

Public Health Division

Mission

The mission of the Public Health Division (PHD) is to protect, preserve and promote the health of all the people of Oregon by preventing unnecessary illness, death and disability, improving the health status of Oregon's communities, and reducing the need for costly illness care for all Oregonians.

To fulfill this mission, public health officials work to:

- Prevent epidemics and the spread of disease
- Protect against environmental hazards
- Prevent injuries and ensure the safety of all Oregonians receiving health care
- Promote and encourage healthy behaviors
- Develop policies and plans that support individual and community health efforts
- Respond to disasters and assist communities with recovery efforts
- Ensure health services are effective for all communities, especially those experiencing health disparities
- Provide prevention and nutrition services to children
- Ensure the quality and accessibility of health services
- Assess and monitor the health status of Oregonians

Goals

The division's goals for the 2009-2011 biennium include:

- Secure authority and funding to improve state and local health authority and capacity to protect Oregon communities.

- Continue improvements in early childhood health through improved oral health, school-based health centers, access for pregnant women to prenatal care, increased physical activities and better nutrition.
- Reduce health risks in the environment.
- Reduce health risks that relate to personal behaviors.
- Strengthen the statewide Tobacco Prevention and Education Program.
- Improve the quality of health care services, facilities and systems.
- Identify and respond to new and emerging public health threats.
- Ensure access to timely, comprehensive health-related data in order to assess health needs, develop policies and programs, and evaluate health outcomes and services.

History

Oregon was one of the last three states in the nation to officially organize public health. Because of concern about infectious disease outbreaks — smallpox, bubonic plague and tuberculosis — the 1903 Legislature created a State Board of Health with a \$5,000 budget. This legislation also provided for a public health laboratory, a vital statistics registry and county boards of health.

By the 1920s public health nursing services and children’s programs were added. The Federal Social Security Act of 1935 gave a financial boost to maternal and child health services including dental health programs, immunization and hearing tests. A sanitary authority was created in 1938 to address water pollution.

In the mid-1940s public health became responsible for administering federal grants to construct hospitals and other health facilities, as well as the licensing of health care facilities. In 1951 Oregon became the first state in the nation to pass an air pollution law.

The 1971 Legislature created the Oregon Department of Human Resources (DHR) as an umbrella agency for public health, mental health, social services, corrections and employment. The State Board of Health became the Oregon Health Division.

During the next 30 years the division grew in response to a variety of challenges including growing refugee populations in the 1970s, the AIDS epidemic of the 1980s and increasing concern with radiation exposure following the Chernobyl disaster in the Soviet Union. The nation's first bioterrorist event occurred in Wasco County when persons associated with the Rajneeshpuram community intentionally contaminated a salad bar in The Dalles with salmonella. Epidemiologic and laboratory investigation by the division identified and documented the extent of this episode.

Nationally, public health received extensive scrutiny that culminated in a 1988 report by the Institute of Medicine pointing to major systemic problems. By the late 1990s federal initiatives were developed to strengthen communicable disease, maternal and child health, and environmental health programs. The federal Healthy People 2000 and 2010 set national goals for health status improvement, a large portion of which were tied to public health services. The terror attacks of 2001, including anthrax exposure, led to the perception of public health as a key element of public safety and significant new investment in federal public health preparedness funding.

Today, the Public Health Division and its local partners are involved in a range of activities to protect the health of Oregonians by preserving the public health achievements of the past (such as safe drinking water, reduction in outbreaks of measles and other childhood diseases, and control of tuberculosis) and by addressing new and emerging hazards (new infectious diseases, environmental hazards and emergency preparedness).

One of the new challenges is the increasing impact of chronic disease and injuries in Oregon's communities. Heart disease, cancer and stroke are the major causes of death and disability. Injury is the third leading cause of death nationally and the leading cause of death for children and young adults. The improvements in life expectancy and health have stalled, and the route to improvement includes community-based public health prevention and early intervention activities. The system that was created by the 1903 legislation – including local service delivery, a state laboratory and a strong reliance on data – provides the foundation for better public health today.

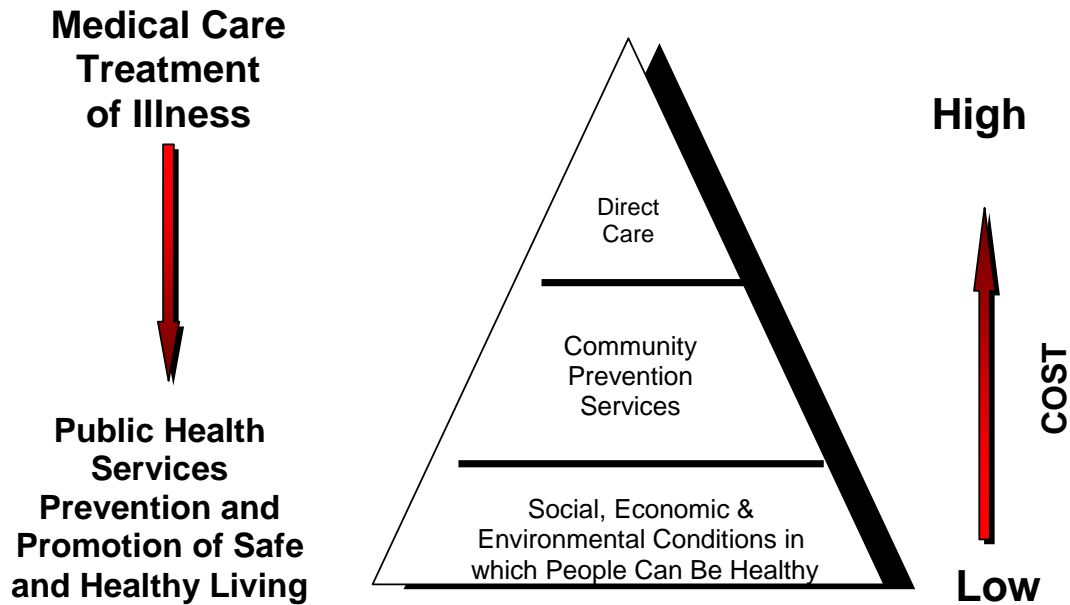
Services provided

Public health is fundamentally about prevention and about working with communities to create conditions that support health, in contrast to the medical care system which primarily treats illnesses in individuals. Since 1900, life expectancy in the United States has increased by more than 30 years, most of which is attributable to advances in public health — safe drinking water, improved nutrition, sewage disposal and broad-scale immunizations.

Although public health has been the most significant factor in improving health and longevity, only 1.5 percent of DHS General Fund (GF) resources are spent on these preventive and community-based public health services. While Oregonians should never be denied the medical care they need, efforts to prevent illness and promote healthy living can greatly reduce the burden and cost of disease and ultimately of medical care.

The health services pyramid illustrates a public policy dilemma. Currently, society invests most health dollars in direct medical care for those who can gain access. It invests relatively little in low-cost, preventive population-based services. Investment in ensuring the health of Oregon's communities could significantly reduce overall medical care costs.

Investments in community preventive services often are taken for granted or unnoticed by the general public. These investments include working with health professionals to improve health screening; organizing community efforts to address the causes of diseases such as diabetes, asthma or stroke; conducting media campaigns to encourage healthy and responsible behaviors; and gathering and distributing health data and vital records.



County health departments play a strong role in the delivery of many public health services, with the state providing technical support and oversight. These include programs for communicable diseases, immunizations, preventive services for children and women, and inspections of food and water systems. Other programs and services primarily are delivered at the state level, including statewide regulation of some services and potential hazards, scientific analysis and the development of statewide plans to prevent epidemics, control disease, reduce exposure to health hazards, ensure safe food and water, and promote healthy behaviors. Public health programs frequently collaborate with a range of health care and other organizations and agencies.

Recent years have brought recognition of new risks to the health of the public. These risks include new or potential diseases such as SARS, West Nile virus, and Avian and pandemic flu, and “old” diseases that are returning with epidemic potential such as whooping cough, tuberculosis and E. coli. This has increased the need for disease surveillance, public education and preparedness. The public also is increasingly concerned about the need to prevent injuries, suicide and exposure to environmental hazards.

Risky behavior in some populations is on the rise, as evidenced by the increased number of new HIV infections.

At the same time, the number of uninsured or underinsured individuals has risen, increasing need for local safety net services and for public health programs to develop innovative community systems for access to health care.

With rising concerns about the risks of terrorist attacks and concerns about natural disasters, state and local public health systems have become major players in emergency preparedness. Federal funding for public health emergency preparedness activities has directed many of the activities of state and local public health programs, but has not been sufficient to meet the preparedness expectations of Oregon's communities.

Public health programs that regulate and investigate health care facilities are expected to ensure that health care practices are evidence-based and that patient safety is safeguarded.

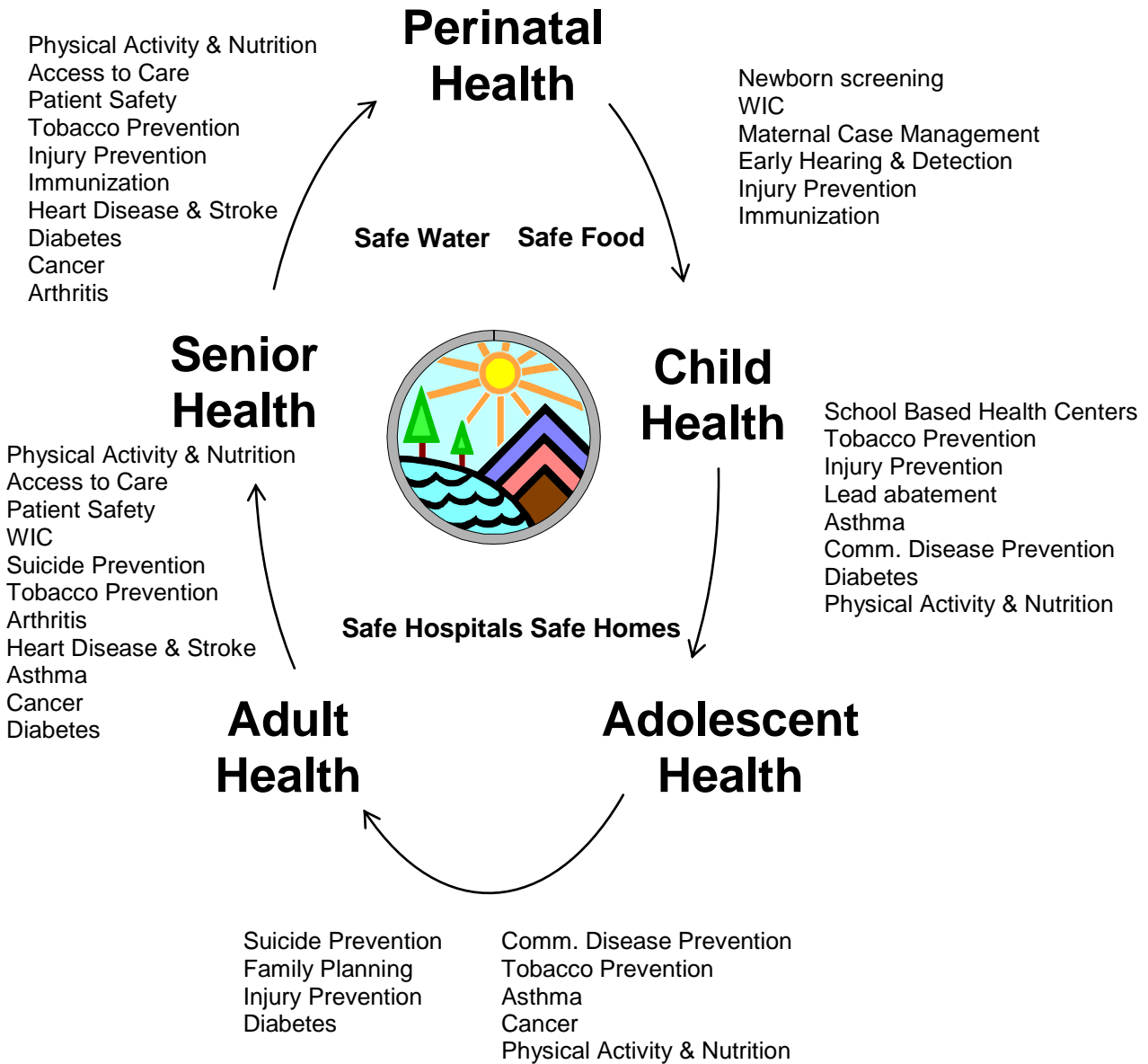
With reduced or static funding in recent years for state and local public health programs, the gap between expectations and actual capacity to protect people has worsened. Chronic under-funding and increasingly fragmented and narrow financial support for public health have eroded many previously strong programs and have limited the ability of Oregon's state and local public health system to appropriately protect Oregonians.

Programs

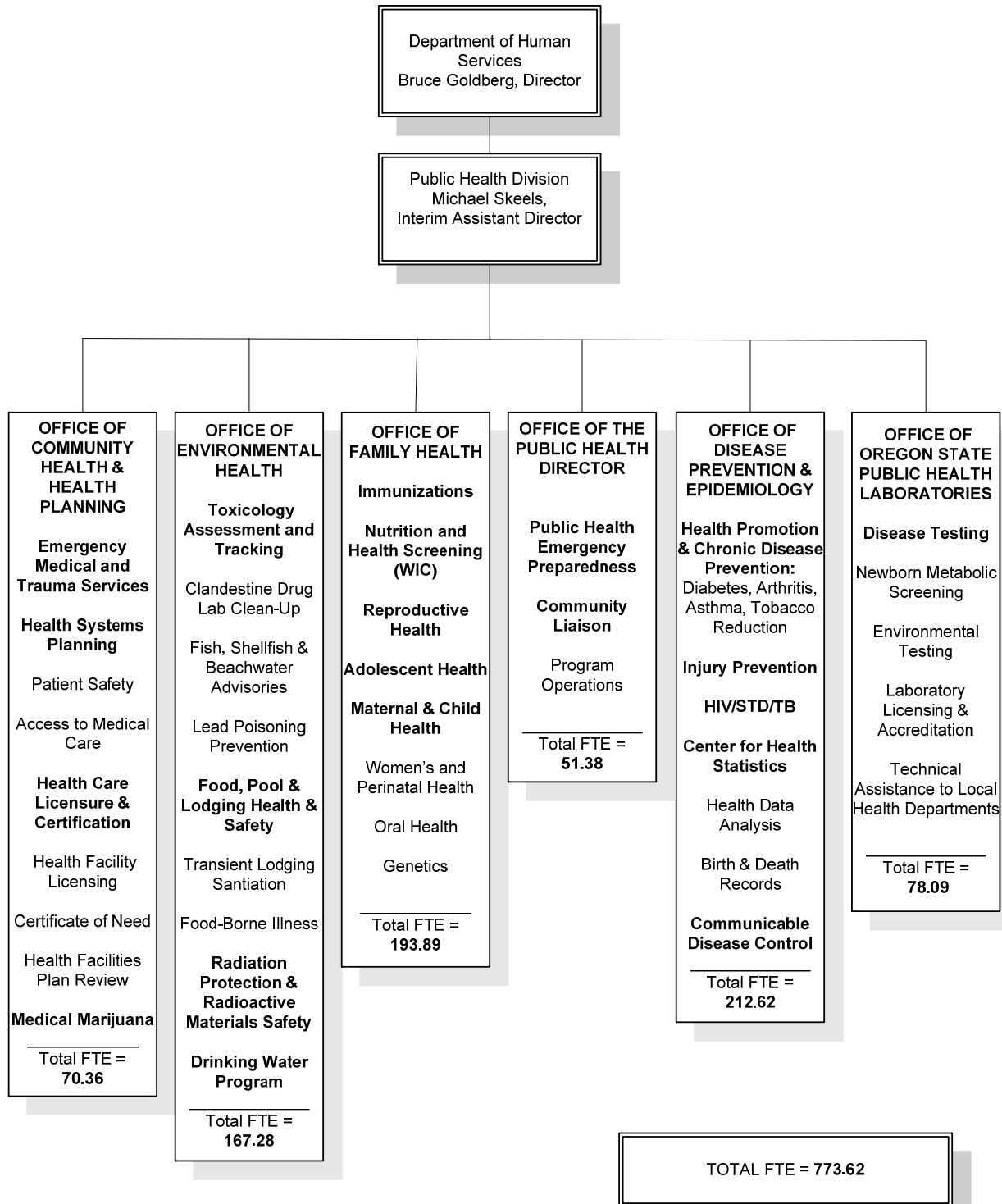
The following chart outlines the Public Health Division's major program areas and the DHS principles they support.

PH PROGRAM AREA	Child Health	Prevention	Comm. Disease	Access to Care	Environmental Health	Licensing & Regulation
Office of State Public Health Director						
Public Health Officer						X
PH Emergency Preparedness			X		X	
Community Liaison	X	X	X	X	X	X
Office of Community Health & Health Planning						
Emergency Medical Services				X		X
Health Systems Planning	X			X		X
Health Care Licensure and Certification						X
Medical Marijuana Program						X
Office of Environmental Public Health						
Toxicology, Assessment and Tracking Services		X			X	X
Drinking Water		X			X	X
Food, Pools, and Lodging Safety		X				X
Radiation Protection		X			X	X
Office of Family Health						
Immunization	X	X	X			X
Nutrition & Health Screening (WIC)	X	X		X		
Reproductive Health	X	X		X		
Adolescent Health		X		X		
Maternal & Child Health (MCH)	X	X		X		
Office of Disease Prevention & Epidemiology						
Health Promotion, Chronic Disease Prevention		X				
Injury Prevention & Epidemiology		X				
HIV/STD/TB			X			
Health Statistics (Vital Records)						X
Acute & Communicable Disease			X			
Office of the State Public Health Laboratories						
Newborn Screening	X	X		X		
Lab compliance & quality assurance					X	X
Virology/Immunology	X		X	X		
Microbiology	X		X	X	X	

Public health services touch the lives of all Oregonians every day. Preventive services are an investment with life-long benefit.



Organizational structure



Office of the State Public Health Director (OSPHD)

Key programs

The Office of the State Public Health Director (OSPHD) provides public health policy and direction to the public health programs within the division, and ensures that the disparate programs within and outside the division create an effective and coherent public health system for the state. This includes extensive interactions with a range of state and local agencies and organizations, many of them outside the health care community.

OSPHD manages the Public Health Emergency Preparedness Program (PHEP) which ensures that every community and hospital has an improving level of preparedness for health and medical emergencies by supporting the development and testing of plans, training, and collaboration between communities and with adjacent states. PHEP has been a part of state leadership in advancing the state's plans for pandemic influenza and the development of a state Crisis Communication Plan. Although the planning and training are still incomplete, through the activities and coordination of this program the communities of Oregon and the state overall are far better prepared to detect and respond to a public health emergency.

The Community Liaison (CL) unit provides support and oversight to local health departments. While PHD programs interact with the local health departments, the CL unit serves to coordinate the various activities and serves as the primary resource for the local public health systems overall. This is accomplished through technical assistance, coordinating required agency reviews, overseeing the disbursement of state support for public health funds to local health departments, directing the annual plan process and related budget revisions, and identifying grants and assisting with their preparation.

The Program Operations unit provides important administrative services to the OSPHD to support the effective use of resources to meet DHS and PHD goals and objectives. The unit includes staff with specialized skills to plan, develop and implement policies, procedures and program priorities with respect to tracking and expending resources.

The major sources of funding for OSPHD include:

- Centers for Disease Control and Preparedness Emergency Preparedness Grant,

- Health and Human Services National Bioterrorism Hospital Preparedness Grant,
- Centers for Disease Control and Prevention Preventive Health Block Grant, and
- State Support for Public Health (General Fund per capita).

Public Health Emergency Preparedness Program (PHEP)

Services provided

The Public Health Emergency Preparedness Program (PHEP) has two primary roles.

The first role is to develop emergency-ready state and local public health programs by upgrading, integrating and evaluating state and local public health preparedness for and response to terrorism, pandemic influenza and other public health emergencies. These activities include federal, state, local and tribal governments, the private sector, and non-governmental organizations.

Funding for these activities comes to PHEP through the Cooperative Agreement for Public Health Preparedness and Response for Bioterrorism from the Centers for Disease Control and Prevention (CDC).

The second role is to improve the ability of hospitals and health care systems to prepare for and respond to pandemics, bioterrorism, natural disasters and other public health emergencies.

Funding for these activities comes to the program through the National Bioterrorism Hospital Preparedness Program from the Hospitals Resources and Administrative Services (HRSA).

Where service recipients are located

Anyone, anywhere within Oregon's borders – or potentially in neighboring states – could be a recipient of services should a public health emergency event occur in the state or region. Within the Public Health Division PHEP activities are located across program offices in:

- Public Health Operations, Planning and Training programs (PHEP)
- Acute and Communicable Disease Program (ACDP)
- Oregon State Public Health Laboratories (OSPHL)
- Radiation Protection Services (RPS)
- Toxicology, Assessment and Tracking (TAT)
- Emergency Medical Services and Trauma (EMS/T)

- Maternal and Child Health (MCH)
- Immunization Program (IP)

Funding is provided to 34 local health departments and tribes to perform the activities that support the CDC grant guidance. The Oregon Association of Hospital and Healthcare Systems (OAHHS) and seven Regional Lead Agencies (RLAs) are partners that contract with PHD to support the work activities of the HRSA grant guidance.

Who receives services

The services are provided statewide through two contracting sources. For the CDC activities, PHEP contracts with 34 local health departments for the work activities that support the grant guidance. For the HRSA activities, PHEP contracts with the OAHHS and the seven RLAs.

How services are delivered

Services are provided by PHD staff and staff within public health departments, hospitals, health care facilities and tribes.

Why these services are significant to Oregonians

One of the fundamental responsibilities of state government is to provide for the safety of the people of the state. While the activities of PHEP are constrained by the guidance that accompanies the federal grants, PHEP endeavors to integrate its activities with the emergency preparedness activities of other agencies and organizations, especially those of other emergency responders. The primary intent of the CDC cooperative agreement is to fund the creation, deployment and continuous improvement of a state system of public health emergency preparedness using the CDC Preparedness Goals and associated measures to monitor performance.

The goal of the HRSA agreement is to prepare hospitals and supporting health care systems, in collaboration with other partners, to deliver coordinated and effective care to victims of terrorism and other public health emergencies. Activities include

improving hospital bed and personnel surge capacity, decontamination capabilities, isolation capacity, pharmaceutical supplies and supporting training, education, and drills and exercises.

Performance Measures

While PHEP does not have a DHS key performance measure (KPM), its state and local partnerships help further the DHS mission that people are healthy. PHEP reports to the federal government on an extensive list of measures and performance outcomes required by the grants.

Quality and Efficiency Improvements

In order to improve the quality of preparedness activities, PHEP works with its key partners to:

- Increase the use and development of interventions known to prevent human illness from chemical, biological and radiological agents as well as naturally occurring health threats.
- Decrease the time needed to classify health events as terrorism or naturally occurring.
- Decrease the time needed to detect and respond to chemical, biological and radiological agents in tissue, food or environmental samples that cause threats to the public's health.
- Improve the timeliness and accuracy of communications to health care providers and the general public regarding threats to the public's health.
- Decrease the time to identify causes, risk factors and appropriate interventions for those affected by threats to the public's health.
- Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.
- Decrease the time needed to restore operations to provide general public health services.
- Increase the long-term follow-up provided to those affected by threats to the public's health.

- Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.
- Increase the number of public health and medical service staff in Oregon's emergency volunteer program.
- Increase the number of health care partners that provide alternate care sites.
- Increase the capability of tracking the hospital bed availability system.
- Increase interoperable communication systems within the public health and medical services areas.
- Increase state, local and tribal public health and medical service personnel who receive training to support the National Response Plan.
- Increase all-hazard planning, training, exercise, evaluation and corrective actions for state, local and tribal public health and medical service personnel.

During 2007 – 2008 PHEP staff conducted 71 training sessions for approximately 2100 persons from various state, local and tribal agencies. Also during this time, approximately 1200 persons across the state attended 36 emergency preparedness exercises that PHEP conducted or participated in. Examples of the trainings and exercises include:

- Pan Flu orientation and school closure exercises conducted in 12 cities across Oregon.
- Avian Influenza animal emergency exercises and trainings held in 4 Oregon communities.
- Communication - various trainings and exercises were held throughout the state related to the following communication systems: Incident Command System, Agency Operation Center, Joint Information System, and Health Alert Network system.
- Radiological response - various trainings and exercises were held across the state related to aspects of radiological preparedness and response.
- TOPOFF 4: A 4-day full-scale event conducted to respond to a simulated terrorist generated dirty bomb scenario. Participating with the U.S. Department of State in this exercise were the states of Oregon (PHEP) and Arizona, the

United States Territory of Guam, and three international partners: Canada, the United Kingdom, and Australia. In the exercise, radiological incidents originated in Portland, Phoenix and Guam. State, territorial, and local officials in Oregon and Guam conducted a full-scale exercise, while Arizona officials participated in a functional exercise. Concurrent full-scale exercises were conducted in Canada, the UK and Australia.

Key budget drivers and issues

Historically PHEP program has been 100 percent federally funded. However, beginning August 2009, the state will be required to provide a ten percent match in order to continue federal grant funding. Additionally during the past four years the funds have been reduced at a rate of 10-15 percent annually. These reductions in turn have a significant impact on local health departments' ability to sustain and improve preparedness efforts at the community level.

Community Liaison (CL)

Services provided

The Community Liaison (CL) unit provides services that support the 34 county local health departments (LHDs). These services include ensuring compliance with the local public health portion of ORS 431, site visits to LHDs to ensure compliance with contract and minimum standards, and public health nursing workforce development. The CL unit also serves as the state's resource for the Conference of Local Health Officials (CLHO).

Where service recipients are located

The services are provided statewide through the 34 LHDs.

Who receives services

Services are provided to the 34 LHDs and state program staff who lack expertise in local public health issues.

How services are delivered

The compliance, workforce development and technical assistance to LHDs are provided by three CL staff. Site visits to each county LHD occur at least once during the year and staff have frequent contacts with LHDs on a regional or state basis.

Why these services are significant to Oregonians

The services provided by the CL unit ensure a state-local partnership and a state-local public health system. The services help ensure compliance with federal and state statutes and rules, state-local contracts, and minimum standards for local public health.

Performance Measures

While the CL unit does not have a DHS key performance measure, its state and local partnerships help further the DHS mission that people are healthy.

How Oregon compares to other states

No comparable data are available.

Quality and Efficiency Improvements

In order to improve the quality of services provided by LHDs the CL unit participates in all state-county public health workgroups, visits each county at least once during the year, and has created a Community Liaison Web site that provides LHDs with review tools, contract information, treatment protocols and a job announcement site.

Key budget drivers and issues

The CL unit is presently funded 100 percent by the federal Preventive Health and Health Services Block Grant. The President's proposed 2009 budget reduces this appropriation from \$97 million to \$0 nationally. This would result in a reduction of approximately \$1.4 million to PHD. At the same time, LHDs are experiencing a reduction in funding because of the loss of county timber revenues. This is expected to lead to a significant increase in need for assistance, information and direct consultations from the CL unit, as well as other PHD programs.

Office of Community Health and Health Planning (OCHHP)

Key programs

The Office of Community Health and Health Planning (OCHHP) promotes access to high-quality, safe health care by collaborating with a variety of public and private partners on policy development and program implementation. Through its regulatory activities, OCHHP also ensures that established standards are met by hospitals, other health care facilities and agencies, emergency medical technicians, ambulance services, and hospital trauma systems. OCHHP also administers several special programs including the Oregon Medical Marijuana Program.

