# Umatilla County

# Community Health Improvement Plan

# 2013-2015

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## Executive Summary

Beginning in 2011, the Umatilla County Community Health Partnership (UCCHP) met to initiate the first collaborative countywide health assessment. In the years leading up to this assessment, numerous agencies had been routinely completing varying degrees of assessments to assist in identifying the needs of county residents. The catalyst for this new, collaborative countywide assessment project occurred during a community coalition meeting to discuss the development of a free medical clinic. The coalition group rapidly recognized—and ultimately recommended—that a comprehensive community health assessment was needed in order to proceed with the project. As a result, the UCCHP was created.

The purpose of the collaborative countywide health assessment is to measure the current health status of Umatilla County residents, identify service gaps and needs, and be a catalyst for positive change. Following the completion and review of the findings from the initial phase of the countywide assessment, a group of stakeholders has met monthly since June 2012. This core group further subdivided into smaller work groups to develop and set goals to address the three top-ranked health issues. Research into **evidence-based practices** that have been successfully employed in similar community settings is being used to help determine the interventions, goals, and measures of success that partner agencies in Umatilla County will utilize to address residents' identified health needs. The UCCHP intends to complete a collaborative countywide health assessment on a triennial basis. due in 2014?

### Strategies:

| Priority Health Issues for Umatilla County |
|---|
| 1. **Decrease obesity rates** |
| 2. **Decrease tobacco use** |
| 3. **Decrease chronic disease rates: diabetes & asthma** |

### Areas of Health Priority:

To decrease **obesity rates**, Umatilla County will focus on the following target impact areas: 1) Decrease the consumption of sugar sweetened beverages, 2) Decrease the total hours of screen time each day, 3) Implement walking school buses, 4) Utilized Employer Wellness Tool Kits, 5) Utilize message boards for wellness education, 6) Implement a Community Wellness Calendar, 7) Collaborate with the Independent Physician Association to provide wellness education to their patients.

To decrease **tobacco use**, as well as decreasing **the burden of asthma**, Umatilla County will focus on the following target impact areas: 1) Promote tobacco free work sites and promotion of the Oregon Tobacco Quit line and local resources to help protect people from secondhand smoke and help people quit, 2) Provide employees, health care clients, and area residents with increased opportunities to quit tobacco.

To decrease chronic disease rates (specifically, **diabetes**) Umatilla County will focus on the following target impact areas: 1) Develop and implement community healthy cooking classes, 2) Utilize 211info.org to provide community with diabetes education and/or resources, 3) Develop and implement a local diabetes supply network for zero to low-income and underinsured persons.

### Action Steps:

To work toward decreasing **obesity**, the following action steps are recommended: 1) Work with Blue Mountain Community College to develop a policy to remove the availability of soda/sugar sweetened beverages on school grounds from vending machines, cafeterias, and snack shops, 2) Utilize the We Can! Awareness campaign to educate parents and caregivers of the benefits of reducing screen time, 3) Work with the school board, PTA, and school administration to implement walking school bus using state guidelines, 4)

? → Look it up

Identify four (4) employers who are interested in utilizing Oregon's Wellness Tool Kits to improve the health of their employees, 5) Invite business owners to share wellness messages on bulletin boards every month, 6) Create a wellness calendar quarterly that identifies wellness events in the community, post on various community websites, 7) Utilize primary care provider to provide ongoing education for their elderly patients around healthy diets, weight management, and physical activity.

To work toward decreasing **tobacco use and the burden of asthma,** the following actions steps are recommended: 1) Promote Oregon Tobacco Quit Line and local resources to community members, 2) Provide employees, health care clients, and Umatilla County residents with increased opportunities to quit tobacco by; Increasing the number of face to face tobacco cessation support options in the community to help people quit and by increasing the number of trained tobacco cessation counselors in Pendleton and Umatilla County.

To work toward decreasing **diabetes,** the following actions steps are recommended: 1) Implement community healthy cooking classes, 2) Utilize 2011info.org for education, 3) Implement local diabetes supply network.

An additional action step was identified: to complete a **Hispanic Community Health Assessment** to better understand this population and their needs.

## Partners

### Acknowledgements

The Umatilla County Community Health Partnership wishes to acknowledge the numerous contributions of the following partners and stakeholders.

### Umatilla County Community Health Partnership Members:

Blue Mountain Community College
Cancer Community renewal Partnership
CAPECO
Clearview Medication
Commission on Children and Family
Domestic Violence Services, Inc.
Eastern Oregon Alcoholism Foundation
Foster Grandparents/Senior Companions
Good Shepherd Health Systems
Head Start of Umatilla and Morrow Counties
Healthy Communities Coalition
Lifeways Mental Health Services
Mirasol Family health Center
Oregon Child Development Coalition
Oregon Department of Human Services
Pendleton Ministerial Fellowship
Milton-Freewater School District
Pioneer Relief Nursery
Salvation Army
St. Anthony Hospital
St. Mary Medical Center
Umatilla County Emergency Management
Umatilla County Public Health
United Way
Yellowhawk Tribal Health Center

Rod Harwood, MDiv, MA, BCC, from St Anthony Hospital Pendleton, Oregon, facilitated this strategic planning process.

## Strategic Planning Model

Beginning in June 2012, the Umatilla County Community Health Partnership Committee began meeting to develop strategies to address the findings identified in the Community Health Assessment. Over the course of next year, this group met on a monthly basis.

1. **Choosing Priorities**- Use of quantitative and qualitative data to prioritize target impact areas

2. **Ranking Priorities**- Ranking the health problems based on magnitude, seriousness of consequences, and feasibility of correcting

3. **Resource Assessment**- Determine existing programs, services, and activities in the community that address the priority target impact areas and look at the number of programs that address each outcome, geographic area served, prevention programs, and interventions

4. **Gap Analysis**- Determine existing discrepancies between community needs and viable community resources to address local priorities; Identify strengths, weaknesses, and evaluation strategies; and Strategic Action Identification

5. **Best Practices**- Review of best practices and proven strategies, Evidence Continuum, and Feasibility Continuum

6. **Goal Development**-Small groups formed to identify goals and best practices to address target areas identified in the Health Assessment.

7. **Draft Plan**- Review of all steps taken; Action step recommendations based on one or more the following: Enhancing existing efforts, Implementing new programs or services, Building infrastructure, Implementing evidence based practices, and Feasibility of implementation

## Needs Assessment

The Strategic Planning Committee reviewed the 2011 Umatilla County Health Assessment. Each member completed an "Identifying Key Issues and Concerns" worksheet. The following table shows the group results.

**What are the most significant <u>ADULT</u> health issues or concerns identified in the 2011 assessment report?**

| Key Issue or Concern | % of Population Most at Risk | Age Group Most at Risk | Gender Most at Risk |
|---|---|---|---|
| **1. Obesity (28.4/30 points)** | 67% | Adults | Men—72%<br>Women—61% |
| **2. Tobacco (26.8/30 points)** | 18% | Under 30-64 years | Both |
| **3. Chronic Disease (26.4/30 points)** | | | |
| **Asthma** | 20% | Under 30 | Both |
| **Diabetes** | 13% | Age 65 & over—27% | Males—15%<br>Females—10% |
| **4. Addiction (26.25/30 points)** | | | |
| **Alcohol—Binge Drinkers** | 18% | Under 30 | Males—41%<br>Females—31% |
| **Marijuana/Other Drugs** | 7%/9% | Under 30 | Both |
| **5. Mental Health (24.2/30 points)** | 21% | Over 45<br>interesting... | Unknown |
| **6. Access to Care—Low Income/Underserved (23.4/30 points)** | 16% Without Insurance<br>22% Without Primary Physician<br>38% Did Not Get Care They Needed | Under 30 | Both |

## Priorities Chosen

The Umatilla County Strategic Planning Committee completed an exercise where they ranked the key issues based on the magnitude of the issue, seriousness of the consequence, and the feasibility of correcting the issue. A total score was given to each priority. The max score was 30. All committee members' scores were combined and then average numbers were determined. Based on the results, the group decided to focus on the following three issues: adult obesity, tobacco use and chronic disease-diabetes and asthma. The results were sent out to the full committee for review and approval.

