



# COLUMBIA HEALTH DISTRICT

Public Health Authority 9 Columbia River Community Hospital

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May 7, 2007

Tom Engle  
Office of Community Liaison  
DHS Public Health Services  
800 NE Oregon St.  
Portland, Oregon 97232

Dear Tom:

Please accept this letter and the attachments as our Columbia County Annual Plan update for fiscal year 2007-2008. Columbia Health District is mid-cycle this year and so we are submitting an update only. The following components have been updated:

- Executive summary
- Assessment
- WIC was required to be submitted in April, but a copy is attached
  
- MCH plan update
- Organizational chart
- Minimum standards indicators

As you know, this is a legislative session year. Budget numbers are not available at this time. For our public budget process, we have used the most recent state financial assistance contract information minus any program dollars that we might have learned about (i.e. HIV prevention dollars being eliminated for our county).

State public health has defined July 2007 as the timeline for receiving projected revenue sheets from the state. At that time, Columbia Health District will complete the defined fiscal process. Our fiscal manager is Thalia Piano. Her contact information is [tpiano@chdpublichealth.com](mailto:tpiano@chdpublichealth.com). Her telephone information is (503)397-4651.

The local Public Health Authority is submitting the annual plan pursuant to ORS 431.385 and assures that the activities defined in ORS 431.375-431.385 and ORS 431.416 are performed.

For Columbia Health District Public Health Authority

_____ Gary Heide, Chair	_____ date
_____ Laura Tomanka, Vice Chair	_____
_____ Jay Tappan, Secretary	_____
_____ Alice Dorschler, Treasurer	_____
_____ David Schmor	_____

## Executive Summary

The local public health plan for Columbia County and its updates can be found at [www.oregon.gov/dhs/ph/lhd/reference.shtml](http://www.oregon.gov/dhs/ph/lhd/reference.shtml). This year the county submits an update to the comprehensive plan. The requirement for a local public health annual plan is in statute ORS 431.375-431.385 and ORS 431.416. and Oregon Administrative Rule (OAR) Chapter 333, Division 14. ORS 431.375 defines policy for local public health services. Policy states that the public health system in Oregon is to provide basic public health services, that counties can provide or contract responsibility or relinquish these services to the state, and that all public funds utilized for public health services must be approved by the local public health authority.

The Minimum Standards for Local Health Departments states “ In the state of Oregon, responsibility for public health protection is shared between the state Department of Human Services, health services section and the local public health authorities. Local and state agencies perform different tasks. They have unique, but complimentary roles and they rely on one another to make the public health system work effectively.” The community should be able to rely upon the partnership between the state and local government.

Were there unlimited amounts of funding, one might expect that most public health needs would be met. The State of Oregon allots only 2.5% of its DHS budget to public health functions at the state and local levels combined. Those funds that reach the local level are for specific programs. In Columbia County, those dollars supplement federal dollars to provide home visits to high risk infants and children, supplement federal dollars that help fund emergency preparedness and communicable disease epidemiological response, and supplement federal dollars that help provide prenatal care for women in need. The state also provides funding to school-based health centers. St. Helen’s school district in Columbia County receives funding that is passed through the local health department for health care to some elementary school students in the district.

The services delivered locally are restricted by funding streams that are provided by federal and state dollars. Those services are effected by formulas developed at the state level by a state/local partnership. Most funding formulas are developed with representation from Conference of Local Health Officials.

ORS 431.380 states that the distribution of funds to the local public health authority are to be used for public health services.

ORS 431.385 states that the local annual plan shall be submitted annually to DHS, that DHS shall review and approve/disapprove the plan, and that there shall be an appeals process if the plan is disapproved. It also states that the local Commission on Children and Families shall reference the public health plan in its comprehensive plan (ORS 417.775).

The local public health authority duties according to ORS 431.416 are to:

1. Administer and enforce the rules of the local public health authority and the public health rules and law of DHS
2. Assure activities necessary for the preservation of health or prevention of disease in the area under its jurisdiction as provided in the annual plan of the authority or district are performed. These activities shall include:
  - a. epidemiology and control of preventable diseases and disorders
  - a. parent and child health services, including family planning clinics (ORS 435.205)
  - b. collection and reporting of health statistics
  - c. health information and referral
  - d. environmental health services

These services are further defined in OAR Chapter 333, Division 14 as well as the Minimum Standards for Local Health Departments document.

The minimum standards document is designed to include elements of the essential public health services as identified by the American Public Health Association publication, Public Health in America, 1994. The document identifies two key concepts: The first is that public health:

1. prevents epidemics and the spread of disease
2. protects against environmental hazards
3. prevents injuries
4. promotes and encourages health behaviors
5. responds to disasters and communities in the recovery phase
6. assures the quality and accessibility of health services

The second key concept is the ten essential public health services that are actually quite limited in Oregon rural counties. Lack of funds can be restrictive in meeting public health needs. Sufficient resources to achieve these standards are necessary for compliance.

The action plan for this year will focus on current programs and their goals, objectives, actions, and evaluation.

# ASSESSMENT

Columbia County is 687 square miles of picturesque scenery. The Columbia River defines the northern and eastern borders of the county. The terrain is mountainous with winding two lane roads. Columbia County's history is agriculture and timber oriented. Most of the agricultural land has been sold to developers and no longer produces fruits and vegetables. The timber industry is also decreasing. Housing development has replaced the farms. Family wage jobs are becoming more scarce. Commuting to the Portland metro area is becoming the norm. There is not a public transportation system that allows people to commute by train or bus to the metro area to work.

## DEMOGRAPHIC CHARTS

Other demographic characteristics about Columbia County include:

**Geography:** Northwest Oregon, 687 square miles.

**Average Temperature:** January 39E July 68.4E

**Annual Precipitation:** 44.6"

**County** 57.19% 27,856 28,852 31,858

**Unincorporated**

**County**

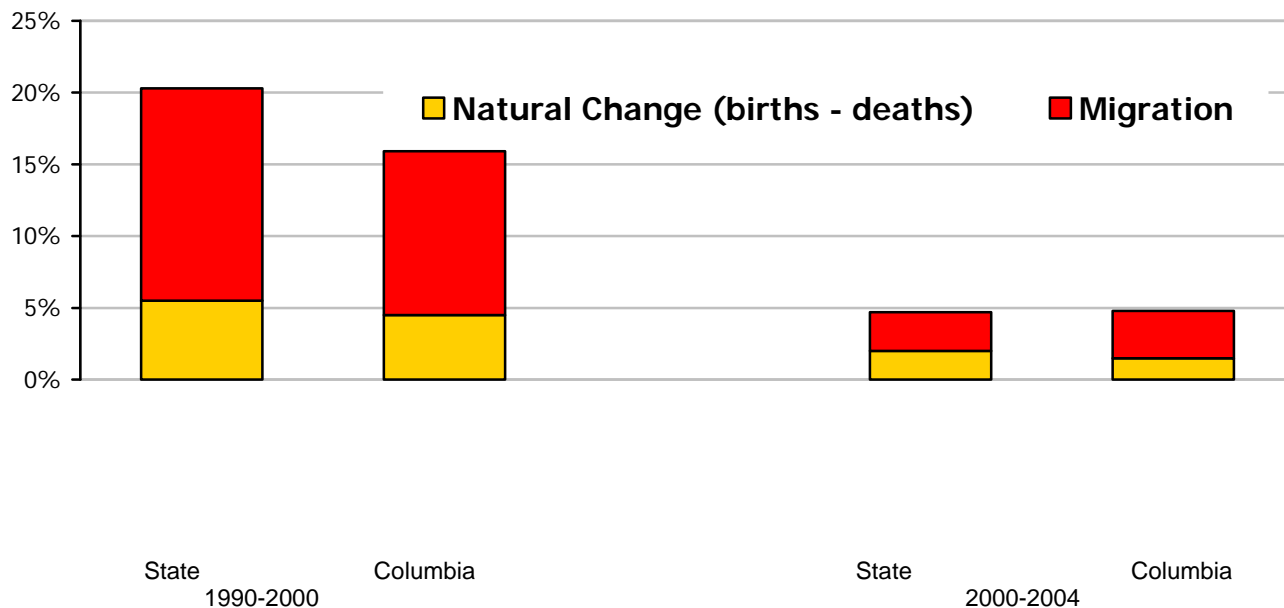
42.80% 20,098 21,500 23,742

**COUNTY TOTAL 100.00% 48,641 50,352 55,600**

*Note: Based on the assumption of a continuing 20 year trend in population proportion.*

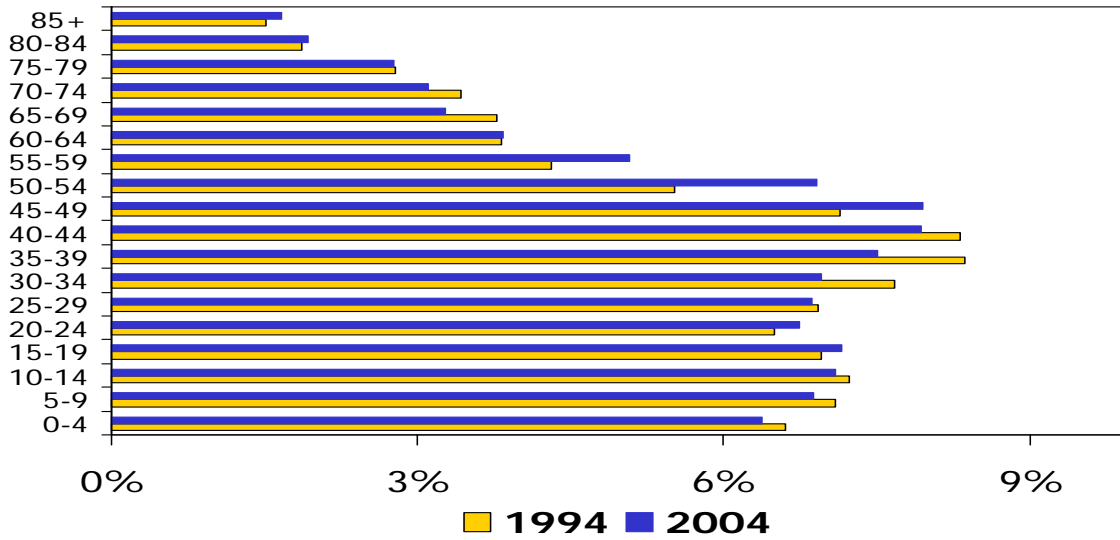
The information is from Population Research Center, College of Urban and Public Affairs, Portland State University,