Through its four major program areas, OCHHP:

- Develops and helps set health policy and direction
- Supports health care service providers in improving access to high-quality care and reducing disparities in health services
- Facilitates patient safety efforts and encourages the provision of patient-centered care
- Regulates acute care facilities, community-based providers; and certain caregivers to ensure safe, high-quality health care
- Regulates statewide programs and systems that provide emergency and definitive care to victims of sudden illness or traumatic injury
- Administers a registration system for patients, caregivers and growers eligible to participate in the Oregon Medical Marijuana Program
- Manages other special programs such as the Institutional Review Board for protecting human subjects involved in research

The major funding sources for OCHHP include:

- Fees through regulatory licensure, certifications and inspections
- Other fees for cardholders
- J-1 Visa Waiver (Conrad 30)
- Health and Human Services Cooperative Agreement

Emergency Medical Services and Trauma Systems (EMS/TS)

Key programs

The Emergency Medical Services and Trauma Systems (EMS/TS) program regulates and provides technical assistance and support to emergency medical care providers throughout Oregon, encourages improvements in the emergency care of pediatric patients, and develops, supports and regulates systems that provide emergency care to victims of sudden illness or traumatic injury. The program:

- Ensures that responders comply with training and equipment standards for staff and emergency vehicles and emergency systems are functioning efficiently and effectively.
- Sets standards, approves course work, tests and certifies emergency medical technicians and first responders.
- Delivers emergency medical training to small agencies in areas that do not have educational resources through the Mobile Training Unit and distance learning.
- Inspects and licenses ambulances and ambulance services including approximately 600 ambulances, including air ambulances, and 150 Emergency Medical Service agencies.
- Enforces professional standards for emergency medical technicians, first responders and ambulance services including issuing certifications to approximately 9,100 emergency medical technicians.
- Evaluates and implements trauma systems.
- Provides recommendations in the development of policies, legislative actions, technological advances and resource sharing to the State Interoperability Executive Council, which coordinates and implements Oregon's public safety communications interoperability issues.
- Organizes and evaluates the system for emergency response by emergency medical providers and hospitals to traumatic injury and sudden illness.
- Ensures trauma system standards are followed, which has resulted in a decrease in mortality from 25 percent preventable deaths pre-trauma system to a current 4 percent death rate.
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Where service recipients are located

The EMS/TS program serves everyone in Oregon who experiences urgent illness or injury.

Who receives services

Direct recipients are Oregon's Emergency Medical Service providers including ambulance and non-transporting EMS agencies and trauma hospitals. In addition, the program indirectly serves thousands of Oregon residents and visitors by its efforts to ensure appropriate care for their urgent illness or injury.

How services are delivered

EMS/TS staff provide information and technical assistance directly to providers. Services provided locally include education, consultation, technical assistance, and verification of compliance with state statutes and rules.

Why these services are significant to Oregonians

The EMS/TS program furthers the DHS goal of keeping people safe by ensuring the effectiveness and coordination of the state's emergency response system for illness and injury.

Performance Measures

There are no DHS key performance measures applicable to this program. The EMS/TS program has one measure.

Measure: Continue implementation and evaluation of the Oregon Trauma System, the emergency medical services system, and the designation of facilities to provide definitive care to specific patients; to monitor the quality and effectiveness of trauma systems, the emergency medical services system and the care provided by designated specialty care facilities. Additionally, the program will evaluate the standards used to designate the levels of care available in these systems.

Purpose

This measure tracks the ability of the EMS/TS program to decrease the human and fiscal impact of morbidity and mortality due to trauma and sudden illness. The program uses this data to develop and implement a quality improvement process

for pre-hospital and in-hospital treatment of citizens and visitors who are victims of traumatic injury or sudden illness.

How Oregon compares to other states

Oregon was one of the first states in the nation to enact and implement an inclusive Trauma System. The standards are updated regularly using the data gathered to reach the goal of decreased morbidity and mortality due to trauma injury. The funding available to provide the infrastructure has limited the ability to improve the trauma care system. Additionally, research has demonstrated that establishing similar designation systems for heart attack, stroke, and pediatric patients can significantly improve the outcomes of these patients. Finally, a recent evaluation of the EMS system noted that Oregon lags behind in several areas, especially implementation of data systems, EMS system evaluation and quality improvement.

Proposed Outcome Measures

Measure: Continue to implement and evaluate initial and continuing education for First Responders and EMTs, Course Directors and Coordinators.

Purpose

The purpose of this measure is to improve the consistency and availability of initial and continuing education for those seeking to become emergency medical technicians and first responders, as well as to enrich the available methods and practices of those responsible for education (i.e., course directors and coordinators).

How Oregon compares to other states

Oregon uses the U.S. Department of Transportation National Standard Curriculum for First Responders, EMT-Basics and Paramedics. Staff have developed and implemented an Oregon-specific curriculum for EMT-Intermediates to specifically serve the rural and frontier regions of the state. Additionally, Oregon was one of the beta-test states for Computer Adaptive Testing and is using this new technology and methodology to improve availability, accuracy and timeliness of the exam process. Oregon is one of the nation's leaders in passing scores on the EMT-Basic and Paramedic written exams due largely to the stringent academic requirements of the EMS Education Model. The U.S. Department of Transportation National Standard Curriculum will no longer be available after

2012, so the EMS/TS program and the Oregon Medical Board's EMS Committee have established a workgroup to study the situation and propose a plan for Oregon to follow when this change occurs.

Measure: Develop a statewide EMS Patient Encounter Database that will document the care provided to critically ill and injured patients, support the provision of technical assistance and consultative services regarding quality improvement of emergency care and to encourage injury prevention activities.

Purpose

The purpose of this measure is to gather pertinent data on the care provided to EMS patients into one central registry system. Information will be analyzed to measure and improve the availability and quality of transportation and treatment of those citizens and visitors in need of emergent pre-hospital medical care. It can also be used to determine how to improve the quality and availability of EMS services.

How Oregon compares to other states

Oregon is in the research and development stage of implementing the Oregon EMS Patient Encounter Database. More than half of the states have or are implementing EMS Patient Encounter Databases. Washington and Idaho both established contracts for EMS patient encounter databases in 2007.

Quality and Efficiency Improvements

Oregon's EMS/TS program implemented a new licensing and certification data system, License 2000 (L2K), with the goal of enabling streamlined processing of applications and licenses for agencies, ambulances and EMTs. This change has decreased processing time by about seven days, however, the cost and technical support available to implement the L2K system has slowed implementation.

Additionally, by increasing emphasis on providing technical and educational assistance to EMS agencies and pre-hospital providers, EMS/TS expects to improve overall compliance with standards and therefore improve quality of services by community providers.

Key budget drivers and issues

Continued erosion from prior levels of funding has contributed to the overall decline in the quality of the EMS/TS program. This decline in quality from prior years was confirmed by a federal assessment of the program released in April 2006. During the past three years, the Rural Access for Emergency Devices grant from HRSA provided \$523,430 in funding to Oregon. This federal grant was discontinued, therefore, Oregon's rural EMS agencies no longer have access to these resources to either purchase life-saving equipment or replace outdated models. For example, funds have been used to equip 125 rural EMS, fire and law enforcement agencies with 310 automated external defibrillators (AEDs) and training in CPR and AED use. First responders have saved lives after sudden cardiac death because of these AEDs. Most of Oregon's small rural volunteer agencies deal with inconsistent funding sources, and rely heavily on grants for their equipment and training. The Oregon Department of transportation did make approximately \$100,000 available to support the pilot project to determine the costs and barriers to establishing an EMS patient encounter database. It is hoped that these funds can continue to be available to address significant problems in the EMS program.

Health Systems Planning (HSP)

Services provided

The Health Systems Planning (HSP) program helps the state improve access to primary health care, reduce disparities in health services, improve patient safety and increase the level of patient-centered care.

HSP is committed to the health of all Oregonians and especially those who are most vulnerable because of poverty, lack of access to health care, geographic isolation, disability, age, race or ethnicity. The program:

- Determines health professional shortage areas, and medically underserved populations and areas.
- Addresses health workforce needs by connecting providers with communities who need them including National Health Service Corps practitioners; J-1 Visa Waiver physicians, and supporting those community placements.
- Helps communities start clinics, expand capacity, add new services and take other steps to improve the health of residents.
- Partners with racial and ethnic communities to improve access to care.
- Provides staff support to the Safety Net Advisory Council and partners with the Office of Health Policy and Research to support access-related work of the Oregon Health Policy Commission and Oregon Health Fund Board.
- Analyzes health access issues and works with state and local leaders to devise solutions.

HSP works with consumers, health care providers, health care organizations and other state partners to improve the quality of health care. The program:

- Develops, encourages, coordinates and supports efforts to improve patient safety and reduce medical errors through statutory responsibility related to the Oregon Patient Safety Commission and other avenues.
- Develops, encourages and supports efforts by physicians, nurses and other practitioners to provide leadership in improving the quality of health care.
- Develops, encourages and supports efforts to make health care more patient-centered.

HSP works with consumers, health care providers, health care organizations, local health departments and others to improve the effectiveness of the health care system. The program:

- Works with health systems and hospitals to ensure standards for facility needs and safety are met.
- Develops and implements ideas to leverage funds and better target funding for important health care services.
- Develops and supports efforts to improve communication and coordination between different parts of the health care system.
- Works with partners to better use electronic health records and data to improve the health care system.
- Assists local health departments with analysis of data to identify critical health problems in their communities.

Where service recipients are located

Service recipients include health care organizations, public and private health care systems and communities across Oregon. The ultimate beneficiaries are Oregonians who are able to find access to safe, effective and patient-centered health care.

Who receives services

Direct service recipients include rural health clinics, federally qualified health centers, migrant health centers, school-based health centers, volunteer clinics, county health departments, fully-capitated health plans, mental health organizations, dental care organizations, urban and rural community initiatives, physicians, dentists, and health systems. The HSP unit supports:

- A network of approximately 120 J-1 Visa Waiver primary care and specialty and National Health Service Corps physicians who provide care to underserved populations across Oregon.
- Technical assistance to migrant and community health centers and other organizations that care for the estimated 175,000 migrant and seasonal farm workers in Oregon.

- Technical assistance to health safety organizations that serve more than 120,000 of the 600,000 uninsured individuals in Oregon.
- Efforts of more than 20 communities in Oregon to identify and respond to access needs and improve health status.
- Designation of medically underserved areas or populations and health professional shortage areas to ensure the flow of federal funds to more than 200 primary care clinic sites and organizations across the state.
- The Oregon Patient Safety Commission, including the certification of its reporting system.

End beneficiaries of services are Oregonians of all ages in urban and rural areas, low-income Oregonians, migrant and seasonal farm workers, Medicaid and Medicare recipients, and the uninsured.

How services are delivered

Whenever possible, HSP delivers its services through collaborative efforts with public and private partners. Often this includes direct contact with local providers and organizations, many times with on-site consultation provided to the community.

HSP uses multiple data sources to determine health professional shortage areas and medically underserved areas and populations. HSP works with HRSA and CMS, which then publishes these designations. Identified communities are eligible to apply for federal resources including annual funding for health centers, cost-based rates, National Health Service Corps and J-1 Visa physician placement.

HSP staff advise and assist communities regarding potential programs, community assessment and planning, and grant applications. The program also partners with other organizations to ensure the most appropriate and timely response to community requests for assistance.

Other services include:

- Assisting communities to establish, expand and maintain health centers serving vulnerable populations, engage in health promotion, and leverage resources through public and private partnerships.

- Assisting with staffing the Safety Net Advisory Council and Oregon Health Policy Commission work groups.
- Connecting communities with potential funding sources and facilitating the sharing of best practices across Oregon.
- Working to certify the integrity of the Oregon Patient Safety Commission reporting system and partnering with other public and private entities to reduce medical errors and improve patient safety.
- Providing technical assistance to local health departments to improve their data analysis capabilities.

Why these services are significant to Oregonians

HSP helps ensure that Oregonians, especially those facing barriers to care, have access to care that is safe, capable and timely. HSP provides communities with the tools they need to maintain and improve their residents' health, and assists public and private health systems to be more effective and efficient. As a result of these services, Oregonians are healthier.

Performance Measures

HSP has one key performance measure.

KPM #27 – Safety Net Clinic Use: The number of uninsured Oregonians served by safety net clinics.

Purpose

This measure helps policy makers and planners assess access to care for the uninsured and the role and needs of the health safety net. HSP focuses on ensuring access to care for individuals who face significant barriers to care. Lack of insurance is a major barrier to care. The number of uninsured in Oregon has been very high in recent years and has increased as eligibility for OHP has been reduced. The health safety net includes a number of clinics whose core mission includes providing care to those who face barriers to care and rural providers who often are the only area source for care.

How Oregon compares to other states

No comparable data are available.

Quality and Efficiency Improvements

Every two years HSP conducts a survey of physicians and dentists in order to complete health professional shortage designations. As a result of increased federal requests for information and limited resources, staff redesigned the approach to conducting the study and created a more streamlined and effective process to respond to changed circumstances.

During the last biennium, federal HRSA staff reviewed the work of HSP through an onsite visit and cited HSP as an exemplary primary care office and one that fulfilled the vision for which federal officials had hoped.

Key budget drivers and issues

Several major health trends will affect programs, services and populations. These include:

- Rising health care costs and fewer people with health insurance is a trend that continues to create challenges for lower income Oregonians to receive needed health care. A slowing economy may contribute to this trend.
- Projected workforce shortages across the healthcare system as the result of retiring baby boomers and other factors are of increasing concern. This exacerbates the already significant challenges faced by rural areas.
- An increase in resources for safety net providers has not been commensurate with increases in the number of uninsured individuals.
- Many employers are reducing or eliminating medical benefits for employees.
- The Oregon Health Fund Board has developed recommendations for the 2009 Legislative Session that will address coverage and benefits, access, quality, transparency, and delivery system reform with many implications for programs, services and populations.

- Increasing interest in public and private healthcare organizations in better integrating mental and physical holds promise for improving care and reducing cost.
- Oregon's demographics are changing, particularly in regard to an increasing Hispanic population. There now are many more indigenous migrants from Mexico and Central and South America than in previous years. This has implications for outreach and the delivery of care.
- The health care system is becoming receptive to reporting on medical errors, which is likely to bode well for increased patient safety as hospitals, nursing facilities, pharmacies and other entities analyze and learn from those events.

Health Care Licensure and Certification (HCLC)

Services provided

The Health Care Licensure and Certification (HCLC) program ensures that Oregonians have wide access to the health care they need and that it will be safe and of high quality. This is accomplished through state licensure and federal Medicare certification of health facilities, providers and suppliers. HCLC:

- Sets standards for high-quality, safe health care through administrative rule promulgation
- Conducts onsite surveys to evaluate compliance with state licensure rules and federal Medicare conditions of participation and coverage
- Investigates complaints and allegations of poor medical care
- Performs onsite building inspections for health care facility construction projects
- Provides information and education for staff in health care facilities and agencies
- Completes initial licensure and certification surveys of new providers in a timely manner

Where service recipients are located

Health care facilities throughout Oregon are served by HCLC.

Who receives services

Services are provided at the facility level, except for certification of Hemodialysis Technicians. These facilities include:

- Ambulatory Surgical Clinics
- Birthing Centers
- Comprehensive Outpatient Rehabilitation Facilities
- Dialysis Facilities
- Hemodialysis Technicians
- Home Health Agencies

- Hospice Agencies (Medicare certified only)
- Hospitals
- In-Home Care Agencies
- Outpatient Physical and Speech Therapy Agencies
- Portable X-ray Providers
- Rural Health Clinics
- Special Inpatient Care Facilities

How services are delivered

Services are provided by onsite visits for routine inspections and complaint investigations. Information and consultation also are provided by telephone and mail.

Why these services are significant to Oregonians

Services ensure that health care facilities in Oregon meet minimum state and federal regulations, and thereby provide safe patient care in a safe patient environment.

Performance Measures

There are no DHS key performance measures applicable to this program. The HCLC program has one measure.

Measure: Annual State Performance Audit by Federal Grant Partner (Medicare). Includes onsite review by federal government including review of records and staff interviews and ongoing review of data submitted by the state in mandatory federal data system.

Purpose

The purpose of this measure is to ensure that Oregon meets minimum grant requirements on productivity and quality.

How Oregon compares to other states

According to federal data, Oregon operates near the mean of other states in enforcement actions, number of surveys completed, and the percentage of complaint investigations that are substantiated.

Quality and Efficiency Improvements

HCLC has recently shifted a nurse to an Operations and Policy Analyst position to ensure that the licensing programs are providing high quality service to health providers, and ensure timely inspections and response to provider questions.

Key budget drivers and issues

With present staffing levels, the HCLC program has experienced a delay in health facility oversight. Both the number of inspections and the quality of the inspection (reduced survey hours) have been affected. For FFY 2008, the department met minimum coverage levels for three of four work load tiers and initial certification surveys were only provided for a few provider types with approval from Medicare. Without additional funding in FFY 2009 the department will continue to not meet minimum coverage levels.

Oregon Medical Marijuana Program (OMMP)

Services provided

The Oregon Medical Marijuana Program (OMMP) administers the registration program of the Oregon Medical Marijuana Act (OMMA) that provides legal protection from state civil and criminal prosecution for qualified patients who comply with program requirements to grow and use marijuana as an alternative medicine.

The OMMP:

- Conducts the administrative process of reviewing applications for the purpose of issuing a medical marijuana registry identification card.
- Maintains records in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- Provides administrative support to the Advisory Committee on Medical Marijuana, whose members are appointed by the DHS director.
- Promotes knowledge of the Oregon Medical Marijuana Act, program policies and processes to patients, caregivers and growers by participating in advocate work group sessions.
- Promotes consistency and awareness concerning the OMMA by providing statewide training to law enforcement agencies.
- Monitors the 24/7 electronic law enforcement verification data system to ensure that OMMP cardholders receive the best protection against arrest and prosecution while providing law enforcement officers with real-time information.

Where service recipients are located

OMMP serves patients statewide. The number of patients registered with the program has increased from approximately 600 in May 2000 to more than 20,875 as of July 2008.

Who receives services

Patients who have one of the following qualifying debilitation medical conditions, or a medical condition or treatment for a medical condition that produces one of the following may become a registered identification cardholder:

- Agitation due to Alzheimer's disease
- Cancer
- Glaucoma
- HIV positive status
- AIDS
- Cachexia
- Severe pain
- Severe nausea
- Seizures
- Persistent muscle spasms

Pain is the number one condition cited for participation in the program.

How services are delivered

The OMMP process applications from Oregonians suffering from qualifying debilitating medical conditions for the use of medical marijuana without the fear of civil or criminal penalties when a physician advises that such use may provide a medical benefit.

Why these services are significant to Oregonians

Since the inception of the OMMA in 1998, the program has shown continued growth. To date, there are over 21,400 patients in the program and over 32,000 registered OMMP cardholders, including caregivers and growers. This includes patients, caregivers and persons responsible for a medical marijuana grow site.

This program allows Oregonians suffering from a debilitating medical condition to use medical marijuana without fear of civil or criminal penalties.

Performance Measures

There are no DHS key performance measures applicable to this program. The OMMP has one measure.

Measure: Number of days to issue a registry identification card once an application is considered complete.

Purpose

Oregon statute requires that the department shall approve or deny an application within 30 days of receipt of a completed application. A registry identification card shall be issued within five days of verification of the completed application.

How Oregon compares to other states

No comparable data are available.

Measure: Percentage of time Verification System is available to authorized law enforcement personnel.

Purpose

Oregon statute requires a system by which authorized employees of state and local law enforcement agencies to verify at all times whether a person is a lawful possessor of a registry identification card, or the designated primary caregiver of a lawful possessor of a registry identification card, or a location is an authorized marijuana grow site.

How Oregon compared to other states

No comparable data are available.

Quality and Efficiency Improvements

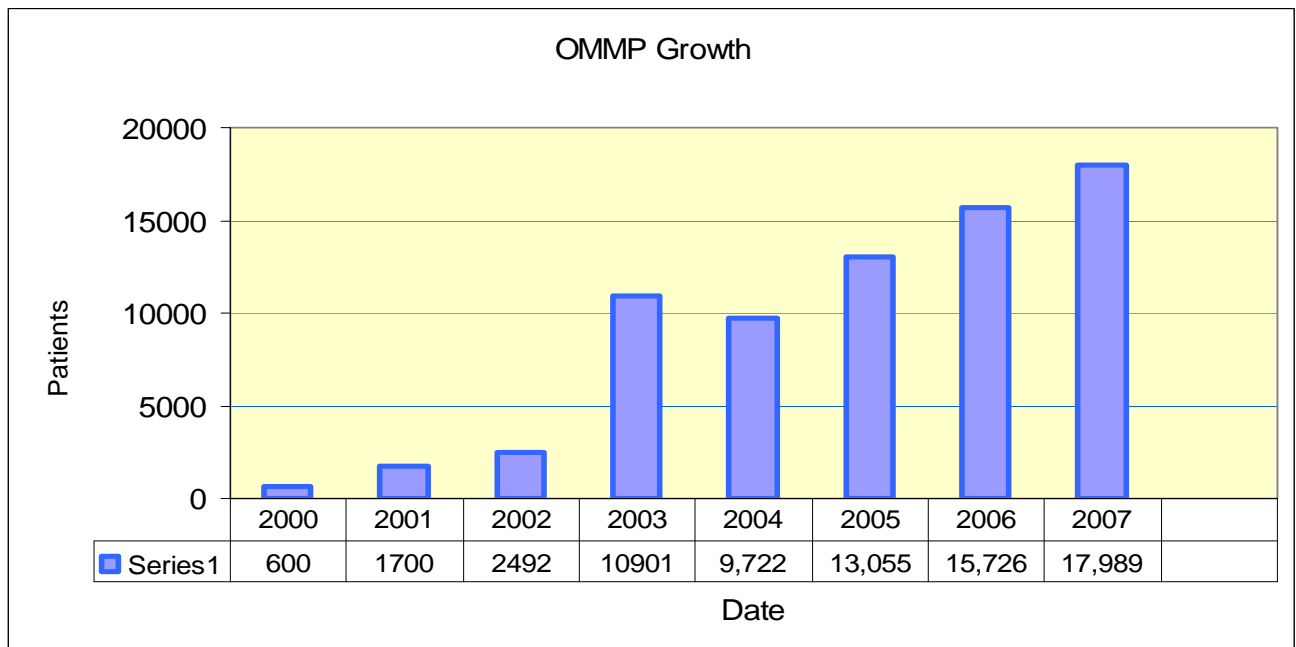
The program actively pursues administrative streamlining processes in an effort to better serve patients while maintaining the highest level of confidentiality. Multiple

states have requested information on Oregon’s program to use as a model for their medical marijuana initiatives and registration systems.

The program currently is in the process of implementing the My License Office (MLO) for its registry. Replacing an outdated system developed for relatively small numbers of individuals, MLO will reduce processing time, improve search capabilities for providing information to cardholders, and enhance report capabilities.

Key budget drivers and issues

The OMMP continues to see an increase in the number of applications received. While the program is actively pursuing streamlining the application process and achieving efficiencies, substantial resources have been and continue to be invested to make this occur.



Office of Environmental Public Health (OEPH)

OEPH leads the state's effort to protect Oregonians from environmental health hazards in areas as diverse as drinking water, radiation, recreational waters, lead, food, occupational safety, air quality, consumer products, clandestine drug labs and toxic chemical releases. OEPH partners with local health departments, private businesses, state agencies, community groups, academic institutions, scientific and medical experts, and others to provide technical assistance, case management, public information, scientific expertise and regulatory oversight.

The office is comprised of four program sections:

- The Toxicology Assessment and Tracking Services section prevents or minimizes human health effects from hazardous working conditions, injuries and exposure to hazardous waste and other environmental dangers.
- The Food, Pool, Lodging Health and Safety section is home to Oregon's food-borne illness protection program, and provides leadership for local health departments to ensure safety in Oregon's 18,000 food facilities, 3,400 public pools and 2,300 tourist accommodations.
- The Radiation Protection Services section protects both workers and the public from unnecessary and unhealthy radiation exposure, and provides Oregon's sole public resource for radiation-related incidents, whether accidental or intentional.
- The Drinking Water Program works to ensure safe drinking by reducing the risk of waterborne disease and exposure to chemical contaminants in Oregon's 3,600 public drinking water systems.

Major funding sources for OEPH include:

- Environmental Protection Agency (EPA) Drinking Water Primacy and State Revolving Loan Fund
- EPA Beach Monitoring
- EPA Indoor Radon Monitoring
- Food and Drug Administration (FDA) Mammography Facility Inspections
- National Center for Environmental Health National Environmental Public Health Tracking

- EPA Childhood Lead
- National Institute for Occupational Safety and Health's Oregon Worker Illness and Injury Prevention Program
- CDC Elevated Blood Lead in Adults
- CDC/Agency for Toxic Substances and Disease Registry (ATSDR) Surveillance of Hazardous Events
- CDC/ATSDR's Program to Conduct and Coordinate Site Specific Activities
- Pesticide Analytical Response Center (PARC)
- Licensure, inspection and certification fees
- County Remittance of a portion of Food, Pool, Spa & Lodging license fees
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Toxicology, Assessment & Tracking Services (TATS)

Services provided

The Toxicology, Assessment & Tracking Services focuses on the identification, intervention and prevention of occupational and environmental illnesses and injuries to Oregonians and is the State's primary point of technical leadership and expertise on diverse toxicological health concerns in the built and natural environments. The section conducts surveillance on reportable and targeted environmental and occupational injuries and diseases, and provides information and education on preventive strategies about environmental and work place health risks to the public and health providers. Our mission is to improve the safety and health status of all Oregonians.

Where service recipients are located

Service recipients of all programs live in all areas of the state. TATs also provides services to other state and local governments, tribes and businesses throughout the state. Several programs, such as OBMP Monitoring and blue-green algae oversight, also provide an important service to out-of-state visitors.

The statewide programs in TATS include:

- Oregon Beach Monitoring program (OBMP)
- Clandestine Drug Lab program (CDL)
- Environmental Health Assessment program (EHAP)
- Environmental Public Health Tracking program (EPHT)
- Hazardous Substances Event Surveillance System (HSEES)
- Lead Poisoning Prevention Program (LEAD)
- Oregon Worker Injury and Illness Protection Program (OWIIPP)
- Pesticide Exposure Safety and Tracking program (PEST)
- Toxicology Consulting Services (TOCS)

Who receives services

OBMP - services are provided to individuals who swim and recreate in marine waters at recreational beaches along the Oregon coast.

CDL - works directly with owners of unfit-for-use properties, contractors who perform work on these properties, local government officials, and unfit for use property neighbors. The program also indirectly affects any member of the public who may come into contact with an unfit site.

EHAP - serves communities that live near or are affected by Superfund and hazardous waste sites throughout Oregon.

EPHT - customers at this stage in development will be state agencies, such as the Oregon Department of Environmental Quality, Oregon Department of Education, DHS, local health departments, and other stakeholders such as universities that collect environmental or health data. As the EPHT program develops, users will include community and non-profit groups and the general public.

LEAD - services are provided to individuals throughout the state who may be exposed to or affected by lead hazards and to agencies that provide services to these individuals.

HSEES - serves employees and industry management, emergency responders, emergency managers, local governments, students in school, and the general public through education and outreach efforts based on analysis of surveillance data.

OWIIPP - customers include the entire working population of Oregon, as well as agencies that serve or advocate for Oregon's workers.

PEST – customers include the entire population of Oregon whose health may be adversely affected by exposure to pesticides, as well as multiple state agencies that have jurisdiction over pesticides in the State.

TOCS - is Oregon's public health resource for environmental toxicology. Schools, child care centers, businesses, tribes, local governments, natural resource organizations, other state agencies, the medical community and the general public routinely seek consultation, risk assessment and expert advice.

How services are delivered

OBMP - monitors and assesses for the pathogen indicator, enterococcus, on coastal recreational waters adjacent to OBMPs or similar points of access that are used by the public for swimming, bathing, surfing or similar water contact activities.