The rankings were as follows:

1. Obesity—28.4
2. Tobacco—26.8
3. Chronic Disease (Asthma/Diabetes)—26.4
4. Addictions—26.25
5. Mental Health—24.2
6. Access to Care (Low Income/Underserved)—23.4

## The Role of the Local Coalition in the CHIP Process

A key part of the implantation strategy for the Umatilla County Community Health Partnership is the local community health coalitions. Hermiston, which is on the west end of the county, has had an active coalition for a number of years called the Healthy Communities Coalition. Pendleton has just started a local coalition called the Pendleton Community Health Partnership. Milton-Freewater plans on starting their own coalition in the next few months. The Umatilla County Community Health Partnership will work with its partners in each part of county to develop and strengthen coalition development. It will also seek ways in which the partners through the coalition can collaborate together. It was decided that in order to effectively address the needs in each part of the county the local community health coalitions would need to develop implementation strategy plans for their part of the county. Key partners in each of these local coalitions are listed below:

| Hermiston Healthy Communities Coalition (Westside) | Pendleton Community Health Partnership (Eastside) | Milton-Freewater Community Health Partnership (Northside) |
|---|---|---|
| Good Shepherd Health Systems | St. Anthony Hospital | Providence St. Mary Medical Center |
| Marisol-Yakima Valley Farm Worker Clinic | Yellowhawk Tribal Clinic | Walla Walla General Hospital |
| Umatilla County Public Health | Umatilla County Public Health | Family Care Clinic- Yakima Valley Farm Workers Clinic |
| Lifeways (Mental Health) | Lifeways (Mental Health) | Umatilla County Public Health |
| CAPECO | CAPECO | Walla Walla County Public Health |
| OCDC | | CAPECO |

# Umatilla County
# Forces of Change

| Force of Change | Impact |
|---|---|
| **Increased access to fast foods, and less access to recreational facilities in Umatilla County; Lower college graduation rate in Umatilla County** | • Rising rates of obesity and children living in poverty http://www.countyhealthrankings.org/app/oregon/2013/umatilla/county/outcomes/overall/snapshot/by-rank |
| **Funding cuts** | • Sequestration affecting many programs |
| **Affordable Care Act (Medicaid Expansion); Health reform in Oregon; Creation of Coordinated Care Organizations (CCOs) in Oregon—locally the Eastern Oregon Coordinated Care Organization (EOCCO) to address needs of Medicaid recipients**<br><br>http://www.oregon.gov/oha/OHPB/pages/health-reform/providers/index.aspx | • CCOs (locally governed, shared budget) being developed to bring together physical, mental and eventually dental health care services that will focus on prevention, chronic illness management; will have flexibility within the allotted budget to provide services to Medicaid clients<br>• Eastern Oregon CCO has 13 counties in it—very difficult to coordinate all the local providers, local health plans, communities, and stakeholders<br>• Will encourage development of behavioral/mental health services, & integration into primary care medical home |
| **Navigation of the market place for health insurance coverage** | • Affordable Care Act will force individuals/employers to purchase health insurance<br>• New insurance navigation resource through "Cover Oregon" available 10/1/2013 http://coveroregon.com/ |
| **Electronic Health Records (EHR)** | • Increased ability to watch health trends better than in the past |
| **Medical Home; Patient-Centered Primary Care Homes are a central focus of Oregon's health system transformation efforts**<br><br>http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/publications/maps.cfm | • At **0.76 primary care physicians/1000 population**, there are potentially not enough primary care physicians to serve county population as medical homes<br>• Umatilla County has only 2 clinics recognized as Patient-Centered Primary Care Homes by the State of Oregon (one each in Hermiston & Pendleton): http://www.oregon.gov/oha/OHPR/pages/HEALTHREFORM/PCPCH/recognized-clinics.aspx |
| **Shortage of physicians**<br><br>http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/publications/maps.cfm | • Rural Umatilla County has **1.4 physicians/1000 population**—compared to 5.2 physicians/1000 population in urban Multnomah County<br>• New legislation proposed to pay medical school bills in exchange for service commitment in rural Oregon |
| **Nurse Practitioners (NPs)—better rate than much of Oregon** http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/publications/maps.cfm | • At **0.93 NPs/1000 population**, Umatilla County has one of the highest levels of NPs in the state<br>• Increases access to care, often for the medically underserved/underinsured |
| **Health Professional Shortage Area (HPSA) designations for Umatilla County** http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/publications/maps.cfm | • Dental care shortage area for low income population<br>• Migrant worker primary health care shortage area<br>• Geographical access shortage for mental health services |
| **Collaborative Community Health Needs Assessment & Strategic Planning** | • Greater cooperation between systems & agencies<br>• Shared Community Health Improvement Plan (CHIP) |
| **Health Department—Accreditation (similar to Joint Commission nation-wide accreditation)** | • Quality improvement |

# Strategy #1: Decrease Obesity Rates
# Obesity Indicators

***67% of Umatilla County adults were overweight or obese based on Body Mass Index (BMI).***

**Weight Status**

The 2011 Umatilla County Health Assessment indicates that 35% of adults were overweight and 32% were obese based on Body Mass Index (BMI). Both of these categories are higher than the state and nation. The 2011 BRFSS reported that 28% of Oregonians and U.S. adults were obese while 28% of Oregonians and 36% of U.S. adults were overweight.

**Nutrition**

In 2011, 7% of Umatilla County adults ate 5 or more servings of fruits and vegetables per day; 88% of adults ate one to four servings per day. The American Cancer Society recommends that adults eat 5-9 servings of fruits and vegetables per day to reduce the risk of cancer and to maintain good health. The 2009 Oregon Behavioral Risk Factor Surveillance System (BRFSS) reported that only 26% of Oregon adults and 23% of adults nationwide were eating the recommended number of servings of fruits and vegetables.

73% of Umatilla County adults drank soda pop, punch, Kool-Aide, energy drinks, sports drinks, or other fruit flavored drinks in the past week. 21% of adults drank at least one of these drinks daily. Umatilla County adults ate out or had takeout and average of 1.9 times per week.

**Physical Activity**

In Umatilla County, 56% of adults were engaging in physical activity for at least 30 minutes on three or more days per week. 33% of adults exercised five or more days per week and 24% of adults reported they did not participate in any physical activity in the past week, including those who were unable to exercise.

The CDC recommends that adults participate in moderate exercise for at least 2 hours and 30 minutes every week or vigorous exercise for at least 1 hour and 15 minutes every week. Umatilla County adults gave the following reasons for not exercising: time 27%, weather 21%, pain/discomfort 19%, too tired 18%, cannot affod a gym membership 15%, they choose not to exercise 10%, no child care 6%, no sidewalks 5%, no walking or biking trails 4%, do not know what activity to do 3%, no gym available 3%, safety 3%, doctor advised them not to 3%, and other 12%.

## Strategy #1: Decrease Obesity Rates
## Obesity Indicators for Youth and Adults

| 2008 Youth Indicators | Umatilla County 2008 (8th) | Oregon 2008 (8th) | Umatilla County 2008 (11th) | Oregon 2008 (11th) |
|---|---|---|---|---|
| BMI identified as overweight or obese | 31% | 25.9% | 29% | 26.8% |
| Described themselves as slightly or very overweight | 32.5% | 28.7% | 34.7% | 32.2% |
| Drank 100% fruit juice 1-6 times during the past 7 days | 52.2% | 53.9% | 55% | 57.2% |
| Did not eat any fruit during the past 7 days | 11.9% | 8.9% | 9.2% | 8.4% |
| Did not eat a green salad on any day during the past 7 days | 40.2% | 35.4% | 33.4% | 31.3% |
| Did not eat vegetables during the past 7 days (excluding carrots) | 18.6% | 15.5% | 15.2% | 12.9% |
| Ate breakfast everyday during the past 7 days | 46.8% | 42.5% | 38% | 38.3% |
| Drank soda or pop 1-3 times during the past 7 days | 44.2% | 42.2% | 35.8% | 37.9% |
| Did not purchase any soda or pop at school during past 7 days | 80.2% | 87.6% | 74.9% | 82.2% |
| Did not participate in at least 60 minutes of physical activity on any day in past week | 6.1% | 7.1% | 12.7% | 11% |
| Participate in PE 5 days a week while in school | 36.4% | 50.6% | 18.1% | 22.1% |
| Watched TV 3 or more hours per day on a school day | 30.3% | 27.3% | 25.3% | 22.1% |
| Played video or computer games 2 or more hours per day on a school day | 39.4 % | 35.4% | 33.6% | 33.1% |

*Use for Obesity Committee

| Adult Comparisons | Umatilla County 2011 | Oregon 2010 | U.S. 2010 |
|---|---|---|---|
| Obese | 32% | 28% | 28% |
| Overweight | 35% | 33% | 36% |

## Strategy #1: Decrease Obesity Among Adults and Youth Resource Assessment

| Program/Strategy/ Service | Responsible Agency | Population(s) Served | Continuum of Care (prevention, early intervention, or treatment) | Evidence of Effectiveness |
|---|---|---|---|---|
| Backpack/Food program | Altrusa of Hermiston | All incomes & ages | Prevention/Early Intervention/Treatment | None |
| Classes, health fairs, community events. Nursing students often assist with health fairs & health screenings. Has active worksite wellness committee for employees. | Blue Mountain Community College | All incomes & ages, may have fees | Prevention/Early Intervention/Treatment | Numbers of participants |
| Breastfeeding Peer Counseling Program, nutrition education, high risk counseling | WIC | Low income pregnant and breastfeeding women, mothers of at-risk infants & children | Prevention/Early Intervention/Treatment | Weight, height, hematocrit, breastfeeding or bottle feeding |
| Fitness classes | Club 24 Express Fitness | Those under 18 must be with an adult | Prevention/Early Intervention/Treatment | Numbers of participants |
| Personal trainers, fitness classes, exercise facilities | Columbia Court Club | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| Personal trainers, fitness classes, exercise facilities | Pendleton Round-Up Athletic Club | All incomes & ages, fee based | Prevention/Early Intervention/Treatment | Numbers of participants |
| Family Health & Fitness Day-GSMC and Healthy Communities Coalition | Good Shepherd Medical Center | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| Health & wellness activities for girls 5-9 years old | Girl Scouts of America | Girls age 5-9 | Prevention/Early Intervention | None |
| Assist families in establishing medical and dental homes for children. Assist with appointments, transportation, care plans, children with asthma and/or diabetes, nutrition assessments, and individualized plans to address obesity. | Head Start | Low income children enrolled in Head Start | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Programs and activities for all ages that promote health and wellness. | Pendleton Parks & Recreation | All incomes & ages | Prevention/Early Intervention/Treatment | Numbers of participants |
| Provides fresh veggies/fruits locally grown, along with activities | Pendleton Farmers' Market/ Hermiston Saturday Market | All incomes & ages; Food stamps accepted at many vendors | Prevention/Early Intervention/Treatment | None |
| Space for community to grow their own vegetables and herbs | Community Garden—Lovin' Spoonful in Hermiston | All incomes & ages | Prevention/Early Intervention | Numbers of participants |