## Percent and source of change in population 1990-2000 & 2000-2004

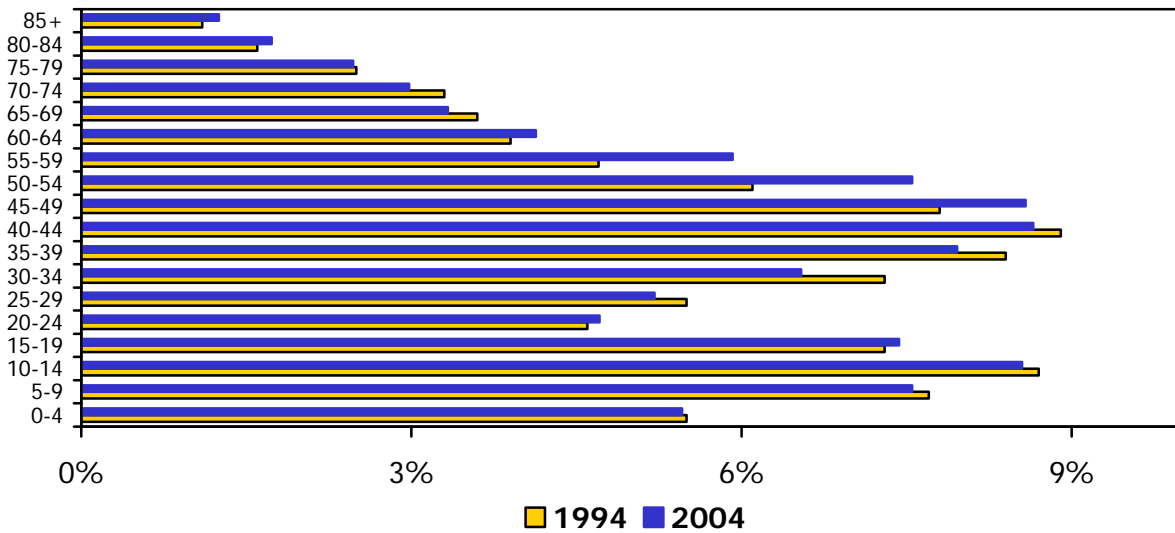


# Population by age, 1994 and 2004

## Oregon

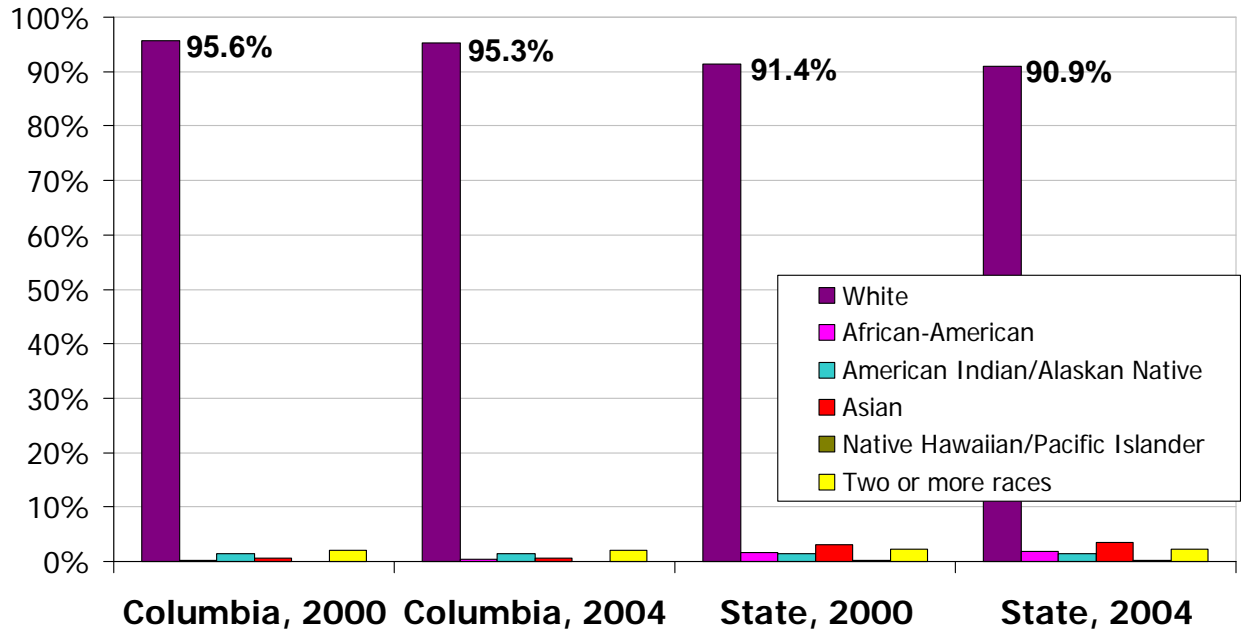


## Columbia County

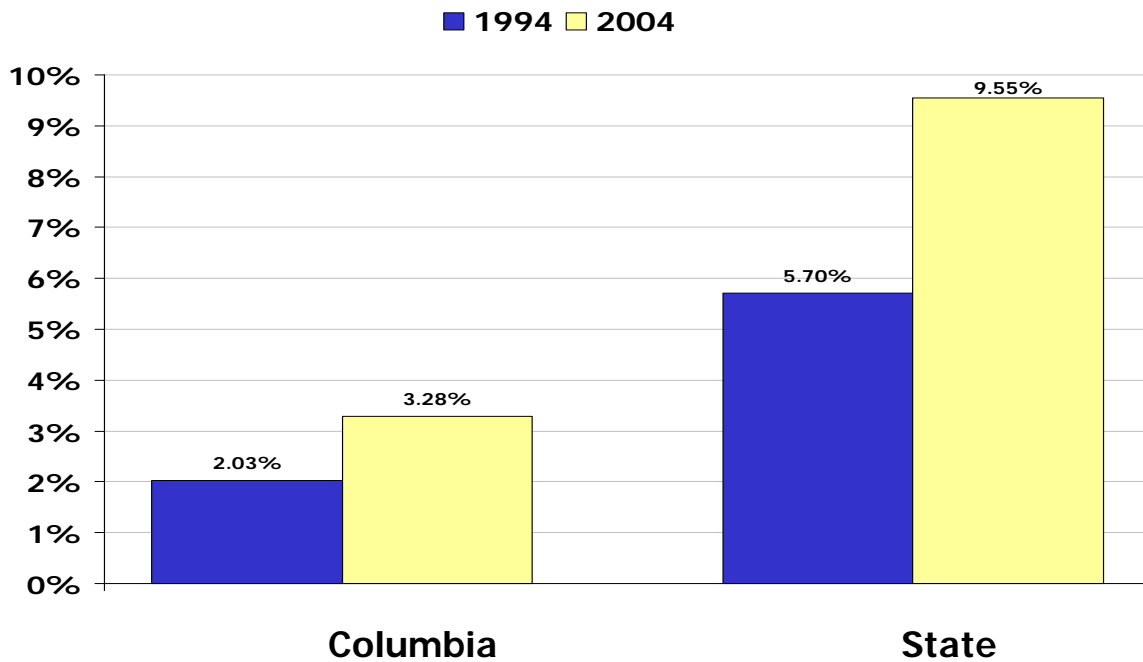


## Population by race, 2000 and 2004

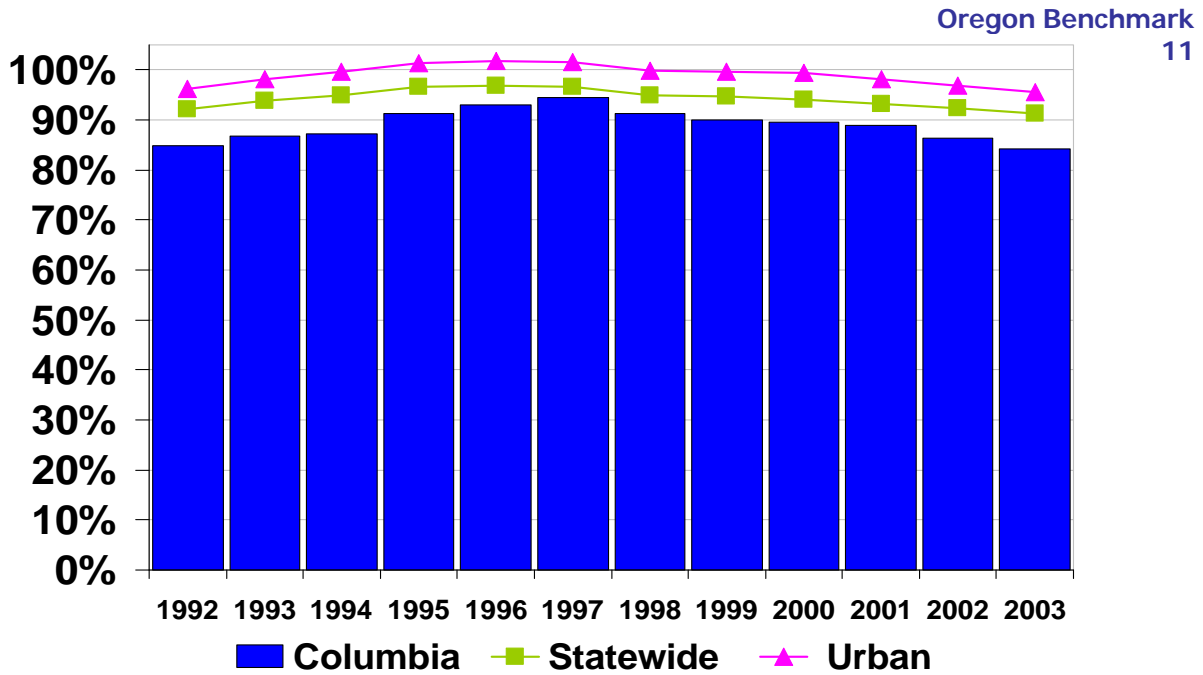
(Hispanics, an ethnic group, are represented in all racial categories).



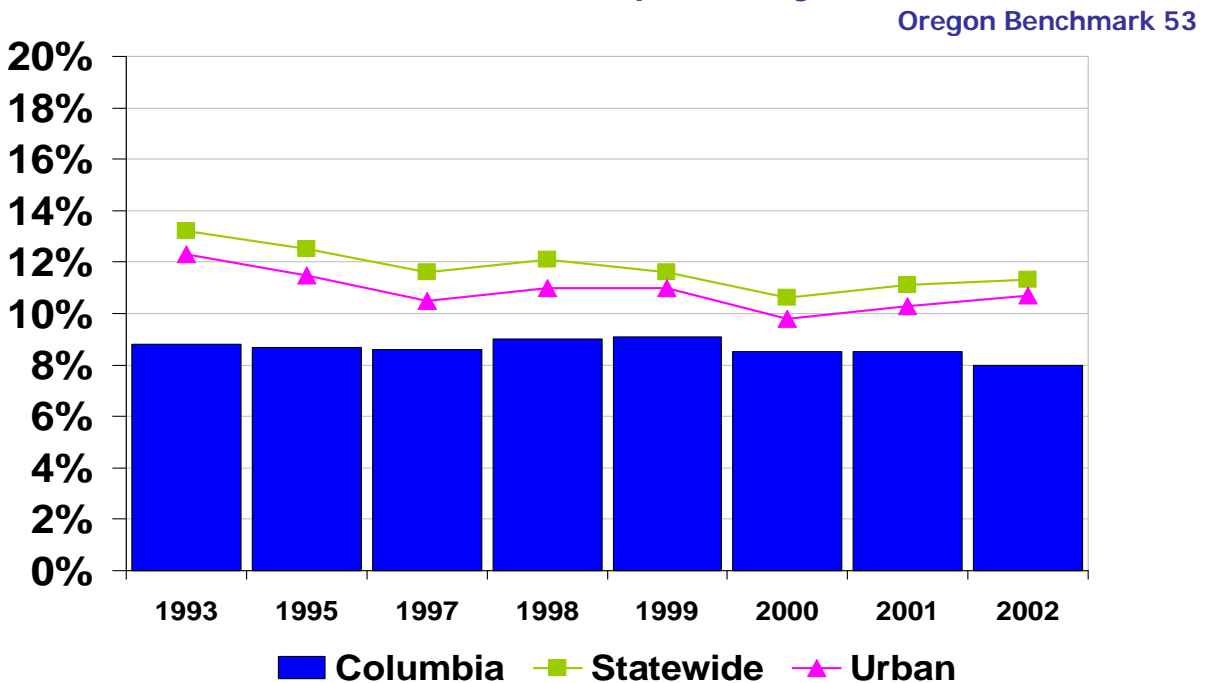
## Percent that is Hispanic, 1994 & 2004



## Per capita personal income as percent of the U.S. per capita income



## Percent of population with incomes below 100% of the federal poverty level



## NUMBER OF PERSONS ELIGIBLE FOR MEDICAID AND FOOD STAMPS COLUMBIA COUNTY

### Date Number Eligible for Medicaid & Food Stamps

Oct. 2001	3,477	3,851
Oct. 2002	3,944	4,337
Oct. 2003	3,614	4,839
Oct. 2004	4,513	5,188
Oct. 2006	4,514	5,404

Information provided by the Department of Human Services

### SOURCES

#### Child Welfare, Homelessness, Poverty, Self Sufficiency

Department of Human Services, Oregon Children, Adults and Families, Data Charts, October, 2005

[http://www.oregon.gov/DHS/assistance/data/caf\\_charts/102005.pdf](http://www.oregon.gov/DHS/assistance/data/caf_charts/102005.pdf)

[www.dhs.state.or.us/abuse/publications/childabusereports.htm](http://www.dhs.state.or.us/abuse/publications/childabusereports.htm)

Community Action Team

<http://www.cat-team.org/>

### PUBLIC HEALTH AND THE COMMUNITY

Public health services as well as the authority for enforcement are provided by the Columbia Health District in an intergovernmental agreement between Columbia County and the Columbia Health District. The District, a public non-profit with a publicly elected board, provides the public health services required in ORS 431.375 - 431.385 and ORS 431.416 and rule (Chapter 333, Division 14). Mental health services are contracted out from the county to a private, non-profit agency and the county retains the authority. Columbia Community Mental Health agency subcontracts services to other private, non-profit entities. The Children and Families Commission in Columbia County is a department within county government. State DHS services (i.e. self sufficiency services, food stamps, and senior and disabled services) are provided by state staff in yet another agency..