- During the peak-use season (May through September), four OBMPs are monitored weekly, 13 OBMPs are monitored every two weeks and three OBMPs are monitored monthly. Resampling occurs within 96 hours of a finding in excess of safe limits (referred to as an “exceedance.”)
- During the non-peak-use season (October through April), 14 OBMPs are monitored every two weeks and two OBMPs are monitored monthly. Resampling does not occur.
- Program staff notify the public when the coastal recreational water quality standard of 158 orgs/100ml is exceeded.
- The public is notified about exceedances of the marine water quality standard by news releases to coastal and other media outlets; posting of advisory sign(s) at access points on the affected OBMP; posting of the news releases on the OBMP Web site; posting on the Earth911 Web site; updating the statewide toll-free hotline with the latest OBMP advisory information; phone calls to city and county officials; and e-mail notification of the news release to local and other government agencies, people and organizations who have requested notification.

CDL - services are provided statewide and incorporate off-site training, presentations and audits.

EHAP - works with partner agencies to inform citizens of the potential health effects of environmental exposures in their communities through public health assessment and consultation reports, public meetings, fact sheets, and other health education materials.

EPHT - data and information services will be accessible on a secure Web site that will provide data, analytic tools and reports to customers who are trained in privacy laws. In the future, the public will be able to access data, information and reports generated by the EPHT program and its partners through an open Web site.

In addition to these services, EPHT will collaborate with state agencies and local health departments to deliver customized data and analytic services.

HSEES - provides data-driven presentations, reports, website postings, e-mail alerts, participation in meetings of community emergency preparedness groups, telephone support and one-on-one contacts.

Lead - Lead Poisoning Prevention services are delivered statewide to Oregonians by a variety of different outreach mechanisms. Technical assistance is provided via website postings, reports, mail, phone, toll-free phone service, outreach events and e-mail correspondence. Program staff provide educational materials, training and presentations to interested businesses, agencies, community members, medical providers, community-based organizations and county health departments.

OWIIPP - surveillance data and intervention strategies are delivered to the working population of Oregon through partnerships with private worker compensation insurers, researchers, advisory committee members, and various other partners and stakeholders.

PEST – performs case-based surveillance on acute health affects related to pesticide exposure and provides educational materials to the public to inform best practices in using and storing pesticides. In addition, provides a public health perspective to the Pesticide Analytical Response Center, or PARC, an eight-agency panel consisting of organizations with jurisdiction over pesticides in Oregon.

TOCS - provides services via telephone, e-mail, use of Web-based materials, distribution of fact sheets and attendance at public meetings. In addition, ETS provides numerous interagency services at the county, state and federal levels.

Why these services are significant to Oregonians

OBMP services protect the health of Oregon's beach water users. Exposure to recreational marine waters contaminated with bacteria, viruses or other disease-causing organisms can result in a variety of illnesses (e.g., gastrointestinal problems) in people using these waters. Water quality monitoring and reporting can help reduce the period of time in which people are potentially exposed to high levels of these waterborne organisms.

CDL services help Oregonians keep themselves and their families safe by working to ensure that they aren't exposed to contamination due to the manufacturing of illegal drugs (primarily methamphetamine). The health effects of living in former labs can vary greatly and are not well documented, but the chemicals used do have a potential for serious consequences. The program helps protect the public by giving people the information they need to avoid exposing themselves or their children to possible contamination. The CDL program also regulates how that contamination is abated and attempts to set reasonable standards for a property before it can be certified fit for use and people once again are allowed to use it.

The services provided by EHAP help citizens make informed decisions about reducing or preventing exposures to environmental contaminants. For example, EHAP has worked at sites where there was exposure, or suspected exposure, to such carcinogens as asbestos, arsenic, mercury and/or chlorinated solvents.

The EPHT network will help strengthen Oregon's ability to track and prevent health problems linked to the environment. More specifically, communities may learn about health and the environment in their area, scientists may get information to help their research, and officials may get information to set policy and promote activities to protect and improve health in communities. For example, EPHT will provide critical information on the association between asthma and the environment, which will help reduce the economic cost of this disease. Nationally, in 2000, the cost for emergency room visits for asthma alone exceeded \$650 million.

The goal of the HSEES system is to prevent morbidity and mortality among the citizens of Oregon associated with acute releases of hazardous substances.

Lead - Blood lead testing became a reportable health condition in 1991. The state's surveillance system currently receives all testing results for both adults and children. Due to increasing awareness of the dangers of lead exposure provided by education and outreach activities, blood lead testing of at-risk children in Oregon continues to increase each year. Children living in older (primarily pre-1950) housing are at increased risk for lead exposure and poisoning. According to the 2000 U.S. Census, Oregon's share of pre-1950 housing stock (20.6 percent) is found in all 36 counties. Since 2005, approximately 500 people have been trained by OEPH to ensure toxic paint is handled safely.

The services that OWIIPP provides help identify the occupations and industries that have a high risk of illness or injury in order to develop targeted intervention strategies to ensure that Oregon workers stay healthy. For example, OWIIP projects have focused on occupational burn injuries, latex sensitivity and injuries to youth workers.

The services provided by PEST aim to reduce acute pesticide related illness and injury by collecting data on the human health effects from pesticide exposure. This data is used to look for trends in exposure or illness and injuries in order to provide data-driven recommendations to the PARC board.

Schools, day care centers, businesses, tribes, local governments, natural resource organizations, state agencies, the medical community and the general public are served by TOCS. Services include consultation, risk assessment and expert advice from the TOCS team regarding the potential health effects of exposure to environmental toxins or contamination.

Performance Measures

There are no DHS key Performance measures identified for TATS.

Quality and Efficiency Improvements

TATS programs continually work with evaluation and facilitation experts to assess processes and products, especially as to how program activities meet the needs of partners and stakeholders

Key budget drivers and issues

The majority of TATS programs are federally funded, with the exception of CDL and the Lead Paint programs which are partially funded by fees. Most of these programs have been flat funded or have seen a significant decrease in federal funding during recent years. Continuous annual reports and competitive application processes result in time away from providing services and create uncertainty about continued funding. State funding to support environmental, occupational health and toxicological surveillance would be an important improvement.

CDL - Since late 2005 the number of new properties with which CDL deals has dropped considerably, due in part to August 2005 legislation limiting the availability of materials required to manufacture methamphetamine. This has resulted in an 84 percent drop in cases from the busiest year of the program – from 327 new cases in 2001 to 52 in 2006 and 22 in 2007. CDL is fee-based, and receives money only when property owners submit information for each step in the assessment and decontamination process. Although new cases are declining, the program continues to work with property owners of older cases to help them bring their properties through the program.

Food, Pool and Lodging Health and Safety Section (FPLHSS)

Services provided

The Food, Pool and Lodging Health and Safety Section (FPLHSS) implements and maintains intervention and regulatory strategies to prevent illness and injury of the public as a result of patronizing Oregon's food, pool and lodging facilities.

The Foodborne Illness Prevention Program works in partnership with local public health authorities, the food service industry, businesses, academia, and state and federal agencies to reduce or eliminate known common causes of foodborne illness.

The Public Pool and Tourist Facility programs work in partnership with local public health authorities, industry and businesses to reduce or eliminate the risk of waterborne illness and accidental injury and death of the public from using public pools or tourist facilities.

Where service recipients are located

Services are provided through Local Health Departments, to businesses and facilities statewide.

Who receives services

Licensing, inspection and outbreak investigation services are provided to nearly 18,000 restaurants, 3,400 public pools and 2,300 tourist accommodations benefiting Oregonians and visitors.

How services are delivered

Services are delivered by intergovernmental agreements with 36 local public health authorities. County environmental health staff are the direct service providers.

Why these services are significant to Oregonians

The foodborne illness prevention and public pool and tourist programs focus their efforts on the prevention of illness and accidental injury. The impacts of foodborne illness are significant:

- From January 2004 through July 2006, more than 1,835 people were sickened in 103 foodborne illness outbreaks in Oregon.
- A foodborne illness outbreak costs an establishment an average of \$75,000.
- When a restaurant is sued and the source of the illness is known, the expected award is \$82,333. (National Restaurant Association)
- The economic cost of foodborne illness, related to five pathogens (including E. Coli 0157-H7 and Salmonella) is estimated at \$6.9 billion annually.
- Foodborne illness in the United States costs between \$10 billion and \$83 billion annually. (USFDA)

Performance Measures

There are no DHS key performance measures for FPLHSS.

Quality and Efficiency Improvements

In order to improve the quality of services provided to clients, program staff reviewed seven counties and accompanied 18 inspectors during their routine food service inspections. Performance and trends are tracked to create a record of improvement in efforts to eliminate the known causes of foodborne illness.

**Field Review Summary:
Percent In Compliance**

Category	2000	2001	2002	2003	2004	2005	2007
Introduced self to the operator prior to starting the inspection and provided business card	83%	100%	97%	100%	100%	100%	83%
Washed their hands at the beginning and as needed during the inspection	100%	100%	97%	100%	100%	100%	100%
Checked each hand sink for accessibility, hot & cold water, soap and paper towels	89%	96%	97%	100%	100%	100%	100%
Took temperatures on the cook line, hot holding units, and cold holding units	94%	96%	90%	94%	97%	94%	67%
Asked open-ended questions and listened to the operator	89%	96%	100%	98%	100%	100%	83%
Observed food handlers for handling of raw product, personal hygiene and hand washing	83%	79%	93%	98%	95%	95%	83%
Asked operators about the availability, use, calibration, and cleaning of probe thermometers	78%	88%	80%	96%	93%	93%	83%
Checked for refrigerator thermometers	83%	100%	100%	100%	100%	100%	83%
Checked wipe cloths for sanitizer residual	94%	100%	87%	100%	100%	100%	100%
Asked operators about their use of sanitizer test strips	94%	100%	97%	94%	96%	96%	83%
Asked about cleaning procedures of in-place equipment	72%	96%	97%	84%	100%	94%	83%

Asked how and where food is prepared	89%	92%	97%	100%	100%	100%	100%
Asked cooks how they know when an item is cooked to proper temperature	83%	92%	90%	100%	100%	100%	83%
Asked cooks how they cool food items prepared in advance and in large quantities	94%	100%	97%	100%	100%	100%	100%
Asked cooks about their procedures on how Foods are reheated	89%	92%	97%	100%	100%	100%	100%
Asked operators about their hand washing and ill employee policies	61%	92%	86%	100%	96%	96%	67%
Asked about catering activities	56%	88%	78%	94%	96%	100%	67%
Asked about menu changes	44%	88%	87%	100%	96%	100%	100%
Verified that critical violations were corrected or an approved alternative was in place before leaving the facility	61%	100%	100%	100%	96%	100%	100%
Asked questions regarding food handler cards	72%	100%	100%	100%	96%	94%	67%

Specific areas for improvement statewide are:

- Taking temperatures of food products in hot and cold holding units
- Asking about procedures for cleaning in-place equipment such as slicers, cutting boards and culinary sinks
- Taking final cooking temperatures of food on the cookline
- Observing food handlers during the inspection to be sure they are washing their hands and handling foods appropriately

- Asking about glove use, employee illness policies and watching for proper habits
- Asking the manager if he or she has access to the Oregon Food Sanitation Rules
- Checking that food service workers have a food handler card onsite

Key budget drivers and issues

The costs of the State and Local Restaurant Food Safety Programs – \$5.4 million – are borne by the Oregon restaurant industry. No GF money is used.

Radiation Protection Services (RPS)

Services provided

The mission of Radiation Protection Services (RPS) is to protect the health and safety of the citizens and workers in Oregon from unnecessary radiation exposure. RPS is charged with the responsibility of conducting a statewide radiological health and safety program in Oregon. The purpose is to:

- Protect the general public and the environment against unnecessary radiation levels
- Reduce the possibilities of accidental radiation exposures
- Train local and state emergency services personnel
- Keep occupational radiation exposure as low as possible
- Reduce unnecessary radiation exposure to workers and patients.
-
- On-site reviews of registrants and licensees are conducted, samples are collected and analyzed, training is provided, and statutes and administrative rules are enforced. Every Oregonian is potentially affected via medical, dental or environmental avenues.

Where service recipients are located

Service recipients are located throughout Oregon. Approximately 13,600 sources of radiation are licensed and inspected in more than 4,400 facilities located in all Oregon counties (including hospitals, dental clinics, radiation oncology clinics, tanning salons, high tech manufacturing firms, academic and research facilities, paper and pulp processing plants, foundries, and mineral extraction facilities).

Who receives services

Services are provided to an estimated 3.6 million Oregonians through licensing and inspection programs to test all X-ray equipment in dental offices, medical clinics, hospitals, veterinary clinics, chiropractic and podiatry clinics, and industrial locations. Radioactive materials are used in more than half of all Oregon counties

in hospitals, universities, research labs and mills for wood and paper products. Tanning salons also are inspected in all counties.

How services are delivered

More than 1,300 on-site safety inspections are completed each year for facilities licensed to use sources of radiation in every county in Oregon. More than 4,100 X-ray machines and tanning devices are tested each year to ensure they are operating safely and meet all state and federal requirements. Additionally, trained radiation safety personnel respond to approximately 85 incidents each year involving radiation sources.

Why these services are significant to Oregonians

In approximately 35 percent of all X-ray inspections, radiation exposure is able to be reduced to lower levels with diagnostic image quality preserved or improved in each case to help ensure worker and patient safety. Emergency responses to incidents involving radiation sources also result in many investigations done in cooperation with Oregon OSHA that improve radiation safety operating conditions for workers and patients.

Patient Exposure Reduction Achieved by the X-Ray Program
7/1/2004 - 6/30/2008

Facility Type	Number of facilities inspected	Number of facilities with 1 or more machines requiring patient exposure reduction	% of facilities with 1 or more machines requiring patient exposure reduction	Average radiation exposure reduction to patient
All	1845	645	35%	28%
Dental	1349	560	42%	40%
Other facility type	496	85	17%	37%

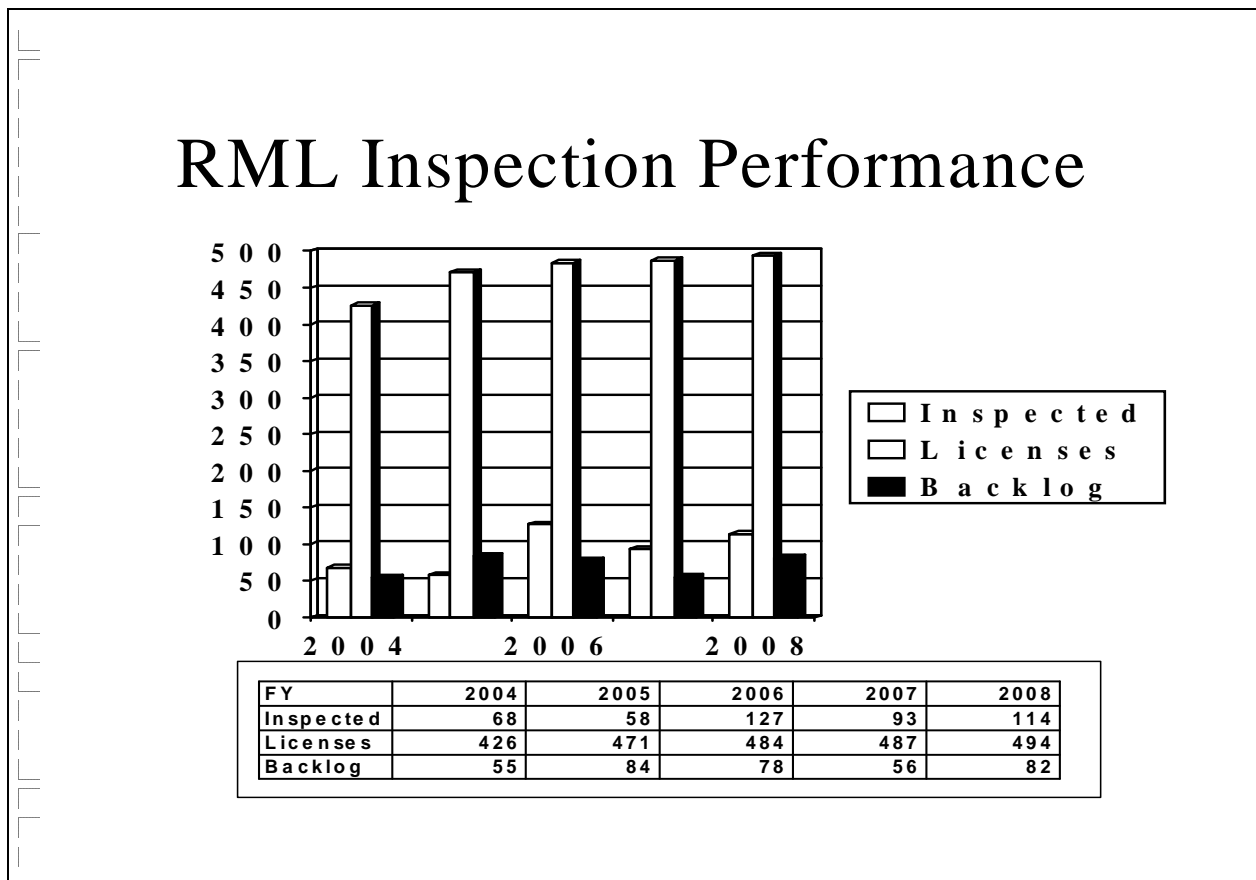
Facility Type Other = Medical, Hospital ,Chiropractor , Osteopath, Radiologist, PA/NP, State Hospital, State Medical, Naturopath

Facility Type Dental = Denturist, State Dental, Dentist, State Dentist

Performance Measures

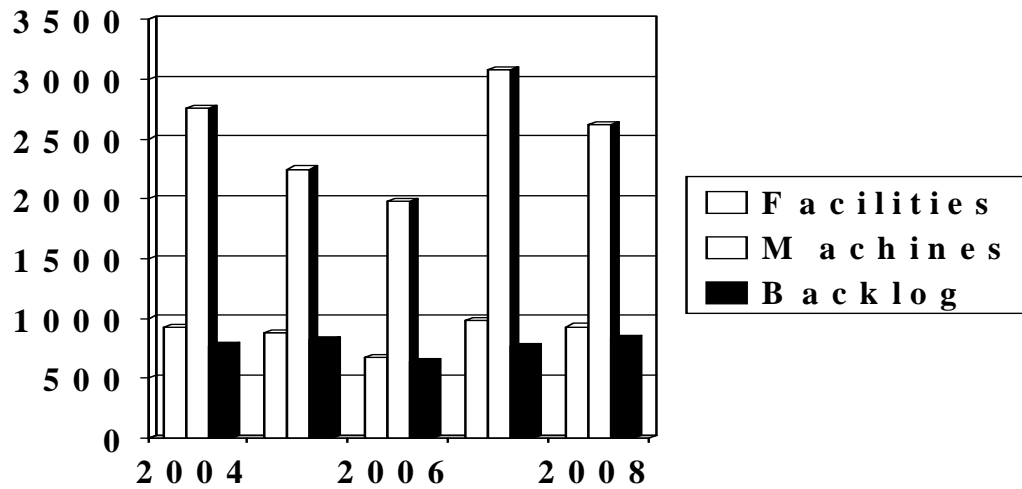
There are no DHS key performance measures for RPS.

The RPS management team has, however, set goals for performance in completion of all required radioactive materials licensing inspections within the U.S. Nuclear Regulatory Commission guidelines of less than 25% past the specified inspection frequency. Current staffing levels and specialized NRC Core training are critical to performing at this level. Evaluation of the performance of this goal is periodically reviewed by the U.S. Nuclear Regulatory Commission through Integrated Materials Performance Evaluation Program (IMPEP) audits required as part of our federal/state agreement since 1965. Federal program audits are performed every four years.



For the X-ray machine testing and inspection program, the RPS management team has also set goals for performance in completion of all required X-ray facility and machine testing inspections within due dates specified in administrative rule. Current staffing levels and U.S. FDA and other specialized training are critical to performing at this level. At the current growth rate for X-ray facilities, additional inspection staffing of 1-2 FTE will be required by 2011.

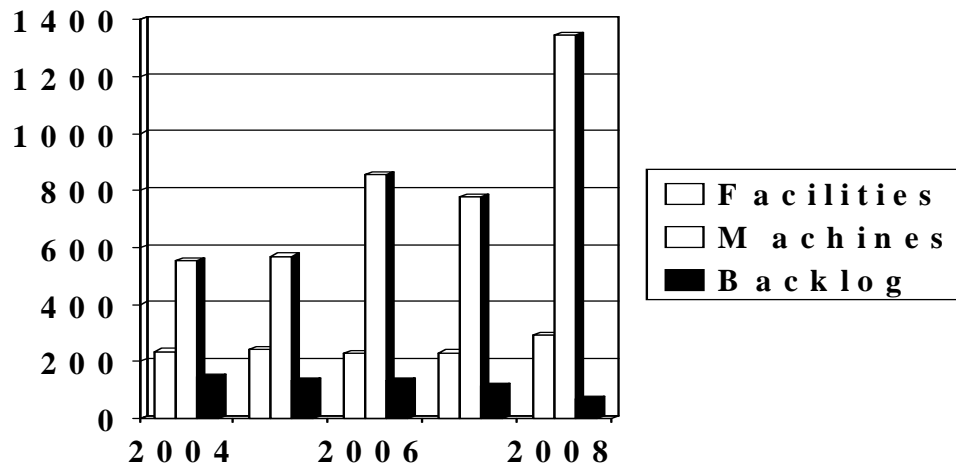
X-Ray Inspection Performance



Inspected	2004	2005	2006	2007	2008
Facilities	928	881	673	984	932
Machines	2757	2249	1978	3080	2622
Backlog	773	824	637	769	834

For the tanning device testing and inspection program, the RPS management team has also set goals for performance in completion of all required tanning facility and FDA compliance testing inspections within a 2-3 year period. Current staffing levels and U.S. FDA and other specialized training are critical to performing at this level. At the current growth rate for tanning facilities, current staffing should be adequate until 2015.

Tanning Inspection Performance



Inspected	2004	2005	2006	2007	2008
Facilities	236	242	230	231	294
Machines	554	569	856	779	1346
Backlog	145	134	134	113	67

Quality and Efficiency Improvements

X-ray inspections are scheduled with registrants to lessen business impact during inspections. Unannounced inspections are performed at problematic facilities to ensure compliance with state and federal standards. Turnaround time for licensing has been greatly improved during the current biennium.

Enforcement will become more effective with authority to impose civil penalties through proposed legislation to standardize enforcement authority and penalties for noncompliant licensees and registrants. This legislation will promote better regulatory standardization in the future and allow removal of obsolete enforcement language from several public health statutes.

Key budget drivers and issues

Federal regulatory authority over licensed users of radioactive materials has significantly increased during the past decade to improve security of this critical material used for medical imaging, blood irradiation, research, measurement of density of materials, process improvement and cancer therapy. These additional security concerns require more staff time and enforcement activities, translating into additional program costs. Funding for this increased workload and enforcement activity was adjusted during the 2007 Legislative session. Another adjustment will likely be required during the 2011 session in order to offset increased staffing and related enforcement activity costs.

Environmental health programs generally use fee-for-service funding by licensees who directly benefit from the licensed activities authorized under environmental health programs. Very limited GF support currently is provided in environmental health programs that may have traditionally received GF moneys in prior biennia to fund incident and emergency response activities. COLA and workload increases are the primary drivers for requesting additional funding support from fee-based programs to improve public health and safety.

Program efficiencies have been affected through travel consolidation, office centralization, crosstraining of inspection and compliance staff, and streamlined administrative procedures. Within the constraints of federal mandates, continued efforts to improve processes and streamline licensing and regulatory procedures are ongoing throughout environmental health programs.

Drinking Water Program (DWP)

Services Provided

The Drinking Water Program reduces the risk of disease for people who consume drinking water at public water systems in Oregon. The program is carried out through partnership with local public health agencies and other state departments, as well as direct service by DWP. The program helps carry out the mission of the department by reducing the risk of waterborne disease and reducing exposure to hazardous substances potentially present in drinking water supplies.

Where recipients are located

More than 3,600 public water systems located throughout Oregon serve drinking water to more than three and a half million Oregonians and Oregon's visitors. Individual public water systems vary widely in type, size and capacity, from very large water systems like the City of Portland to very small federal, state and private campgrounds.

Who receives services

Services are provided to protect the health of more than three and a half million Oregonians and Oregon visitors who consume water from public drinking water systems.

How services are delivered

Drinking water oversight is delivered by a partnership of PHD, local county public health departments and other state agencies. PHD staff are located in Portland, Pendleton, Springfield and Medford. Twenty-six county health departments and the Oregon Department of Agriculture deliver local drinking water protection services under contract. Services also are provided under contract with the Oregon Department of Economic and Community Development (drinking water loan fund) and the Oregon Department of Environmental Quality (protect drinking water sources).

Why these services are significant to Oregonians

Safe tap water from every public water system in the state is essential to protect people's health, support local economies, and sustain Oregon's quality of life.

Performance Measures

There are no DHS key performance measures for DWP. However DWP has lead responsibility for Oregon Benchmark #69, "percentage of Oregonians served by community drinking water systems that meet health-based standards" and "percent of community drinking water systems that meet health based standards."

Quality and Efficiency Improvements

In order to improve services provided to clients, the drinking water program implemented federal drinking water standards beginning in 1986, and has worked with local communities since then to improve local water systems and dramatically reduce the number of community acute waterborne disease outbreaks. The program improved access to and use of water supplier drinking water testing data by posting these on a Web site for water suppliers, the consuming public, and state and local agency partners. The program also improved drinking water safety by training and certifying water system operators, by making loans to communities for safe drinking water construction projects, and by assessing and protecting sources of drinking water to prevent future contamination.

Key budget drivers and issues

Changes in federal law require significant revisions to the way Oregon assures safe drinking water protection. The number of federally regulated drinking water contaminants rose from 23 in 1986 to 91 in 2006. In 2007, Oregon received the resources to 1) fully implement all current federal drinking water standards at all 2,700 public water systems subject to federal requirements; 2) implement three new federal drinking water standards specified by the 1996 Safe Drinking Water Amendments; 3) oversee the estimated 1000 very small public water systems (4-14 connections) subject to state law. Currently, Oregon is completing initial implementation using these resources including hiring new staff, expanding county contacts, expanding the Drinking Water Advisory Committee, improving water system inspections and implementing a new inspection fee. This allows DWP to adopt all remaining EPA drinking water standards.

Office of Family Health (OFH)

The Office of Family Health (OFH) administers programs directed at improving the overall health of Oregon's women, children and families through preventive health programs and services. Objectives and activities include collecting and sharing data through the FamilyNet data system to assess the health of women, children and families, developing and implementing public health policy based on these data, and ensuring the availability, quality and accessibility of health services and health promotion. It also reduces and eliminates disparities and provides technical assistance, consultation, and resources to local health departments and other community partners. The major program areas within OFH include: Maternal and Child Health (MCH) Programs that encompass Perinatal, Child and Oral Health, Adolescent Health and Genetics, Women's and Reproductive Health, Nutrition and Health Screening (WIC), and Immunization.

Major funding sources for the Office of Family Health include:

- U.S. Department of Agriculture – Nutrition and Health Screening for Women, Infants and Children (WIC)
- U.S. Department of Health and Human Services (DHHS) – Family Planning Title X and Family Planning Expansion Waiver Title XIX
- DHHS Center for Disease Control and Prevention (CDC) Immunization and Vaccines for Children (VFC)
- DHHS – Title V Maternal and Child Health Block Grant (MCH)
- Medicaid Administrative Match in Immunization
- State General Fund match requirement for Family Planning Expansion Program (FPEP)
- School-Based Health Center Program
- CDC WiseWoman (WW) and Breast & Cervical Cancer Program (BCCP)

Maternal and Child Health (MCH) Program

The Maternal and Child Health (MCH) Program is comprised of individual programs and activities that together provide a continuum of care that promotes and protects the health of pregnant women, infants and children. The MCH section includes statewide programs that support providers and services to families through policy analysis, program evaluation, technical assistance, and training in best practices and service delivery. Program areas cover perinatal health (prenatal and post-partum), child health, oral health, and early newborn hearing screening detection and intervention. MCH also supports local health departments with state and federal funding, technical assistance, program evaluation and training to deliver Maternity Case Management (MCM) and Babies First! High-Risk Infant (HRI) monitoring and home visiting. Detailed program descriptions are provided for MCM, HRI home visiting, Child Care Health Consultation and Oral Health.