## Strategy #1: Decrease Obesity Among Adults and Youth Resource Assessment, continued

| Program/Strategy/ Service | Responsible Agency | Population(s) Served | Continuum of Care (prevention, early intervention, or treatment) | Evidence of Effectiveness |
|---|---|---|---|---|
| Health education programs intended to promote health careers. Programs include: Brain Awareness, Girls in Science, health speakers' series, and In-A-Box. | Northeastern Oregon Area Health Education Center (NEOAHEC) at Eastern Oregon University | Open to schools & colleges in Northeastern Oregon | Prevention/Early Intervention | Numbers of participants |
| Free summer meal sites and activities—4 locations in Pendleton | Summer Meals—Nourishing Oregon's Kids by Oregon Dept. of Education | Kids and teens ages 1-18 | Prevention/Early Intervention | Numbers of participants compared to numbers of children who rely on school lunch |
| Nurse-Family Partnership is a program for women having a baby. If enrolled, a registered nurse will visits first-time mothers in home and throughout pregnancy until baby is 2 years old. | Umatilla County Public Health Department | First-time mothers | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Providing a coordinated and collaborative delivery system of parent education opportunities. | Oregon Parent Education Collaborative | Open to residents of Umatilla & Morrow Counties | Prevention/Early Intervention | Numbers of participants |
| Emergency Food Bank | Salvation Army | All people in need | None | Numbers of participants |
| Midday meal | Pendleton Senior Center | Seniors and disabled individuals, open to the public | Prevention/Early Intervention | Numbers of participants |
| Supports health and human services throughout Umatilla County. | United Way of Umatilla County | All incomes & ages | Prevention/Early Intervention/Treatment | Programs supported |
| Master Gardner program, school and community presentations, 4-H Youth Program, SNAP | Umatilla County Extension Services (OSU) | All incomes & ages | Prevention/Early Intervention | Numbers of participants |
| Health & wellness education, support | PEBB Health Engagement Model | State of Oregon employees & families | Prevention/Early Intervention/Treatment | Employee health status tracking, private information |
| Master Gardener Community Gardens | OSU Extension | Public volunteers | Prevention/Early Intervention/Treatment | Numbers of participants |
| Races (Relay for Life, Salmon Walk, Hermiston Fun Run for Education Foundation, etc.) | Various | All ages | Prevention/Early Intervention/Treatment | None |
| Bicycling events | Pendleton on Wheels | All ages | Prevention/Early Intervention/Treatment | None |

## Strategy #1: Decrease Obesity Among Adults and Youth Resource Assessment, continued

| Program/Strategy/ Service | Responsible Agency | Population(s) Served | Continuum of Care (prevention, early intervention, or treatment) | Evidence of Effectiveness |
|---|---|---|---|---|
| Cooking Matters: Cooking classes that are co-sponsored by Head Start and GSMC | Head Start & GSMC | All incomes & ages | Prevention/Early Intervention/Treatment | Numbers of participants |
| Exercise band class for strength & flexibility | GSMC | Adults | Prevention/Early Intervention/Treatment | Numbers of participants |
| GSMC Lactation Services: Assisting mothers and families with breastfeeding | GSMC | All incomes & ages, by appointment & referral | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Family Health & Fitness Day: Offers information, screenings, and activities on health, wellness, and safety | GSMC and Healthy Communities Coalition | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| Fiesta Foods Health Fair: Offers information and activities on health and wellness | Fiesta Foods Store in Hermiston | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| On staff nurse that assists with health and wellness promotion, assessments, and prevention. | Hermiston School District | Public school students ages 5-18 | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| I-Factor: After school program for Sunset Elementary students. Guest presenters share health and wellness information. | Sunset Elementary in Hermiston | Students of Sunset Elementary | Prevention/Early Intervention | Numbers of participants |
| **Living Well with Chronic Conditions:** Quarterly classes that provides support and education for those living with a chronic illness. 6-week class focuses on managing chronic illness. | Head Start & GSMC | People with chronic illnesses, their families & friends | Early Intervention/Treatment | Evidence-based program that has demographic information about participants |
| Provides structured events and activities around health and wellness. | Northwest Housing Authority | Based upon age & income-based housing | Prevention/Early Intervention/Treatment | Numbers of participants |
| Open Table: Free lunches served: Mon-First Christian Church; Tues/Fri-Catholic Church; Wed/Thurs-Methodist Church- | Hermiston churches | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| Comprehensive health and services for parents and children | Oregon Child Development Coalition | Farm workers with children ages 6 weeks to 5 years old | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Safe Solutions Program: Promotes safe biking and pedestrian safety events | ODOT & GSMC | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| Tai chi | GSMC | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| Wellness assessments—one on one | GSMC | All incomes & ages | Prevention/Early Intervention/Treatment | Demographics of participants |
| Providing food staples for those in need | Stanfield Food Bank | Underserved & seniors | None | Numbers of participants |

## Strategy #1: Decrease Obesity Among Adults and Youth Resource Assessment, continued

| Program/Strategy/ Service | Responsible Agency | Population(s) Served | Continuum of Care (prevention, early intervention, or treatment) | Evidence of Effectiveness |
|---|---|---|---|---|
| Healthier Communities Class Offerings – Hearth Healthy Eating Class, Grocery Store Tour, and others | St Anthony Hospital | All ages, income, and ethnicities | Prevention, early intervention | Pre and post testing of participants |
| Healthier Communities-Spring Health Fair –Complete Blood Draw Panel & PSA for Men | St. Anthony Hospital | All Ages (free) | Prevention/Early Intervention/Treatment | |
| Nutrition Services-Provide one-on-one medical nutrition therapy for various health conditions | St Anthony Hospital-Nutrition Services | Age 5 through adult | Prevention/Early Intervention/Treatment | Improvement in intermediate health indicators (cholesterol, weight, etc.) |
| Nurse Practitioner conducts health and wellness promotion, assessments, diagnosis, treatment, and prevention. | Pendleton High School-Based Health Center | Pendleton High School students | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Karate, Yoga, Dance Classes, etc. | Privately offered classes | Open to public, fee based | Prevention/Early Intervention/Treatment | None |
| Pendleton River Walk Pathway—distances marked | City of Pendleton | Open to public | Prevention/Early Intervention/Treatment | None |

## Strategy #1: Decrease Obesity Rates
## Gaps & Potential Strategies

| Gaps | Potential Strategies |
|---|---|
| **Expand community programs for free or low cost exercise** | • Work with local businesses to offer rates based on income/need<br>• Encourage employers to provide service to employees<br>• Engage public<br>• Work with Eastern Oregon Coordinated Care Organization (EOCCO) to provide exercise facilities' membership for those insured |
| **Lack of health insurance** | • Work with employers to expand coverage<br>• Promote EOCCO coverage |
| **Awareness of Farmer's Market** | • Increase awareness of this resource<br>• Utilize community reader boards to advertise<br>• PSAs<br>• Print media |
| **Worksite wellness programs** | • Policy issues<br>• Dedicated staff to employer education of worksite wellness<br>• Educate on insurance savings and incentives |
| **School-based physical education (PE)** | • Lobby legislature on importance of PE<br>• Work with schools to promote PE<br>• Engage parents<br>• Engage students |
| **Nutrition education** | • Promote portion control<br>• Cooking classes<br>• Educate on health effects of poor diet |
| **Support groups for activity** | • Engage businesses, churches, and organizations to provide space for groups to meet<br>• Enlist help of local wellness groups to organize |
| **Sidewalk improvements** | • Present sidewalk needs to city council<br>• Work with cities to find grants to improve sidewalks |

# Strategy #1: Decrease Obesity Among Adults and Youth
# Best Practices

## Best Practices

The following programs and policies have been reviewed and have proven strategies to **reduce obesity:**

1. The CDC states that **eating a diet high in fruits and vegetables** is associated with a decreased risk of many chronic diseases, including heart disease, stroke, high blood pressure, diabetes, and some cancers. Research also has found that replacing foods of high energy density (high calories per weight of food) with foods of lower energy density, such as fruits and vegetables, can be an important part of a weight-management strategy. The following strategies focus on policy and environmental changes that are designed to increase access to and improve the availability of fruits and vegetables, with the expectation that these changes will lead to increased consumption. Strategies were selected on the best available evidence, as well as the knowledge and expertise of the authors and Centers for Disease Control and Prevention (CDC) partners. For more information, go to **The CDC Guide to Strategies to Increase the consumption of Fruits and Vegetables** at http://www.cdc.gov/obesity/resources/recommendations.html
    a. Promote food policy councils as a way to improve the food environment at state and local levels
    b. Improve access to retail stores that sell high-quality fruits and vegetables or increase the availability of high-quality fruits and vegetables at retail stores in underserved communities
    c. Start or expand farm-to-institution programs in schools, hospitals, workplaces, and other institutions
    d. Start or expand farmers' markets in all settings
    e. Start or expand community-supported agricultural programs in all settings
    f. Ensure access to fruits and vegetable in workplace cafeterias and other food service venues
    g. Ensure access to fruits and vegetables at workplace meetings and events
    h. Support and promote community and home gardens
    i. Establish policies to incorporate fruit and vegetable activities into schools as a way to increase consumption
    j. Include fruits and vegetables in emergency food programs

2. The CDC, in its **Implementation and Measurement Guide**, shares that research has shown that the availability of less healthy foods in schools is inversely associated with fruit and vegetable consumption and is positively associated with fat intake among students. In this guide, for each strategy, **measurement questions are suggested to allow communities to track progress over time, and to compare themselves to similar communities**. For more information, please go to **Recommended Community Strategies and Measurements to Prevent Obesity in the United States** at http://www.cdc.gov/obesity/resources/recommendations.html Some recommended strategies:
    a. Schools can restrict the availability of less healthy foods by setting standards for the types of foods sold, restricting access to vending machines, banning snack foods and food as rewards in classrooms, or prohibiting food sales at certain times of the school day.
    b. Other public service venues that can restrict the availability of less healthy foods include afterschool programs, regulated childcare centers, community recreational facilities (e.g., parks, swimming pools), city and county buildings, and prisons and juvenile detention centers.