We continue to participate with the Commission on Children and Families by having staff on the executive board of the Commission. We participate in the early childhood planning efforts of the Commission. We participate in the tough decisions that the Commission is having to make as the dollars decrease in their agency as well.

Involvement of staff in the local communities takes many forms. The staff each participate in committees linked to their role in the agency. The following are committees that CHD staff participate in the local communities:

#### Columbia County mental health advisory committee

- Columbia County local alcohol and drug prevention committee
- Head Start advisory committee
- Healthy Start advisory committee
- Early intervention advisory committee
- District attorney's MDT committee
- CASA advisory committee
- St. Helens school-based health center advisory board

- Local Commission on Children and Families
- Columbia County emergency planning association
- Medical reserve corps
- Homeland security emergency planning committee
- Public health foundation of Columbia County

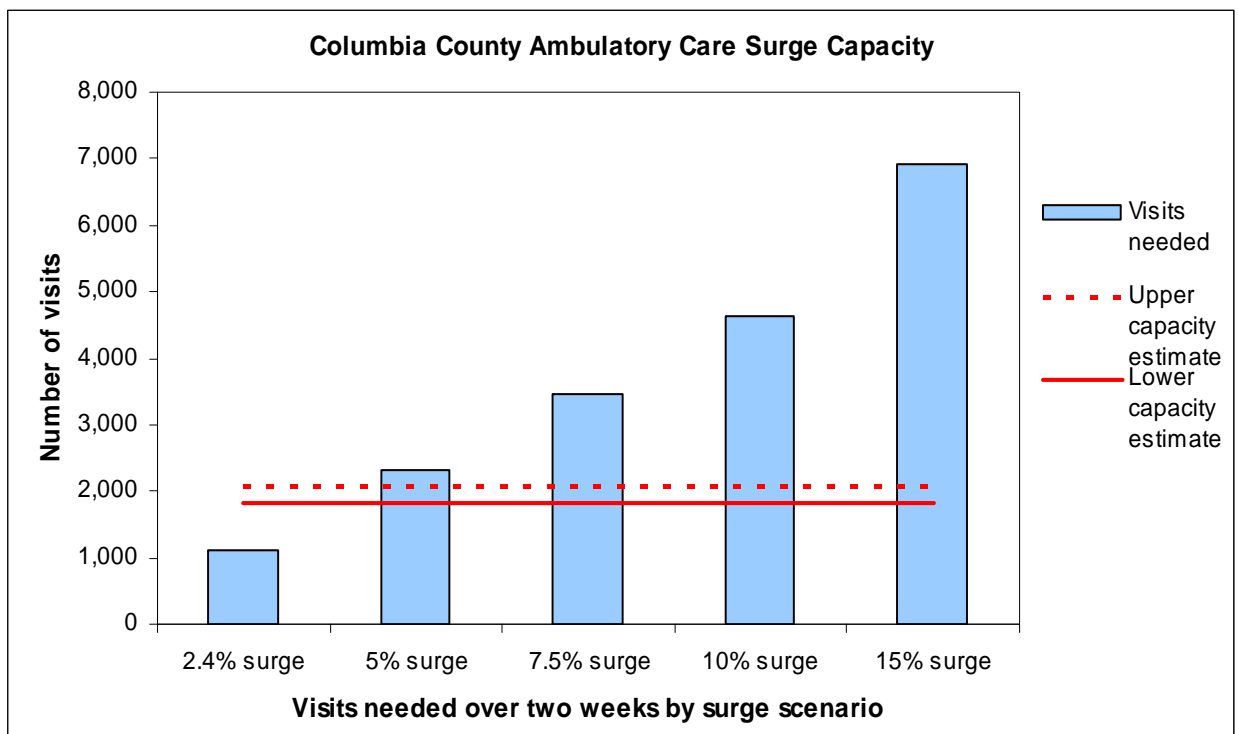
Regionally, staff are involved in the Northwest Region I regional emergency planning committee and the 6 county City Readiness Initiative.

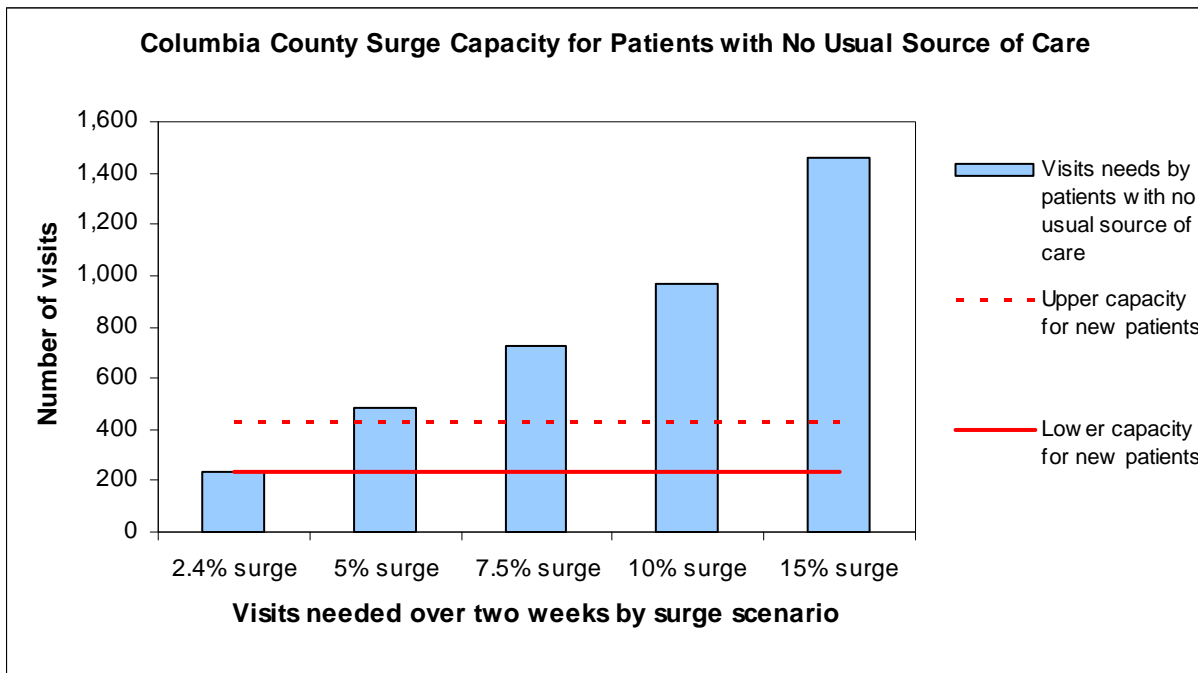
Columbia County, according to the state of Oregon’s Area of Unmet Healthcare Needs evaluation, is the most medically under served county in Oregon. The St. Helen’s Hospital closed during the 1990’s federal reimbursement cutbacks. About 400 hospitals closed across the nation during that time. Columbia Health District has been working to build a critical access hospital in the county. In 2004 the district passed a referendum to establish a new tax rate. Since that time, the district has hired an architectural firm, a project management firm and had a second feasibility study. Currently, the district is looking at property and hospital design.

We have only 10 full-time equivalent physicians (only five of those are full-time) in the entire county. The closest hospital is 30 miles away currently. There is one urgent care clinic operating in St. Helens eight hours per day six days a week.

If an epidemic were to occur, our county would be behind the curve in caring for the population, surveillance, control activities, and prevention. Although our link with local health care providers and veterinarians has improved with the emergency communications work we are doing through the Federal bioterrorism grant, we fight an uphill battle because we lack basic infrastructure. If an epidemic were to occur and the county needed to expand health care, it would be difficult for the current providers to scale up to meet the demand. A recent study bears this out.

The Office for Oregon Health Policy and Research prepared a report entitled: Ambulatory Surge Capacity in Northwest Oregon in May 2006. The following charts are from that report;





### Emergency Planning

Columbia County has a newly created Homeland Security Emergency Planning Committee. It will have representation from public and private entities throughout the county. Columbia Health District Public Health Authority has been included in the membership. Even though Public Health provides no primary care services, Public Health’s role is often seen as medical by the emergency planners because there is no other entity to fill this role. A hospital would be a more appropriate source to rely on for surge capacity and could provide the needed expertise and be a great planning partner. Multnomah and Washington counties are the two major health care access points for Columbia County citizens. Multnomah, Washington, Clackamas, Clark (Washington state), and Columbia counties are working on a regional memorandum of understanding, exercises and medical reserve corps for emergencies.

The current public health emergency response system is linked to the 9-1-1 system in the county. Public health during the past year has worked to implement a call-out system that is integrated with the rest of the emergency infrastructure in the county. Public health will now be given notice of all biohazard 1 and biohazard 2 events by 9-1-1.

The 9-1-1 district has a community alert network system (CAN) that can be used by public health to notify residents of emergencies. Public Health could notify water systems’ users to boil water or shelter in place or preventive measures with this system during emergencies. Additionally, select populations can be singled out for notification, so people would receive only applicable information. Public health used this notification system during the PanDorA exercise last November. The 9-1-1 system notified first responders on the first day of the exercise to report for influenza vaccinations. The system worked well.

### Communicable Disease

As required by Chapter 333-014-0040, Columbia Health District "provides control of communicable disease which includes providing epidemiologic investigations which report, monitor, and control communicable disease and other health hazards; providing diagnostic and consultative communicable disease services; assuring early detection, education, and prevention activities which reduce the morbidity and mortality of reportable communicable disease; assuring the availability of immunizations for human and animal target populations; and collecting and analyzing of communicable disease and other health hazard data for program planning and management to assure the health of the public;"

During fiscal year 2005, the following reportable disease cases occurred:

	Columbia County	State of Oregon
AIDS	1	155
Campylobacteriosis	5	646
Chlamydiosis	89	9018
Cryptosporidiosis	0	69
E. coli 0157 infection	2	149
Giardiasis	6	419
Gonorrhea	14	1562
H. Influenza	0	54
Hepatitis A	0	50
Hepatitis B (acute)	2	101
Hepatitis B (chronic)	4	407
Hepatitis C (acute)	0	19
HIV	2	296
HUS	0	6
Legionellosis	0	15
Listeriosis	0	11
Lyme Disease	0	21
Malaria	0	13
Meningococcal Disease	1	56
Pertussis	1	623
Rabies, animal	0	8
Salmonellosis	2	409
Shigellosis	0	127
Early Syphilis	0	57
Tuberculosis	1	101
Vibrio parahaemolyticus	0	6
West Nile infection	0	8
Yersiniosis	0	17

All of these infections require varying levels of disease investigation, partner notification, patient education, and follow up. Gonorrhea cases in Columbia County have increased significantly over the last several years. No one cause for this increase has been identified. The

hepatitides (A and B) have decreased dramatically with the advent of vaccine. Vaccines are the best preventive measure that medicine has and have clearly proven that. Although 42% of the reportable diseases in Oregon in 2005 were hepatitides, we are still catching up on this new reporting element for hepatitis C. More in-depth investigations may further increase our workload. Enteric illnesses contributed 40% of the reported diseases in 2005. The summer months are known for picnics, potlucks, and diarrhea caused by an enteric pathogen.

Investigations for Norovirus outbreaks in nursing homes and assisted living facilities have become the norm for the winter months. The investigations are performed by the Public Health Environmental Health Specialist. The facilities follow the advice of their epidemiologist to break the chain of communicability.

The public health officer participates in the investigations now given our public health preparedness grant. Public Health has also established an e-mail list of health professionals and is sending out CDC alerts regularly to update the community health care professionals on unusual occurrences or outbreaks.