Services provided

Maternity Case Management (MCM): MCM services improve pregnancy outcomes by reducing the effects of risk factors such as tobacco and alcohol use, promote adequate prenatal care for pregnant women, optimize the family's health, and decrease the risks for low birth weight and premature births. The MCM Program provides an expansion of traditional prenatal services to include management of health, social, economic, environmental and nutritional factors that may jeopardize the health of the mother or infant.

During Fiscal Year 2007, thirty county health departments provided these services for 6,447 women. Oregon MothersCare, also included in MCH, helps women enroll in the Oregon Health Plan as early as possible in their pregnancy. During Fiscal Year 2007, twenty nine Oregon MothersCare sites provided services for 5,337 women.

Children of women receiving Maternity Case Management services are often enrolled in the Babies First! program, creating a continuum of case management from early pregnancy through the child's fifth year.

Babies First! High Risk Infant (HRI) Home Visiting: The HRI services are delivered by county public health nurses to identify infants with risk factors associated with poor physical and emotional health, and improve their health

outcomes through prevention or early identification of problems. Public Health Nurses conduct assessment and screening in the home including monitoring growth, physical and emotional health, oral health status, immunization status, standardized screening for vision and hearing, developmental status, maternal-infant interaction, and family assessment. Together, MCM and HRI provide screening, referral, and care coordination during approximately 50,000 visits to about 15,000 infants and families a year in their home environments.

Babies First! Services are provided to children who have medical and social risk factors for chronic health conditions and developmental delay. Based on reported data from our newly released FamilyNet ORCHIDS database, 74% of HRI children are on Medicaid. From January 1, 2008 to June 30, 2008, local programs that utilized the Oregon Child Health Information Data System (ORCHIDS), which currently excludes Multnomah and Yamhill Counties, served 3,202 infants and children. Nearly 60% of Babies First! high-risk infants and children had multiple risk factors. This includes prematurity – 16%, drug exposed infants – 8%, parental alcohol or substance abuse – 11%, and at-risk caregivers who include parents with a history of child abuse or incarceration – 18%.

Child Care Health Consultation (CCHC): Health Consultation strengthens the skills and practices of child care providers and promotes the health and safety of children in their care. CCHC is community-based, using a multidisciplinary team of experts on children's health and safety to help child care providers give the highest quality care. CCHC services have built support for the promotion of health, mental health, and safety and the delivery of information and consultation to the child care providers over a four year demonstration project. It is one of several strategies for achieving the Oregon's early childhood comprehensive strategic plan goals and objectives to build capacity in the area of health.

Oral Health Program: Oral health provides several key services such as school-based dental sealants, school-based fluoride tablets, oral health screening surveillance, support to early childhood cavities prevention programs, and technical assistance regarding community water fluoridation.

Where service recipients are located

Maternity Case Management Program services are provided throughout the state by county health departments, managed care organizations, and private providers through the Oregon Health Plan.

MCM Clients served by county health departments July 2006-June 2007

County	Clients	County	Clients
Benton	13	Lane	296
Clackamas	76	Lincoln	308
Clatsop	70	Linn	88
Columbia	109	Malheur	16
Coos	99	Marion	42
Curry	3	Morrow	0
Deschutes	179	Multnomah	4,116
Douglas	168	Polk	37
Grant	1	Tillamook	1
Harney	0	Umatilla	6
Hood River	24	Union	32
Jackson	169	Wallowa	0
Jefferson	23	Wasco-Sherman	71
Josephine	274	Washington	223
Lake	0	Yamhill	33

Oregon MothersCare (OMC) services from 01/01/2007-12/31/2007

County	Client Numbers	Services
Baker	23	90
Benton	155	910
Clackamas	449	1,708
Coos	272	1,530
Crook	56	283
Curry	49	305
Deschutes	577	3,950
Douglas	157	1,127
Grant	4	34
Hood River	57	437
Jackson	413	2,438
Josephine	136	556
Klamath	73	198
Lane	620	3,225
Lincoln	167	636
Linn (2 sites)	142	1,071
Malheur (2 sites)	118	508
Marion (4 sites)	945	5,420
Morrow	39	202
Wallowa	14	77
Wasco	198	1,579
Washington	552	3,069

The Babies First! High Risk Infant (HRI) Home Visiting Program services are provided by local county health department public health nurses who visit infants and their families in their homes.

Babies First! High Risk Infant Tracking January 1, 2008 to June 30th 2008*

County	Clients Served	Visits	County	Clients Served	Visits
Baker	102	213	Klamath	179	252
Benton	20	48	Lake	11	28
Clackamas	127	311	Lane	185	302
Clatsop	55	122	Lincoln	252	929
Columbia	10	39	Linn	98	228
Coos	113	449	Malheur	46	86
Crook	15	22	Marion	320	826
Curry	9	9	Morrow	6	14
Deschutes	166	277	Multnomah	*	*
Douglas	227	796	Polk	73	205
Gilliam	2	2	Tillamook	80	187
Grant	2	2	Umatilla	23	24
Harney	2	3	Union	159	908
Hood River	90	205	Wallowa	0	0
Jackson	186	619	Wasco/Sherman	80	134
Jefferson	44	151	Washington	433	1,480
Josephine	93	154	Yamhill	*	*
State Totals*	3,2020	9,025			

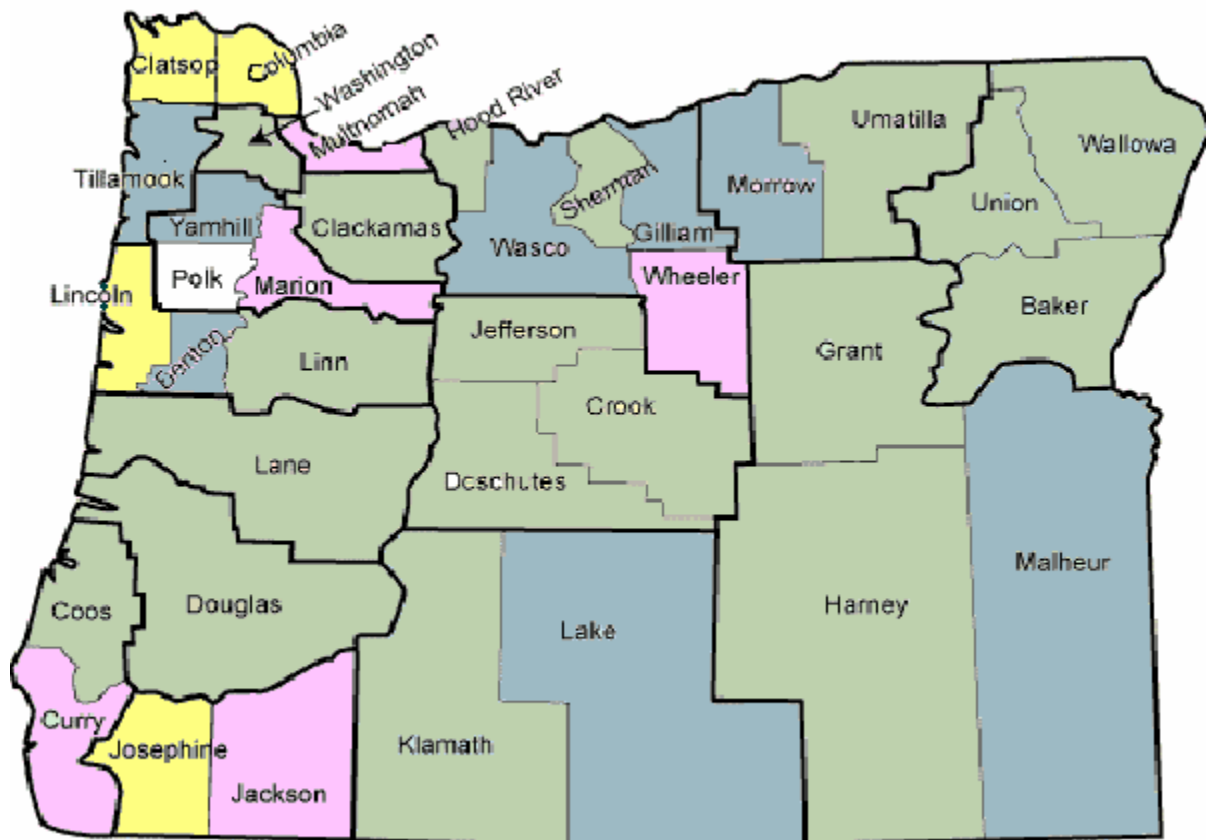
The Child Care Health Consultation services are provided by local multidisciplinary teams of experts on health and safety in four demonstration sites to child care providers, parents and children in Baker/Union, Clackamas, Lincoln and Multnomah Counties.

The Oral Health Program provides services statewide through more than 100 elementary schools, local county health departments, and local coalitions.

Who receives services

School-Based Programs in 2008-09 School Year:
Dental Sealants and Fluoride Tablet/Rinse

- Green** = County has schools participating both dental sealants and fluoride programs (51)
- Blue** = County has schools participating in the dental sealants program (139)
- Yellow** = County has schools participating in the fluoride program (116)
- Pink** = Locally managed programs in addition to our services



Maternity Case Management (MCM): Approximately 5,600 pregnant women received MCM services and 3,000 received clinical prenatal services in 46,000 visits in 2006, of which about 56% were MCM services to women with Oregon Health Plan coverage. MCM services are provided for pregnant women regardless of insurance status. Eighty-eight percent of the women served are white and seventy-four percent are Non-Hispanic. Typical issues addressed for a client include inadequate dental care during pregnancy, smoking cessation, assistance maintaining prenatal care access, and perinatal depression.

Babies First! High Risk Infant (HRI) Home Visiting: Services are provided to children from birth to age five with health and social histories that place the child at-risk for health and development problems.

Child Care Health Consultation (CCHC): Over the four-year demonstration project (2003-2007), CCHC consultants provided 6,408 consultations to child care providers. Of those, 1,732 were delivered through site visits with 831 child care providers. In addition, the program held a total of 970 group training and community health events for child care providers, parents and children.

Oral Health Program: Oral health screening surveillance occurs in a sample of Oregon elementary schools. School-based fluoride tablets are available to children in elementary schools with more than 40% of the student body eligible for the Federal Free and Reduced Lunch Program. School-based dental sealants are provided to all children in elementary schools with 50% or more of the student body eligible for the Federal Free and Reduced Lunch Program. During the 2007-08 school year, 5,721 dental sealants were placed in students from schools in the nine counties that participated. Almost 18,000 dental sealants are expected to be placed during the 2008-09 school year and over 190,000 during the 2009-2011 biennium.

How services are delivered

Maternity Case Management: Pregnant women are referred to MCM services from programs and providers including Oregon MothersCare, WIC, and social services. The Maternity Case Manager assists the client in the management of health, economic, social and nutrition factors through the prenatal and postpartum periods, including linkage and referrals to other services as needed. This is provided

through face-to-face contact, ideally in the client's home and generally by county health department public health nurses.

Babies First! High Risk Infant (HRI) Home Visiting: During the home visit, the public health nurse conducts standardized health and development assessments for the child's growth and nutritional status. Infants receive developmental screening, monitoring of growth, hearing, vision and dental screening, assessments of parent child interaction, and immunization status. Parents receive information and education about learning opportunities, safety in the home, Sudden Infant Death Syndrome (SIDS) Support Services, and overall child health. Referrals are made for medical care and social services as needed.

Child Care Health Consultation: Health consultants provide on-site needs assessment, goal development, and health consultations with child care providers and connect them with other Health Resource Team services. Health Resource Teams include the health consultant, a mental health consultant, an early childhood educator, and a child care specialist.

Oral Health Program: School-based dental sealants are delivered by dental hygienists with the aid of dental assistants. These dental professionals volunteer or work on a small stipend through the Office of Family Health. School-based fluoride tablets are delivered through an onsite school coordinator who has received training from the Office of Family Health. Oral health screening-surveillance is conducted by dental hygienists. These dental hygienists are specially trained and on contract with the Office of Family Health. Early childhood cavities prevention programs are delivered by public health nurses, dental hygienists, and other health care professionals in local county health departments, head start sites, and WIC. Non-dental providers are trained by the Office of Family Health.

Why these services are significant to Oregonians

Women and infants served by Maternity Case Management and Babies First! programs benefit from long term health, social, economic, and emotional support early in pregnancy and throughout the early stages of life. Early brain development is most critical in the first months and years of life, as is improving the health of the mother and baby during pregnancy and in the years afterwards. Research has repeatedly shown that early identification and intervention for chronic conditions

will improve the health, functioning and mental health of both the child and parent. These individual family improvements strengthen early learning opportunities and reduce negative long term societal impacts such as juvenile delinquency.

Child Care Health Consultation recognizes that approximately 37% (232,000) of all Oregon children age 0-12 spend an average of 29.1 hours in paid child care each week. Evidence indicates that many of these children are not getting what they need to grow, develop and learn. Both national and Oregon studies have found early care settings to be of mediocre quality and sometimes even dangerous. One study found 16% of children 1-12 years old do not always feel safe and secure in child care. Another study found 20% of Oregon children ill equipped for Kindergarten. The four year demonstration evaluation showed that the program services had a positive impact on child care providers' health knowledge and practices in child health (21%), child safety (19%), children's emotional and behavioral health and development (20%), connecting and coordinating with health care resources (20%), and professional development (18%). After health consultation services, child care providers were more likely to write and post child health policies and review them with parents. The program also demonstrated an increase in the number of children with known health care providers (18%) and dental care providers (14%), as well as a 30% increase in children in care with up-to-date recommended immunizations.

Basic oral health prevention services that are identified as best practices assure overall health of children and adults. Underserved children suffer oral disease disproportionately and these services create a system for access and ultimately reduce dental decay and disease significantly, thereby reducing overall lifetime treatment costs. According to the Smile Survey 2007, a screening survey of first, second, and third graders in Oregon:

- Nearly 2-out-of-3 first, second, and third graders have cavities.
- More than 1-in-3 has decay that has not been treated.
- 1-in-5 children have rampant decay that is decay in 7 or more teeth.
- On any given day, more than 5,000 children are in need of urgent treatment due to severe pain or infection.

Performance Measures

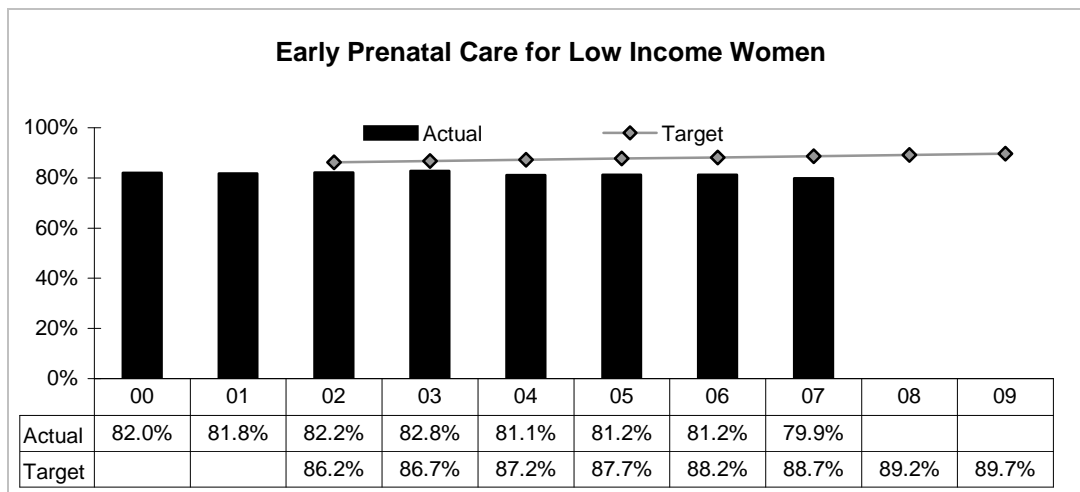
The Maternal and Child Health (MCH) Program has the following DHS key performance measures (KPM) and Healthy People 2010 outcome measures.

Prenatal care for women in the first trimester (Related to KPM #17 – Early prenatal care for low-income women; see DMAP section)

Purpose

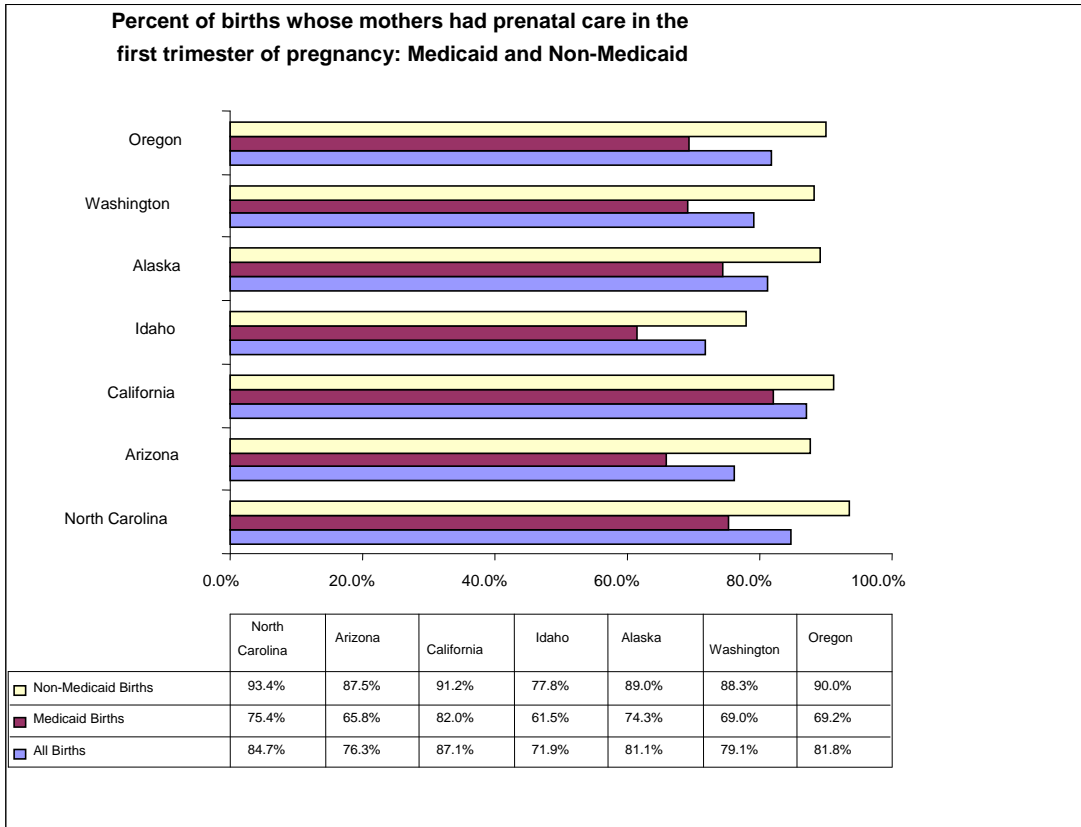
Early prenatal care is an important strategy for preventing early childhood diseases and conditions, and promotion of healthy growth and development. Low-income infants are statistically at higher risk for poor health outcomes, and DHS programs and services are focused on this population. The indicator for early prenatal care measures change and improvement in the health and social system performance in reaching the low-income pregnant women to promote healthy babies.

Trends in early prenatal care reflect the reductions in Oregon Health Plan (OHP) eligibility. Low-income women who are already covered by Medicaid when they become pregnant must re-apply after they find out they are pregnant to receive OHP-Plus benefits. For those not previously eligible, it is possible that some of them do not know that they now qualify because they are pregnant, especially if they were recently told they were ineligible for OHP due to income.



How Oregon compares to other states

Overall, Oregon ranks in the middle nationally for early prenatal care among all births and Medicaid births. Oregon is about the same as both Washington and Alaska, although California has the best outcomes on the west coast.



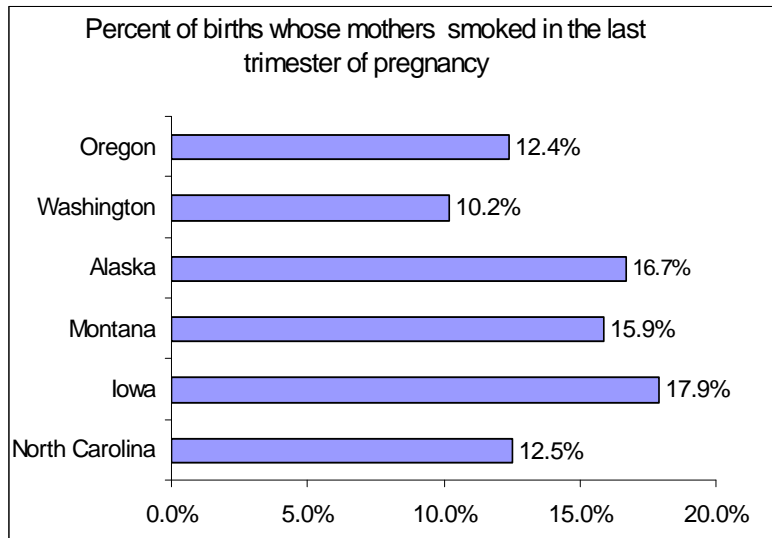
KPM #20 – Tobacco use among a) adults, b) youth, c) pregnant women

Purpose

A woman’s use of tobacco during pregnancy is associated with serious and at times fatal health problems for the child, ranging from low birth weight and premature births, to stillbirth and Sudden Infant Death Syndrome (SIDS). Smoking cessation assessment and counseling for pregnant women and parents are delivered through Maternity Case Management and Babies First! programs, as well as private health providers.

How Oregon compares to other states

Oregon ranks in the middle of states in terms of smoking in the last trimester of pregnancy, but trails Washington in reducing smoking rates.



Child Care Health Consultation: The Child Care Health Consultation (CCHC) program supports KPM #8 — the number of child care providers who are providing enhanced quality of care.

While this KPM is under the direction of the Children, Adults and Families (CAF) Division, CCHC contributes by addressing needs of family and at-home child care. Health consultation is based on Caring For Our Children, the National Health and Safety Standards. The Health Consultation Training is standardized training from the National Training Institute.

Oral Health Program: The Oral Health Program has three outcome measures based upon national benchmarks, but no current DHS Key Performance Measures.

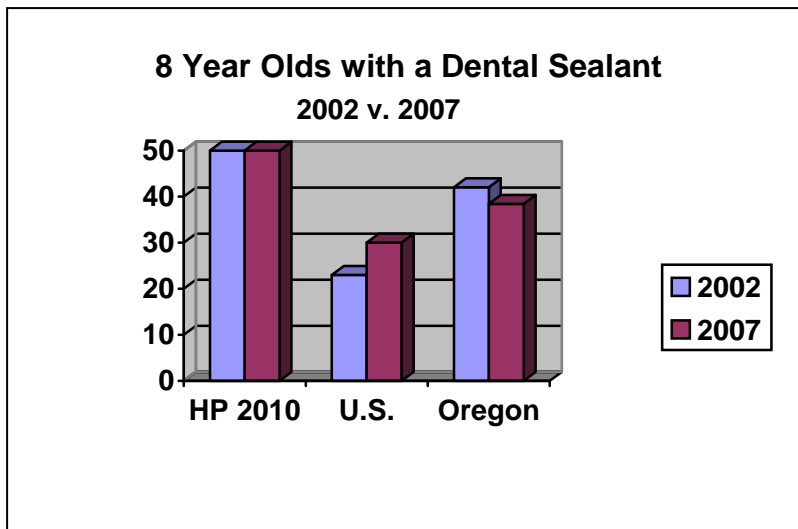
Healthy People 2010 Objective # 21.8 – Percent of 8 year olds with dental sealants as collected in the Smile Survey.

Purpose

Dental sealants are considered a best practice in preventing dental decay and disease in the first set of permanent molars (where most decay usually occurs). This measure is an indicator of potential lifetime disease and treatment costs averted.

How Oregon compares to other states

According to the 2007 Oregon Smile Survey, 38.4% of 8 year olds had dental sealants compared with a national average of 30%. Please note that the Oregon rate reflects the success of the Multnomah County Health Department Dental Sealant Program. In 2007, 62.7% of third graders in Region 1 (Multnomah County) had a dental sealant compared to the state average of 43% of third graders. *Regional data was analyzed by grade, not age.



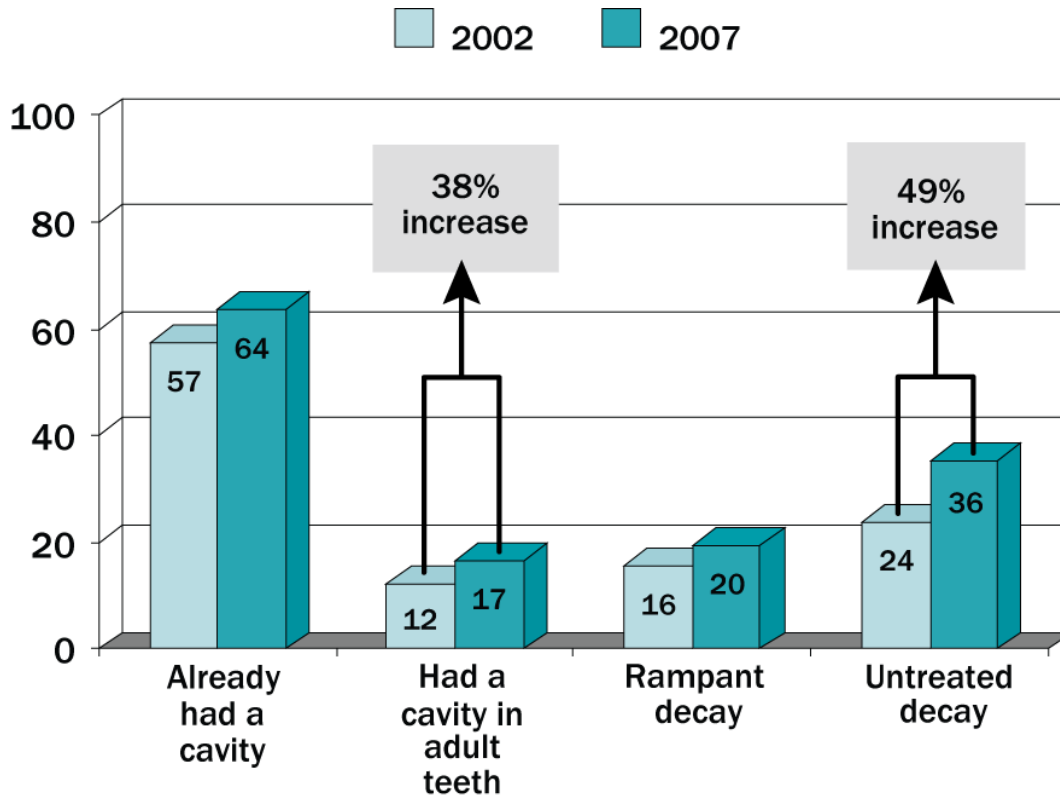
Healthy People 2010 Objective #21.1 – Rate of decay among 6-8 year olds as collected in the Smile Survey.

Purpose

Children who experience decay tend to continue to experience decay at a greater rate as they grow older. Dental decay is a chronic condition.

How Oregon compares to other states

According to the 2007 Oregon Smile Survey, 62.7% of 6-8 year olds have dental decay experience in primary or permanent teeth. Additionally, among 6-8 year olds 34.6% have untreated decay. This represents an increase of 49% since 2002. Oregon ranks 26th out of 32 states with comparable data.



Healthy People 2010 Objective #21.12 – Increase preventive dental services to poor children as collected in the Smile Survey.