3. **Community campaigns to promote physical activity**. Build or become a part of partnerships in your community that include local agencies and organizations that plan and implement initiatives that promote physical activity, such as parks and recreation centers; fitness facilities; and programs in schools, community and senior centers, and hospitals. These partners may be able to offer activities and events as part of the campaign. The Taskforce on Community Preventive Services rates the evidence as strong for communitywide campaigns. For more information, please go to **The CDC Guide to Strategies to Increase Physical Activity** at http://www.cdc.gov/obesity/resources/recommendations.html
    a. Point of decision prompts to encourage use of stairs instead of elevators

b. Social support interventions in community settings (e.g., "Buddy System," or "Neighbor Walk"); go to http://www.americawalks.org
c. Creation of enhanced places for physical activity combined with informational outreach activities
d. Community and street-scale urban design and land-use policies
e. Active transport to school (including safe walking and biking routs to school)
f. Enhanced school-based physical education

4. **Worksite nutrition and physical activity programs** are designed to improve health-related behaviors and health outcomes. These programs can include one or more approaches to support behavioral change including informational and educational, behavioral and social, and policy and environmental strategies. The Community Preventive Services Taskforce recommends worksite programs intended to improve diet and/or physical activity behaviors based on strong evidence of their effectiveness for reducing weight among employees. For more information, please go to http://www.thecommunityguide.org/obesity/workprograms.html
    a. Informational and educational strategies aim to increase knowledge about a healthy diet and physical activity. Examples include:
        i. Lectures
        ii. Written materials (provided in print or online)
        iii. Educational software
    b. Behavioral and social strategies target the thoughts (e.g. awareness, self-efficacy) and social factors that effect behavior changes. Examples include:
        i. Individual or group behavioral counseling
        ii. Skill-building activities such as cue control
        iii. Rewards or reinforcement
        iv. Inclusion of co-workers or family members to build support systems
    c. Policy and environmental approaches aim to make healthy choices easier and target the entire workforce by changing physical or organizational structures. Examples of this include:
        i. Improving access to healthy foods (e.g. changing cafeteria options, vending machine content)
        ii. Providing more opportunities to be physically active (e.g. providing on-site facilities for exercise)
    d. Policy strategies may also change rules and procedures for employees such as health insurance benefits or costs or money for health club membership.
    e. Worksite weight control strategies may occur separately or as part of a comprehensive worksite wellness program that addresses several health issues (e.g., smoking cessation, stress management, cholesterol reduction).

5. **Behavioral interventions to reduce screen time**. Screen time is time spent watching TV, videotapes, or DVDs; playing video or computer games; and surfing the Internet. Components of behavioral interventions to reduce screen time (mostly "TV time reduction") include skills building, tips, goal setting, rto einforcement techniques, workbooks, messages, TV turnoff challenges, and family support. The Community Preventive Services Taskforce recommends behavioral interventions aimed at reducing screen time based on sufficient evidence of effectiveness for reducing measured screen time and improving weight-related outcomes among children and adolescents and in a variety of settings. For more information, please go to http://www.thecommunityguide.org/obesity/RRbehavioral.html

## Strategy #1: Decrease Obesity Among Adults and Youth
## Best Practices, continued

6. **Multi-component coaching interventions** with the goal of influencing weight-related behaviors. **Technology-supported multicomponent coaching or counseling interventions** use technology to facilitate or mediate interactions between a coach or counselor and an individual or group, with a goal of influencing weight-related behaviors or weight-related outcomes. These interventions often also include other components, which may be technological or non-technological. Technology-supported components may include the use of computers (e.g., internet, CD-ROM, e-mail, kiosk, computer program), video conferencing, personal digital assistants, pagers, pedometers with computer interaction, or computerized telephone system interventions targeting physical activity, nutrition, or weight. **Non-technological components** may include in-person counseling, manual tracking, printed lessons, and written feedback. Because of differences in implementation and in the intended outcomes, interventions aimed at reducing weight were considered separately from those intended to maintain weight loss. The Community Preventive Services Taskforce recommends technology-supported multicomponent coaching or counseling interventions intended to reduce weight on the basis of sufficient evidence that they are effective in improving weight-related behaviors or weight-related outcomes. For more information, please go to http://www.thecommunityguide.org/obesity/RRTechnologicalCoaching.html

# Pendleton Community Health Partnership - Eastside
# Strategy #1: Decrease Obesity Among Adults and Youth
# Action Step Recommendations & Action Plan

## Action Step Recommendations

To work toward decreasing **youth obesity**, the following action steps are recommended:

1. Implement a Walking School Bus for children.
2. Increase opportunities for children to be active by decreasing the total number of screen time hours spent in each day.
3. Implement a soda and sugar sweetened beverage policy at community college.

To work toward decreasing **adult obesity**, the following action steps are recommended:

1. Implement a community bulletin board campaign advertising wellness messages every month.
2. Update and disseminate community wellness calendars that contain information about events where you can be active i.e., bike riding, running, walking, swimming.
3. Utilize wellness tool kits to assist employers in engaging their employees in making better choices related to diet, activity, and a healthy lifestyle.
4. Implement a contract between local providers and EOCCO identifying key educational measures to be provided at medical appointments to include healthy diet, weight management, and physical activity.

## Action Plan

| Decrease Obesity | | |
|---|---|---|
| Action Step | Responsible Person/Agency | Timeline |
| **Year 1**: Work with local business owner to commit to sharing wellness messages on their public bulletin boards every month.<br>• Four local businesses will agree to participate<br>• Wellness bulletin boards will be created by each business<br>• Bulletin boards to be posted for 1 month at each location<br>• End of each month the wellness messages created will be passed to another participating business<br>• Each business is only responsible for creating one wellness bulletin board each year | Obesity Work Group | May 2014 |
| Obesity Work Group will complete a wellness calendar that will be shared quarterly with the community.<br>• List of events from CHA group to be compiled<br>• Outreach to Parks & Rec, CTUIR, School District, County, and City of Pendleton to identify upcoming events.<br>• Posting of the calendar will be on four partnership web pages<br>• Local papers to be provided calendar<br>• Calendars to be provided to Chamber, Parks & Rec, Radio media, Print media, City of Pendleton, and CTUIR<br>• Calendars to be included in water bills quarterly | Obesity Work Group | August 2013 |

→ Last meeting we said 12. Are we being over zealous?

# Pendleton Community Health Partnership - Eastside
## Strategy #1: Decrease Obesity Among Adults and Youth
## Action Step Recommendations & Action Plan, continued

| Decrease Obesity | | |
|---|---|---|
| Action Step | Responsible Person/Agency | Timeline |
| Contract to be implemented with EOCCO and local providers to assure that health and wellness education is being provided at all medical appointments.<br>• Obesity Work Group to meet with Independent Physician Association (IPA) to discuss obesity issues among their patients.<br>• Identify what providers feel will be best educational areas for their patients in relation to health and wellness<br>• Present desire to cover healthy diet, weight management, and physical activity<br>• Meet with EOCCO to present strategies discussed with IPA in addressing health and wellness education at all medical appointments.<br>• Implement a contract between EOCCO and providers for compensation for providing health and wellness information at each medical appointment. | Obesity work group<br>– TRACK BMIs? | February 2014 |
| **Year 2:** Implement a county-wide campaign to educate community on the importance of screen time reduction<br>• Educate service organization about WE Can! Program<br>• Meet with local media for PSA's<br>• Work with school districts/colleges/day cares/ parks and rec to educate on the We Can! Program.<br>• Hold a community health event to launch We Can! Program | Obesity Work Group | February 2015 |
| Utilize a wellness tool kit that will assist employers in getting employees engaged in making better choices related to diet, activity, and a healthy lifestyle.<br>• Utilize Oregon Public Health Employer Wellness tool kits<br>• Present information on wellness tool kits to local businesses<br>• Attend local service organization meeting to present information on wellness tool kits<br>• Serve as a resource for the employers | Obesity Work Group | May 2015 |