Public Health has invested time in educating the public and Columbia County Board of Commissioners on current and upcoming issues ( i.e. West Nile Virus and Severe Acute Respiratory Syndrome). A portion of Columbia County is covered by a vector control district. The director of the Vector Control District and the public health administrator have presented to the county commissioners about issues around spraying and lack of vector control services in some parts of the county. The DHS health services flyers have been sent out to community agencies throughout the county. Last year, West Nile virus was isolated from a dead bird in Clatskanie.

### **Health Statistics**

The Columbia County registrar provides "health statistics which include birth and death reporting, recording, and registration; analysis of health indicators related to morbidity and mortality; and analysis of services provided with technical assistance from the state health division" according to Chapter 333-014-0050. Columbia County does not have a hospital and so only home births are recorded locally. The county registrar estimates three births were recorded during calendar year 2003. These babies are delivered by midwives or EMTs or lay people. Deaths are recorded in the county for those citizens who die in the county.

There were 514 babies born to Columbia County parents in 2005. Of those, 396 pregnant mothers received adequate prenatal care. Three hundred and sixty four of the pregnant mothers received care starting in their first trimester. There were missing data on about 90 mothers.

Of the deaths recorded for Columbia County residents in 2005, cancers and heart disease were the number one and two killers respectively. The cancer death rate was significantly higher than the state of Oregon rate with lung cancer being the most prevalent cancer.

### **Maternal and Child Health**

The growing cost of healthcare in Oregon and the U.S. has been higher than the rest of the market for the last decade. The Office of Health Policy and Research produced a paper to the 74<sup>th</sup> legislative assembly titled "Trends in Oregon's Healthcare Market and the Oregon Health Plan" The short executive summary follows:

Chapter 1 focuses on *Oregon population trends and demographics* as well as *how much we spend on healthcare, healthcare affordability and the main drivers of healthcare costs.*

- One driver of changing healthcare needs and costs is a growing and shifting population. Oregon's population is changing rapidly, not only in total size but also in its age distribution, racial and ethnic makeup, and on economic factors. These changes have implications for health, health coverage, and healthcare utilization and costs in the years to come.
  - Between 2006 and 2013, the fastest growing segments of the population in Oregon are those 65 to 64 years of age (26% projected growth) and those 70 to 74 years of age (45% projected growth). As these individuals age, their care will begin shifting from the employment-based private insurance system to the publicly financed Medicare program. As a result, Medicare spending will begin to rise.
  - Approximately 72% of healthcare dollars spent in Oregon are spent on hospital care, physician services, and prescription drugs.
  - Total spending for acute healthcare services in Oregon is estimated at \$16.8 billion in 2006 and is projected to be \$19.3 billion by 2008.
    - Budget studies based on work completed by the Economic Policy Institute show that Oregon families do not have the financial capacity to contribute significantly toward healthcare costs until they are earning at least 250% of the federal poverty level (\$51,625 for a family of four in 2007).
    - New medical technology is generally thought to be the most important long-term driver of healthcare cost, accounting for one-half to two thirds of the increase in healthcare spending in excess of general inflation.. Other cost drivers include the rise in medical treatment, waste and inefficiency in the healthcare system, the overall structure of health insurance and medical errors and medical liability.
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Chapter 2 focuses on *the Oregon Health Plan* looking at trends and program changes from 2003 to 2006.

- Budget cuts in both entitlement and discretionary programs at the federal level due have resulted in significant challenges for Oregon. The Deficit Reduction Act of 2005, with new rules and requirements around citizenship, third party resources, targeted case management, provider taxes, transportation and rehabilitative services affects the Oregon Health Plan (OHP), the State Children's Health Insurance Program (SCHIP) and the Family Health Insurance Assistance Program (FHIAP).
- There were a total of 401,008 total OHP Medicaid and SCHIP enrollees in September 2006. Of total eligibles, 55% were children 18 years and under, 35% were adults 19-64 years of age, and 9% were adults 65 years and older. The OHP expansion population (OHP Standard) has decreased over 78,000 people or 78% since changes were made to the program in 2003. The OHP Standard program operates entirely without General Fund resources, using provider taxes, which are set to sunset in 2008, from the hospitals and managed care organizations.
- For every \$1 that Oregon invests in Medicaid, the federal government matches with approximately \$1.57. This injection of federal dollars has a positive impact on state business activity, available jobs, and aggregate state income. Medicaid payments to hospitals, nursing homes, and other health-related businesses pay for goods and services and support jobs in the state, triggering successive rounds of earning and purchases as they continue to circulate through the economy.

Chapter 3 focuses on *health insurance*, looking at trends in Medicare and private sources of coverage.

- Medicare provides health insurance coverage to over 531,000 Oregonians who are eligible because they are 65 or older (with ten years of Medicare-covered employment), have a disability as determined by the Social Security Administration, or have permanent kidney failure.
- Under the new Medicare prescription drug program that began on January 1, 2006, states must pay a percentage (90% in 2006, declining over nine years to 75%) of their fiscal year 2003 Medicaid spending for prescription drugs, for each dual eligible person enrolled in the Medicare prescription drug program. The revised payment by Oregon to CMS for was \$57.1 million dollars (\$6.1 million dollars less than the original scheduled payment) for 2006.
- As of January 2007, 62% of Oregon's Medicare population and 54% of the U.S. Medicare population was enrolled in Medicare Part D plans.
- The average annual increase in Oregon's health insurance premiums for most years between 1997 and 2004 far outpace the growth in per capita income or inflation. Due to an economic downturn and rising unemployment during the early 2000s, employers in Oregon offering insurance and employees eligible for insurance during 2004 was at the lowest point in nine years.

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- The percent of private sector establishments in Oregon that offer health insurance to their employees has dropped from 86% in 1996 to 80% in 2004. The percent of employees working in establishments that offer health insurance has declined from 62% to 53% from 1996 to 2004.
  - Health Savings Accounts have increased in popularity both nationally and in Oregon in recent years and premiums for these products are generally lower than the average single or family health insurance product. However, some economists remain skeptical that HSAs will significantly increase health insurance coverage in the U.S. – primarily because 71 percent of the uninsured in the United States are in a 10-percent-or-lower income tax bracket (55% are in the 0% tax bracket), and they have little to gain from the tax savings imparted by HSAs.

Chapter 4 focuses on *who's not covered* examining the impacts, trends and characteristics of the uninsured in Oregon.

- Oregon's recovering economy has not resulted in improvements in health insurance coverage – increasingly expensive health insurance premiums and declining employer-sponsored coverage are both likely contributors to Oregon's uninsured population, which remained statistically flat from 2004 at 17% uninsured to 15.6% uninsured in 2006.
- 43% of adults from age 18 to 64 who earn less than 100% of the federal poverty level (FPL), and 35% of adults who earn less than 200% FPL are uninsured in Oregon.
- OHP changes since 2003 have had impacts on access to healthcare for vulnerable populations, with most who lost coverage remaining uninsured and facing higher unmet needs for medical care, urgent care, mental healthcare and prescription medications. This is especially true for those with chronic illness. This could result in increased costs for these populations stemming from deferring or delaying care.

Chapter 5 focuses on *access* presenting information about the healthcare safety net in Oregon.

- A 2004 survey of children from low-income families in Oregon found that only 68% of those without healthcare coverage had a regular source of care. Children without a usual source of care were three times more likely to be taken to an emergency room or an urgent care clinic for regular care.
- Access to care for the uninsured and underinsured is provided in large part by the healthcare safety net. The healthcare safety net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.
- Oregon's healthcare safety net includes Federally Qualified Health Centers (FQHC), Rural Health Centers, Tribal Health Centers, County Health Departments, Migrant Health Centers, School-Based Health Clinics (SBHC)

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Veteran's Administration Clinics, Volunteer and Free Clinics and hospital emergency departments, as well as some private healthcare providers.

- The provision of uncompensated care serves as an indicator of both the need for healthcare among people who are unable to pay, and the willingness and capacity of healthcare providers to absorb the impacts of making such care available in a community. Trends for uncompensated care often reflect increasing numbers of uninsured individuals and families in the community.

Chapter 6 focuses on *racial and ethnic health disparities* in Oregon by looking at what is known about disparities in healthcare, the changing make-up of Oregon's population, and the need for increased data collection efforts.

- In 1990, racial and ethnic minorities made up 9.2% of Oregon's population; in 2005, an estimated 17% of Oregon's population self-identifies as African-American, Native American, Asian/Pacific Islander and/or of Hispanic ethnicity.
- Disparities in access and coverage have serious negative health consequences: the infant death rate among African-Americans in Oregon is almost twice that of non-Hispanic whites.
- The physician workforce in Oregon, while largely representative of the underlying population, is under-represented for African-American physicians (.6%) and over-represented for Asian physicians (6.3%).
- Data is not routinely collected on access, health status or utilization for Oregon's racial and ethnic minorities. Standardized data collection is critically important to inform policy and to understand and eliminate racial and ethnic disparities in Oregon.

Chapter 7 focuses on *health status* by looking at the prevalence of chronic disease, high-risk conditions and modifiable risk behaviors.

- Access to healthcare services impacts health status, but health status also influences demand for and the cost of healthcare. It is important, therefore, to examine healthcare both in the context of health status and as an important determinant of health outcomes.
- Chronic disease in Oregon represents areas of opportunity for the state where improved quality and access to primary healthcare can improve health status and reduce costs associated with these conditions. Although heart disease has decreased over the last fifteen years, diabetes has increased.
- High-risk conditions such as high blood pressure, high cholesterol, and obesity are strongly related to many chronic conditions. Screening for these conditions can help to detect chronic disease early in its development. Decreasing prevalence of these conditions is important in reducing the chronic disease burden in the population.

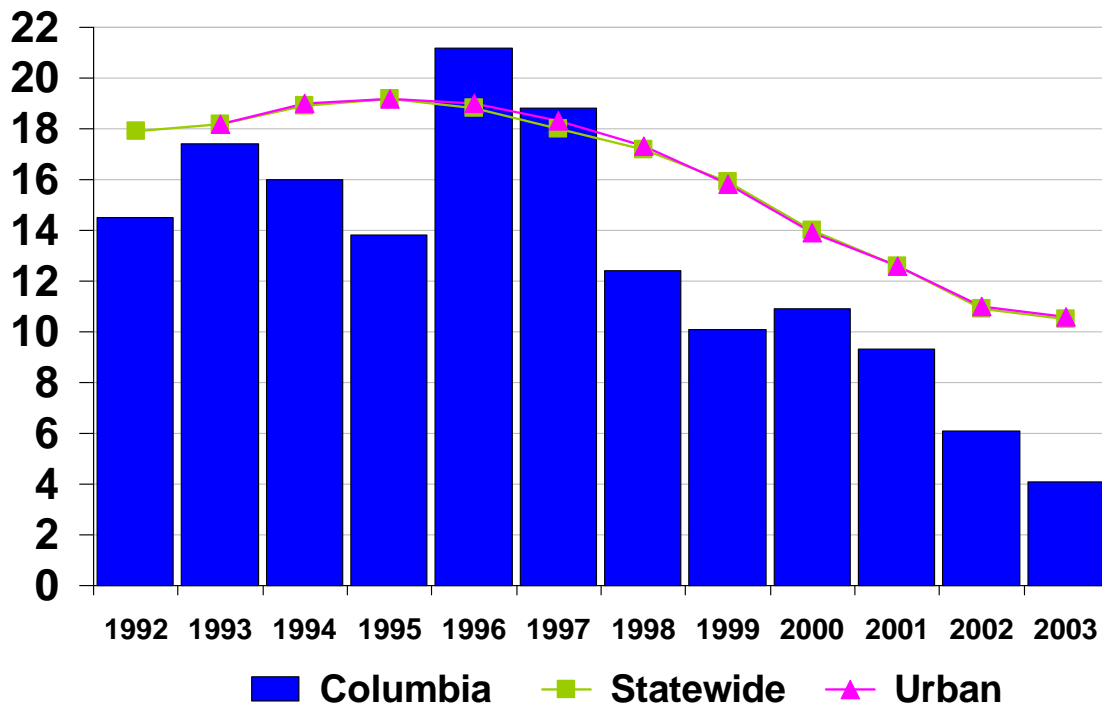
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Chapter 8 focuses on *healthcare reform* by looking at current challenges and opportunities in Oregon as well as in other states.