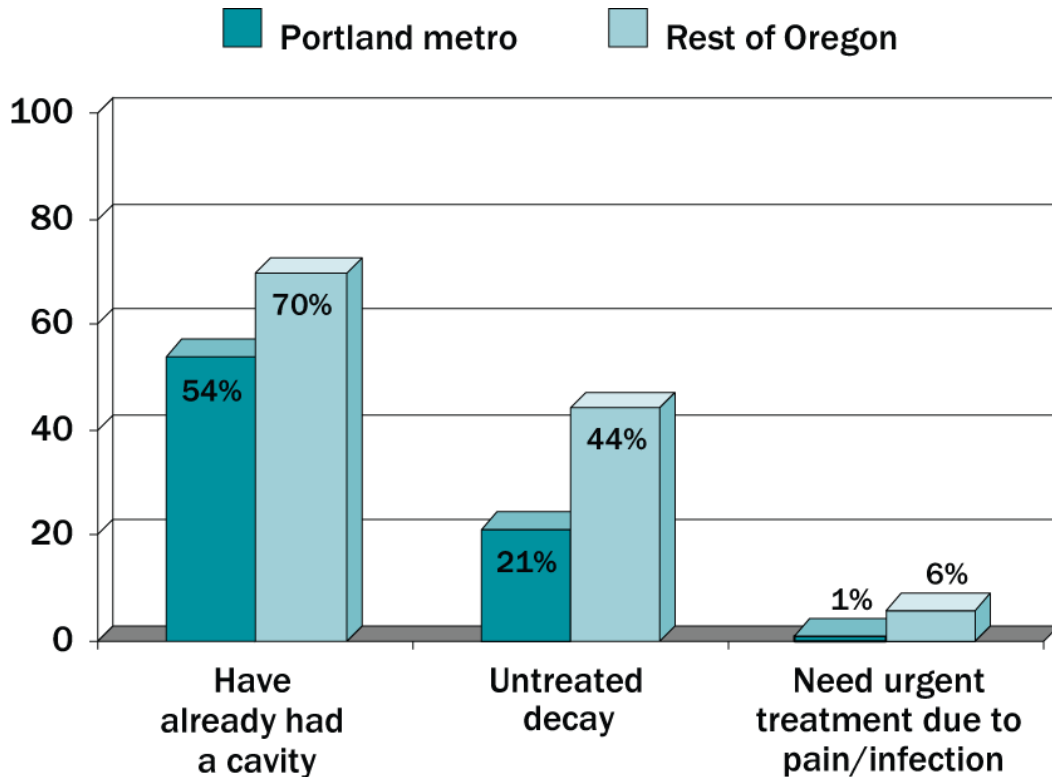
Purpose

Poor children suffer decay disproportionately and have less access to preventive services.

How Oregon compares to other states

According to the 2007 Oregon Smile Survey, 74% of poor children have dental decay experience in primary or permanent teeth compared with 46.6% of their more affluent peers. Furthermore, children who live outside the Portland metro

area have greater dental decay experience (70% v. 54%) and greater untreated decay (44% v. 21%). National and state comparisons are not available.



Quality and Efficiency Improvements

In 2007, the Maternal and Child Health section of OFH released a new data system, Oregon Child Health Information Data System (ORCHDS), designed to gather data for Oregon’s public health home visitation programs. The outdated and inefficient DOS-based Women and Child Health Data System (WCHDS) was retired. MCH successfully partnered with county health departments to assure uniform data collection statewide. Over 100 Oregon nurses and staff were trained in the data collection and entry into the system. Initial data analysis shows promising information that will be used to evaluate the current home visiting continuum and will help inform future program evaluation and planning. For the first time in history, Oregon’s public health home visitation program data is collected into one database. This same database is linked to Oregon’s WIC and

Immunization program databases (FamilyNet) to provide a broader understanding of how Oregon families use these services.

The CCHC improves child care quality and supports healthy, safe and nurturing child care for children across the state. Expanding the scope and scale of the program would promote the early identification and treatment of children with physical and social or emotional health and development concerns, and facilitate their inclusion and retention in community-based child care. Expansion is based on principles that support statewide incremental expansion at a pace consistent with available and sustainable funding and community support. The goal of the CCHC partners is to expand the program from four county-based sites to a regional approach making program services available to 4,000 child care providers in the state. The proposed expansion will increase capacity to serve 20% of those child-care providers (approximately 800 providers and 8,800 children) with on-site consultation. It would begin with expansion into the Child Care Resource & Referral Network service districts surrounding the current county-based programs and additional service districts for a total of 4,000 child care providers. The long-term goal is to grow to provide service to 20% of all child-care providers in Oregon with on-site consultation (approximately 1,400 providers and 15,400 children) by leveraging knowledge and skills between existing and new local programs and sites

The school-based dental sealant program administered by the Oral Health Program addresses quality assurance and efficiency in several ways: the model follows the best practice recommendations from the Association of State and Territorial Dental Directors for school-based dental sealant programs; schools have been identified as an ideal setting for delivering sealants because they ensure access to all children, cause minimal disruption to class time, do not require children miss a school day to see a dentist, and remove travel barriers. Data is collected in a uniform manner and inputted into a statewide dental sealant surveillance system.

Health Disparities

Babies First! High Risk Infant (HRI) Home Visiting Program: The US Census Bureau reported Oregon's population in 2006 as divided into 10% Hispanics, 81% white, non-Hispanic, and 1.9% African American. Early race/ethnicity data from ORCHIDS indicate that Babies First! is succeeding at reaching out to minority populations who experience health disparities. A key component of Babies First!

HRI services includes case management services to assure all children enrolled in the program have access to needed medical and social services.

Babies First! - Race/Ethnicity of Clients*

White	88%
Black/African American	3%
Native Hawaiian/Pacific Islander	2%
Asian	2%
American Indian/Alaska Native	12%
Unknown Race	1%
Hispanic	32%

*Data for Multnomah and Yamhill counties is not available

Child Care Health Consultation: The CCHC program serves all interested child care providers, with a priority for family child care providers, exempt providers and those who care for children from populations that are known to have barriers to health care. These include low-income families, children with special needs, and families with cultural and language diversity, e.g., consultation to Russian-speaking child care providers in Russian by a health consultant from the community. The program also reaches out to providers who care for children receiving child care subsidies through the Department of Human Services.

The OFH created a mechanism for tribal governments to access federal funds for maternal and child health services. In January 2007, tribes were able to apply for “mini-grants” of \$5,000 for 6 months to develop triennial plans and population data to be used in the state’s funding formula for equitable distribution of the MCH Title V Block Grant (pursuant to SB 855, 2005 Legislative Session).

Currently, two tribes have developed proposals around MCH oral health and received mini-grants: the Health Clinics of the Coquille Indian Tribe and the Cow Creek Band of Umpqua Tribe of Indians. OFH staff will provide technical assistance and consultation in the implementation of their programs. We are also in the process of working with the Warm Springs tribe on a proposal to assist with funding a public health nurse. Interested tribes may apply for these MCH Planning “mini-grants” at any time.

Key budget drivers and issues

Federal funds continue to be flat funded, including the MCH Title V Block Grant in 2007. Over the last biennium, we have seen a 5.5% decrease because of this flat funding. These funds support state level analysis, assessment, technical assistance and training work, and support local services that cannot be billed to the Oregon Health Plan or other third party payer, including community-based assessment and health education. The match rate of 40% GF to 60% for Targeted Case Management, which supports the Babies First! High Risk Infant Tracking and other nurse home visiting services, is at risk of reductions at the federal level. Final changes will be implemented April 2009 with a potential impact of a \$4.4 million loss to Local Health Departments to receive Medicaid reimbursement to this program.

In addition, the CDC did not re-fund a critical grant for OFH's Oral Health Program -- a grant which supported state-level infrastructure to implement key statewide program initiatives. Without sustainable funding, the program will not be able to:

- Expand the statewide school-based dental disease prevention program (dental sealants and fluoride supplement programs).
- Continue an oral health surveillance system (including conducting disease prevalence data on children: Smile Survey).
- Administer the state oral health plan.
- Bring key stakeholders together to discuss oral health issues and provide technical assistance on oral health best practice and evidenced based practice to decision makers, County Health Departments and other partners.

Additionally, the lack of an Oral Health Program would result in Public Health not being eligible for most future oral health grants.

Adolescent Health Program (AH)

Adolescent Health (AP) includes Public Health programs or resources that include School-Based Health Centers (SBHCs), Coordinated School Health, Teen Pregnancy, Nutrition & Physical Activity and Adolescent Health Policy. The SBHC program is described here as a program that is most closely related or aligned with direct services to the population.

Services provided

The School-Based Health Center (SBHC) program provides access to a comprehensive set of developmentally and age appropriate preventive health, primary care and mental health services for school-aged youth. Services include: performing routine physical exams, including sports physicals; well-child and adolescent exams; diagnosis and treatment of acute and chronic illness; prescribing medications; treatment of minor injuries; vision, dental and blood pressure screenings; administration of immunizations; emotional and mental health services; age-appropriate reproductive health services; health education, counseling and wellness promotion; and presenting in classrooms on relevant health issues.

Oregon has more than a twenty-year history of supporting SBHCs. During 2006-07, 45 SBHCs in 19 counties served nearly 21,000 youth in grades K-12 for 69,000 visits. Twelve additional centers, three in new counties and nine in existing counties, are in the planning stages, pending final certification review in spring 2009.

The Adolescent Health Section is also leading Oregon's Coordinated School Health Program, Healthy Kids Learn Better (HKLB). Coordinated School Health (CSH) is an evidence-based model that the CDC created in the 1990's to support schools in addressing student health. Core to this model is the evidence base around the link between health and learning. The CSH model has been used to address the following student health needs: physical activity, nutrition, tobacco prevention, safety, and asthma.

Healthy Kids Learn Better is the first CSH program in the nation to use the CSH model to address mental health. This year, HKLB is pleased to embark on its third year of the Mental Health Demonstration Project, in which schools use a Coordinated School Health Approach to address mental and emotional health

needs. The goal of this project is to improve access for children and youth to a full continuum of mental health services and create environments that promote optimal social and emotional development on school campuses. Beginning this fall, selected schools will participate in a series of training institutes, will pilot test new assessment tools, and will receive tailored technical assistance to assess campus mental health needs and develop an action plan to address a priority mental health issue. Oregon is currently working with the CDC and the National Assembly of School Based Health Care to further develop the use of CSH to support school mental health.

Where service recipients are located

The services are provided at the local level through public-private partnerships and medical sponsorships that develop a SBHC on school property. SBHCs are found in Elementary Schools (ES), Middle Schools (MS), High Schools (HS) and combined grade campuses.

County	School	Clients	Visits
Baker	Total	276	1,191
	Baker HS	276	1,191
Benton	Total	1,574	3,650
	Lincoln ES	1,136	2,648
	Monroe ES/MS	438	1,002
Clackamas	Total	342	1,197
	Oregon City HS	342	1,197
Columbia	Total	367	830
	Lewis and Clark ES	367	830
Coos	Total	257	598
	Marshfield HS	257	598
Deschutes	Total	327	589
	La Pine K-12	327	589
Douglas	Total	430	3,348
	Roseburg HS	430	3,348
Jackson	Total	2,451	10,086
	Ashland HS	576	1,787
	Crater HS	391	916
	Hanby MS	286	1,565

	Jackson ES	306	1,609
	Oak Grove ES	303	1,347
	Phoenix ES	294	1,390
	Washington ES	295	1,472
Jefferson	Total	201	515
	Madras HS	201	515
Josephine	Total	684	2,823
	Illinois Valley HS	246	706
	Lorna Byrne MS	438	2,117
Lane	Total	4,560	13,279
	Churchill HS	733	2,284
	North Eugene HS	905	2,637
	Sheldon HS	896	3,785
	South Eugene	758	2,429
	Springfield HS	1268	2,144
Lincoln	Total	801	3,725
	Newport HS	293	1,140
	Taft HS	172	959
	Toledo HS	137	682
	Waldport HS	199	944
Marion	Total	137	206
	Hoover ES	137	206
Multnomah	Total	6,381	19,148
	Binnsmead MS	285	1,108
	Cleveland HS	734	2,145
	George MS	231	885
	Grant HS	725	1,951
	Jefferson HS	461	1,812
	Lane MS	236	831
	Lincoln Park ES	513	887
	Madison HS	539	1,818
	Marshall HS	854	2,207
	Parkrose HS	857	2,101
	Portsmouth MS	198	1,352
	Roosevelt HS	748	2,051
Umatilla	Total	1185	5,541
	Pendleton HS	668	3,238

	Sunridge MS	517	2,303
Union	Total	315	1,112
	La Grande HS	315	1,112
Washington	Total	158	382
	Merlo Station HS	158	382
Wheeler	Total	119	281
	Mitchell K-12	119	281
Yamhill	Total	266	533
	Willamina HS	266	533

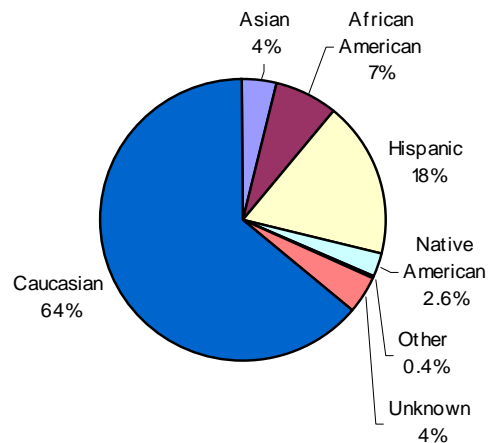
Who receives services

Services are provided to school-aged youth grades K-12 regardless of insurance status. Some SBHCs offer additional services to school staff or other community members through extended hours/agreements.

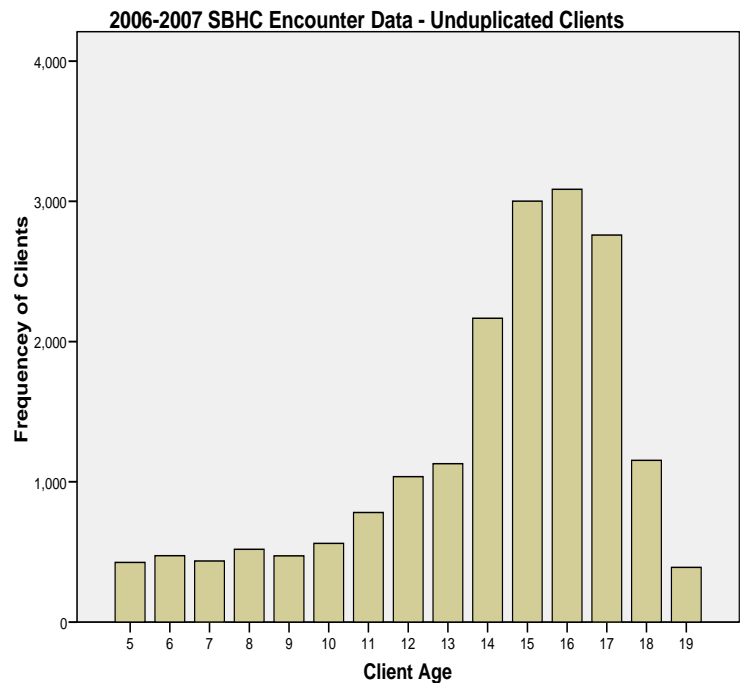
In the 2006-2007 Service Year, there were 69,034 visits made by 20,831 clients. Females (59%) were more likely to be an SBHC client than males (41%) and accounted for a larger proportion of all encounters (63%). Client reported insurance status at the time of their first visit: 42% uninsured, 28% public, 22% private, and 8% unknown.

Client Race/Ethnicity 2006-2007

Asian	4%
Black	7%
Hispanic	18%
Native American	2.6%
Other	0.4%
Unknown	4%
White	64%



County	Clients	Visits
Baker	276	1,191
Benton	1,574	3,650
Clackamas	342	1,197
Columbia	367	830
Coos	257	598
Deschutes	327	589
Douglas	430	3,348
Jackson	2,451	10,086
Jefferson	201	515
Josephine	684	2,823
Lane	4,560	13,279
Lincoln	801	3,725
Marion	137	206
Multnomah	6,381	19,148
Umatilla	1,185	5,541
Union	315	1,112
Washington	158	382
Wheeler	119	281
Yamhill	266	533



How services are delivered

Services are provided in the SBHCs by qualified medical and/or mental health providers located on school property. The facility may be integral to the school’s main building or in an adjacent modular unit specifically designed as a medical facility. Slightly over 60 percent of SBHCs are sponsored by Federally Qualified Health Centers (FQHCs). Local health departments receive funding using a formula based on the number of certified SBHCs in their county. The current formula consists of four ranges: A (\$60K for 1-2 centers), B (\$120K for 3-5 centers), C (\$180K for 6-9 centers) and D (\$240K for 10 or more). The distribution and sharing of those dollars is determined at a local level in consideration of need, medical sponsorships, and local agreements. For every state GF dollar invested, it is estimated that 3-4 local dollars are leveraged.

Why these services are significant to Oregonians

School-Based Health Centers are an important part of the safety net system, support the educational mission, are overwhelmingly embraced by Oregonians

across the state and are cost efficient. Health care needs are trending upwards for Oregon's children & teens, and rates of uninsured among 0-18 year olds are rising and are highest for adolescents. Many Oregon students report unmet health care needs and are more likely to depend on school-based health centers as a regular source of care. SBHCs have demonstrated their ability to reduce barriers to care and improve access to all youth regardless of insurance status. SBHCs keep kids in the classroom, help youth maximize instructional time, and promote positive health and mental health status, which is linked to academic achievement. Nationally, the SBHC model has been linked to Medicaid savings and reduced emergency room and hospitalization utilization.

Performance Measures

The AH Program has one main DHS key performance measure. The program most strongly relates to key performance measure (KPM) #31, Safety Net Clinic Use.

Because preventive and early intervention services provided in SBHCs relate to so many other health indicators for school-aged youth, SBHCs are secondarily linked (but not reported on here) to several other performance measures including: KPM # 8 (teen pregnancy), KPM #13 (teen suicide), KPM #17 (intended pregnancy), KPM #22 (8th grade risk for alcohol and drug use), KPM #24 (tobacco use), KPM #28 (HIV rate), KPM #29 (OHP clients receiving routine health care).

KPM #31 – Safety Net Clinic Use

Purpose

SBHCs are an important part of the safety net system of care. Because SBHCs are designed as an access model, and current data suggest up to 68 percent of all students seen in an SBHC likely would not have received services regardless of insurance status, the performance measure focuses on the number of students who have access and the number of clients (users) of SBHC services rather than on insurance status of students within this safety net component.

Other Performance Measures Related to Safety Net Clinic Use

Measure: Number of students who had access to a School-Based Health Center in a Service Year (SY)							
Identify whether the measures is an: Existing Internal Measure <input checked="" type="checkbox"/> New Measure for POP <input type="checkbox"/> Existing Internal Measures <input type="checkbox"/>							
DATA:	2005	2006	2007	2008	2009	2010	2011
Actual	39,249	37,320	38,306	38,980	NA	NA	NA
Target					42,000	44,000	46,000
Target Impact: Increase students with access to a SBHC by 3,000 to 7,000; (est. due to school size selection variable)							

Measure: Number of unduplicated clients served in a School-Based Health Center in a Service Year (SY)							
Identify whether the measures is an: Existing Internal Measure <input checked="" type="checkbox"/> New Measure for POP <input type="checkbox"/> Existing Internal Measures <input type="checkbox"/>							
DATA:	2005	2006	2007	2008¹	2009	2010	2011
Actual	17,702	20,177	20,831	NA	NA	NA	NA
Target				23,000	25,000	27,000	29,000
Target Impact: Increase number of clients served in a SBHC by 5,000; (est. due to school size selection variable)							

How Oregon compares to other states

Nationally, there were 1,709 SBHCs in 45 states according to the 2004-2005 National Assembly on School-Based Health Care Census Survey. Oregon reported on 45 SBHCs in that survey while Washington state reported on 18 SBHCs. Oregon was ranked 15th overall in the total number of SBHCs. Some of the more populous states have a large number of centers, such as New York (195) and California (140), while less populous states had relatively few centers, e.g. Alaska (2), New Hampshire (1).

¹ SBHC data is collected on a school-year basis. 2007 data represents the 2007-08 school year; 2008 data will be available at the conclusion of the 2008-09 school year.

The chart below compares Oregon’s answers to the overall National response to questions on operations, funding sources, and whether selected services were offered at the time of the 2004-2005 Survey.

	Oregon SBHCs	Nationwide
Selected Services	%	%
Comprehensive Health Assessments	100	94
Dental Preventive Care (sealants, fluoride, cleaning)	11	22
On-Site STD Diagnosis and Treatment for Adolescents	95	52
Asthma Treatment	93	92
Nutrition/ fitness/ weight management	53	55
Immunizations	100	87
Mental Health Assessment	83	86
Brief Therapy	85	73
Grief and Loss Therapy	78	81
Conflict Resolution/ Mediation	82	79
Operations	%	%
Bill Medicaid	84	70
Prearranged After Hours Care	64	65
Hours	Hours/Week	Hours/Week
Average Operating Hours	32	29
Funding Received From	%	%
Federal government	37	36
State government	93	71
County and city government	80	44
Private Foundations	85	62
Corporation/ businesses	39	38

Source: National Census of School-Based Health Centers, SY 2004-05, National Assembly on School-Based Health Care, 2006, www.nasbhc.org Note that National Census data is only collected and available every 3-4 years.

Quality and Efficiency Improvements

In order to improve the quality of services provided to SBHCs, the following quality improvement plan was adopted for implementation during the next biennium:

Goal: SBHCs are committed to high-quality, age appropriate, accessible health care for school-age children. To ensure this goal, SBHCs are targeting key health performance measures.

Approach: Year 1 of implementation (SY2006-2007) was an introduction to the tool and allowed time for sites to identify local system issues that may challenge completion and/or accurate data collection. Year 2 (SY 2007-2008) was used to identify baseline targets for sites and statewide goals were set accordingly. Year 3 (2008-2009) will be full implementation of the key performance measures and will be tied to county contracts. Because many services are included within the comprehensive exam, they will remain ongoing KPMs. The third KPM may alternate based on emerging adolescent health issues. Sites that are unable to meet the goal KPM will need to complete KPM Improvement Forms to identify and implement an action plan to improve practice. Progress must be demonstrated from year to year and meet statewide target goal within 2 years, otherwise funding may be reduced.

Measures:

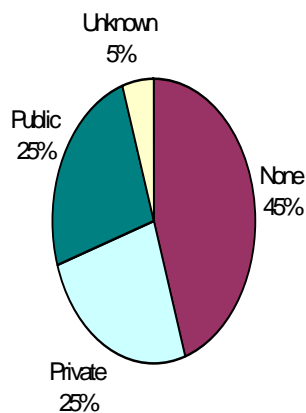
Sentinel Condition	State Goal
1. Risk Assessment¹	Complete risk assessment done every service year after 3 visits (Baseline or 15%)
2. Comprehensive Physical Exam²	Complete Physical exam every 2 years after child has been seen 3 times in one service year (Baseline or 15%)
3. Height, weight, & BMI	At least 1 recording of each measure for children seen at least 3 times in the SBHC in one service year (Baseline or 25%).

Health Disparities

SBHCs are a health care access model, recognized as part of the Oregon Safety Net system. This access model works to reduce health disparities by breaking down traditional barriers to health care faced by children and adolescents. Adolescents represent the highest uninsured age group; they are limited to receiving health care services due to transportation and financial barriers, along with concerns of stigma and confidentiality. SBHCs provide physical, mental and preventive health services to any student regardless of their ability to pay, in a safe, youth friendly and confidential setting on school grounds.

SBHCs work to reduce health disparities by providing services to any student regardless of health insurance status and their ability to pay. In 2006-07, 45% of SBHC clients were uninsured, representing the largest insurance category. See figure below.

**Client Reported Insurance Status
at First Visit 2006-2007**



The US Census data from 2006 report that 1.7% of the Oregon population is African American and 10% of Oregon citizens are of Hispanic or Latino origin. In contrast, 7% of students attending Oregon School Based Health Centers are African American and a full 18% are of Hispanic origin.

SBHCs also reduce health disparities by nature of their locations. SBHCs are located in both rural and urban communities. Oregon's 44 SBHCs are located in both rural and urban communities; 2 centers are frontier, 17 are rural and 25 are urban -14 of which are located in the Portland metropolitan area. In some of these

communities, the health services provided in the SBHC are the only health care services for many miles.

Key budget drivers and issues

The 2007 SBHC Establishment Act is the first Federal authorization for School-Based Health Centers and has bipartisan support in both the House and the Senate. The legislation would create a grant-based program and has requested \$50M in funding for FY 2009 through FY 2012. The Act lays out requirements for submitting applications with an emphasis on medically underserved populations. Individual SBHCs in Oregon, the state, or other entities could possibly become eligible applicants depending on the design of the grant-based program if the legislation is passed and funded. At this time, it is too early in the federal legislative process to determine the potential impact or benefit for Oregon.

At the local level, the availability of local matching and/or operational funds comprises the primary SBHC budgetary challenges. The current funding formula requires a 3-4 local dollar match for every state dollar. Sustainability planning at the local level is influenced by numerous factors including insurance coverage, mix of services, reimbursement rates, billing capacity, business infrastructure, medical sponsorship, and strength of community partnerships. The current SBHC funding model is an ‘investment’ model and does not pay for the full cost or ongoing operation of an SBHC. The ability of a school-community to develop a financial model to sustain such local investments continues to be the major challenge of SBHCs.

Women's & Reproductive Health (WRH) Program

Services provided

The Women's & Reproductive Health section (WRH) consists of three main program areas: Reproductive Health (RH), the Oregon Breast and Cervical Cancer Program (BCCP), and Women's Health (WH). BCCP was previously a part of the Office of Disease Prevention and Epidemiology, but transferred to OFH in 2007. WRH develops and supports statewide programs and policies to promote the health of individuals, families and communities with a specific emphasis on improving women's health throughout the lifespan.

The Reproductive Health (RH) Program provides a range of health services, counseling, and education to help Oregonians plan the timing and spacing of their children and to remain free of disease. Specific services provided through Reproductive Health include: birth control counseling and supplies; annual gynecological exams including cancer screenings; vasectomies; and STD/HIV prevention counseling; abortions are not provided. Referrals are made for primary care and many other health and social services. Services provided through the BCCP include clinical breast examinations, mammograms, Pap tests, diagnostic testing after an abnormal screening result, surgical consultations, and referrals to treatment. BCCP is part of the National Breast and Cervical Cancer Early Detection Program. In June 2008, the Women's Health program was awarded a WiseWoman (WW) grant, which will support screening for heart disease, stroke, tobacco use, obesity, and diabetes for women already being served through BCCP. WW will also make referrals to classes and other support for chronic disease management.

Where service recipients are located

Both RH and BCCP/WW provide services through a network of local providers across the state. In RH, services are provided at approximately 165 clinic locations. The table below shows the number of clients served in 2007, by county of service:

County	Clients Served 2007	County	Clients Served 2007
Baker	433	Lake	249
Benton	4,707	Lane	14,943
Clackamas	3,844	Lincoln	1,485
Clatsop	1,059	Linn	2,407
Columbia	709	Malheur	890
Coos	2,052	Marion	6,813
Crook	429	Morrow	345
Curry	467	Multnomah	27,253
Deschutes	6,638	Polk	1,548
Douglas	2,757	Sherman	12
Gilliam	18	Tillamook	1,168
Grant	285	Umatilla	1,976
Harney	168	Union	867
Hood River	1,192	Wallowa	252
Jackson	8,946	Wasco	1,012
Jefferson	724	Washington	14,103
Josephine	3,051	Wheeler	7
Klamath	2,101	Yamhill	1,155

BCCP currently works with approximately 123 enrolling providers, who provide primary screening and case management services, and 111 ancillary providers such as labs, radiology facilities, surgeons, and hospitals. The table below shows the number of clients served by BCCP in 2007, by county of service:

County	Clients Served 2007	County	Clients Served 2007
Baker	11	Lake	14
Benton	95	Lane	355
Clackamas	161	Lincoln	90
Clatsop	138	Linn	183
Columbia	36	Malheur	13
Coos	398	Marion	1,027
Crook	131	Morrow	7
Curry	121	Multnomah	1,126
Deschutes	402	Polk	0
Douglas	246	Sherman	17
Gilliam	3	Tillamook	67
Grant	74	Umatilla	73
Harney	28	Union	4
Hood River	201	Wallowa	8
Jackson	1,206	Wasco	114
Jefferson	111	Washington	1,174
Josephine	159	Wheeler	3
Klamath	0	Yamhill	352

The WW program works with the same provider base as BCCP. In its initial year, the WW services will be offered in two to three sites.