## Pendleton Community Health Partnership - Eastside
## Strategy #1: Decrease Obesity Among Adults and You
## Action Step Recommendations & Action Plan, continued

| Decrease Obesity | | |
|---|---|---|
| Action Step | Responsible Person/Agency | Timeline |
| **Year 3**: Blue Mountain Community College will implement a policy to remove the availability of soda/sugar sweetened beverages on school grounds from vending machines, cafeterias, and snack shops<br>• Review current policy from Pendleton School District<br>• Contact Blue Mountain Community College to ascertain if a policy exists<br>• Educate college board and student government on benefits of removal of soda/sugar sweetened beverages from college campuses<br>• Assist Blue Mountain Community College in writing a policy | Obesity Work Group | June 2016 |
| Create a walking school bus program for local schools<br>• Meet with school board to discuss benefits and feasibility of walking school bus<br>• Meet with schools to discuss logistics of walking school bus<br>• Develop an awareness campaign for the community<br>• Meet with PTA and foster grandparents to solicit volunteers | Obesity Work Group | May 2015 |

## Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma)
## Tobacco and Asthma Indicators

***In 2011, the health assessment results indicated that 18% or adults were current smokers, and $25 million is spent on medical care for tobacco-related illnesses, with an additional $22 million lost in productivity due to tobacco-related deaths. The 2011 health assessment results also indicated that 20% of Umatilla County adults had been diagnosed with asthma, increasing to 46% of those under the age of 30.***

**Tobacco Use and Prevalence of Asthma**

One of the most important triggers of asthma attacks is cigarette/secondhand smoke. Eliminating tobacco smoke from the home is the single most important thing a family can do to help household occupants diagnosed with asthma.

According to the 2009 Oregon Behavioral Risk Factor Surveillance System (BRFSS—found at http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Asthma/Pages/burdenrpt.aspx), those with no high school diploma are more likely to have asthma. In Oregon, tobacco use is higher among people with lower education levels; college graduates have the lowest percentage of smokers. There is also a strong correlation between asthma and income level. Oregonians from a household with an annual income of less than $15,000 consistently report higher percentages of asthma than all other income levels. Nationally, a higher percentage of people who live below the federal poverty level report having asthma than people who live above the federal poverty level. The percentage of smokers among people with an income of $15,000 or less is more than three times higher than those making greater than $50,000. Lower income individuals also have greater exposure to asthma triggers such as mold, mildew, and cockroaches, due to substandard housing.

| 2011 Adult Comparison of Tobacco Use | Umatilla County 2011 | Oregon 2010 | U.S. 2010 |
|---|---|---|---|
| Current smoker | 18% | 15% | 17% |
| Former smoker | 17% | 28% | 25% |

| 2011 Adult Comparisons of Asthma | Umatilla County 2011 | Oregon 2010 | USA 2010 |
|---|---|---|---|
| Adults diagnosed with asthma | 20% | 16% | 14% |

## Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma) Resource Assessment

| Program/Strategy/ Service | Responsible Agency | Population(s) Served | Continuum of Care (prevention, early intervention, or treatment) | Evidence of Effectiveness |
|---|---|---|---|---|
| Assist with gas cards, lodging, referrals, and resources, as well as health presentations. | American Cancer Society | All incomes & ages | Early Intervention/Treatment | Demographic data about participants |
| Classes, health fairs, community events. Nursing students often assist with health fairs & health screenings. Has active worksite wellness committee for employees. | Blue Mountain Community College | All incomes & ages, may have fees | Prevention/Early Intervention/Treatment | Numbers of participants |
| Assesses families for strengths and needs in 10 areas, including tobacco use and readiness to quit and alcohol/drug use (as well as other health factors). Provides resources unique to parent's needs around tobacco quit and reduce children's exposure to second-hand smoke. Link to community resources to address needs and follow care plans, including asthma. | Head Start | Low income children enrolled in Head Start | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Health education programs intended to promote health careers. Programs include: Brain Awareness, Girls in Science, health speakers' series, and In-A-Box. | Northeastern Oregon Area Health Education Center (NEOAHEC) at Eastern Oregon University | Open to schools & colleges in Northeastern Oregon | Prevention/Early Intervention | Numbers of participants |
| Providing a coordinated and collaborative delivery system of parent education opportunities. | Oregon Parent Education Collaborative | Open to residents of Umatilla & Morrow Counties | Prevention/Early Intervention | Numbers of participants |
| The **Oregon Tobacco Quit Line** provides free counseling to help quit tobacco. Some callers may be eligible for free nicotine patches or gum. Additional web resources such as Mylastdip.com are also linked on the web site. Includes assistance for health care providers. | Oregon Tobacco Quit Line | Teens & adults of all ages | Early Intervention/Treatment | Quit Line user multiple demographics report available per month and by county |
| Tobacco cessation support group; counseling by appointment | GSMC | All incomes & ages | Early Intervention/Treatment | Demographic /numbers of participants |
| Nurse Practitioner conducts health and wellness promotion, assessments, diagnosis, treatment, and prevention. | Pendleton High School-Based Health Center | Pendleton High School students | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |

## Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma) Resource Assessment, continued

| Program/Strategy/ Service | Responsible Agency | Population(s) Served | Continuum of Care (prevention, early intervention, or treatment) | Evidence of Effectiveness |
|---|---|---|---|---|
| Health & wellness education, support | PEBB Health Engagement Model | State of Oregon employees & families | Prevention/Early Intervention/Treatment | Employee health status tracking, private information |
| **Oregon Asthma Resource Bank**: In response to the need for easily accessible, reliable materials, a collaboration of healthcare providers in Oregon came together to create the nationally recognized Oregon Asthma Resource Bank website and produce a variety of asthma education handouts and provider tools. | Oregon Health Authority (OHA) | Healthcare providers, patients and families, school staff | Prevention/Early Intervention/Treatment | State & countywide statistics as gathered by the OHA through the BRFSS and the Healthy Teens Survey, as well as other demographic data |
| Nurse-Family Partnership is a program for women having a baby. If enrolled, a registered nurse will visits first-time mothers in home and throughout pregnancy until baby is 2 years old. | Umatilla County Public Health Department | First-time mothers | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Assists Worksites, Organizations, Schools, Health Care Providers, Communities and families in prevention, education and policy efforts to reduce exposure or access to secondhand smoke, tobacco products, and advertising and promotion of tobacco. Promotes Oregon's Tobacco Quit Line and local Quit resources. | Umatilla County Public Health Tobacco Education and Prevention Program | Open to the public | Prevention/Early Intervention/Treatment | Programs served |
| Supports health and human services throughout Umatilla County. | United Way of Umatilla County | All incomes & ages | Prevention/Early Intervention/Treatment | Programs supported |
| Family Health & Fitness Day: Offers information, screenings, and activities on health, wellness, and safety | GSMC and Healthy Communities Coalition | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| Fiesta Foods Health Fair: Offers information and activities on health and wellness | Fiesta Foods Store in Hermiston | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |

## Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma) Resource Assessment, continued

| Program/Strategy/ Service | Responsible Agency | Population(s) Served | Continuum of Care (prevention, early intervention, or treatment) | Evidence of Effectiveness |
|---|---|---|---|---|
| On staff nurse that assists with health and wellness promotion, assessments, and prevention. | Hermiston School District | Public school students ages 5-18 | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| I-Factor: After school program for Sunset Elementary students. Guest presenters share health and wellness information. | Sunset Elementary in Hermiston | Students of Sunset Elementary | Prevention/Early Intervention | Numbers of participants |
| **Living Well with Chronic Conditions:** Quarterly classes that provides support and education for those living with a chronic illness. 6-week class focuses on managing chronic illness. | Head Start & GSMC | People with chronic illnesses, their families & friends | Early Intervention/Treatment | Evidence-based program that has demographic information about participants |
| Provides structured events and activities around health and wellness. | Northwest Housing Authority | Based upon age & income-based housing | Prevention/Early Intervention/Treatment | Numbers of participants |
| Comprehensive health and services for parents and children | Oregon Child Development Coalition | Farm workers with children ages 6 weeks to 5 years old | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Wellness assessments—one on one | GSMC | All incomes & ages | Prevention/Early Intervention/Treatment | Demographics of participants |

## Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma) Gaps and Potential Strategies

| Gaps | Potential Strategies |
|---|---|
| **Casino allows smoking** | • Work with casino to create policy to implement tobacco free facility<br>• Work with tribal board and members to develop support for tobacco free casino<br>• Engage casino employees |
| **Mixed State/local policy adoption** | • Work with both state public health and LPH to create policy at both levels<br>• Engage local legislature<br>• Engage County Commissioners |
| **Cigarette butt garbage** | • Use signs to identify area as no smoking |
| **Not all parks are tobacco free** | • Engage community and educate about tobacco dangers<br>• Work with city council to create policy<br>• Engage PTA and other organizations that support children and their activities |
| **Community education program on asthma management to include healthcare providers, patients and their families, and school staff** | • Engage local hospital and providers to develop talking points based upon the materials available at the **Oregon Asthma Resource Bank** of the Oregon Health Authority, as well as information about the **Asthma Action Plan** at the CDC<br>o PSAs<br>o Print media<br>o Radio media |
| **Lack of health care specialists who work with asthma** | • Engage local hospital to look into recruitment of specialist to educate the public about the Asthma Action Plan<br>o Assist in the implementation of the National Asthma Education and Prevention Program's (NAEPP) **Guidelines for the Diagnosis and Management of Asthma** among healthcare practitioners, hospitals, health plans, and systems. |

# Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma) Best Practices

## Best Practices

The following programs and policies have been reviewed and have proven strategies to **address tobacco use and asthma**:

**Reducing the Burden of Tobacco:**

1. Public and private policies require workplaces and public places to be tobacco-free. The Community Preventive Services Taskforce recommends **smoke-free policies** to reduce secondhand smoke exposure and tobacco use on the basis of strong evidence of effectiveness. Evidence is considered strong based on results from studies that showed effectiveness of smoke-free policies in: reducing exposure to secondhand smoke; reducing the prevalence of tobacco use; increasing the number of tobacco users who quit; reducing the initiation of tobacco use among young people; reducing tobacco-related morbidity and mortality, including acute cardiovascular events. Economic evidence indicates that smoke-free policies can reduce healthcare costs substantially. In addition, the evidence shows smoke-free policies do not have an adverse economic impact on businesses, including bars and restaurants. For more information, please go to http://www.thecommunityguide.org/tobacco/smokefreepolicies.html
    a. Public policies establish outdoor venues such as parks, fairs, and community events as tobacco-free.
    b. Community colleges adopt tobacco-free policies.
    c. Hospitals and clinics adopt and enforce tobacco-free campus policies.
    d. Public and private policies require smoke free multi-unit housing.