- In 2006, Governor Kulongoski directed the Oregon Health Policy Commission (OHPC) to write a blueprint for building a sustainable system that provides access to affordable healthcare to every Oregonian, to set measurable goals for healthcare system change, and to recommend ways to finance the system.
- OHPC recommendations include:
  - o Universal health insurance for children
  - o Creation of a Health Insurance Exchange to bring together individuals, coverage options, employers, and public subsidies
  - o Offer low-income Oregonians publicly-financed coverage subsidies to ensure coverage is affordable
  - o Requirements that all Oregonians purchase health insurance coverage
  - o Encourage and organize public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes
  - o Support for community efforts to improve healthcare access and delivery
  - o Establish financing for reform that is sustainable and equitable with a broad-based employer contribution
  - o Design and implement comprehensive evaluation of system reform

# Pregnancy rate per 1,000 females ages 10-17

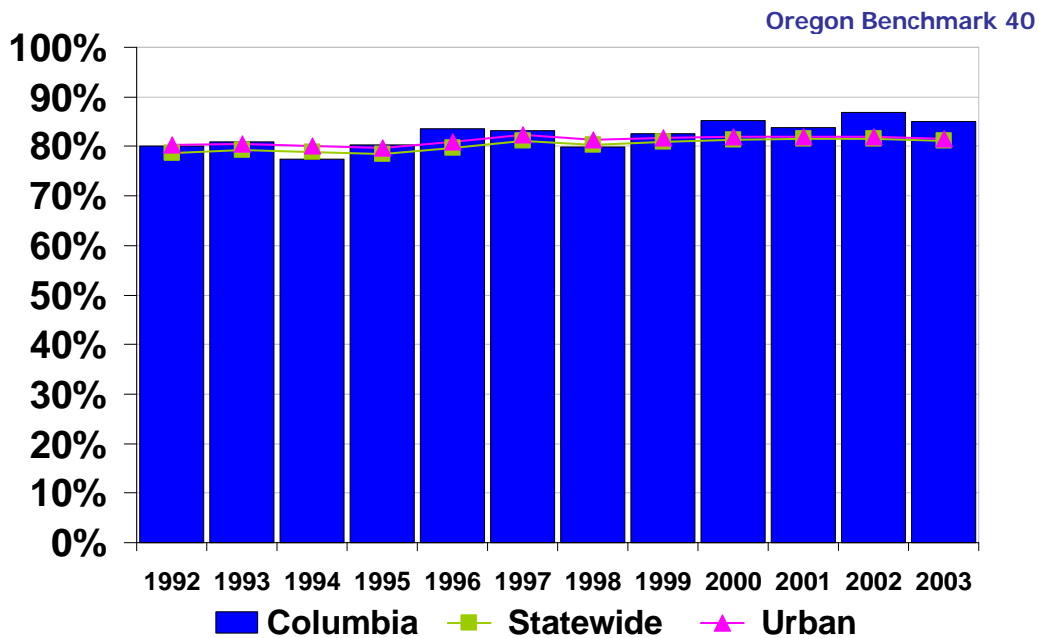
Oregon Benchmark 39



Our teen pregnancy rate is less than the state rate at 10.9 girls age 10-17 yrs./1000. This statistic comes from the Status of Oregon's Children 2001 report. We attribute this to our STARS program and our family planning program. A recent report by the Guttmacher Institute states that abstinence only programs are not effective as stand alone programs in decreasing teen sexual activity. Availability of contraceptive services is effective in preventing teen pregnancy for sexually active teens.

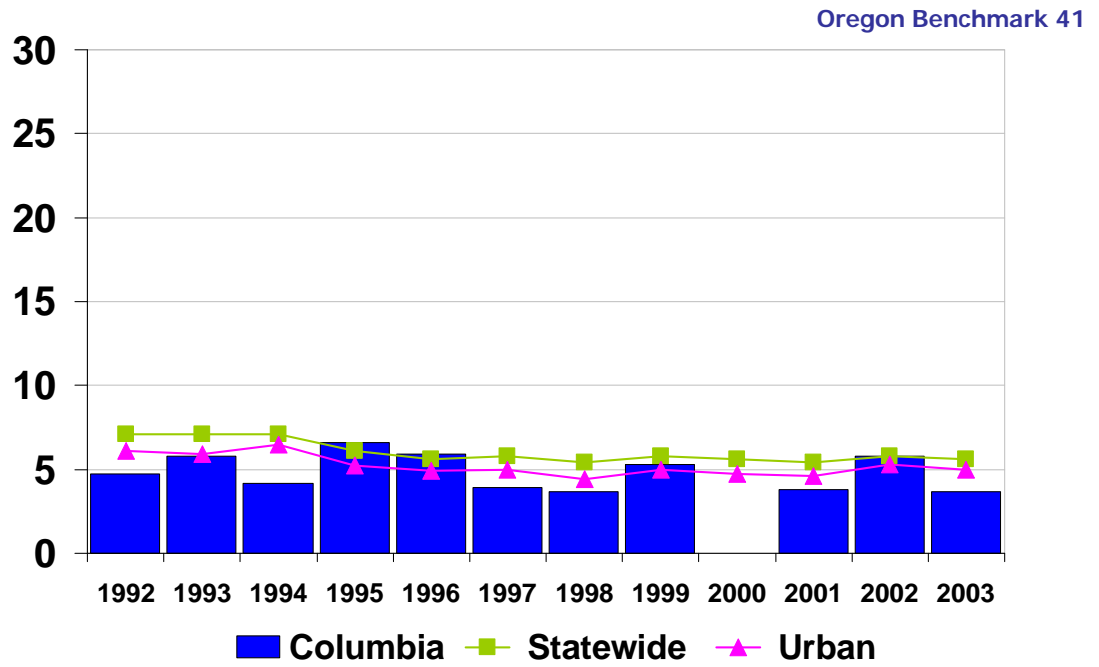
Agency staff provide home visits to new mothers, newborns, and infants with social or medical risk factors. Our nurses make referrals to medical and social services as needed. Staff time is extremely limited for these services and we hope in the future to be able to offer home visit nursing services to all parents of newborns in the county.

## Percent of babies whose mothers received prenatal care beginning in the first trimester



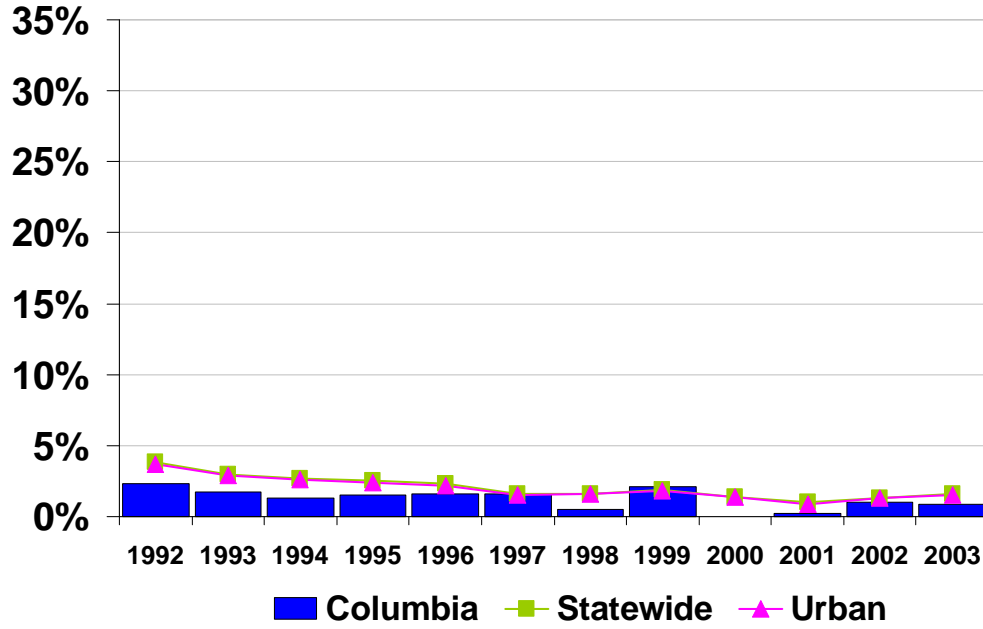
In 2005, there were 9 births to teens aged 10-17 years. Statistics from 2003-2005, list St. Helens with the highest number of teen births among the 15-17 yr. old range. There were 24 births during that three year timeframe in St. Helens.

# Infant mortality rate per 1,000



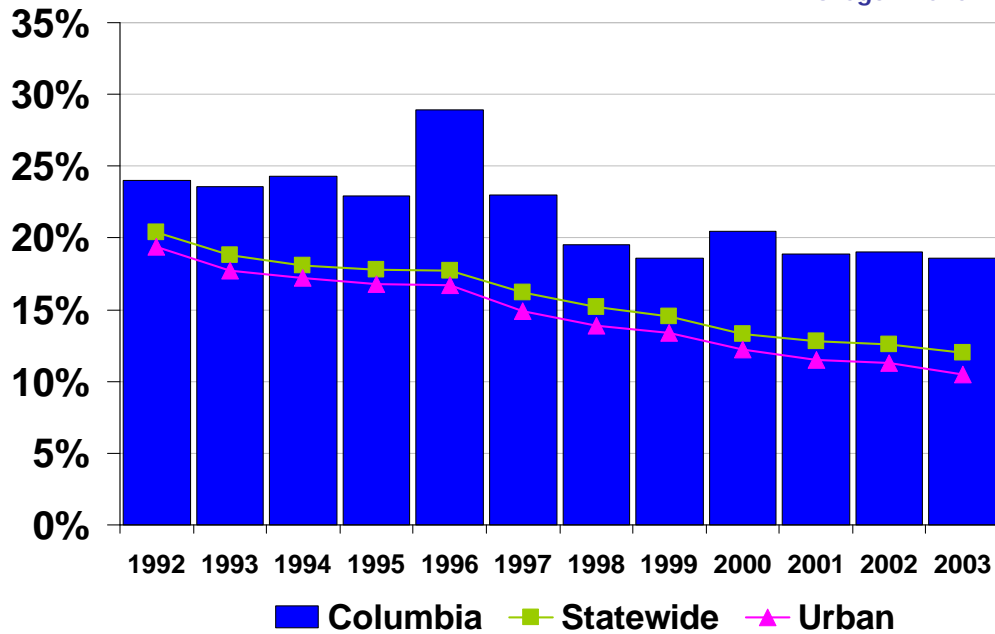
# Percent of infants whose mothers used alcohol during pregnancy (self reported)

Oregon Benchmark 52a



## Percent of infants whose mothers used tobacco during pregnancy (self reported)

Oregon Benchmark 52b



Infant mortality during 2001 was higher than the year prior, but better than Oregon's average, when comparing a five year average rate. In 2004, there were two infant deaths. This is a difficult indicator to make any statements about because the numbers are too small for statistical comment. Columbia County has no obstetricians/gynecologists. Public Health offers a prenatal care program in conjunction with Oregon Health Sciences University. Legacy Health Systems offers prenatal care in St. Helens with two nurse midwives.

Columbia County has over 500 births a year, but no hospital where women can deliver their babies. They must travel to Washington state or to Portland to a hospital or deliver their babies at home. Women have access to three nurse midwives and one family practice physician countywide for prenatal care. Most women travel to Portland for prenatal care. High risk pregnant women are referred to Portland for their care. There are no local doctors who manage high risk pregnancies.

Low birth weight babies during 2005 born to Columbia County parents numbered 29 babies. This rate was lower than the previous year and lower than the state rate over a five year period of time. Entry into prenatal care in the first trimester was 87 percent, but six percent had inadequate care, defined as less than five visits or late entry into care. The risk factors for these women were not significantly different from the state's overall maternal risk factors. Ninety-nine of 524 pregnant women smoked during pregnancy. This indicator is higher than the state and higher than the urban area. Smoking has a

tremendous impact on both the baby and the mother's health. That impact continues to negatively impact infants and children as they grow.