Who receives services

Priority for Reproductive Health services is given to individuals under 250% of the federal poverty level (FPL). Women, men, and teens are all eligible. In 2007, local clinics served 119,605 people in total; this number includes 115,765 women and 3,480 men; 87,935 clients below 100% FPL; and 12,480 clients with limited English proficiency.

The BCCP services are offered to women age 40-64 who are at or below 250% of the federal poverty level and do not have insurance or are underinsured. WW services will be offered to the same group. Priority populations include women age 50-64, women living in rural areas, women of color, women with disabilities, and lesbian women. Women under 40 and men of any age who are symptomatic for breast cancer are eligible for breast diagnostic services.

How services are delivered

There is a significant overlap between Reproductive Health providers and BCCP/WW enrolling or primary screening sites. Clinics through which RH services are delivered include County Health Departments, Federally Qualified Health Centers, Rural Health Centers, Planned Parenthood clinics, School-based Health Centers, and private medical professionals.

BCCP/WW providers include County Health Departments, Federally Qualified Health Centers, Rural Health Centers, laboratories, imaging facilities, hospital systems, outpatient radiology centers, surgeons, family physicians and other primary care providers, radiologists, pathologists, medical oncologists, radiation oncologists, ambulatory surgery centers, and radiation therapy facilities.

Why these services are significant to Oregonians

RH services protect and promote Oregonians' health by helping families have children only when they are ready for them. Almost 120,000 Oregon women and men count on publicly funded family planning clinics for reproductive health care that they would be unable to afford otherwise. The program benefits all Oregonians by reducing public spending on maternal and infant health services whenever an unintended pregnancy is prevented.

BCCP helps to reduce cancer mortality and morbidity by screening medically underserved women for breast and cervical cancer at no cost to them and by making referrals to treatment for clients with a cancer diagnosis. The program's clients would be unlikely to access cancer screening without the BCCP and its provider network. BCCP also provides a point of entry into the Oregon Health Plan (OHP) for breast and/or cervical cancer treatment. At present, only women screened through BCCP can enroll in OHP's breast and cervical cancer medical program (BCCM).

The leading causes of death for women in Oregon are cancer, heart disease and stroke. With the WW Program, the WRH section will offer prevention services in all three areas.

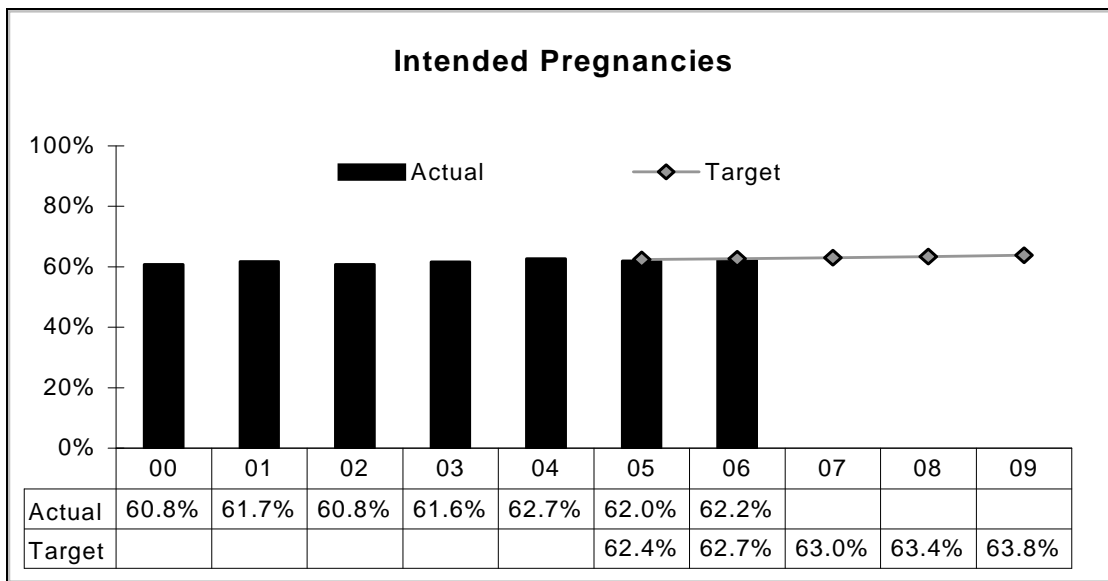
Performance Measures (RH)

The Reproductive Health program has one DHS key performance measure (KPM).

KPM #17 – Percentage of births where mothers report that the pregnancy was intended.

Purpose

This measure provides an indication of how effective RH is in helping women prevent unintended pregnancies before they occur. Clearly, pregnancy intent involves more than one person and is often influenced by complex feelings and attitudes that may not be amenable to state intervention. However, this measure is directly linked to national goals, most notably the Healthy People 2010 Objective 9-1: Increase the proportion of pregnancies that are intended.



How Oregon compares to other states

Healthy People 2010 Objective 9-1 sets an ambitious goal of increasing the proportion of U.S. pregnancies that are intended to 70%. Oregon currently falls a little short of this goal, as do many other states. The table below shows the proportion of pregnancies that were intended among a few of the 27 states participating in PRAMS, the Pregnancy Risk Assessment Monitoring System, in 2002. Unfortunately, this is the most recent year of data available.

State	% of Pregnancies Intended (2002)
New York (excluding New York City)	65.3%
Rhode Island	64.4%
Oregon	60.8%
Washington	60.3%
Oklahoma	48.5%
Louisiana	45.7%
27 state average	57.4%

Nationally, the percentage of pregnancies that were intended declined by 4% between 1995 and 2002 (the most recent year for which data are available), so Oregon's slight increase on this measure is notable. The Alan Guttmacher Institute ranks Oregon 9th in the nation for its efforts to help women avoid unintended pregnancy.

Performance Measures (BCCP & WW)

The Breast and Cervical Cancer Program has 11 data quality indicator guidelines (DQIGs) by which program performance is measured on a biannual basis. The indicators primarily measure timeliness and appropriateness of care for BCCP clients from initial screening to additional diagnostic procedures (if needed) and final diagnosis and treatment (if required). At the latest CDC review, BCCP met or exceeded the CDC standards for all DQIGs.

Purpose

These indicators measure quality and timeliness of care and are mandated by the federal grants supporting BCCP and WW. The measures are reviewed on a

biannual basis to ensure high quality service delivery and adherence to clinical guidelines by providers, as well as to evaluate the quality of the two programs.

How Oregon compares to other states

At the current funding level, approximately 7,000 medically underserved women receive screening services for early detection of breast and cervical cancer each year through BCCP. Approximately 37,000 additional women in Oregon are in need of these lifesaving screening services and are unable to access them due to program funding limitations. Nationwide, state Breast and Cervical Cancer Programs reach approximately 14% of the eligible population; Oregon is currently reaching close to 16% of the eligible population. However, Oregon also has a greater need for services. According to the CDC, Oregon and Washington have higher breast cancer incidence rates than most other states. For every 100,000 people in the Northwest, about 130 develop breast cancer, as compared to about 114 in California and 106 in Nevada. This variance in incidence rates has not been explained.

Quality and Efficiency Improvements (WRH)

Reproductive Health engages in many activities designed to improve the quality and effectiveness of the services it supports. Continuing education on a range of topics (e.g. new contraceptive methods, cost analysis, program integrity, culturally and linguistically appropriate services) is offered to local clinic staff at biannual meetings and periodic training events. Agencies' performance and compliance with program standards are monitored by triennial reviews that encompass clinical, fiscal, and administrative operations, as well as by regular audits.

Over the past two years, the BCCP transitioned from a local county health department-operated to a centrally administered program. This process involved streamlining and defining the requirements for providers to participate in the program, including collection of key data. During the past ten months, the BCCP developed and promulgated Oregon Administrative Rules for the program, drafted and finalized a new Medical Services Agreement for providers, developed an interim database for more accurate and efficient claims processing, and secured additional funding for infrastructure development and outreach activities. The program worked with providers to design a new web-based data system for data collection and claims processing that will be launched in the fall of 2008. This new

system will expedite provider payment and ensure high quality care is provided to DHS/BCCP clients.

Health Disparities (WRH)

In 2008, the Reproductive Health program began work to help each of its provider agencies meet the Culturally and Linguistically Appropriate Services (CLAS) guidelines for healthcare. The fourteen CLAS standards address culturally competent delivery of health care, language access services, and organizational supports for cultural competence, with the ultimate goal of delivering the highest quality of care to every patient regardless of race, ethnicity, cultural background, or English proficiency. All provider agencies, and the RH program itself, have conducted CLAS self-assessments and are now developing strategies for improving performance.

The BCCP and WW priority populations include women living in rural areas, women of color, lesbian women, and women with disabilities. A key program goal is to eliminate health disparities through outreach to these populations and the provision of breast and cervical cancer early detection and prevention messages and services. BCCP:

- Collaborates with organizations such as the Native American Rehabilitation Association, Inc. (NARA) Indian Health Clinic, Salud Medical Center, Virginia Garcia Memorial Health Center, and Yakima Valley Farm Workers to reach Native American and Latina women.
- Gives all contracted medical providers access to translation services to facilitate communication with non-English speaking patients.
- Contracts with Oregon SafeNet to respond to non-English speaking callers with information and referrals to providers in over 75 languages.

Key budget drivers and issues (WRH)

Several factors have combined to introduce volatility into the 2009-2011 Reproductive Health budget. Late in 2006, Medicaid citizenship documentation regulations were implemented for RH's family planning Medicaid waiver, called FPEP. The regulations prompted considerable changes in program enrollment procedures, making it more difficult for clients to qualify for services and creating a great deal of additional, uncompensated work for clinic staff.

During the 2007 legislative session, FPEP was allocated about \$3.8 million in new GF. Some of the additional funds were to support measures intended to mitigate the negative effect of citizenship documentation, such as 100% state-funded 'one-time exception' visits for individuals initially unable to provide documentation. Another portion went to increase FPEP provider reimbursement rates, which had not been adjusted since 2001. A third, large portion was intended to cover as many as 26,000 new clients. However, Medicaid citizenship documentation and other regulations have been significant barriers to FPEP client enrollment; one year after implementation of the regulations, FPEP client volume had declined by almost 30%. RH has initiated significant client outreach and provider recruitment efforts in response to this loss and the program hopes to see FPEP client volume recover in the latter half of 2008.

For the Breast and Cervical Cancer Program, the key issue is limited funding for breast and cervical cancer screening and diagnostic services. BCCP is funded by a grant from the CDC. These funds are used largely for direct services. BCCP leverages these Federal dollars with matching funds from the Susan G. Komen for the Cure (Komen) SW Washington and Oregon Affiliate (i.e., the CDC provides \$3 for every \$1 Komen). The Oregon program does not receive any state GF. At the current funding level, approximately 7,000 medically underserved women receive screening services for early detection of breast and cervical cancer each year through BCCP. Approximately 37,000 additional women in need of these lifesaving screening services are unable to access them due to program funding limitations. Thus, the program is only able to serve approximately 16% of the eligible population in Oregon.

Nutrition and Health Screening (WIC) Program

Services provided

The Nutrition and Health Screening (WIC) Program provides individual assessment of growth and health; education and counseling on nutrition and physical activity, including promotion of a healthy lifestyle and prevention of chronic diseases including obesity; breastfeeding education and support; and referrals to other preventive health services and social services.

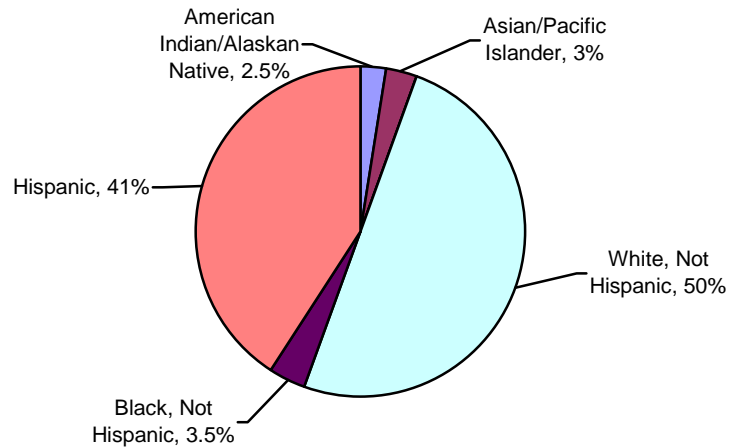
Where service recipients are located

The services are provided to recipients in all areas of the state.

Mothers and Children Served by Local Agency during June 2008:

County	Clients Served	County	Clients Served
Baker	489	Josephine	2,747
Benton	1,375	Klamath	2,624
Clackamas	6,026	Lake	210
Clatsop	1,280	Lane	7,573
Columbia	1,258	Lincoln	1,516
Coos	1,792	Linn	3,716
Crook	647	Malheur	1,731
CT Umatilla	152	Marion	9,888
CT Warm Springs	491	Multnomah	18,605
Curry	518	Polk	1,366
Deschutes	4,338	Salud	9,578
Douglas	3,469	Tillamook	759
Grant	200	Umatilla/Morrow	4,087
Harney	216	Union	191
Hood River	1,078	Wallowa	127
Jackson	6,162	Wasco/Sherman	994
Jefferson	821	Washington	12,827
State Total:		109,627	

Participant Race/Ethnicity 2007-2008



Who receives services

Services are provided to lower-income pregnant, postpartum, and breastfeeding women, and children under the age of 5 who have a health or nutrition risk. In 2007, local programs served 168,000 women, infants and children. This includes 40% of all infants born in the state; 51% of all infants born in rural counties; and 1 in 3 Oregon children under the age of 5. More than 72% of those served are working families.

How services are delivered

The services are provided by staff located in local communities across Oregon through a partnership with 29 local health departments, 2 tribal organizations, and 2 nonprofit organizations.

Why these services are significant to Oregonians

The services provided by the WIC Program are designed to reach families most in need of preventive health services at a critical time in their lives. The Program provides a unique set of targeted services to help families give their children a healthy start.

The WIC Program is the primary promoter of breastfeeding for low-income women. Promoting breastfeeding and supporting women who breastfeed is a

proven public health intervention. Breastfeeding protects both mother and child from immediate and future health problems with corresponding reductions in health care costs.

WIC families purchase \$75.5 million of nutritious foods at more than 630 stores statewide. The WIC Farm Direct Nutrition Program helps lower-income young families purchase \$417,876 in local fresh fruits and vegetables. This supports local farmers by infusing moneys into local communities statewide.

Performance Measures

The WIC Program is an important provider of preventive health services and economic security for lower income young Oregon families. The program most strongly relates to key performance measure 1.08 (KPM) #10, Food Stamp Utilization.

The program is supportive of the National Title V Performance Measures for 2005-2010: measure 11, measuring the percent of mothers who breastfeed their infants at 6 months of age; and measure 14, looking at Body Mass Index levels of WIC children between 2-5 years of age. The program is also supportive of several Oregon MCH priorities including: individuals and families exhibit healthy lifestyles; parents and providers are confident in caring for children; and eating more fresh fruits and vegetables means better nutrition and healthier weights in children.

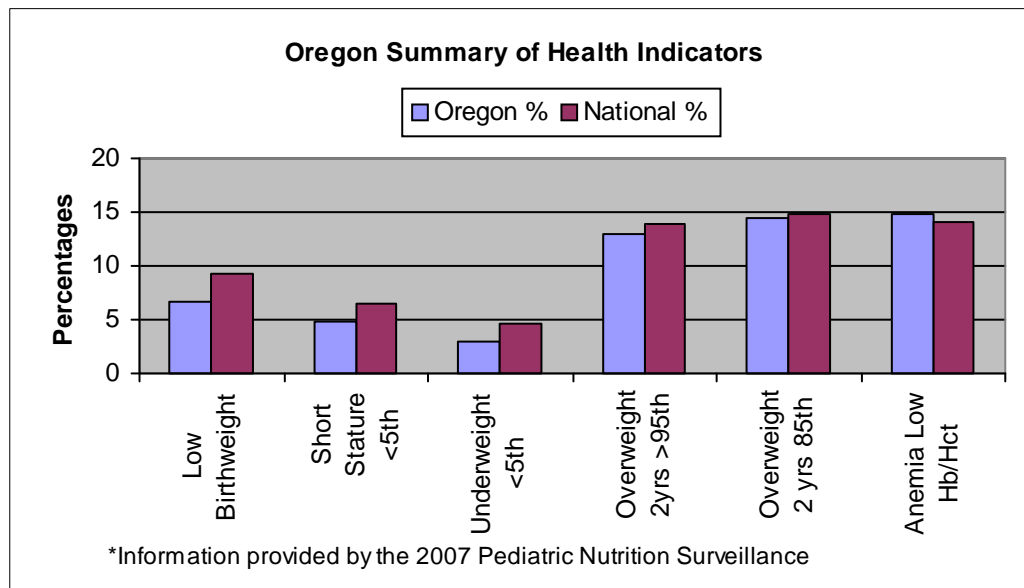
KPM #10 – Food Stamp Utilization.

Purpose

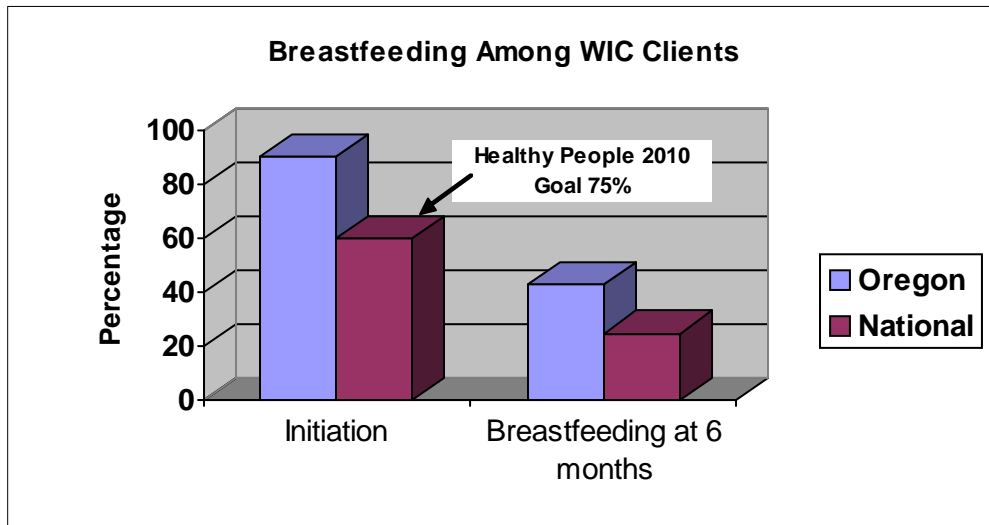
WIC staff routinely screen WIC participants for eligibility for food stamps, and refer eligible participants to that program. Slightly more than 47% of WIC participants also participate in the food stamp program, which is an increase from last year's 40%. Many farmers' markets accept the food stamp benefit. The WIC Farm Direct Nutrition Program frees up food stamp dollars that would have been spent at farmers' markets.

How Oregon compares to other states

Oregon scores better than the national average on most health indicators for the WIC child population, according to data from the 2007 Pediatric Nutrition Surveillance Survey, which collects data primarily from State WIC programs and includes most of the States and territories in the U.S. In particular, Oregon's rate of low birth weight, underweight, and low iron (hematocrit, or hct) are significantly better (-lower) than the national rates. One area of concern is that Oregon's percentage of 2-5 year olds classified as at-risk for being overweight exceeds the national average, although Oregon is not among the states with highest rates of overweight preschoolers. However, Oregon's lower ranking does help to reinforce that programs targeting underlying influencers of being overweight, such as healthy eating habits, increased physical activity, and community resources are vital to helping families stay healthy. The Nutrition and Health Screening Program focuses education on those influencers of overweight.



Oregon leads the nation in the number of mothers who begin breastfeeding (90.4% in Oregon vs. 60.1% nationally) and continue to nurse at six months and beyond (43% in Oregon vs. 25% nationally). Oregon also enjoys the smallest disparity between WIC mothers and non-WIC mothers in relation to breastfeeding. Nationally, the difference in breastfeeding initiation is about 20%, while in Oregon it is less than 10%. As breastfeeding is associated with a reduced risk of a myriad of negative health conditions for both mother and infant (ear infections, diabetes, breast cancer, etc), Oregon is focused on making breast milk a vital part of a baby's early preventive care.



Quality and Efficiency Improvements

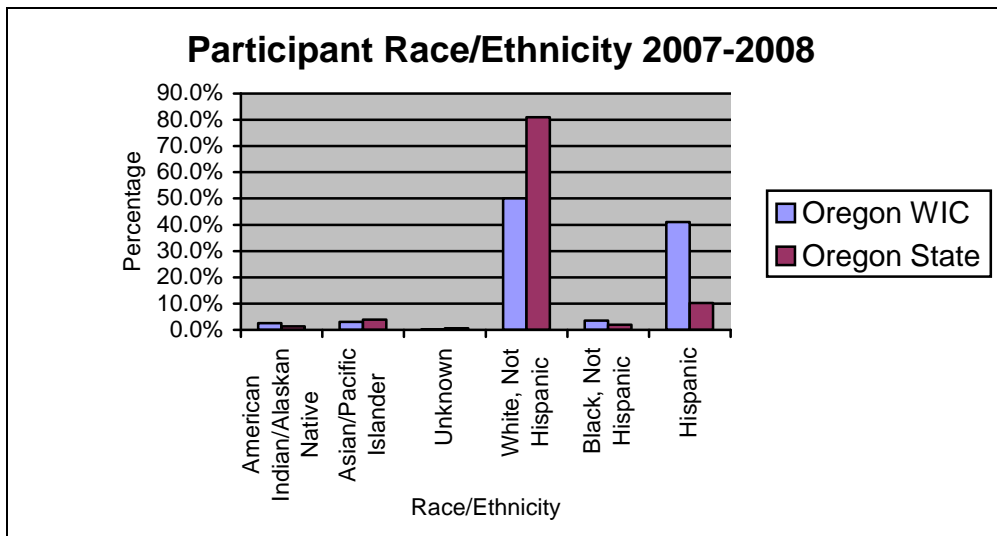
In order to improve the quality of services provided to WIC clients, training support is provided for all local agency WIC staff. The training plan includes training support for new staff, for existing staff, for breastfeeding expertise, for new initiatives, and in-services and a statewide meeting every other year.

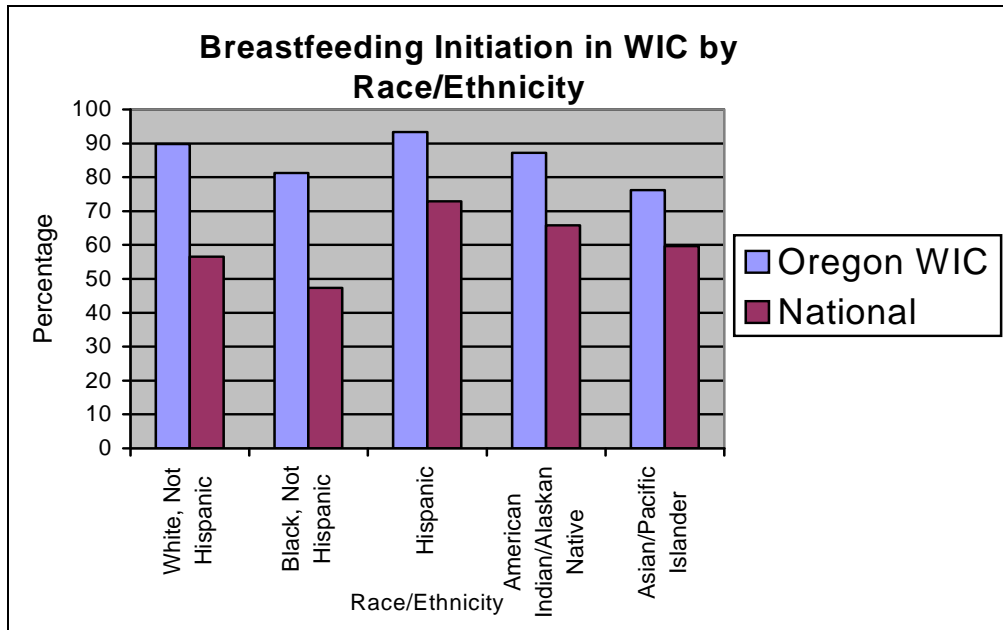
Over 91 percent of Oregon women start out breastfeeding in the hospital after delivery, the highest rate in the nation. Lack of breastfeeding support and barriers when returning to work make it difficult for most women to continue breastfeeding for the 12 months recommended by the American Academy of Pediatrics. For many lower-income women, the Nutrition & Health Screening (WIC) Program provides their only breastfeeding support. The program has a no cost breast pump loaner program for women returning to work, school, or jobs training. To address the disparity in access to breastfeeding support and consultation, the program has targeted non-English speaking local WIC staff for in-depth breastfeeding training and certification. 90.3% of Oregon WIC mothers initiate breastfeeding, compared with 60.1% nationally.

In order to shift costs and administrative effort from over-burdened local offices, the State WIC office has purchased laptop computers for satellite clinics, has the voucher stock printed and shipped to clinics, purchases lab equipment for local use, purchases the breast pumps, provides printer maintenance for the voucher printers, and contracts with a company to calibrate scales at all clinics.

Health Disparities

The Oregon WIC program is assisting in the effort to decrease health disparities through its outreach, research, and health promotion efforts. For example, WIC has targeted outreach strategies and materials to effectively reach traditionally underserved communities. In addition, WIC has done a research study on breastfeeding peer counseling and to what degree peer counseling improves breastfeeding rates. WIC has incorporated motivational interviewing as the method of delivering nutrition education. These both contribute to WIC's ability to increase the cultural competency of how services are delivered and help more mothers to breastfeed.





Key budget drivers and issues

Uncertainty around the final funding level of federal fiscal year 2009 could impact the program, as all funding is from the federal government. Rapidly increased participation coupled with skyrocketing food inflation is a huge concern for the WIC program. Reduced funding during a time of major federally mandated changes and increased county budget deficits are very problematic. In addition, WIC caseload has increased by 4.5% over the past year to the current level of 110,387 participants in July 2008.