2. Integrate into all community & worksite efforts: promotion of the **Oregon Tobacco Quit Line** as well as local quit resources and supports; education about cessation benefits, and warnings of the dangers of tobacco. Quit-lines use the telephone to provide evidence-based behavioral counseling and support to help tobacco users who want to quit. Counseling is provided by trained cessation specialists who follow standardized protocols that may include several sessions delivered over one or more months. The Community Preventive Services Taskforce recommends quit-line interventions, particularly proactive quit-lines (i.e. those that offer follow-up counseling calls), based on strong evidence of effectiveness in increasing tobacco cessation among clients interested in quitting. For more information, please go to http://www.thecommunityguide.org/tobacco/quitlines.html
    a. Quitline counseling is widely accessible, convenient to use, and generally provided at no cost to users.

3. The Community Preventive Services Taskforce recommends community mobilization combined with additional interventions—such as **stronger local laws directed at retailers, active enforcement of retailer sales laws, and retailer education with reinforcement**—on the basis of sufficient evidence of effectiveness in **reducing youth tobacco use and access to tobacco products** from commercial sources. Preemption is a significant barrier to the implementation of the intervention combinations evaluated in this report. The published literature describes a number of legislative efforts to weaken, replace, or prevent the implementation and conduct of these interventions. For more information, please go to http://www.thecommunityguide.org/tobacco/RRcommunityinterventions.html

## Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma) Best Practices, continued

4. Substantial evidence shows that **intensive tobacco dependence interventions** produce higher success rates than do less intensive interventions. Intensive tobacco dependence treatment can be provided by any suitably trained clinician. Tobacco dependence interventions offered by specialists represent an important treatment resource for patients even if they received tobacco dependence treatment from their own clinician. In addition, tobacco cessation specialists can serve as resources to non-specialists. For more information, please go to http://www.ncbi.nlm.nih.gov/books/NBK63953/#A28355

5. **Worksite-based Incentives and Competitions When Combined with Additional Interventions to Reduce Tobacco Use among Workers.** To support an individual's efforts to quit using tobacco products, in this intervention incentives and competitions are offered in conjunction with additional interventions. These additional interventions may include these components: smoking cessation groups; self-help cessation materials; telephone cessation support; workplace smoke-free policies; and social support networks among others. The Task Force recommends worksite-based incentives and competitions when combined with additional interventions to support individual cessation efforts, based on strong evidence that they are effective in reducing tobacco use among workers. For more information, please go to http://www.thecommunityguide.org/tobacco/RRincentives.html

**Reducing the Burden of Asthma:**

1. Smoke free worksites, multi-unit housing, and parks.

2. Research and case studies that have looked at ways to best manage asthma in schools found that successful school-based asthma programs: establish strong links with asthma care clinicians to ensure appropriate and ongoing medical care; target students who are the most affected by asthma at school to identify and intervene with those in greatest need; get administrative buy-in and build a team of enthusiastic people, including a full-time school nurse, to support the program; use a coordinated, multi-component and collaborative approach that includes school nursing services, asthma education for students and professional development for school staff; support evaluation of school-based programs and use adequate and appropriate outcome measures. For more information, see **Controlling Asthma in Schools** at http://www.cdc.gov/asthma/
    1. Encouraging students with asthma to carry their inhalers at school.
    2. Schools, worksites, and multi-unit housing integrating pest management policies to achieve pest control with fewer toxic methods.
    3. No vehicle idling policies at schools and worksites.
    4. Fragrance free and in-door air quality policies for schools and worksites.

3. **Two or more home-based visits** that use multi-trigger, multi-component interventions for children and adolescents with asthma. These interventions involve trained personnel making one or more home visits to conduct activities within the home. These activities focus on reducing exposures to a range of asthma triggers (allergens and irritants) through environmental assessment, education, and remediation. Most programs include additional components, such as self-management training, social support, and coordinated care, in conjunction with efforts to reduce asthma triggers in the home environment.. The Community Preventive Services Taskforce recommends the use of home-based, multi-trigger, multicomponent interventions with an environmental focus for children and adolescents with asthma on the basis of strong evidence of effectiveness in reducing symptom days, improving quality of life or symptom scores, and in reducing the number of school days missed. The Task Force finds that the combination of minor to moderate environmental remediation with an educational component provides good value for the money invested based on improvement in symptom free days and savings from averted costs of asthma care and improvement in productivity. For more information, please go to http://www.thecommunityguide.org/asthma/rrchildren.html

## Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma) Best Practices, continued

4. **Standardize use of self-management tools** (including the personalized Asthma Action Plan as prescribed by the healthcare provider) available for healthcare providers, patients, children and their families, and school staff through the **Oregon Asthma Resource Bank** at http://public.health.oregon.gov/DISEASESCONDITIONS/CHRONICDISEASE/ASTHMA/RESOURCEBANK/Pages/index.aspx

5. **Reimbursement for evidence based self-management programs**. The Stanford Patient Education Research Center developed a Chronic Disease Self-Management Program (CDSMP), a workshop given two and a half hours, once a week, for six weeks in community settings for people with chronic health problems, facilitated by two trained leaders, at least one of whom has a chronic disease themselves. Individuals who participated in the CDSMP—when compared to those who did not—demonstrated significant improvements in exercise, cognitive symptom management, talking with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatient visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:4. Many of these results persist for as long as three years. For more information, please go to http://patienteducation.stanford.edu/programs/cdsmp.html. In one report, Kaiser Permanente paid approximately $200 per participant for CDSMP training, materials, and administration. With 489 participants, Kaiser's total cost was $97,800. However, if the cost to care for each participant decreased $990 because participants used fewer health services, Kaiser Permanente's net savings would be nearly $400,000. For more information, please go to http://www.ahrq.gov/research/findings/factsheets/aging/elderdis/index.html.

Prevention related activities clearly give the most bang for our buck. We need to embrace primary methods of prevention but also look at those areas which we can impact now in order to reduce costs immediately i.e. ER Visits, Tobacco cessation, & increasing activities for all members of our community

# Pendleton Community Health Partnership - Eastside
# Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma)
# Action Step Recommendations & Action Plan

## Action Step Recommendations

To work toward **decreasing tobacco use,** the following actions steps are recommended:

1. Promote tobacco free worksites
2. Promote Oregon Tobacco Quit Line and local resources
3. Increase number of face to face tobacco cessation support options in the community
4. Increase number of trained tobacco cessation counselors in Umatilla County → Train Case Managers

## Action Plan

| Decrease Tobacco Use | | |
|---|---|---|
| Action Step | Responsible Person/Agency | Timeline |
| **Promote tobacco free worksites and promotion of the Oregon Tobacco Quit Line and local resources to help protect people from second hand smoke and help people quit** | | |
| **Year 1**:<br>• Umatilla County employees will form a Tobacco Policy and Cessation Promotion workgroup to examine current tobacco policies for all County Owned Properties and current employee benefits for cessation. By April 2014 they will present their findings to the Board of Commissioners including any suggestions to strengthen tobacco policies and or/benefits.<br>• Identify seven additional governments, businesses to work with for tobacco policy adoption over the next three years.<br>• Conduct Key Informant interviews with leadership, HR, and employees to determine which organizations are ready to move forward with strengthened tobacco policies in years one, two and three.<br>• Offer to provide tools and technical assistance to businesses as they move towards adopting tobacco-free or smoke-free campus policies.<br>• Continue to offer enforcement, communication and education support to early adopters of tobacco free campuses, and develop talking points with updated tobacco free policy successes.<br>• Support implementation and promotion of the Addictions and Mental Health Tobacco Freedom Policy for AMH facilities in Umatilla County.<br>• Promote cessation throughout the process through promotion of the Tobacco Quit Line, recommendations from "Helping Benefit Oregon Smokers, and working to offer more local quit resources. | Tobacco workgroup | December 2014 |