### **Top causes of Death and Prevention**

The Centers for Disease Control (CDC) list the top ten actual causes of death in the following order:

1. Tobacco use or second-hand smoke
2. Poor diet
3. Alcohol consumption
4. Microbial agents
5. Toxic agents
6. Motor vehicle accidents
7. Firearms
8. Sexual behavior
9. Illicit drug use

This past year our county received limited tobacco dollars, although the state has both tobacco tax dollars and tobacco settlement dollars. Columbia County receives a small grant to educate and work with businesses and government around business policy. This program also works with schools and student groups. This is a limited three year focus.

Oregon has a clean indoor air act. The counties respond to complaints and provide the footwork for the state. The state health division also has very limited funds available to provide two counties with an asthma grant to help reduce the burden of respiratory problems in local communities. Columbia County is not a recipient of one of these grants.

The Dept. of Environmental Quality (DEQ) is the primary state agency to enforce outdoor air quality and has a very limited impact due to resources.

The second actual cause of death in the U.S. is poor diet. Counties provide diet education to several population groups. Through WIC, counties serve pregnant and breastfeeding women, infants and children through the age of four with nutritional risks. School-based health clinics and women's health clinics assess diet and educate if the client is interested. Columbia County has one school-based health clinic in St. Helens. It serves the K- 6 grade population. The community education programs available to the general public in our county are provided by the Columbia County Extension Service.

Public health in Columbia County has no program directed to alcohol consumption – the third leading cause of death in the U.S. There is information and referral to the local mental health agency which does provide alcohol and drug programs in the county. There are Alcoholics Anonymous (AA) programs available in every community in Columbia County.

The fourth largest actual cause of death in the U.S. is microbial agents. At this point in the top causes of death list, public health finally has invested dollars that will help protect the entire population. Columbia County public health has for 20 years offered both influenza and pneumonia vaccinations to the entire population.

Currently, some of the public health preparedness dollars are being used to purchase both of these vaccines. As part of our public health preparedness plan, we have developed a pandemic attachment to our overall emergency plan. This funding gives us the opportunity to plan for the most likely major public health problem that might occur.

Planning is essential and so is practice. The agency is practicing, using these vaccines and administering them to infrastructure resources in our communities as well the general population. When employees change, memories are short. Plans are not necessarily followed and chaos is created, so we continue to test our plans and exercise our employees on a yearly basis.

CDC's list of actual causes of death numbers five, six, and seven are not vested in any public health dollars in our county and so no services are provided.

The eighth cause of death from the list is sexual behavior. Here, public health is vested in providing family planning services that include sexually transmitted disease education well as screening. HPV vaccine is offered to all of our age appropriate clients. Public health also offers a sexually transmitted disease clinic for some types of sexually transmitted diseases.

Illicit drug use is the tenth actual cause of death in the CDC list. Our community mental health agency does the only drug treatment with extensive education in our county.

The unmet needs are many here. The dollars are finite and stretched thin.

### Local Process and Progress

We continue to work with a health planning process. During a year-long process, we identified healthcare needs. With projected growth in the county, we need to address an increasing demand for services in an area where there is already a lack of supply. Columbia County is medically one of the most underserved counties in Oregon, and the only county its size without a hospital. We found a common barrier prevents much of our health planning for the county from being successful: the lack of a licensed inpatient hospital in the County. A hospital is central to a health service delivery system, and without one, isolated health services cannot develop into systematic health service delivery.

We lack physicians. The county needs about 19 primary care and 40 specialists. There is no hospital and no emergency room in the county and the closest ER is approximately 30 miles away. There is one urgent care clinic in the county and it does not provide services 24 hours a day. We have major unmet prevention and mental health needs, and all services in outlying rural areas are minimal.

***Our population base is growing rapidly, yet we are not served by a transportation service. Additionally many residents have low income levels, and receive fewer services because of the lack of local health services and the challenges of transportation to outside services.***

***Children are particularly under served--we have a projected need for four pediatricians, yet only one currently practices in the county. In both Clatskanie and Vernonia, there is a higher death rate among young people than the rate for Oregon.***

While some of following needs may be addressed individually, a hospital could provide a partial solution to many different problems and greatly enhance all efforts to increase health services

1. Need to obtain an emergency room that operates 24 hours/day and an inpatient hospital
2. Need to generate and distribute a recruitment packet for potential healthcare providers outlining advantages to practicing in Columbia County.

A local hospital is the cornerstone of a community health care system. The existence of a hospital is likely to support the presence of other medically related businesses and activities. Most commonly these are physician services, pharmacies, independent allied health professionals and others. These businesses or services are connected through a hospital and with each other.

A hospital can provide an enhanced sense of medical community among providers, i.e. medical staff and medical society. It makes it easier to attract and recruit physicians and specialists. It enables opportunities for improved coordination of existing local resources such as nursing homes, mental health, and physical therapy.

Further, it provides local infrastructure to a community.

## **FY 2007 - 2008 WIC Nutrition Education Plan**

County/Agency: Columbia County

Person Completing Form: Patty Barker

Date: May 10, 2007

Phone Number: 503-397-4651-x207

Email Address: pbarker@chdpublichealth.com

Goal 1: Oregon WIC Staff will have the knowledge to provide quality Nutrition education.

Year 1 Objective: During plan period, staff will be able to correctly assess nutrition and dietary risks.

Activity 1:

All certifiers will complete the Nutrition Risk Module by December 31, 2007.

Resources: Nutrition Risk Module distributed to all agencies 2/07.

Information provided from Nutrition Risk Module Regional Train-the-Trainer sessions 4/07.

Implementation Plan and Timeline:

April 2, 2007: Patty Barker, Jana Mann, and Sheri Lemont attended the train the trainer session.

Activity 2:

All certifiers will complete the revised Dietary Risk Module (to be released September 2007) by March 31, 2008.

Resources: Information provided from Dietary Risk Module Training.

Implementation Plan and Timeline:

We will complete the revised dietary risk module by March 31, 2008. The module will be reviewed and presented at 5 WIC in-service staff meetings: October 16,2007; November 20, 2007; January 15, 2008; February 19,2008; and March 18,2008.

Activity 3:

We have selected one staff member to participate in a State workgroup to identify key nutrition messages used in WIC and implement strategies for integrating these messages into clinic practices.

Staff name: Jana Mann

Email address:jmann@chdpublichealth.com

Phone Number: 503-397-4651x208

Activity 4:

Our agency training supervisors are Patty Barker, Jana Mann and Sheri Lemont. See attachment B for projected staff in-service training dates and topics for FY 2007-2008.

Goal 2: Nutrition Education offered by the local agency will be appropriate to the clients' needs.

Year 1 Objective A: During Plan period, we will implement strategies to provide targeted, quality nutrition education.

Activity 1:

Implementation Plan and Timeline:

Using state provided resources; we will conduct a needs assessment of our community by September 30, 2007, to determine relevant nutritional health concerns and assure that our nutrition education offerings meet the needs of our WIC population.

Resources include: TWIST Reports, PEDS Data, Oral Health Data, and Healthy Active Oregon Communities' Initiatives. Resources will be provided July 2007.

Activity 2:

Complete Activity 2A nutrition education activities our agency offers.

Resources include: Information from Goal 2, Activity 1, and Oregon WIC

## Nutrition Education Guidance.

### Activity 2A:

#### Implementation Plan and Timeline:

We will submit an Annual Group Nutrition Education schedule for our agency by October 31, 2007 for 2008. We will complete and return Attachment C by October 31, 2007.

Goal 3: Improve the health outcomes of clients and staff in the local agency service delivery area.

Year 1 Objective: During Plan period, we will develop at least one specific objective and implement at least one activity to help facilitate healthy behavior change for WIC staff and at least one specific objective and activity to help facilitate healthy behavior change for WIC clients. This objective gives us the opportunity to address relevant issues and "customize" activities for our agency.

### Activity 1:

Local Agency Objective to facilitate healthy behavior change for WIC Staff: Our agency continues to offer a fitness incentive program to all employees.

Local Agency Staff Activity: We plan to continue to participate in the agency fitness incentive program and move towards 100% participation.

Implementation Plan and Timeline: This objective was chosen to not only encourage physical fitness, but also promote partnering with team spirit. We are continuing to implement the program, and we hope to change participation levels while improving team spirit in the office.

We will evaluate its effectiveness by measure the increase in percentage of participation.

### Activity 2:

Local Agency Objective to facilitate healthy behavior change for WIC

Clients: to make current information more readily available to WIC clients.

Local Agency Client Activity: We plan to have informative, attractive bulletin boards with current information rotated quarterly.

Implementation Plan and Timeline: This objective was chosen to increase the times clients can see and take to read, and the "tell me more" opportunities. We hope to change the frequency of positive client feedback. We have current begun the activity, and will begin to evaluate its effectiveness by noting the client feedback.

Goal 4: Improve breastfeeding outcomes of clients and staff in the local agency service delivery area.

Year 1 Objective: During Plan period, each local agency will develop at least one objective and activity to help improve breastfeeding outcomes for WIC staff or WIC clients.

We considered the findings from the prior 3 Year Nutrition Education Plan to identify and address common barriers to breastfeeding.

Activity 1:

Breastfeeding Objective: We want to promote breastfeeding for babies ages six months and beyond.

Breastfeeding Activity supporting the above objective:

We are offering more supportive classes offered at a variety of times with a varied curriculum.

Implementation Plan and Timeline: We chose this objective to decrease the number of mothers that chose to stop breastfeeding before the infant is six months of age. We have begun to implement the activity, and we will evaluate its effectiveness based on the increased longevity of exclusively breast feeding mothers and increased 2008 class attendance and feedback.

### **Family Planning Program Action Plan 07-08**

- A. Assure Continued High Quality Clinical Family Planning and Related Preventive Health Services to Improve Overall Individual and Community Health.**
  
- B. Reduce Risk of Unintended Pregnancy in Local Community.**

#### **CURRENT CONDITION OR PROBLEM:**

Columbia County statistics showed an estimated 2,061 *Women In Need (WIN)* 2005, ages 13-44 according to the *Title X Family Planning Agency Data* information provided by DHS.

Our family planning clinic served 780 unduplicated female clients, 10-44 years of age for FY 2006, or 37.8% of *Women In Need (WIN)*, well above the state average of 33.1%. From the *Title X Family Planning Agency Data* we also see that there were 589 *Women in need (WIN)* Teens 13-19 years of age for FY 2005. Our family planning clinic served 328 unduplicated female teen clients 10-19 years of age for the FY 2006, or 41.3% teen clients as a % of total clients, well above the State average of 30.2%.

Pregnancy Rates of Teens by County of Residence, Oregon 2005 shows teen pregnancy rate in ages 10-17 as 4.0 per 1000 women in Columbia County. This is significantly lower than the State average of 9.5%. (We are the 2<sup>nd</sup> lowest in the State!). \**Oregon Vital Statistics Annual Report 2005, DHS, Table 4-5*. This is a reduction from the Oregon 2004 data, which showed the teen pregnancy rate ages 10-17 as 6.6 per 1000 women.

Our Teen pregnancy rate for 10-17 year old women CY'04 = 6.6 – 5 year average = 7.4 (State rate CY'04=9.5). Our Rolling Rate from 10/04-0/05 = 4.0, well below the State Rolling Rate = 9.5. \**Data supplied by DHS 11/06 at Annual Review*.

Many teens in Columbia County are unemployed, or working at minimum wage jobs. The U.S. Census 2000 Quick facts shows the percent of High School graduates in Columbia County ages 25+ as 85.6%, and those with a Bachelor's degree or higher as 14.0%. The Median household income in Columbia County for 2003 = \$47,072. \*U.S. Census Bureau State & County Quick Facts. Postponing parenthood will allow these young adults more time to improve their wages, continued education and employment possibilities.

Columbia County is a rural community with a limited public transportation system, and our clients must travel by their own transportation, walk, use bicycles, or pay for a Taxi/Metro West.

Our clinic hours of operation remain limited due to funding and space availability. As funds become available we hope to increase staffing, clinic hours and add a space by using a portable. Page 1

We continue to take great pride in providing quality confidential reproductive health care education and information to men, women and teens in need seeking services.