Immunization Program (IP)

Services provided

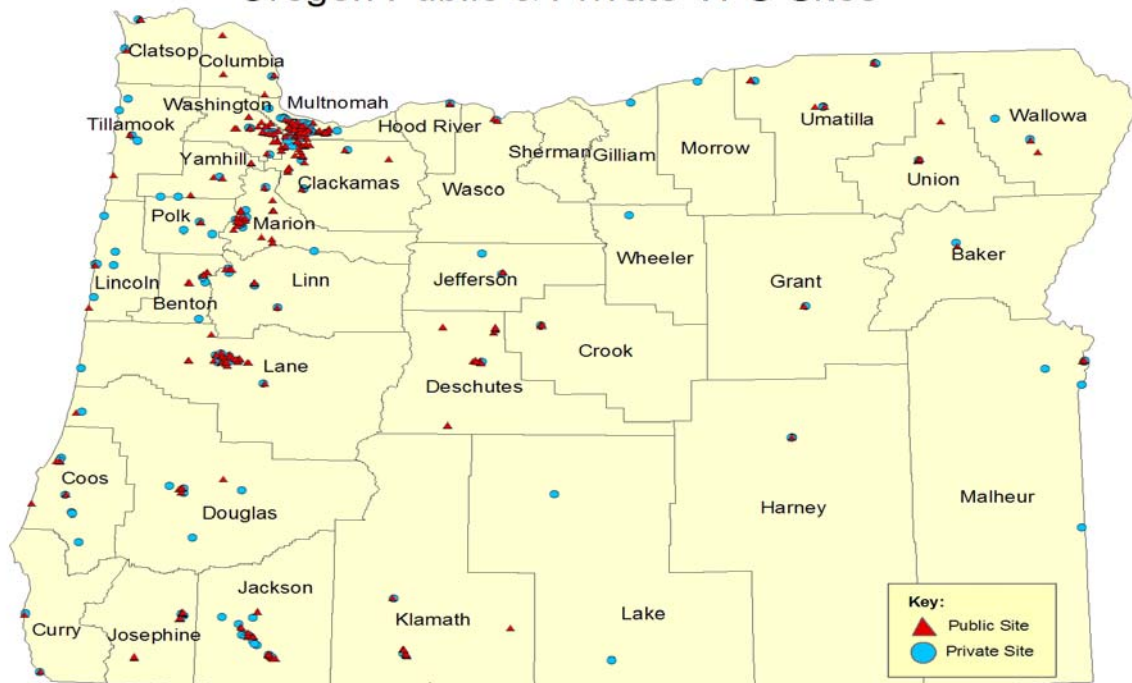
The Immunization Program (IP) provided services in 2007 that included purchasing and distributing \$27.4 million in vaccines to both the public and private sectors. Epidemiology staff, in a team effort with local health department staff, makes disease surveillance and outbreak control a high priority service. Health educators and nursing staff provide model vaccine standing orders, health education materials, training and technical assistance on vaccines to providers. They also provide health education on vaccines for consumers, to assure the public understands the benefits and risks of immunization. They assess immunization rates across the lifespan to measure progress and target additional needs.

A key focus of our program is working with community partners to improve lifespan immunization rates. The program is currently planning to merge the statewide immunization registry and the immunization electronic medical record system for local health departments into a new Immunization Information System in 2009. This is part of the FamilyNet data system for the Office of Family Health. Our program staff works closely with local health departments to enforce the School/Facility Law. Lastly, the program conducts research on ways to address barriers to achieving high immunization rates.

Where service recipients are located

Service recipients mirror where the population in Oregon lives. The eastern two thirds of Oregon is predominantly rural with smaller numbers of recipients, with most of the state's population residing in the western third of the state, along the narrow interstate "I-5 corridor" that extends from Portland southward to the California border. Clinic sites across the state are shown below.

Oregon Public & Private VFC Sites



Source: Oregon Immunization Program, DHS, 2007

Who receives services

Immunization services are a high priority for all children, with special emphasis to children from birth through two years of age, at school entry, and 7th grade. Adult immunizations are targeted to high risk populations like those with diabetes, liver disease, congenital immunodeficiencies, kidney failure, asplenia, HIV, health care workers and those 65 and older.

How services are delivered

Immunization services are delivered by both public and private providers, including pediatricians, family practice docs, local health departments, federally qualified health centers, and rural health clinics. 80% of childhood immunizations are delivered in the private sector and 20% in the public sector.

Why these services are significant to Oregonians

The services provided by the Immunization Program strive to ensure that no one in Oregon suffers the consequences of vaccine-preventable diseases.

Performance Measures

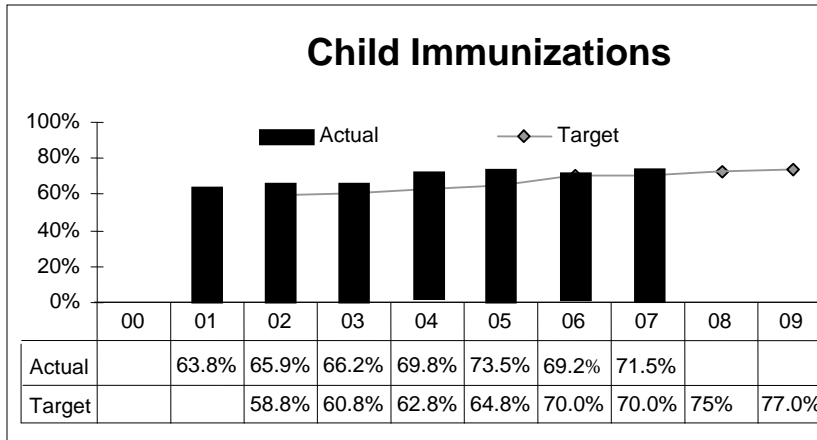
The Immunization Program has the following two key performance measures, and one new outcome measure.

KPM #22 – The percentage of 24-35 month old children served by local health departments who are adequately immunized.

Purpose

This performance measure is the percent of children 24-35 months of age immunized with four or more doses of diphtheria, tetanus and pertussis (DTaP); three or more doses of polio; one or more doses of measles, mumps, rubella (MMR); three or more doses of Haemophilus Influenzae type b; and three or more doses of hepatitis B (4:3:1:3:3). This measure is limited to children served by the local health departments. The goal is to continue to increase immunization rates to meet the Healthy People 2010 objective of 90%.

In 2007, the percent of children immunized with 4:3:1:3:3 reached 71.5% for those children served by local health departments. This up-to-date rate continues to steadily increase.



How Oregon compares to other states

The best comparison available to other states is the National Immunization Survey, a phone survey of residents in each state. The national rate for 4:3:1:3:3 in 2006 based on the National Immunization Survey was 80.5% and 78.8% for Oregon. Oregon's rates have been below the national average for several years. Infants starting shots at a later age, a complicated immunization schedule making it difficult for parents and providers to assure that all shots are given when they are due, and a persistent concern about vaccine safety influence these lower rates.

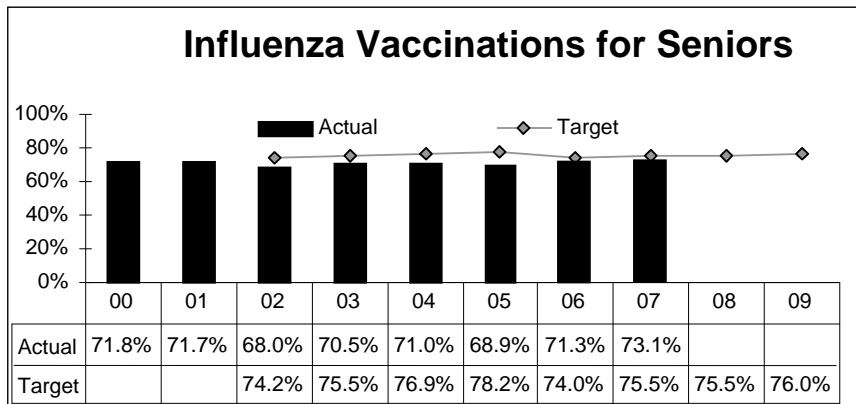
State	Immunization Rate 4:3:1:3:3
Massachusetts (ranked 1 st)	87.0% ± 4.5
California	80.2% ± 4.2
Idaho	78.1% ± 6.2
Nevada	64.7% ± 7.3
Oregon (37th)	78.8% ± 5.9
Washington	77.6% ± 4.3
National	80.5% ± 1.0

KPM #23 - The percentage of adults aged 65 and over who receive an influenza vaccine.

Purpose

This performance measure is the percent of adults, ages 65 and older and living independently, who received an influenza immunization in the past 12 months. The goal is to continue to increase immunization rates to meet the Healthy People 2010 objective of 90%.

The percentage of older adults immunized annually against influenza has remained relatively flat over the past several years and below the targets. Following the influenza vaccine shortage during the 2004-05 season, a survey of Oregon residents found that the top reason for not getting a flu shot were concerns about vaccine efficacy and safety. Additionally, using 2005 data, a disparity in coverage rates was identified between persons self-identified as White and non-White in Oregon.



How Oregon compares to other states

In 2007, the national immunization rate for persons 65 and older was 72.0%, with state rates ranging from 80% in Rhode Island to 61.9% in Nevada. Oregon ranked 19th in rates with 73.1% of the 65+ population immunized.

State	Influenza Immunization Rate
Rhode Island (ranked 1 st)	80.0%
California	69.3%
Idaho	69.1%
Nevada	61.9%
Oregon (19th)	73.1%
Washington	72.0%
National	72.0%

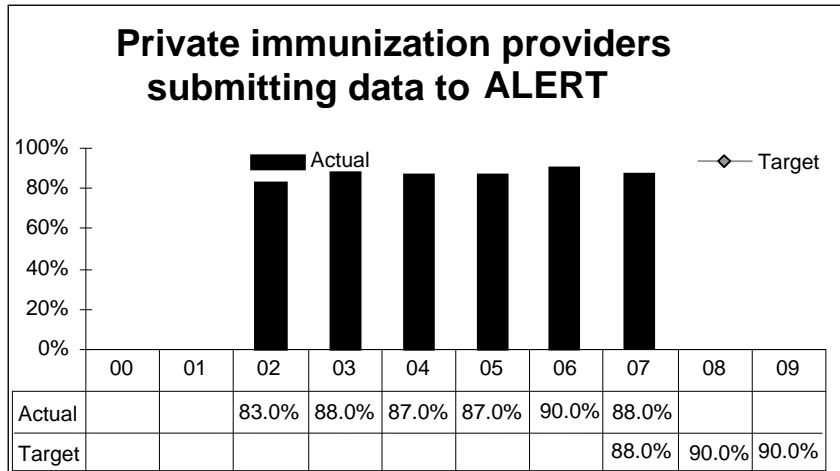
Proposed Outcome Measures

Measure: Percent of private immunization providers submitting data on 0 – 6 year olds to the ALERT registry.

Purpose

This measure tracks the number of private providers in Oregon who immunize children age 0-6 years and who submitted at least one shot in the previous six months. Public providers are not included in this measure, as they are all required by contract to submit data to ALERT. However, participation by the private sector is voluntary.

Increasing provider reporting to ALERT is a key step in increasing immunization rates and decreasing over immunization of children. With a well-populated registry, Oregon is now testing different reminder and recall mailings to parents to help them navigate the complex immunization schedule. Additionally, the registry is a tool relied on statewide by providers to assess immunization status of clients, providing current information for clinical decision-making.



How Oregon compares to other states

This measure is interesting to compare nationally, as each state has promoted registry participation differently. Some promote voluntary participation like Oregon and some require mandatory reporting like Washington. Even with Oregon’s voluntary private provider reporting, 88% of those providers do report, far exceeding participation in neighboring states. 88% is down slightly from 90% in 2006; this change is believed to be due primarily to the addition of new clinical sites that have not yet begun submitting to ALERT, and to sites that have changed to electronic health records and are in the process of converting how they submit data to the registry.

State	Private Provider Participation in Registry
California	21%
Idaho	64%
Nevada	12%
Oregon	88%
Washington	66%

Quality and Efficiency Improvements

Over the past few years, the Immunization Program and the local health departments have implemented new billing requirements that help Oregon extend vaccines to more people. The program worked with public clinics to implement a

new process and culture for billing well-insured clients and their health plans for the cost of vaccines when served in public clinics. The program stopped using taxpayer-funded vaccine to underwrite health plan coverage for immunization. Oregon has collected a total of \$3.2+ million (through 2007) that is now used to buy more vaccine for those who are not well insured, including hepatitis A vaccine for children and hepatitis A and B for adults. Oregon is one of only two states doing this. CDC has adopted this as a new best practice nationally.

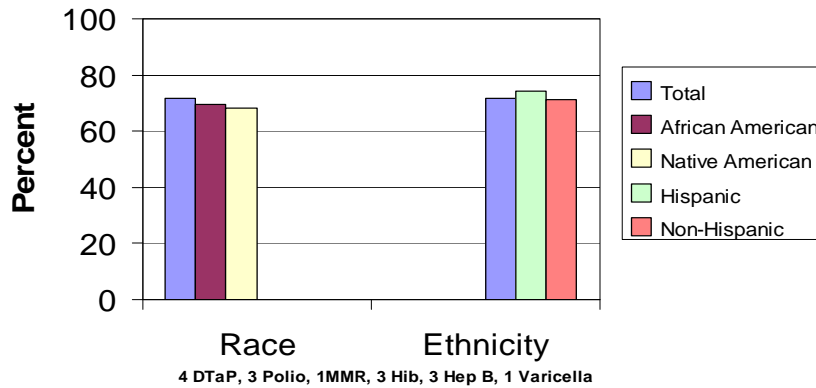
Health Disparities

The Immunization Program will continue its work measuring immunization outcomes in Oregon across racial/ethnic populations, as well as some targeted work to engage the tribal governments in planning and implementation of immunization activities. Other targeted work with the Oregon Partnership to Immunize Children (OPIC) will focus on reducing health disparities and improving cultural competency.

Immunization Rates

Community-specific immunization rates help the IP target interventions and coalition outreach activities. In a 2005 analysis, Oregon's Hispanic community (74%) had higher immunization rates than non-Hispanics (71%). Nationally during the same period, Hispanic immunization rates (75.6%) were below the non-Hispanic average (79.5%). Oregon's African American (70%) and Native American (68%) rates were lower than the state average (72%) in 2005. In order to monitor immunization disparities across racial and ethnic communities, population-based immunization rates will be calculated annually for African-Americans, Native Americans, Asian Americans, and for the Hispanic community beginning in 2008.

**Childhood Immunization rates by
Race and Ethnicity, Oregon
2005 Provisional Data**



Engaging the Tribes

The IP medical epidemiologist and members of the Provider Services Team (PST) will meet with stakeholders, create an action plan for working with each tribal clinic, then implement and evaluate the activities in each plan. The epidemiologist and PST will write an annual summary and present it to the IP staff.

Health Disparities and Cultural Competency

The Oregon Partnership to Immunize Children (OPIC) has an active Health Disparities and Education Committee which has met monthly since 2001. The Committee’s charge is to work with partners in diverse racial and ethnic communities to achieve the long-term goal of closing immunization disparities that impact racial and ethnic communities in Oregon. Using the OPIC Health Disparities Resource Guide (2006), the Committee is dedicated to systematically educating the OPIC leadership, partners, and health care professionals about health disparities, and increasing childhood and adolescent immunization rates. The Committee annually identifies, discusses and disseminates Oregon data relevant to health disparities. OPIC is developing a targeted radio and print campaign (pertussis prevention), which local and state community partners can adapt to multiple languages and cultural settings.

Key budget drivers and issues

Issue: Oregon’s Tiered Vaccine Policy for Children

Oregon has three primary sources of vaccine funding:

- Vaccines for Children (VFC) Program: a Federal entitlement program that covers children who are: uninsured, on OHP/Medicaid, American Indian/Alaskan Native, and underinsured (insured but not for immunization) if served in a federally qualified health center (FQHC). VFC covers all ACIP recommended pediatric vaccines for children birth through 18 years.
- Federal 317 funds: 317 funds are limited and have not increased significantly since late 1990. Currently, 317 funds support only vaccine administered in public clinics.
- Billable funds: the Oregon Immunization Program collects from public providers for insured clients served in the public clinics.

Oregon's vaccine funding (beyond VFC) is not adequate to sustain supporting all childhood ACIP recommended vaccines. From the late 1990's through April 2008, Oregon like a number of other states had a two-tier vaccine eligibility policy. VFC children in Oregon are eligible for all ACIP recommended vaccines, in both public and private clinics. Non-VFC eligible children had to pay out-of-pocket for certain specified vaccines. In May 2008 (with one-time only federal funds), Oregon was able to temporarily eliminate the two-tier system. However, it is unlikely that Oregon will be able to sustain the one-tier system for more than 1 year. The Immunization Program is currently working on options to address this issue.

Office of Disease Prevention and Epidemiology (ODPE)

The Office of Disease Prevention and Epidemiology (ODPE) monitors the occurrence of diseases and injuries and uses what is learned from these data to design and implement prevention programs. Areas covered by ODPE include communicable diseases, chronic diseases and injuries. ODPE also is responsible for the vital statistics system (birth and death certificates).

The major sources of funding for ODPE include:

- Various federal categorical grants, primarily from the CDC, including:
 - ◆ HIV Prevention,
 - ◆ Tuberculosis Control and Prevention,
 - ◆ Violent Death Reporting
 - ◆ Diabetes Risk Reduction, and
 - ◆ Ryan White / AIDS Drug Assistance Program,
 - ◆ Emerging Infections;
- Tobacco Use Reduction Account (Ballot Measure 44); and
- Fees (vital records).

Acute and Communicable Disease Program (ACDP)

Services provided

The Acute and Communicable Disease Program (ACDP) monitors communicable disease occurrence in the state, investigates communicable disease outbreaks, and helps ensure that communicable disease threats, including bioterrorist threats, are responded to appropriately. In addition, ACDP provides information to the public, the media and policymakers about communicable diseases in Oregon.

Where service recipients are located

These services are provided to Oregonians statewide.

Who receives services

Services are provided to all Oregonians.

How services are delivered

Services are provided both from the program's central office and in partnership with 34 local health departments.

Why these services are significant to Oregonians

Every year ACDP helps ensure the appropriate investigation of numerous outbreaks, such as the recent Salmonella outbreak from jalapeno peppers. Local health departments and health care providers rely upon the expertise in this program to protect health and safety.

Performance Measures

ACDP has no DHS key performance measures.

Quality and Efficiency Improvements

None are identified for this program.

Key budget drivers and issues

Because ACDP depends heavily on federal funding, changes in federal appropriations for communicable disease programs and the lack of increases in federal funding for these programs to keep up with inflation can have a large impact on services.

Health Promotion and Chronic Disease Prevention Program (HPCDP)

Services provided

The Health Promotion and Chronic Disease Program (HPCDP) monitors chronic diseases and their risk factors in the state, and works to prevent these diseases, to promote screening for these diseases when appropriate, and to improve care for people with chronic diseases. Diseases currently covered by HPCDP include asthma, arthritis, cancer, diabetes, heart disease and stroke. Program staff work to address the leading underlying risk factors for these diseases: tobacco use, physical inactivity and unhealthy nutrition. HPCDP also provides information to the public, the media and policymakers about chronic diseases and their risk factors in Oregon.

Where service recipients are located

The services are provided to Oregonians statewide.

Who receives services

Services are provided to all Oregonians.

How services are delivered

Services are provided both from the program's central office and in partnership with 34 local health departments, health systems, and numerous community-based organizations.

Why these services are significant to Oregonians

Chronic diseases continue to take a huge toll on Oregonians. Heart disease and cancer, for example, are the leading causes of death for Oregonians. In addition, these diseases are enormous drivers of health care costs. Many of these diseases and their effects are preventable.

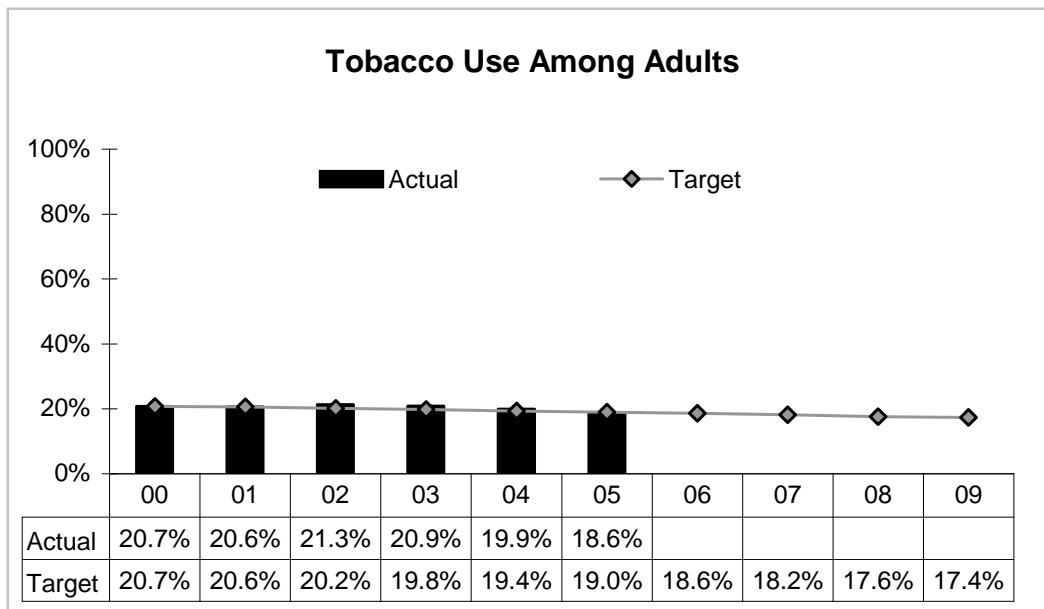
Performance Measures

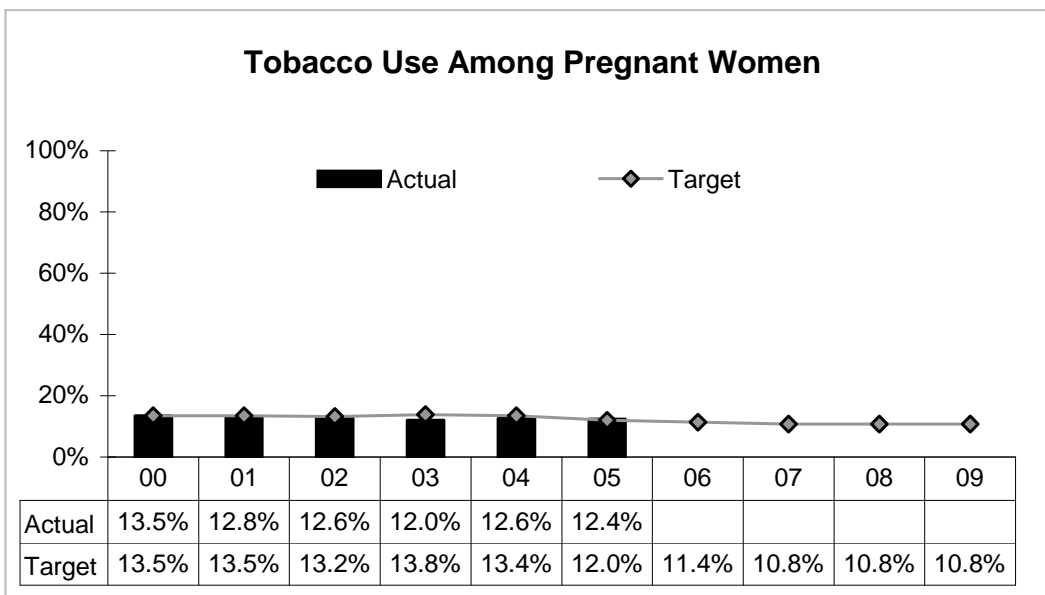
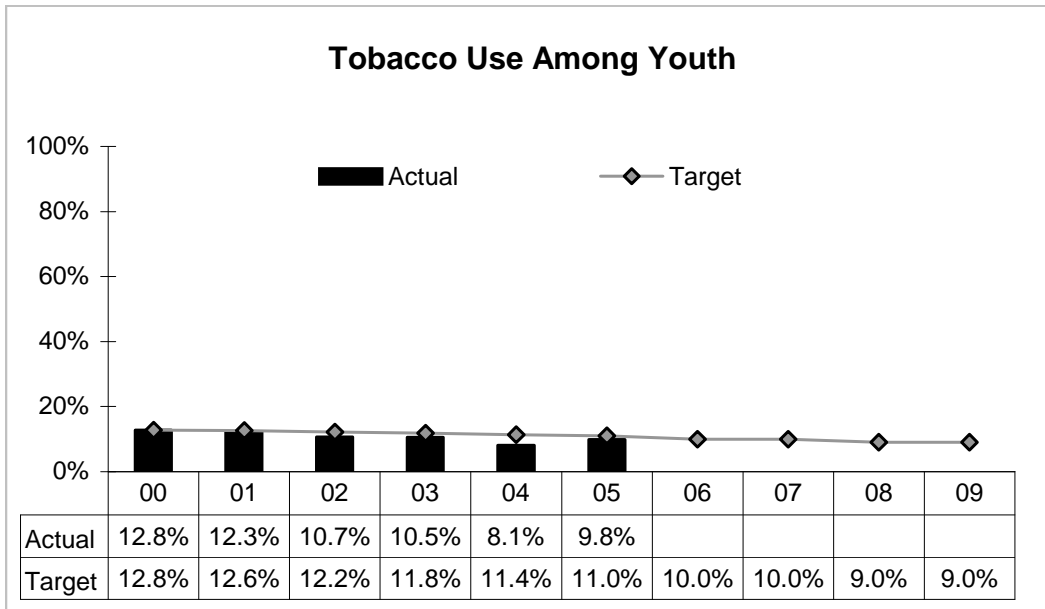
HPCDP has two DHS key performance measures:

KPM #20 – Tobacco Use

Purpose

The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Studies show that 90 percent of adult smokers started smoking before they were 18 years old. Preventing youth from starting to smoke will lead to lower smoking rates among adults in the years ahead. A woman’s use of tobacco during pregnancy is associated with serious, and at times fatal, health problems for the child, ranging from low birth weight and premature births to stillbirth and Sudden Infant Death Syndrome (SIDS). Successful efforts by TPEP to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality, contributing substantially toward the DHS goal “People are healthy” in both the short-term and long-term.

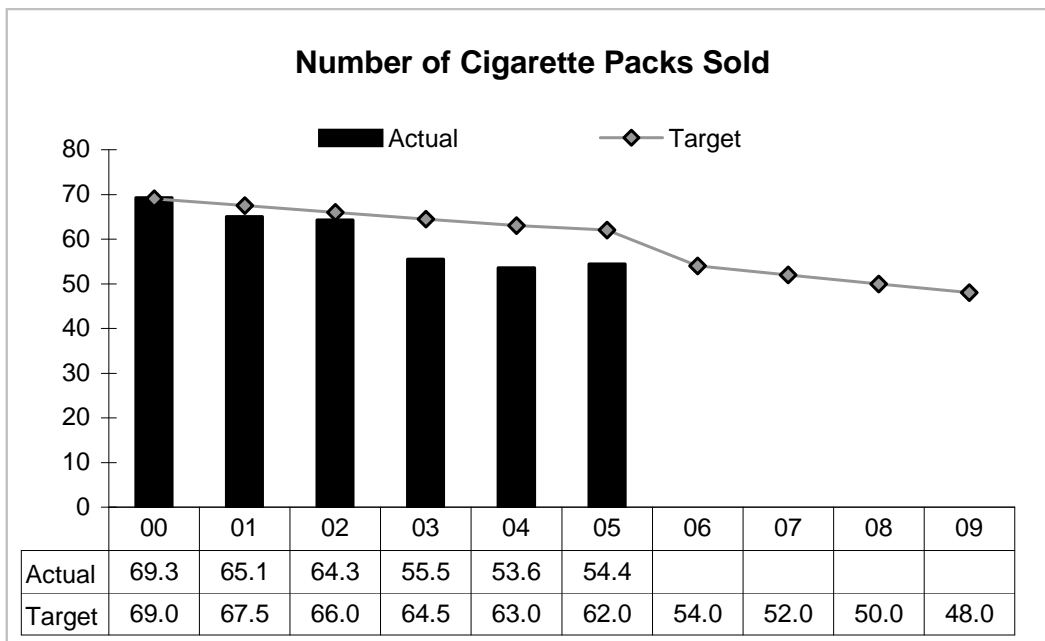




KPM #21 – Cigarette Packs Sold

Purpose

One of the main goals of TPEP is to reduce tobacco use by adults. Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco or reducing the amount smoked has significant health benefits. Reductions in the number of cigarette packs sold per capita results from two distinct phenomena – an increase in former smokers, and a decrease in the quantity of cigarettes smoked among continuing smokers. It is clear that reducing the per capita packs of cigarettes sold will lead to substantial improvement in people’s health, both in the short-term and long-term.