## Pendleton Community Health Partnership - Eastside
## Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma)
## Action Step Recommendations & Action Plan, continued

| Decrease Tobacco Use, continued | | |
|---|---|---|
| Action Step | Responsible Person/Agency | Timeline |
| **Year 2:**<br>• Through personal visits or calls, contact the identified worksites to provide tools and technical assistance on tobacco-free or smoke-free campus policies.<br>• Update talking points with new success stories. Share updates with community leaders and local media.<br>• Offer assistance with any enforcement issues with businesses, organizations or governments that have adopted tobacco free or smoke-free campuses.<br>• Continue to promote cessation throughout the process through promotion of the Tobacco Quit Line, recommendations from "Helping Benefit Oregon Smokers," and working to offer more local quit resources. | Tobacco workgroup | December 2015 |
| **Year 3:**<br>• Through personal visits or calls, contact the identified worksites to provide tools and technical assistance on tobacco-free or smoke-free campus policies.<br>• Update talking points with new success stories. Share updates with community leaders and local media.<br>• Offer assistance with any enforcement issues with businesses, organizations or governments that have adopted tobacco free or smoke-free campuses.<br>• Continue to promote cessation throughout the process through promotion of the Tobacco Quit Line, recommendations from "Helping Benefit Oregon Smokers, and working to offer more local quit resources. | Tobacco workgroup | December 2016 |

# Pendleton Community Health Partnership - Eastside
# Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma)
# Action Step Recommendations & Action Plan, continued

| Provide Employees, Healthcare Clients, and Umatilla County Residents with Increased Opportunities to Quit Tobacco | | |
|---|---|---|
| Action Step | Responsible Person/Agency | Timeline |
| **Year 1:**<br>• Form a local Tobacco Cessation Task Force to:<br>o Identify key steps necessary to increase the number of tobacco users who both attempt quitting and are successful in their quit attempts.<br>o Explore options for bringing tobacco cessation training to local providers and increasing provider awareness of best practices in cessation.<br>o Determine best methods to reach health care providers to promote the Oregon Quit Line (including Fax Referrals) for patients at http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/GetHelpQuitting/Pages/oregonquitline.aspx and resources available for Mental Health and Addictions providers http://www.oregon.gov/oha/amh/pages/tobacco-freedom/main.aspx<br>o Develop a communication time line to promote cessation (using multiple avenues such as newsletters, websites etc.,) for continued outreach to local health care providers (including Mental Health and Addiction providers) and EOCCO contracted providers.<br>o Develop a Cessation Training time line for Years Two and Three.<br>• Task force will collaborate with organizations or businesses that are in the process of adopting tobacco free policies to promote optimum quit coverage for employee benefits such as recommendations from "Helping Benefit Oregon Smokers." | Tobacco workgroup | December 2014 |
| **Year 2**<br>• Based on needs identified in Year One, Task Force or community partner will sponsor local provider cessation training such as 5A's, and/or refresher courses in Motivational Interviewing.<br>o Work with OHSU Smoking Cessation Center, Umatilla County Public Health, and other local and statewide resources to determine training options including continuing education credits.<br>o Offer Cessation training to providers.<br>• Based on communication plan developed in year one, communicate at least twice a year with local providers concerning cessation support available to providers and residents. | Tobacco workgroup | December 2015 |

## Pendleton Community Health Partnership - Eastside
## Strategy #2: Decrease Tobacco Use (and the Prevalence of Asthma)
## Action Step Recommendations & Action Plan, continued

| Provide Employees, Healthcare Clients, and Umatilla County Residents with Increased Opportunities to Quit Tobacco, continued | | |
|---|---|---|
| Action Step | Responsible Person/Agency | Timeline |
| **Year 3:**<br>1. Continue communicating at least twice a year with local providers concerning local cessation support (including new supports available as a result of local cessation training).<br>2. Offer a second Cessation Training to providers.<br><br>**Community Partners to engage:**<br><br>• Umatilla County Public Health Tobacco Prevention and Education Program<br>• St Anthony Hospital<br>• Pendleton Health Care providers<br>• Lifeways<br>• Eastern Oregon Alcohol Foundation<br>• Eastern Oregon Correctional Institute<br>• Eastern Oregon Community Care Organization (EOCCO) and member organizations<br>• County Commissioners, administration, employees, County Counsel, Umatilla County Employee Wellness & Employee Safety Committees<br>• Blue Mountain Community College<br>• Interpath Laboratory<br>• Umatilla Morrow Head Start<br>• Cities of Pendleton, Pilot Rock, and Ukiah<br>• Local organizations, employers and employees and community members<br>• State agencies and wellness committees<br>• Yellowhawk Tribal Health Center, CTUIR Tobacco Coordinator & other Tribal Partners<br>• Good Shepherd Hospital, the Hermiston area Healthy Communities Coalition & Worksite Wellness Committee<br>• Milton-Freewater Community Health Partnership (or other organization(s) established as a result of CHP work | Tobacco workgroup | December 2016 |

# Strategy #3: Decrease Diabetes
# Diabetes Indicators

***In 2011, 13% of Umatilla County adults reported that they had been diagnosed with diabetes.***

The 2011 Umatilla County Health Assessment indicated that 86% were obese or overweight, 77% had been diagnosed with high blood cholesterol, and 57% had been diagnosed with high blood pressure.

Diabetes, especially when combined with high cholesterol and high blood pressure, significantly increases the risk for serious health conditions including eye, foot, and skin complications; kidney disease; heart disease; stroke; cardiovascular disease; and nerve damage. The rise in obesity and diabetes is a public health crisis of gigantic proportions.

According to a report to the 2009 legislature titled "Reversing the Trends of Obesity and Diabetes" (available at http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Diabetes/Pages/index.aspx), Oregonians with low incomes and those who are African American, American Indian/Alaska Native, and Hispanic/Latino are more commonly affected by diabetes and obesity and have less access to health care. In addition, many Oregon children already are overweight and some even have Type 2 diabetes, a diagnosis previously very rare in children. Social factors such as income, education, race and ethnicity play a key role in determining the incidence and severity of obesity, pre-diabetes and diabetes. Population-based approaches need to recognize these determinants and work to eliminate the disparities they cause. Affected communities need to be part of the discussion and planning.

| 2011 Adult Comparisons | Umatilla County 2011 | Oregon 2011 | U.S. 2010 |
|---|---|---|---|
| Diagnosed with diabetes | 13% | 8% | 10% |

## Strategy #3: Decrease Diabetes
## Resource Assessment

| Program/Strategy/ Service | Responsible Agency | Population(s) Served | Continuum of Care (prevention, early intervention, or treatment) | Evidence of Effectiveness |
|---|---|---|---|---|
| Classes, health fairs, community events. Nursing students often assist with health fairs & health screenings. Has active worksite wellness committee for employees. | Blue Mountain Community College | All incomes & ages, may have fees | Prevention/Early Intervention/Treatment | Numbers of participants |
| Assists families in establishing medical and dental homes for children. Assist with appointments, transportation, care plans, children with asthma and/or diabetes, nutrition assessments, and individualized plans to address obesity | Head Start | Low income children enrolled in Head Start | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Health education programs intended to promote health careers. Programs include: Brain Awareness, Girls in Science, health speakers' series, and In-A-Box. | Northeastern Oregon Area Health Education Center (NEOAHEC) at Eastern Oregon University | Open to schools & colleges in Northeastern Oregon | Prevention/Early Intervention | Numbers of participants |
| Providing a coordinated and collaborative delivery system of parent education opportunities. | Oregon Parent Education Collaborative | Open to residents of Umatilla & Morrow Counties | Prevention/Early Intervention | Numbers of participants |
| Master Gardener Community Gardens and Master Gardener Program | OSU Extension | Public volunteers | Prevention/Early Intervention/Treatment | Numbers of participants |
| School and community presentations, 4-H Youth Program, SNAP | Umatilla County Extension Services (OSU) | All incomes & ages | Prevention/Early Intervention | Numbers of participants |
| **Living Well With Chronic Conditions** (the **Chronic Disease Self-Management Program—CDSMP**) program six week workshop that provides tools for living a healthy life with chronic conditions, including diabetes | GSMC & Head Start | People with different chronic conditions and their family or friends | Early Intervention/Treatment | Evidence-based program that has demographic information about participants |
| Nurse Practitioner conducts health and wellness promotion, assessments, diagnosis, treatment, and prevention. | Pendleton High School-Based Health Center | Pendleton High School students | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Health & wellness education, support | PEBB Health Engagement Model | State of Oregon employees & families | Prevention/Early Intervention/Treatment | Employee health status tracking, private information |
| Diabetes education for diabetes self-management | St. Anthony Hospital | Referred clients | Early Intervention/Treatment | Medical tracking in individual health records |
| Nurse-Family Partnership is a program for women having a baby. If enrolled, a registered nurse will visit first-time mothers in home and throughout pregnancy until baby is 2 years old. | Umatilla County Public Health Department | First-time mothers | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |

## Strategy #3: Decrease Diabetes
## Resource Assessment, continued

| Program/Strategy/ Service | Responsible Agency | Population(s) Served | Continuum of Care (prevention, early intervention, or treatment) | Evidence of Effectiveness |
|---|---|---|---|---|
| Supports health and human services throughout Umatilla County. | United Way of Umatilla County | All incomes & ages | Prevention/Early Intervention/Treatment | Programs supported |
| Nutrition education, high risk counseling by registered dietician | WIC | Low income pregnant and breastfeeding women, infants, and children | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| Healthier Communities Class Offerings: Hearth Healthy Eating Class, Grocery Store Tour, and others | St Anthony Hospital | All ages & incomes | Prevention/Early Intervention/Treatment | Pre and post testing of participants |
| Healthier Communities: Spring Health Fair: Complete Blood Draw Panel & PSA for Men | St. Anthony Hospital | All Ages (free) | Prevention/Early Intervention/Treatment | Numbers of participants |
| Nutrition Services: Provide one-on-one medical nutrition therapy for various health conditions | St Anthony Hospital-Nutrition Services | Age 5 through adults | Prevention, early intervention, and treatment | Improvement in intermediate health indicators (cholesterol, weight, etc.) |
| Cooking Matters: Cooking classes that are co-sponsored by Head Start and GSMC | Head Start & GSMC | All incomes & ages | Prevention/Early Intervention/Treatment | Numbers of participants |
| Diabetes education for diabetes self-management: Classes, support group, one on one counseling | GSMC | All incomes & ages | Early Intervention/Treatment | Medical tracking in individual health records |
| Family Health & Fitness Day: Offers information, screenings, and activities on health, wellness, and safety | GSMC and Healthy Communities Coalition | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| Fiesta Foods Health Fair: Offers information and activities on health and wellness | Fiesta Foods Store in Hermiston | Open to public | Prevention/Early Intervention/Treatment | Numbers of participants |
| On staff nurse that assists with health and wellness promotion, assessments, and prevention. | Hermiston School District | Public school students ages 5-18 | Prevention/Early Intervention/Treatment | Medical tracking in individual health records |
| I-Factor: After school program for Sunset Elementary students. Guest presenters share health and wellness information. | Sunset Elementary in Hermiston | Students of Sunset Elementary | Prevention/Early Intervention | Numbers of participants |

## Strategy #3: Decrease Diabetes
## Gaps & Potential Strategies

| Gaps | Potential Strategies |
|---|---|
| **Lack of adequate diabetic education** | • Need more dedicated diabetic educators<br>• Work with hospital on need to expand program<br>• Offer free diabetic education |
| **Not enough community gardens** | • Work with city and county to identify areas for community gardens<br>• Engage community members in identifying locations |
| **Insurance Incentives** | • Contact local businesses to discuss incentive options<br>• Work with area insurance companies to provide rate reductions |
| **Diet education/cooking** | • Work with local providers to provide more in-depth dietary education<br>• Work with local providers to expand diabetic educators in the community<br>• Create cooking classes specific to diabetic individuals |

# Strategy #3: Decrease Diabetes
# Best Practices

## Best Practices

The following programs and policies have been reviewed and have proven strategies to **address diabetes**:

1. **Menu labeling**. There is evidence that calorie labels on restaurant menus impacted food choices and intake, suggesting menu label legislation could potentially contribute to obesity prevention. For more information, please go to http://ajph.aphapublications.org/action/doSearch?searchText=menu+labeling and http://www.ajpmonline.org/search/quick

2. **Tax on sugar sweetened beverages**. Sugar-sweetened beverages are a major contributor to the US obesity and diabetes epidemics. Using the Coronary Heart Disease Policy Model, investigators examined the potential impact on health and health spending of a nationwide penny-per-ounce excise tax on these beverages. Investigators found that the tax would reduce consumption of these beverages by 15 percent among adults ages 25-64. Over the period 2010-20, the tax was estimated to prevent 2.4 million diabetes person-years, 95,000 coronary heart events, 8,000 strokes, and 26,000 premature deaths, while avoiding more than $17 billion in medical costs. In addition to generating approximately $13 billion in annual tax revenue, a modest tax on sugar-sweetened beverages could reduce the adverse health and cost burdens of obesity, diabetes, and cardiovascular diseases. For more information, please go to http://www.ncbi.nlm.nih.gov/pubmed/22232111

3. **Reimbursement for evidence based self-management programs**. The Stanford Patient Education Research Center developed a Chronic Disease Self-Management Program (CDSMP), a workshop given two and a half hours, once a week, for six weeks in community settings for people with chronic health problems, facilitated by two trained leaders, at least one of whom has a chronic disease themselves. Individuals who participated in the CDSMP—when compared to those who did not—demonstrated significant improvements in exercise, cognitive symptom management, talking with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatient visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:4. Many of these results persist for as long as three years. For more information, please go to http://patienteducation.stanford.edu/programs/cdsmp.html. In one report, Kaiser Permanente paid approximately $200 per participant for CDSMP training, materials, and administration. With 489 participants, Kaiser's total cost was $97,800. However, if the cost to care for each participant decreased $990 because participants used fewer health services, Kaiser Permanente's net savings would be nearly $400,000. For more information, please go to http://www.ahrq.gov/research/findings/factsheets/aging/elderdis/index.html.

4. **Self-management programs held in community gathering places**. In this intervention, diabetes self-management education (DSME) is provided to people aged 18 years or older in settings other than the home, clinic, school, or worksite (e.g., community centers, faith-based institutions, libraries, or private facilities such as residential cardiovascular risk-reduction centers). Community gathering places have been pursued because traditional clinical settings may not be ideal for DSME of adults, the home setting is conducive only to individual or family teaching, and education at the worksite does not reach those not working outside the home. On the basis of Community Guide rules of evidence, the Task Force on Community Preventive Services concluded that there is sufficient evidence of effectiveness in improving glycemic control to recommend DSME interventions in community gathering places for adults with Type 2 diabetes. It should be noted, however, that these interventions were rarely coordinated with the patient's clinical care provider, and the nature and extent of care in the clinical setting was unclear. DSME for adults with Type 2 diabetes delivered in the setting of community gathering places should be

## Strategy #3: Decrease Diabetes
## Best Practices, continued

coordinated with the person's primary care provider, and these interventions are not meant to replace education delivered in the clinical setting. For more information, please go to http://www.thecommunityguide.org/diabetes/supportingmaterials/RRcommunity.html

**Case management, combined with self-management** to improve glycemic control. Case management is "a set of activities whereby the needs of populations of patients at risk for excessive resource utilization, poor outcomes, or poor coordination of services are identified and addressed through improved planning, coordination, and provision of care." It usually involves the assignment of authority to a single professional (the case manager, most commonly a nurse) who is not a provider of direct health care. The essential features of case management are (1) the identification of eligible patients, (2) the assessment of individual patients' needs, (3) development of an individual care plan, (4) implementation of that care plan, and (5) monitoring of outcomes. Case management is often combined with disease management but can also stand alone as an intervention, or can be combined with other clinical care interventions (e.g., practice guidelines or patient reminders). Case management is strongly recommended by the Task Force based on strong evidence of its effectiveness in improving glycemic control. Evidence is also available of its effectiveness in improving provider monitoring of long-term blood sugar levels, when case management is combined with disease management. These findings are applicable primarily in the U.S. managed care setting for adults with Type 2 diabetes. For more information, please go to http://www.thecommunityguide.org/diabetes/supportingmaterials/RRcasemgmt.html

# Pendleton Community Health Partnership - Eastside
# Strategy #3: Decrease Diabetes
# Action Step Recommendations & Action Plan

## Action Step Recommendations

To work toward decreasing **diabetes,** the following actions steps are recommended:

1. Increase access to fruits/vegetables
2. Increase diabetes educational opportunities and access to diabetic supplies
3. Increase physical activity

| Decrease Diabetes | | |
|---|---|---|
| Action Step | Responsible Person/Agency | Timeline |
| **Year 1:** Increase access to fresh fruits & vegetables because increased consumption of fruits & vegetables promotes healthy weight.<br><br>• Develop and implement community Healthy Cooking Classes<br>• Obtain commitments from organizations with appropriate facilities<br>• Secure funding for food, advertising and promotion<br>• Enlist volunteers<br>• Involve Farmer's Market, community gardens, and agricultural farmers for produce and advertising | Diabetic workgroup | December, 2014 |
| **Year 2:** Increase diabetes educational opportunities and access to diabetes supplies in order to improve control of disease (community-wide, focus mainly on older youth and adults)<br><br>• Utilize 211info.org to provide community with diabetes education and/or resources<br>  o Gather current local info for data input<br>  o Obtain commitment from 211info.org personnel to provide training<br>  o Hold town hall meeting for data entry by community agencies<br>  o Secure computer classroom for town hall meeting for direct data entry<br>• Develop and implement a local diabetes supply network for zero to low-income and underinsured persons<br>  o Talk with local social service agencies, pharmacies, physicians, and hospitals about current availability of supplies and process for distribution<br>  o Develop a regular source for diabetes supplies Obtain commitment from one agency to provide intake and voucher for supplies<br><br>Obtain commitment from one medical/pharmaceutical business to distribute supplies based on voucher system | Diabetic workgroup | December 2015 |

## Pendleton Community Health Partnership - Eastside
## Strategy #3: Decrease Diabetes
## Action Step Recommendations & Action Plan, continued

| Decrease Diabetes, continued | | |
|---|---|---|
| Action Step | Responsible Person/Agency | Timeline |
| **Year 3:** Increase access to physical exercise to help reduce diabetes and pre-diabetes (community-wide, focus mainly on older youth and adults)<br><br>• Implement a Diabetes Prevention Program in Pendleton | Diabetic workgroup | December 2016 |

## Contact Us

For more information about any of the agencies, programs, and services described in this report, please contact the responsible agency listed or the chair of the community served:

| | | |
|---|---|---|
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