Included in our direct services we provide an abstinent program called STARS (Students Today Aren't Ready for Sex) to St. Helens and Vernonia school districts in Columbia County, through Teen leaders trained in the curriculum. There are approximately 270 active teens involved in STARS in St. Helens School District and approximately 100 active teens involved in STARS in the Vernonia School District.

Due to decreasing funding we will no longer be able to provide the STARS program in FY'08.

**FAMILY PLANNING PROGRAM ANNUAL PLAN FOR  
COUNTY PUBLIC HEALTH DEPARTMENT  
FY'08**

**Agency: Columbia Health District Public Health Authority**  
**Contact: Diana Shrewsbury RN, BS**

**Goal 1: Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.**

Problem Statement	Objective(s)	Planned Activities	Evaluation
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Changes in FPEP Enrollment has led to increased staff time without additional reimbursement, threatening the ability of the agency to maintain current level of service.	1) Increase revenue from donations by 1% for the period ending June 30, 2008	1) Develop a donation policy and procedure consistent with Title X guidelines. 2) Train staff in positions to make the donation requests. 3) Implement donation request policy. 4) Evaluate policy for consistency, fairness and effectiveness.	1) Quarterly and fiscal year end revenue reports. 2) Customer feedback. 3) Staff feedback.

**Goal 2: Assure ongoing access to a broad range of effective family planning methods and related preventive health services.**

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Mirena IUD's available – none inserted to date	1) CNM will offer Mirena IUD as BC Method 2) Insertion of Mirena IUD device	1) Identify clients that are suitable for the Mirena IUD 2) Utilize ARCH foundation for clients who are not FPEP and meet eligibility criteria	1) # of Mirena IUD's inserted

**III. Action Plan 2006-2007**

**B. Parent and child health services, including family planning clinics as described in ORS 435.205**

Review current plan posted with DHS;

*Columbia County Public Health District has no changes to submit in the information provided in the Family Planning Program Plan for FY 2006. We continue to provide a full range of women's health care which includes; pregnancy testing, Family Planning, Maternity Case Management, Prenatal Care, Babies First, Caccoon, Home Visiting provided by a Registered Nurse ,*

*and we have partnered with Sacagawea School Based Health Clinic for ages K-6.*

3. **Family Planning:** Agencies are required to have a plan for each of the following *two goals:*

*\*\* For the two goals do either of:*

- a. Review your current plan that is posted with DHS; or
- b. Submit a new plan using the **problem, goals, activities and evaluation** format.

A. Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.

**Current Condition or Problem:**

*We have no formal process to evaluate assured continued high quality of clinical family planning services and related preventative health services to improve overall individual and community health.*

**Goal:**

*To monitor family planning, preventative health counseling and education topics, and formalize a process to assure that quality services and client concerns are being addressed and documented by providers services at each client visit.*

**Activity:**

*Quarterly Chart Review;*

- *Randomly select 10-12 charts from clients seen for Family Planning Services within previous quarter.*
- *Charts will be reviewed by Professional staff using the newly developed agency chart review tool.*
- *Process will begin FY; June, 2007.*

**Evaluation:**

*Greater than 90% of charts will demonstrate compliance with all items listed on agency chart review tool.*

B. Reduce risk of unintended pregnancy in local community.

**Current Condition or Problem:**

*There remain barriers for men, women and teens who are seeking reproductive health care and family planning services in our Community because of the poverty level and transportation issues.*

*Columbia County is a rural community with a limited public transportation, our clients must either travel by their own transportation, walk, use bicycles, pay for a Taxi/Metro West. A majority of our teenage clients must walk to our clinic during school or after school. A problem that we have encountered is that High School Administrators have been known to call the teen's parents and notify them that the teen has walked to our clinic, making it difficult for them to receive confidential services. (The High School Administrator's allow the students to walk to other businesses without parental notification or consent).*

*Pregnancy Rates of Teens by County of Residence, Oregon 2005 shows teen pregnancy rate in Teens age 10-17 as 4.0 per 1000 women in Columbia County (2<sup>nd</sup> lowest in the State!). Columbia County is significantly lower than the State average of 9.5%. \*Oregon Vital Statistics Annual Report 2005, Table 4-5.*

*"According to the 2000 Census, Columbia County grew 16% between 1989 and 1999." The US Census Bureau found that 9.1% of Columbia County Residents live in Poverty. "This is a 2.5% increase in number of persons living in poverty". "The overall percent of Columbia County population living in poverty decreased from 1989 to 1999, while the number of people living in poverty did not". \*Source: US Census, OHCS: Report on Poverty 2004, pg 111.*

*Columbia County Public Health District takes great pride in providing quality confidential Reproductive Health care education and information to men, women and teens in need seeking services.*

*In Columbia County, for teen's aged 13-19, the total of Women in Need (WIN), was 589, of this total we saw 328 of these teens in FY'06. \*Columbia County Service Data for Oregon Title X Family Planning Agencies, FY 2006, pg 1-revised 1/3/07 edition.*

*The percentage of Teen Clients served FY'06 was 51.2%, well above the State average of 29.4%. Columbia County had a total of 175 pregnancies averted, FY'06. The male client population served for FY'06 was 1.6%, below the State average of 3.7%. \*Columbia County Service Data for Oregon Title X Family Planning Agencies, FY 2006, pg 3-revised 1/3/07 edition.*

*Clinic Services and hours of operation remain limited due to funding and space availability, as funds become available we hope to increase staffing, clinic hours and add a portable for additional space.*

**Goal:**

*Our primary goals are to provide access for Men, Women and Teens with access to comprehensive and uniform Health Education information consisting of Family Planning Services, STD education,*

*contraceptive services and ultimately reducing the number of unintended pregnancies and STD's in our community.*

**Activity:**

- *Collaborate with District School Nurses, Women's Resource Center and other community access delivery systems and community organizations to provide information and request referrals of clients to FPEP program and information for men, women and teens in need.*
- *Extreme flexibility in Family Planning schedule with willingness to see clients on a "walk-in" basis during all hours of clinic operation.*
- *As opportunities arise, educate community groups on broad range of reproductive health topics and advocate for the adoption of sound reproductive health awareness and education.*

**Evaluation:**

*Continued decrease in teen pregnancy.*

**Maternal and Child Health  
Action Plan 07-08**

**CURRENT CONDITION OR PROBLEM:**

Pregnancy totals (including live births and induced abortions) for all ages in Columbia County, Oregon, 2005 = 616. Of this total, there were 514 live births, 5.7% received inadequate prenatal care (less than 5 prenatal visits or care began in 3<sup>rd</sup> trimester), and this is only slightly below the State average of 5.8%.

In 2005, 86.9% of the 514 pregnant women in Columbia County, received prenatal care in the 1<sup>st</sup> trimester, this is significantly higher than the State average of 81.0%. \*Oregon Annual Report, 2005, Table 2-20.

Of the 514 total live births, 29 infants were born with low birth weight, or a low birth rate of 56.4 per 1000 births, compared to the State average low birth rate of 61.2 per 1000 births. \*Oregon Annual Report, 2005, Table 2-32.

Based on the Perinatal Data provided by DHS, Columbia County Public Health Authority provided prenatal care to 110 unduplicated women from July 2005 to June 2006:

- 97 were unplanned
- 78 had Nutritional Risk Factors
- 41 had Tobacco Use
- 12 had Substance Abuse Issues
- 2 noted Domestic Violence
- 21 had no High School Degree
- 3 were 17 years of age or under

- 5 were homeless
- 80 were unmarried

4. **Maternal and child Health Programs:** Agencies are required to have a plan or report for this program area. Plans should be based on the following priority State and National goals. Select one goal from 27 listed in I through v below.

\*\*For the selected goal do either of:

- Review your current plan that is posted with DHS; or
- Submit a new plan using the ***problem, goals, activities*** and ***evaluation*** format.
  - Perinatal Health
    - Decrease prenatal tobacco use

**Current Condition or Problem:**

*Our most difficult problem for pregnant women in Columbia County, is smoking during their pregnancy, or relapsing during the postpartum period. Many of our pregnant women know they should quit, but are lacking the support and tools to help them achieve their smoking cessation goals. A majority of our prenatal clients are motivated to quit smoking during their pregnancy and are in need of the support for smoking cessation and information to help them quit and not relapse. Pregnancy is the best time for a woman to quit smoking. Smoking during pregnancy can cause serious health consequences to the mother and her baby. Statistics show poor birth outcomes such as; low infant birth weights, increased risk of miscarriage, an increased risk of still-births, pre-term births, slower fetal growth, allergies, asthma, ear infections, respiratory illnesses and Sudden Infant Death Syndrome (SIDS).*

*Maternal Risk Factors by County of Residence, Oregon 2005 shows Tobacco use in pregnant women in Columbia County was 22.5%, our County ranks 6<sup>th</sup> highest in the State of Oregon, and above the State average of 12.4%. \*Oregon Annual Report 2005, DHS, Table 2-16.*

**Goal:**

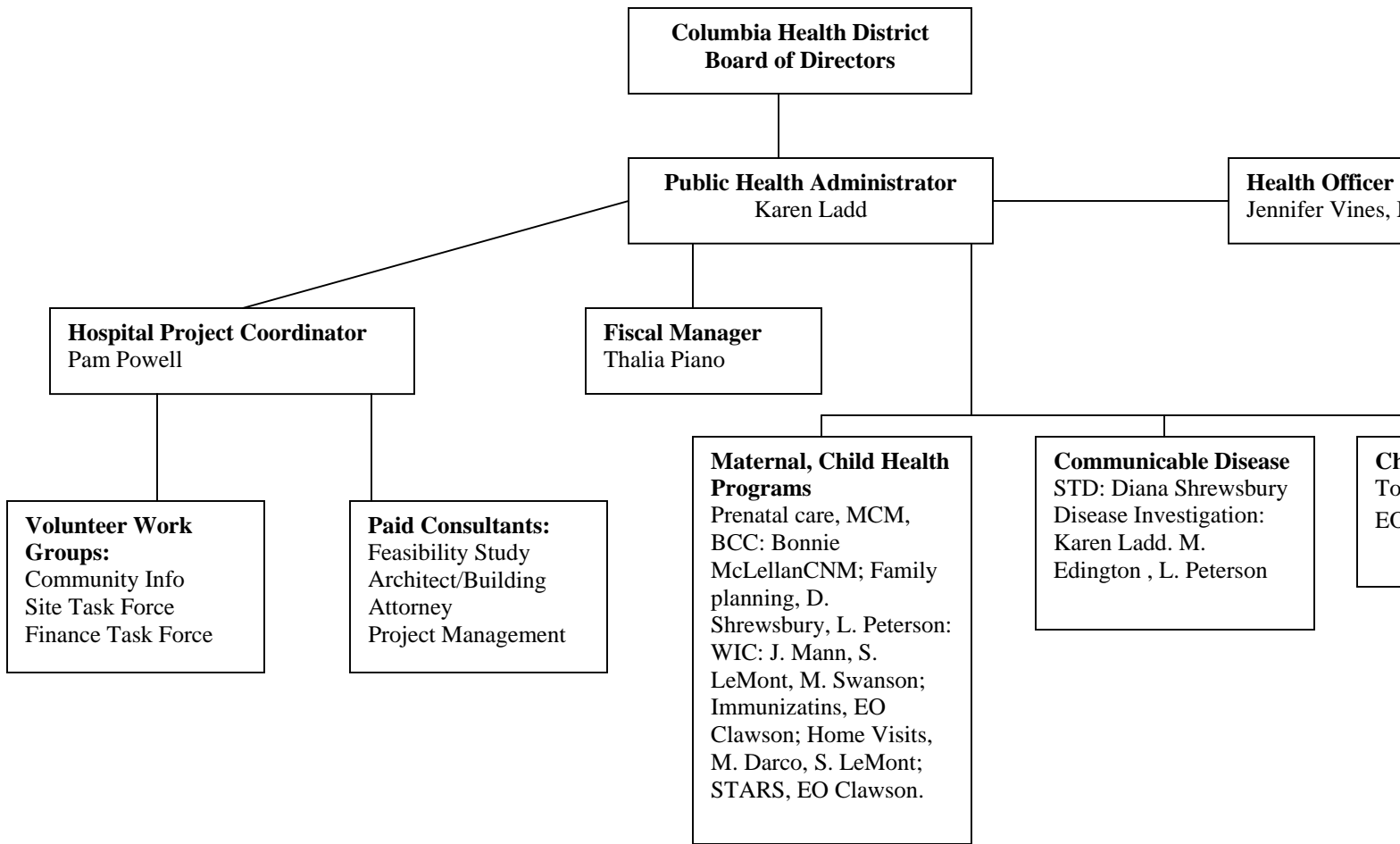
- *Promote smoking cessation during Pregnancy and in the postpartum period.*
- *Provide the Great Start Quit Line and Oregon Tobacco Quit Line phone number and encourage referrals with follow-up at each Prenatal and Postpartum visit.*
- *Decrease SIDS deaths in Columbia County.*

**Activity:**

- *Document the use of the 5A interventions on the Fair form in each prenatal client record at each visit.*
- *Collaborate with WIC staff, Babies First Nurse and Community Health Nurse each month to discuss smoking prenatal clients and progress or regression in each shared client.*
- *Promote smoking case management tools adapted to each client's individual needs to improve success with smoking cessation during pregnancy and in the Post Partum Period.*
- *Continue to praise clients on progress made and refer to either Great Start Quit Line or Oregon Tobacco Quit Line, or both.*

**Evaluation:**

- *Nursing Professionals will continue to track the smoking cessation attempts, the interventions, success and regressions at each prenatal visit.*
- *WIC, Family Planning, MCM, and the home visiting nurse programs will track the smoking status of the prenatal clients during pregnancy and postpartum period.*
- *The Oregon Vital Statistics county Data book will not show an increase in number of pregnant women who use tobacco, and will hopefully see a reduction in this number in the next few years.*



## VII. Minimum Standards

Agencies are **required** to complete this section.