How Oregon compares to other states

In 1997, prior to the TPEP’s inception, Oregon had greater per capita sales of cigarette packs than the rest of the country (92.1 – Oregon, 87.2 – U.S.). In 2005, U.S. per capita sales of cigarette packs was 61.6, and that for Oregon was 54.4. This represents a much steeper decline in per capita cigarette sales in Oregon than in the rest of the country. Nonetheless, Oregon’s per capita pack sales in 2005 were nearly double those of Washington (35.8) and California (33.1), both of which have continued to dedicate significant resources to tobacco prevention activities.

Quality and Efficiency Improvements

Risk behaviors for many chronic diseases overlap and include tobacco use, physical inactivity and unhealthy nutrition. To leverage the multiple disease-specific federal funding streams that HPCDP receives, HPCDP piloted a program last biennium to create local coalitions that address all three of these risk factors and also promote self-management of chronic diseases and timely screening for chronic diseases. This program has been very well received and expansion to other communities is planned as funds permit.

Key budget drivers and issues

Because HPCDP depends heavily on federal funding, changes in federal appropriations for chronic disease programs and the lack of increases in federal funding for these programs to keep up with inflation can have a large impact services.

Injury Prevention and Epidemiology Program (IPE)

Services provided

Injury Prevention and Epidemiology (IPE) monitors both unintentional and violent injuries in the state, and works to prevent them. Current areas of focus for IPE include childhood injury prevention, and youth and older adult suicide prevention. IPE also provides information to the public, the media and policymakers about injuries in Oregon.

Where service recipients are located

The services are provided to all Oregonians statewide.

Who receives services

Services are provided to all Oregonians.

How services are delivered

Services are provided both from IPE's central office and in partnership with local health departments and numerous community-based organizations.

Why these services are significant to Oregonians

Injuries are the leading cause of death for Oregonians aged 1-44. Approximately two thirds of violent deaths each year in Oregon are suicides. Many of these deaths and non-fatal injuries are preventable. The first step to preventing them is understanding who gets injured and under what circumstances.

Performance Measures

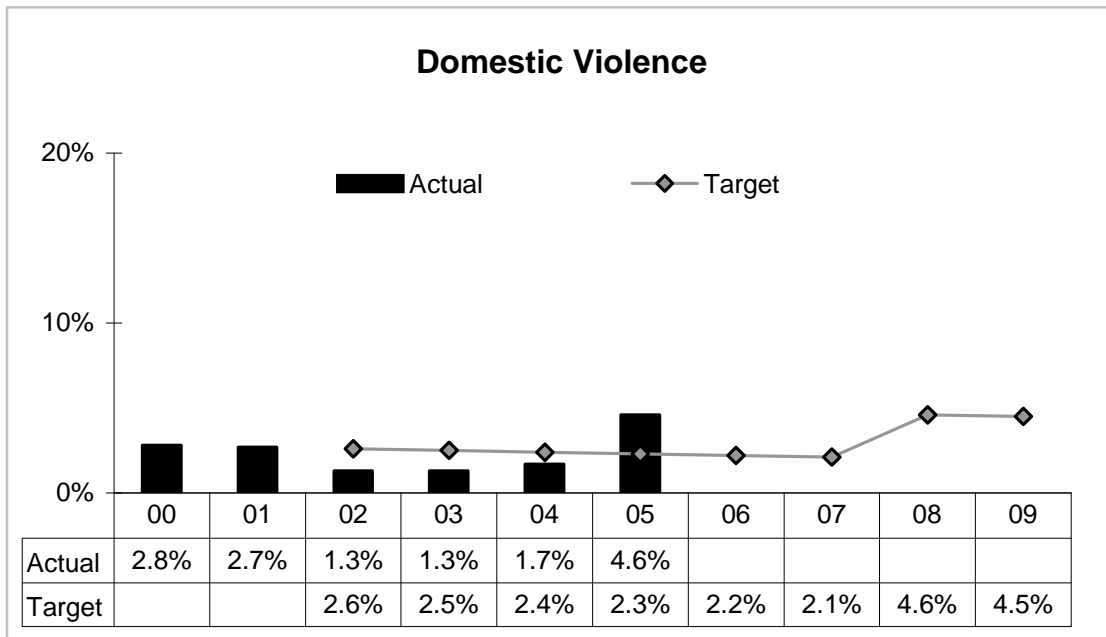
IPE has two DHS key performance measures:

KPM #11 – Domestic Violence

Purpose

In order to reduce the percentage of women subjected to domestic violence each year, DHS regularly provides training on new policies and procedures for staff. The DHS Domestic Violence Council is promoting screening and referral in all DHS service deliveries and DHS has published the "Oregon Violence Against

Women Prevention Plan.” This is a first step for the state in addressing prevention. As yet there are no state funds invested in primary prevention, a public health data system, current program evaluation or research. In 2005, the state published a cost report on violence against women that estimates the cost of intimate partner violence exceeds \$50 million per year, nearly \$35 million of which is for direct medical and mental health care services. Health care expenditures represent more than two thirds of all costs related to domestic violence.



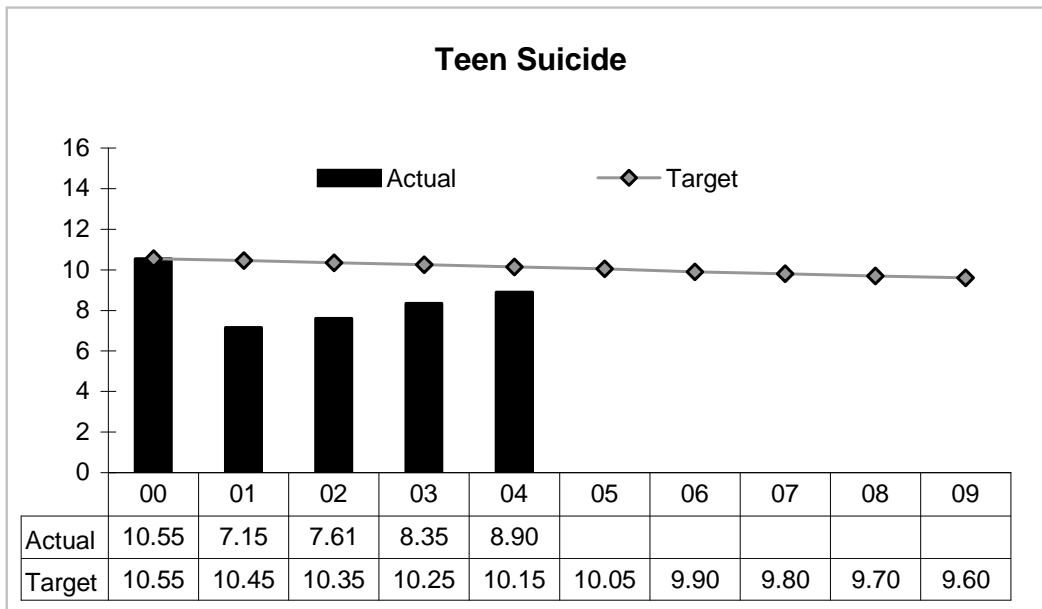
KPM #12 – Teen Suicide

Purpose

Approximately 2,000 suicide attempts among youths are treated in emergency departments in Oregon each year. Approximately 42 percent report a previous attempt and approximately 90 percent are reported to have a diagnosable mental health problem. These youths are at high risk for an additional attempt and death. Reducing suicides among youths will require implementation of multiple strategies over time, including:

- Increasing community readiness to adopt suicide prevention strategies

- Improving screening and assessment that can identify youths at risk in all settings where youths are typically assessed, providing training for professionals in health, behavioral health and social services for youths
- Teaching youths to take suicide talk seriously and report it to an adult
- Establishing procedures and policies in schools
- Reducing the stigma associated with behavioral health care and with suicide



How Oregon compares to other states

Oregon’s suicide rates are consistently higher than the national rate.

Quality and Efficiency Improvements

The National Violent Death Reporting System is a system the CDC has put in place to improve understanding of the causes of violent death in the U.S. It uses data from death certificates, the Medical Examiner's Office, and the state crime lab to lead to a new understanding of violent death that was not possible before. Oregon is one of only 17 states that have been funded for this innovative program that will help prevent violent death in Oregon.

Key budget drivers and issues

Because IPE depends heavily on federal funding, changes in federal appropriations for injury prevention programs and the lack of increases in federal funding for these programs to keep up with inflation can have a large impact on services.

Human Immunodeficiency Virus (HIV), Sexually Transmitted Disease (STD) and Tuberculosis (TB) Program

Services provided

The HIV, STD and TB Program monitors the occurrence of these diseases in the state and works to prevent their spread. Important tools for preventing spread include tracing and ensuring treatment of contacts, counseling and testing for HIV, and the provision of case management and prescription drugs to HIV-infected Oregonians without the means to pay for this treatment. This program also provides information to the public, the media, health care professionals and policymakers about HIV, STDs and TB in Oregon.

Where service recipients are located

The services are provided to Oregonians statewide.

Who receives services

Services are provided to all Oregonians

How services are delivered

Services are provided both from the program's central office and in partnership with local health departments and numerous community-based organizations.

Why these services are significant to Oregonians

HIV is a life-threatening infection. Each year approximately 300 Oregonians get infected with HIV. Appropriate treatment of HIV infection not only extends life, but also reduces the risk of spreading HIV. STDs are the most commonly reported communicable diseases in Oregon. They can facilitate HIV infection and cause serious fertility problems. TB also is a life-threatening infection. Drug-resistant TB is a particularly serious problem that is increasing worldwide. Although not yet a common problem in Oregon, ensuring prompt identification and appropriate treatment of individuals who have been infected with TB is critical to prevent the problem from growing here.

Performance Measures (HIV, STD, TB)

This program has the following DHS key performance measure:

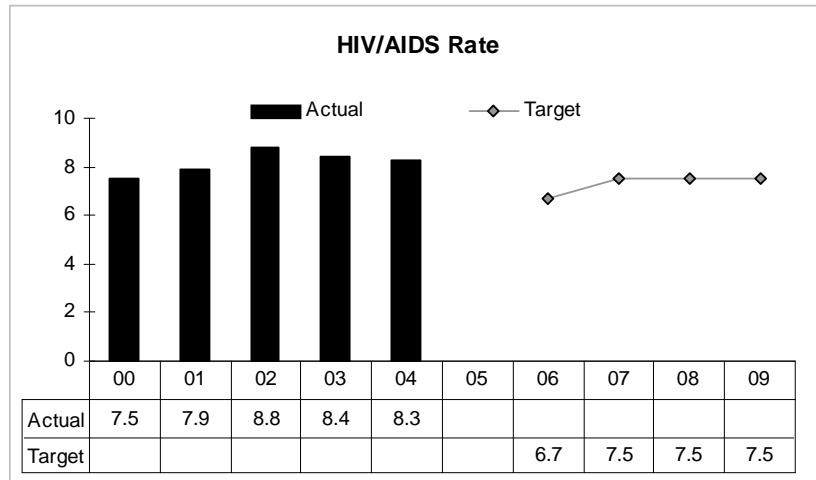
KPM #24 – HIV/AIDS Rate

Purpose

DHS designs and administers state and federal programs for HIV prevention and treatment. Innovative HIV prevention programs include educational campaigns, partner notification and counseling, and HIV testing (anonymous and confidential). More than 19,000 HIV tests were performed by the Oregon State Public Health Laboratory during 2005; the majority of these were funded by programs administered by DHS. HIV treatment programs serve approximately 2,000 people living with HIV statewide and include case management, housing assistance, medication, and health insurance to persons living with HIV and AIDS.

The goal is to reduce the number of new HIV infections per year. Therefore, the program has established initial targets for 2006 consistent with a 20 percent reduction in the measured rate of new infections from 2004. Changes in HIV case reporting rules implemented during 2006 are likely to increase the proportion of new cases detected (completeness of reporting), leading to an anticipated increase in rates beginning in 2007. These increases in reported rates will reflect better public health surveillance, not a true increase in rates of new infection.

Slight declines in new case rates have occurred since 2002. This implies that the average person with HIV/AIDS infects fewer new persons each year, and that prevention and care programs have been effective in reducing the transmission. To meet targets of a further 20 percent reduction for 2006 and beyond will require behavioral changes such as a reduction of high-risk behaviors by those infected or at risk.



How Oregon compares to other states

Rates of HIV, STDs and TB in Oregon tend to be lower than the national rate.

Quality and Efficiency Improvements (HIV, STD, TB)

Clients covered under Medicare Part B are subject to the “donut hole” requirement, which stipulates that Medicare will cover expenditures for pharmaceuticals up to a lower threshold and above a higher threshold, but that the patient themselves must pay for pharmaceuticals when expenditures are between those two thresholds (i.e., in the “donut hole”). For clients covered under our AIDS Drug Assistance Program (ADAP) this meant that once the lower threshold was reached ADAP was required to cover the costs of pharmaceuticals. Because of the “donut hole” rules, however, ADAP expenditures could not be counted towards the total pharmaceutical expenditures. Thus expenditures for ADAP client’s never reached the upper “donut hole” threshold, with the result that Medicare no long covered their pharmaceuticals. To remedy this problem the ADAP program applied to our federal funders for a State Pharmaceutical Assistance Plan, which allows for ADAP expenditures to be counted against the “donut hole”. This saves the ADAP Program substantial funds because the upper limit of the “donut hole” provides a cap on ADAP coverage.

Key budget drivers and issues

Because this program depends heavily on federal funding, changes in federal appropriations for HIV, STD and TB programs and the lack of increases in federal funding for these programs to keep up with inflation can have a large impact on services.

Center for Health Statistics (CHS)

Services provided

The Center for Health Statistics (CHS) provides vital records, including birth, death and marriage certificates, for Oregonians. In addition to playing a critical role as legal documents, these documents make it possible to collect statistics related to these events. CHS collects approximately 33,000 death certificates each year; administers the Oregon Healthy Teens Survey and the Behavioral Risk Factor Surveillance Survey, two important sources of data about risk behaviors; and provides information to the public, the media and policymakers about vital events in Oregon.

Where service recipients are located

The services are provided to Oregonians statewide.

Who receives services

Services are provided to all Oregonians.

How services are delivered

Services are provided both from the program's central office and in partnership with local health departments.

Why these services are significant to Oregonians

Vital records are key legal documents required for a variety of purposes. Data collected by CHS are critical for informed policymaking.

Performance Measures

This program has no DHS key performance measures.

Quality and Efficiency Improvements

In the last biennium CHS began implementation of the Oregon Vital Event Registration System, with the rollout of the Electronic Death Registration System and the Electronic Birth Registration and Fetal Death System. These Systems

allow for data input for vital records documents online at a secure website. The implementation of this system will provide more timely, more accurate and more secure processing of these important documents for Oregonians. As funding permits in the future CHS plans to add other components to the system to cover Induced Termination of Pregnancy, Electronic Marriage Registration System, and Electronic Divorce Registration System.

Key budget drivers and issues

In the context of increased concern about homeland security, there is a special need to ensure that vital records, which can be used for identification purposes, are protected from theft and fraud. Changes in federal requirements related to the security of these records can have a large budgetary impact on this program.

Office of State Public Health Laboratories (OSPHL)

The Office of State Public Health Laboratories (OSPHL) supports state and local public health programs to control communicable diseases, identifies metabolic disorders in newborn infants, and ensures the quality of testing in clinical and environmental laboratories statewide.

During the 2009-2011 biennium, OSPHL will perform approximately 27.4 million tests on 870,000 samples submitted by local health departments, community clinics, hospitals, physicians and others for communicable disease testing and newborn screening.

OSPHL's Northwest Regional Newborn Screening Program tests all infants born in Alaska, Hawaii, Idaho, Nevada, New Mexico and Oregon for 43 different disorders of body chemistry that can cause serious disability or death unless detected and treated soon after birth. During 2007-2009, OSPHL will screen 358,700 infants and refer to treatment approximately 538 children with these disorders.

As an essential part of Oregon's emergency preparedness system, OSPHL provides and coordinates rapid laboratory response to emergencies and threats ranging from pandemic influenza to bioterrorism by testing unknown samples and operating the Laboratory Response Network (LRN). LRN consists of 60 labs whose staff can quickly identify microbes in human samples that represent an emergent threat and refer them to OSPHL for confirmation and typing.

OSPHL certifies 2,200 clinical laboratories in Oregon under the federal Clinical Laboratory Improvement Amendments and accredits 32 Oregon environmental labs in collaboration with the Oregon Department of Environmental Quality and the Oregon Department of Agriculture.

The major funding sources for OSPHL include:

- Various federal grant funding from OSPHD, ODPE and OEPH;
- Newborn Metabolic Screening and other testing fees;
- Laboratory licensing and accreditation fees; and
- Oregon Environmental Laboratory Accreditation Program.

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Services provided

- Communicable disease testing (virology/immunology and microbiology)
- Newborn metabolic screening
- Rapid response to threats and emergencies
- Environmental testing (food and water)
- Laboratory compliance and accreditation
- Technical assistance to local health departments

Where service recipients are located

The hospitals, practitioners, local health departments, clinics and patients who receive OSPHL services are located throughout the state of Oregon. The newborn screening program serves hospitals and patients throughout Alaska, Hawaii, Idaho, Nevada, New Mexico and Oregon. Samples are collected at these sites and transported to OSPHL for testing.

Who receives services

Communicable disease testing and rapid response services are provided to state and local public health programs and their clients throughout Oregon as part of clinic visits, disease surveillance, and outbreak investigations. Newborn screening is provided to all infants born in Alaska, Hawaii, Idaho, Nevada, New Mexico and Oregon. Laboratory compliance activities are provided to all clinical laboratories, and many environmental laboratories in Oregon.

How services are delivered

All staff are located at OSPHL in Hillsboro, where testing is performed in a centralized facility. Laboratory compliance staff travel throughout the state to conduct on-site inspections and to provide technical assistance and training for local health departments.

Why these services are significant to Oregonians

Disease control programs, including local health department clinics, rely heavily upon laboratory testing by OSPHL to identify and prevent the spread of infections in the community. OSPHL also provides tests that are highly specialized, necessary for epidemiologic activities and unavailable elsewhere in Oregon. Newborn screening prevents severe disability and death of infants through early diagnosis and treatment. Laboratory compliance activities protect the public by ensuring that medical and environmental laboratories meet the necessary federal and state standards for accurate testing.

Performance Measures

OSPHL does not have primary responsibility for any DHS key performance measures, but does support the following KPMs:

- #17, Early Prenatal Care for Low Income Women, by providing prenatal testing for hepatitis B, syphilis, *Chlamydia*, and rubella;
- #24, HIV Rate, by performing HIV testing; and
- #27, Safety Net Clinic Use, by providing testing for local health departments, community and migrant clinics, and other safety net providers.

Quality and Efficiency Improvements

During the current biennium, OSPHL has modernized and automated several of its testing methods. This has resulted in more analytical output per staff position and greater accuracy of test results.

OSPHL moved to its new facility in January 2008. It includes a Biosafety Level 3 laboratory which allows for safer handling of infectious agents such as tuberculosis, influenza, and bioterrorism agents (e.g., anthrax, plague, botulism, tularemia, etc.); and expanded testing capability (e.g., rule out smallpox, SARS).

OSPHL has improved the quality of its services by adding new tests, including gonorrhea testing using molecular methods and Quantiferon Gold tuberculosis testing. A new metropolitan area courier service has resulted in faster delivery of specimens and improved specimen integrity.

A feasibility study for a new Laboratory Information Management System (LIMS) to improve the tracking and reporting of samples and results, and to enhance quality assurance monitoring is in process. The new LIMS also will improve data sharing and interoperability with other PHD programs and CDC, as well as Web-based access to test results by OSPHL clients.

OSPHL has a comprehensive Quality Assurance system in place and continues to maintain external accreditation by the College of American Pathologists (CAP). This requires continuous, ongoing evaluation and improvement of all aspects of quality. In September 2006 the OSPHL was inspected and reaccredited by CAP through September 2008. During Summer 2008 OSPHL implemented a new document control system which will cover all laboratory technical and administrative procedures. It keeps the laboratory in regulatory compliance and improves efficiency by providing version control and improved communication and staff training to changes.

Key budget drivers and issues

Because the OSPHL budget depends heavily on Federal Funds from several sources for its core services, fluctuations in federal funding can impact OSPHL's ability to provide basic support for disease control programs.

Division Summary

In recent years reductions to the Oregon Health Plan, increasing health care costs, and a rise in the number of medically uninsured have had a direct impact on funding at both the state and local level, and have changed traditional public health programs and services from a focus on identifying and addressing the health risks for each community to a focus on providing direct primary care health services to uninsured and medically needy citizens.

State and Local Core Capacity of Public Health and Emergency Preparedness

State and local public health officials are increasingly serving in leadership roles in emergency preparedness activities for all health and medical aspects for a range of emergencies including pandemics, natural disasters and biochemical incidents. This presents a variety of challenges to Oregon to put in place the statewide capacity for administering, planning, responding to, and assisting communities with carrying out the required services of a public health authority as well as appropriately responding to, and recovering from, emergencies.

The base funding for core capacity at the state and local levels continue to experience reductions (down 22.4% from 05-07 biennium). To effectively use the categorical preparedness federal funding, a foundation of stable capacity must exist at both the state and local levels. A policy option package is included in the Governor's Recommended Budget to address gaps in the local health departments (LHDs) and state's capacity. Most of the requested \$27 million funding will go directly to county LHDs. A base level of state support is proposed to assist LHDs in achieving:

- minimum staffing standards
- an increase in state funding based on population to ensure that LHDs can provide basic public health services throughout their jurisdictions
- workforce development incentives to improve the level of public health practice throughout the state
- incentives for innovative solutions and approaches to reduce health disparities among different communities and groups
- strategic planning and statewide approaches to build a stronger and more effective public health system

- addressing the increased public health needs of growing communities

There also is funding for seven state staff in areas most essential for successful community capacity and response including community outreach, public information, community liaisons and technical public health support to LHDs.

The Future

The “next frontier” for public health (and health care) is chronic diseases, such as diabetes, arthritis, cardiovascular disease and asthma, which have become more prominent as leading causes of illness and disability. These conditions are related to increasing obesity, smoking, air pollution, sedentary lifestyles and to the aging of the population. The state’s public health programs need to find ways to bring additional attention to the importance and prevention of these conditions, at the same time maintaining support for health provided by the traditional public health programs.

2009 Proposed Legislation

Improving the Public Health System

- Public health authority to control communicable diseases

Amends ORS 433 to allow public health authorities to inspect information sources (e.g., medical records) pertinent to investigating communicable diseases. Contains protections for confidential information gathered in investigations.

- Arsenic testing for private wells

Approximately 600,000 Oregonians rely on private, unregulated wells for their drinking water and other domestic purposes. ORS 448.271 requires that real estate transactions involving such wells must include testing for nitrates and total coliform bacteria. This 1989 statute needs updating to reflect more current scientific understanding about known contaminants that pose human health concerns in Oregon.

- Streamlined requirements of lead-based paint contractors

Current law requires both DHS and the Construction Contractors Board to regulate lead abatement building contractors for safe work practices. Amends law, in

anticipation of new 2010 EPA regulations, to include contractors who conduct renovation, remodeling and painting. It also assigns sole regulatory authority for certification and enforcement of lead safe practices to DHS.

Stopping Major Killers

- Ban the free distribution of non-cigarette tobacco products such as spit tobacco.
- Require landlords to disclose the smoking status of rental property as a standard part of the lease agreement.

The U.S. surgeon general has determined there is no safe exposure level to secondhand smoke. Renters should be apprised that they may be exposed to secondhand smoke if they are renting in a complex or house where smoking is allowed.

- Prohibit the distribution of tobacco through vending machines.

Currently, tobacco vending machines are allowed in taverns and cocktail lounges, hotels and motels. They are also allowed in industrial plants as defined in ORS 308.408. Other laws, such as vendor-assisted sales, have been adopted over the last 10 years to eliminate youth access to tobacco products; this minor adjustment to eliminate these remaining machines, is in step with those measures.

Health Care Access and Quality

- Establish Emergency Medical Services database

The 2006 NHTSA assessment of Oregon's Emergency Medical Services & Trauma Systems program noted the lack of a statewide pre-hospital database as a major weakness. In order to monitor patient care, a database of EMS patient contacts is needed for planning, quality improvement and linking to data from other parts of the health care system. One-time start-up and ongoing funding will be needed to develop and maintain this system.

- Hospital and health care facility inspections and oversight

Minimum standards for inspections, defined roles and responsibilities for providers, and clarified procedures are required to ensure patients' safety. Funding needs to be increased to ensure adequate surveyor staff in Health Care Licensing &

Certification. Requires HCLC to inspect or to accept national accreditation status for all its licensed facilities at least once every three years.

- State licensing and regulatory oversight of hospice agencies

The Department of Justice recommends moving regulatory oversight of Hospice Agencies from the Oregon Hospice Association to an appropriate state agency, such as DHS. Additional resources will be needed to ensure adequate and impartial oversight of hospices within Health Care Licensing & Certification.

- Revision of consent for HIV testing in health care settings and related statutes

Unique consent requirements for HIV testing contribute to as many as 25 percent of people with HIV not being diagnosed. Revision would make testing for HIV in health care settings as convenient as other diagnostic tests thus reducing the likelihood of HIV transmission.

- Expedited partner therapy (EPT)

EPT is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. The CDC recommends this practice.

- Liability protection for health care responders during emergencies placeholder

The Oregon Law Commission will undertake a study of liability issues in Oregon. The next meeting to determine the scope of the study is June 27

- Emergency Medical Services preparedness planning

EMS and trauma systems have not been adequately incorporated into disaster preparedness and response. Planning is underway to address this gap, and new legislation will likely be required to cover some needs, e.g., EMT and ambulance strike teams.

- Oregon State Public Health Laboratory fee increase

Legislative Reports

Report: Tobacco Use Reduction Account
Due: During the Legislative session
Destination: Governor and Legislative Committee on Health
Status: In process
Oregon Administrative Rule 333-010-0370
Reporting

- 1.) *During each biennium the Director shall prepare a report regarding the awarding of grants from the Tobacco Use Reduction Account and the formation of public-private partnerships in connection with the receipt of funds from the account. The report shall include an evaluation of the effectiveness of the program funded by the Tobacco Use Reduction Account.*
- 2.) *The Health Division shall present the report to the Governor and to those committees of the Legislative Assembly to which matters of public health are assigned.*

Stat. Auth.: ORS 431.834

Stats. Implemented: ORS 431.831 - 431.836

Report: Certification Programs for Water and Wastewater
System Operators
Due: January of odd numbered years
Destination: Legislative Assembly
Status: In process

Oregon Revised Statute 448.409:

On or before January 1 of each odd-numbered year, the Department of Environmental Quality and the Department of Human Services shall develop and submit a joint report to the Legislative Assembly. The report shall include, but need not be limited to:

- 1.) *A summary of actions taken under ORS 448.405 to 448.465, 448.992 and 448.994:*
- 2.) *An evaluation of the effectiveness of such actions; and*
- 3.) *Any information and recommendations, including legislative recommendations the Department of Environmental Quality or the Department of Human Services considers appropriate.*

Report: Food Service Advisory Committee
Due: January of odd numbered years
Destination: Legislative Assembly
Status: In process

The Food Service Advisory Committee (FSAC) is authorized by Oregon Revised Statute (ORS) 624.045. The mission of the FSAC is to assist and advise the Food Borne Illness Prevention Program in achieving its goals; represent the Committee's constituencies; and ensure food safety and the protection of Oregon's citizens. The Committee is comprised of 12 to 15 members representing the food service industry, state and federal regulatory officials, consumers, educators, and dietitians.

ORS 624.045 requires the FSAC to submit a biennial report to the Legislative Assembly and the Department of Human Services (DHS) on the implementation of ORS 624.020, 624.060, 624.495, and 624.510, all of which relate to the licensing and regulation of food service facilities.