesses

- Lack of awareness/promotion of services/ lack of advertising
- Lack of outreach/coverage to all areas of the county
- Need to reach more people
- Lack of space
- Poor building for public health (Albany)
- Geography
- Communication between partners and public health and between health services in general (between Mental Health, Public Health, and Developmental Disabilities)
- Referral Pathways
- Lack of Mental Health services
- Breakdown in data between community and Health Department or lack thereof
- Challenges of meeting needs of changing demographics
    - Mobility, homeless
- Lack of epidemiologist to help interpret data
- Aging workforce
- Reduced pay scales
- Funding decisions
- Doing more with less
- Morale
- Telephone system
- Availability: hours and operator
- Client expectation explained/education/responsibilities
- Billing- clearer policies
- Keep accountability at the individual level- not “group punishment”

Opportunities

- Oregon State University- volunteers/interns
- Mobilize Medical Reserve Corps- screen families for programs
- 211 line
- Medical school
- Health oriented community fairs
- Greater presence in schools for health promotion/education
    - Health educators
- Health navigators
- Policy development
- Possible expansion of AHH
- Increase in collaboration/education between providers
- Increase in volunteerism
    - Retired Senior Volunteer Program
- Increase in opportunities for community input and involvement/engagement
- Peer support programs
- Outreach/educate service clubs
- Low cost solutions/media campaigns
- Improve collaboration between Linn County Health, Behavioral Health programs
- Opportunities to collaborate with Samaritan Health
- New medical school- focus on community health

- Program evaluation tied to healthy outcomes
    - Qualitative outcomes vs. quantitative
- Closer collaboration with the FQHC in Lebanon (improve outcomes)
- Research Best Practices

Threats

- Difficulty in navigating public health services
- Image as a government agency/low income
- Reduced funding
- Increased competition for resources
- Inability to utilize services available to them
- Community culture barriers
- Language barrier
- Increase in mobility of population
- Lack of marketing/knowledge
- Increase in complexity in coordination of care
- Personnel burnout
- Staff turnover
- Unemployment
- New state and/or federal mandates or requirements
- Resistance to change
- Returning service personnel
- Loss of locus of control due to CCO

APPENDIX B: STATE OF THE AGENCY PRESENTATION

LINN COUNTY STRATEGIC PLANNING

STATE OF THE AGENCY

December 7th, 2011

What makes a Healthy Community?

- Where we live matters to our health
- Health of community depends on many factors
- Includes individual behavior & environment
- Least healthy counties more likely to have higher rates of smoking, more high school dropouts, higher unemployment!

2011 County Health Rankings

Health Outcomes

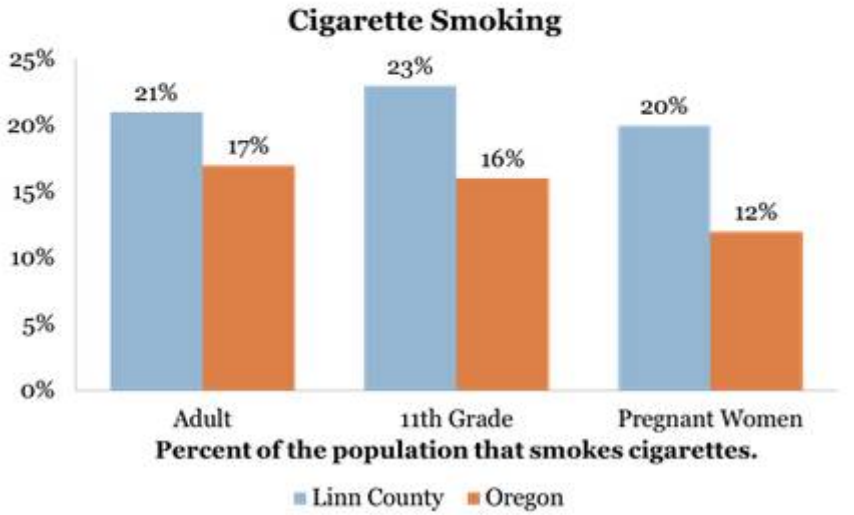
- Linn County ranked 28 out of 33.
- Based on:
  - Mortality
  - Morbidity

Health Factors

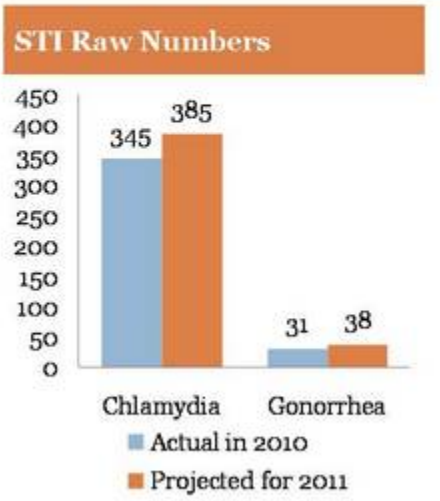
- Linn County ranked 20 out of 33.
- Based on:
  - Health Behaviors
  - Clinical Care
  - Socioeconomic Factors
  - Physical Environment