To the best of your knowledge, are you in compliance with these program indicators from the Minimum Standards for Local Health Departments?

### Organization

1. Yes  No  A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes  No  The Local Health Authority meets at least annually to address public health concerns.
3. Yes  No  A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.
4. Yes  No  Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes  No  Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes  No  Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes  No  Local health officials develop and manage an annual operating budget.
8. Yes  No  Generally accepted public accounting practices are used for managing funds.
9. Yes  No  All revenues generated from public health services are allocated to public health programs.
10. Yes  No  Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes  No  Personnel policies and procedures are available for all employees.
12. Yes  No  All positions have written job descriptions, including minimum qualifications.

13. Yes  No  Written performance evaluations are done annually.
14. Yes  No  Evidence of staff development activities exists.
15. Yes  No  Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes  No  Records include minimum information required by each program.
17. Yes  No  A records manual of all forms used is reviewed annually.
18. Yes  No  There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes  No  Filing and retrieval of health records follow written procedures.
20. Yes  No  Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes  No  Local health department telephone numbers and facilities' addresses are publicized.
22. Yes  No  Health information and referral services are available during regular business hours.
23. Yes  No  Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.
24. Yes  No  100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.
25. Yes  No  To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes  No  Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes  No  Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.

28. Yes  No  A system to obtain reports of deaths of public health significance is in place.
29. Yes  No  Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.
30. Yes  No  Health department administration and county medical examiner review collaborative efforts at least annually.
31. Yes   No  Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes  No  Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes  No  Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes  No  Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes  No  Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.
36. Yes  No  A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

## **Control of Communicable Diseases**

37. Yes   No  There is a mechanism for reporting communicable disease cases to the health department.
38. Yes   No  Investigations of reportable conditions and communicable diseases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
39. Yes  No  Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.

- 40. Yes  No  Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.
- 41. Yes  No  There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
- 42. Yes  No  There is a mechanism for reporting and following up on zoonotic diseases to the local health department.
- 43. Yes  No  A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
- 44. Yes  No  Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
- 45. Yes  No  Immunizations for human target populations are available within the local health department jurisdiction.
- 46. Yes  No  Rabies immunizations for animal target populations are available within the local health department jurisdiction.

## Environmental Health

- 47. Yes  No  Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
- 48. Yes  No  Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
- 49. Yes  No  Training in first aid for choking is available for food service workers.
- 50. Yes  No  Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
- 51. Yes  No  Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
- 52. Yes  No  Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

53. Yes  No  Compliance assistance is provided to public water systems that violate requirements.
54. Yes  No  All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
55. Yes  No  A written plan exists for responding to emergencies involving public water systems.
56. Yes  No  Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes   No  A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.
58. Yes  No  Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes  No  School and public facilities food service operations are inspected for health and safety risks.
60. Yes  No  Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes  No  A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes  No  Indoor clean air complaints in licensed facilities are investigated.
63. Yes  No  Environmental contamination potentially impacting public health or the environment is investigated.
64. Yes  No  The health and safety of the public is being protected through hazardous incidence investigation and response.
65. Yes  No  Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes  No  All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

## Health Education and Health Promotion

67. Yes  No  Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.
68. Yes  No  The health department provides and/or refers to community resources for health education/health promotion.
69. Yes  No  The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.
70. Yes  No  Local health department supports healthy behaviors among employees.
71. Yes  No  Local health department supports continued education and training of staff to provide effective health education.
72. Yes  No  All health department facilities are smoke free.

## Nutrition

73. Yes  No  Local health department reviews population data to promote appropriate nutritional services.
74. The following health department programs include an assessment of nutritional status:
- a. Yes  No  WIC
  - b. Yes  No  Family Planning
  - c. Yes  No  Parent and Child Health
  - d. Yes  No  Older Adult Health
  - e. Yes  No  Corrections Health
75. Yes  No  Clients identified at nutritional risk are provided with or referred for appropriate interventions.
76. Yes  No  Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.
77. Yes  No  Local health department supports continuing education and training of staff to provide effective nutritional education.

## Older Adult Health

78. Yes  No  Health department provides or refers\*to services that promote detecting chronic diseases and preventing their complications.  
*\*limited # of providers*
79. Yes  No  A mechanism exists for intervening where there is reported elder abuse or neglect.
80. Yes  No  Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.
81. Yes  No  Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education.

## Parent and Child Health

82. Yes  No  Perinatal care is provided directly or by referral.
83. Yes  No  Immunizations are provided for infants, children, adolescents and adults either directly or by referral.
84. Yes  No  Comprehensive family planning services are provided directly or by referral.
85. Yes  No  Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.
86. Yes  No  Child abuse prevention and treatment services are provided directly or by referral.
87. Yes  No  There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.
88. Yes  No  There is a system in place for identifying and following up on high risk infants.
89. Yes  No  There is a system in place to follow up on all reported SIDS deaths.

90. Yes  No  Preventive oral health services are provided directly or by referral.
91. Yes  No  Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.
92. Yes  No  Injury prevention services are provided within the community.

### Primary Health Care

93. Yes  No  The local health department identifies barriers to primary health care services.
94. Yes  No  The local health department participates and provides leadership in community efforts to secure or establish and maintain adequate primary health care.
95. Yes  No  The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.
96. Yes  No  Primary health care services are provided directly or by referral.
97. Yes  No  The local health department promotes primary health care that is culturally and linguistically appropriate for community members.
98. Yes  No  The local health department advocates for data collection and analysis for development of population based prevention strategies.

### Cultural Competency

99. Yes  No  The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.
100. Yes  No  The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.
101. Yes  No  The local health department assures that advisory groups reflect the population to be served.

102. Yes X No \_\_\_ The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

### Health Department Personnel Qualifications

**103. Yes X No The local health department Health Administrator meets minimum qualifications:**

A Master's degree from an accredited college or university in public health, health administration, public administration, behavioral, social or health science, or related field, plus two years of related experience.

**If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.**

**104. Yes X No The local health department Supervising Public Health Nurse meets minimum qualifications:**

Licensure as a registered nurse in the State of Oregon, progressively responsible experience in a public health agency;

**AND**

Baccalaureate degree in nursing, with preference for a Master's degree in nursing, public health or public administration or related field, with progressively responsible experience in a public health agency.

**If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.**

**105. Yes X No The local health department Environmental Health Supervisor meets minimum qualifications:**

Registration as a sanitarian in the State of Oregon, pursuant to ORS 700.030, with progressively responsible experience in a public health agency

OR

a Master's degree in an environmental science, public health, public administration or related field with two years progressively responsible experience in a public health agency.

**If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.**

106. Yes \_\_\_ No X The local health department  
Health Officer meets minimum qualifications:

Licensed in the State of Oregon as M.D. or D.O. Two years of practice as licensed physician (two years after internship and/or residency). Training and/or experience in epidemiology and public health.

**If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.**

\*Dr. Jennifer Vines, our Health Officer, interned with Dr. Justin Denny for a year before he left and she was hired as the Columbia County Health Officer. She is presently working with several Metro counties and with Columbia County to obtain the required two years in practice. We have confidence in her experience.

## Appendix A

### Assessment Categories

Aging Issues  
Alcohol & Drug use  
Birth defects  
Births  
Cancer morbidity and mortality  
Chronic disease  
Communicable disease  
Deaths and causes of death  
Dental  
Diabetes  
Domestic Violence  
Elevated blood lead levels  
Emergency preparedness  
Food borne illness reports  
Immunizations  
Incidence of fecal-oral transmission of disease  
Injury morbidity and mortality  
Liquid and solid waste issues in the area  
Low birth weight  
Mental health  
Physical activity, diet, and obesity  
Population by  
    Gender  
    Age  
    Race  
    Geography  
    Socio-economic status  
Premature birth  
Prenatal care  
Safe drinking water  
Safety net medical services  
Teen pregnancy  
Tobacco use  
Unintended pregnancy  
Underage drinking

## **Appendix B**

### **Data Links**

1. Population pyramid, by age and sex:

[http://www.censusscope.org/us/s41/chart\\_age.html](http://www.censusscope.org/us/s41/chart_age.html)

2. Oregon population center:

<http://www.upa.pdx.edu/CPRC/publications/annualorpopulation.html>

3. Federal census center:

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

4. County facts:

<http://bluebook.state.or.us/local/counties/clickmap.htm>

5. Reportable diseases by county, and other disease surveillance data:

<http://oregon.gov/DHS/ph/acd/stats.shtml>

6. County data book:

<http://oregon.gov/DHS/ph/chs/data/cdb.shtml>

7. Chronic disease data:

<http://oregon.gov/DHS/ph/hpcdp/pubs.shtml>

<http://oregon.gov/DHS/ph/hpcdp/index.shtml>

8. Environmental Health licensed facility inspection report:

<http://www.dhs.state.or.us/publichealth/foodsafety/stats.cfm>

9. Youth surveys:

<http://oregon.gov/DHS/ph/chs/youthsurvey/>

10. Benchmark county data:

[http://egov.oregon.gov/DAS/OPB/obm\\_pubs.shtml#Benchmark%20County%20Data%20Books](http://egov.oregon.gov/DAS/OPB/obm_pubs.shtml#Benchmark%20County%20Data%20Books)

11. Local economic information:

<http://www.econ.state.or.us/stats.htm>

12. Detailed census tables:

[http://factfinder.census.gov/servlet/DatasetMainPageServlet?\\_program=DEC&\\_lang=en&\\_ts=](http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=DEC&_lang=en&_ts=)

13. Alcohol and Drug County Data

<http://oregon.gov/DHS/addiction/data/main.shtml#ad>

14. Web-based software for public health assessment

<http://www.oregon.gov/DHS/ph/lhd/vista.pdf>

#### Bibliography:

*“Ambulatory Surge Capacity in Northwest Oregon,”* Office for Oregon Health Policy and Research, May 2006, prepared for NW Oregon Health Preparedness Organization

*“Trends in Oregon’s Healthcare Market and the Oregon Health Plan – a report to the 74<sup>th</sup> Legislative Assembly,”* February 2007, prepared by the Department of Administrative Services Office for Health Policy and Research, Jeanene Smith, MD, MPH, Administrator

Oregon Benchmarks County Data, November 2005, Oregon Progress Board,  
[www.Oregon.gov/DHS/OPB](http://www.Oregon.gov/DHS/OPB)

Oregon Vital Statistics Annual Report, 2004, Vol. 2 & Vol. 2, DHS, Public Health Division, Office of Disease Prevention and Epidemiology