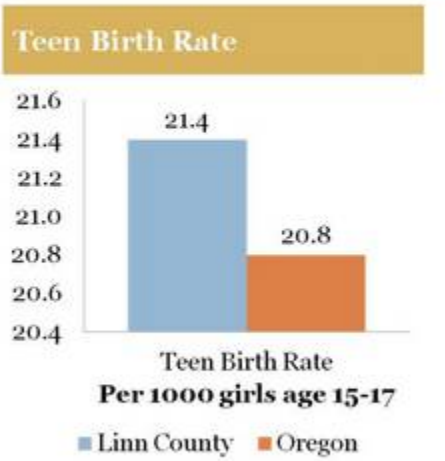
County Health Rankings
Mobilizing Action Toward Community Health

Health Behaviors: Tobacco use

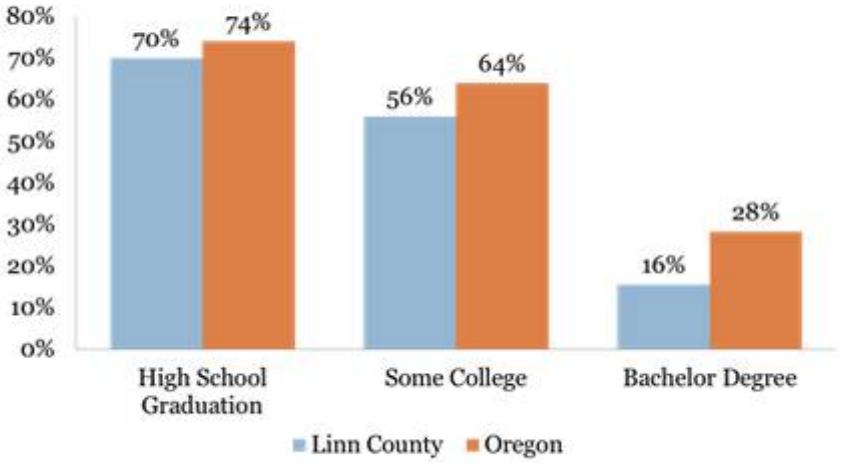


Health Behaviors: Sexual Behavior





Health Factors: Education



Snapshot of Data

Clinical Care	Linn County	Oregon
Ratio of primary care providers to the population	861:1	739:1
Ratio of mental health providers to the population	9614:1	2211:1

Physical Environment	Linn County	Oregon
Air pollution-particulate matter days	21	12
Motor Vehicle Crash Death Rate (per 100,000)	21	14

Snapshot of Data

	Linn County	Oregon
Child Abuse and Neglect (victims per 100 ages 0-17)	12.3	7.3
Infant Mortality (per 1000 live births)	8.4	4.8
Immunization Rate (2 year olds up to date)	57.8%	70.3%
Children in single parent households	32%	29%
Children in poverty	20%	18%

Public Health Program Highlights

- Experienced Staff
- Communicable disease- 705 reports
- Gave 538 TB tests
- Mailed 1300 exclusion letters
- Gave 9000 H1N1 shots in 2009-10 flu season
- WIC –good breastfeeding outcomes
  - 3000 case load overall

Public Health Program Highlights

- Provided care to 1945 reproductive health clients
- Oregon Mothers Care –access to OHP
- Breast and Cervical Cancer Program-partnership with Soroptimist
- Emergency Preparedness-Medical Reserve Corp
- Maternal Child Health – good outcomes
  - 93% of children served have immunizations up to date
  - 94% parent read to children 3x/week
  - 73% parents report reduced parenting stress

Public Health Program Highlights

- Healthy Communities Action Plan
  - Community At Large
  - Health Care
  - Organizations
  - Schools
  - Worksites
- Accreditation
  - Strategic Plan
  - Community Assessment
- Tobacco Prevention
- Worksite Wellness

Public Health Program Challenges

- Space Issues
- WIC
  - Appointment Slots
- Reproductive Health
  - Unable to give education to all schools
- Vital Stats
  - Timely submission of data

Public Health Program Challenges

- Breast Cervical Cancer
  - Not enough $ to serve women in need –limited staff time
- Referral Pathways
- Lack Public Awareness of Services
- High STI Rates
- High Tobacco Rates
- Lack of Chronic Disease Prevention

Community Interactions

- Space for InReach and Community Outreach free medical clinics
- Staff serves on statewide committees
- Teen Maze
- Preceptor for students (OSU, OHSU, WOU...)
- AmeriCorps VISTA Site

Key External Challenges

- Health Care Reform:
  - Coordinated Care Organizations
  - Early Learning Councils
  - Reduced Funding

Hope for the Future

- Work together as a community!
- Medical school
- Be a strong player in Coordinated Care Organizations (CCOs)
- Work with schools
- Policy work

Contact Information

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Albany, OR 97321
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http://www.co.linn.or.us/health/public_health/ph.htm