Coos County Public Health

Annual Plan

2006-2007

Frances Hall Smith
Public Health Administrator
1975 McPherson #1
North Bend, Oregon 97459

Coos County Public Health – Annual Plan 06/07
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Executive Summary

Coos County Public Health provides a wide range of services to meet health needs of the community. With a projected budget of $3.3 million, we currently employ 40 staff (35.4 FTE) who implement our programs through the following subdivisions of the department: Family Health Field Services, Environmental Health, Prevention Services, Clinic Services, Women, Infants and Children's Nutrition Program, Administration and Support Services.

Our Department provides the 5 essential services required by Oregon law. Through these mandated services, we are addressing important social and health problems: teen pregnancy prevention, child abuse prevention, adequate prenatal care, protection from communicable diseases, and assurance of safe food and drinking water for the public. We also record vital statistics and provide health information and referral services.

Most of our programs follow the funding streams that come to us through Oregon's Department of Human Services–State Public Health. Most of these funds have remained static over the years, or have decreased, while our costs have gone up. State support for public health, which is awarded on a per capita basis at 60 cents per person per year is not even sufficient to fund one nurse. The federal funds for public health preparedness have increased our capacity to respond to communicable disease outbreaks as well as support critical emergency response planning. These funds have been reduced, except for a special federal award directed towards pandemic flu preparedness.

We have some concerns: the high rate of sexually transmitted diseases in young people (and the limited funding for HIV prevention); the emergence of active TB in our community; the high level of obesity, and the number of citizens who are uninsured for medical care. Health indicators for Coos County continue to reveal high rates of substance abuse and child abuse--problems that are correlated with the chronic unemployment and poverty in our area. We have one of the highest rates of adult smoking in the state, which contributes to our leading cause of death--cardiovascular disease--and to our county's ranking as number one in the state for the lung cancer death rate. Chronic diseases such as arthritis and diabetes (again, some of the highest rates in the state) affect the quality of life of our aging population.

We are one of the counties receiving funds for a tobacco prevention project, and we will be competing for limited funds for a diabetes, asthma, and cardiovascular project, with which we hope to have an impact on chronic disease in our community. We have seen improvement in other areas where we have worked hard to make a difference, e.g., the declining teen pregnancy rate, more pregnant women receiving early prenatal care, an increase in our clients' parenting skills and the corresponding reduction in child abuse, and our ability to respond promptly to a communicable disease outbreak. This Annual Plan document includes action plans addressing important public health issues. These plans guide the work of our dedicated staff, who continue to meet the challenge of providing a wide range of services, with limited funding, in a community with many needs.

Public Health Indicators in Coos County

Coos County is a rural community of 63,739 (estimated) persons living on the southern Oregon coast. The median age of the current population is 43.1. Residents of Coos County live in one of seven small towns spread out over 1,629 square miles. Coos Bay and North Bend border the largest deep-water port on the Oregon coast. Historically, agriculture, logging and shipping have been the mainstays of the Bay Area's economy. More recently, wood products manufacturing, small entrepreneurial ventures and tourism have become increasingly important segments, according to the Bay Area Chamber of Commerce. For many, seasonal jobs dependent on tourism have replaced family wage jobs. The average per capita income is $24,380 with a median household income of $31,945 (state: $42,593). Fifteen percent of the population lives below the poverty line (state: 11.6%). Ninety-two percent of the population is white. Hispanic or Latinos and Native Americans have the largest minority populations at 3.4% and 2.4% respectively. As of February 2005, 8.8% of adults in Coos County were unemployed, and 40.7% of all persons in Coos County were uninsured.

Public Health concerns in Coos County have multiple causes and are related in part to the unfavorable socio-economic conditions, and in part to our aging population and behavioral factors. Some major issues are:

- **Alcohol Use**: According to the 2005 Youth Risk Behavior Survey (YRBS), 12% of 9-12th grade students reported that they had consumed alcohol an average of 4 times during the past 30 days. More than 49% of the same group reported that it was "very easy" to get alcohol if they wanted to, and 21% of 9th graders also report that during the past 30 days, they have consumed illegal drugs. In 2003, 18 deaths were attributed to alcohol, and alcohol was ranked 4th for potential years of life lost, after unintentional injuries, cancer, and heart disease.

- **Cancer**: During a 5 year period (from 1998-2002) the age adjusted rate showed that Coos County ranked highest in the state for *high incidence* cancers: Coos ranked highest in the state for incidence of lung cancer at 96.3 per 100,000 (state 71/100,000) and highest for death from lung cancer at 77 per 100,000 (state 57.3). Coos ranked 2nd in the state for age adjusted rate of malignant melanoma, at a rate of 31.5 per 100,000; ranked 3rd for oral and pharynx cancer at a rate of 16.7 per 100,000. Coos ranked similar to the state rates for breast cancer at 146.6 per 100,000 (state 145.6) and colon/rectum cancer at 50.4 (state 50.1)

- **Child Abuse and domestic violence**: Coos County has an improved trend, with a rate of 15.6 per 1000 children, compared to 22.1 in 2003. (Child Welfare Services) In the first quarter of 2006, there are 167 children in foster homes. Child abuse continues to be attributed to a high rate of substance abuse and domestic violence in Coos County. Domestic violence continues to be a problem, with 1302 calls placed to the Women's Safety & Resource Center in 2005.

- **Chronic Disease**: Coos County ranks 2nd highest in the state for having 48% of the population suffering from arthritis, compared to the *state rate of 35%;* Asthma in Coos County is at 12%, versus *state rate of 9%.* Diabetes is estimated at 8.5 to 10% of the population (estimate includes 2.4% undiagnosed). Heart disease and stroke combined accounted for 31% of the deaths in Coos County in 2003, surpassing cancer as the cause of 24% of deaths.

- **Hunger related to poverty**: Coos County ranks unfavorably for those living in povery--31st out of 36 counties in the state with 25.5% of those being 5 years of age or younger—more than twice the state rate of 11.6%. Single parent families make up 9.9% of the population in Coos County, further contributing to the problem. 15% of county households receive food stamps; 46.8% of Coos County students qualified for Free and Reduced Lunch Programs. *State poverty level is 11.6%* (US Census Bureau) Coos County rate for food stamp recipients was 153.6 per 1,000, compared to a state rate of 101.

- **Notifiable Communicable Diseases:** Coos County had 211 cases of communicable diseases that were reported by health care providers. 115 of those were chlamydia. One active case of tuberculosis; 46 chronic cases of hepatitis C were reported. (2005 Acute and Communicable Diseases, DHS)

- **Overweight and Obesity**: Childhood and adult obesity pose a significant health risk. In Coos County, 41% of adults are classified as overweight and 23% as obese as compared to the *state rates of 37% overweight, and 20% obese.*

- **Tobacco Use:** More cigarettes are consumed for the first time at the age of 12 than any other age according to 8th graders surveyed for the YRBS for 2005. Adult smoking ranks highest in the state at 27%, state rate 21%. Percent of women who smoke during pregnancy is 23%, almost twice the state rate of 12%. Approximately 25% of Coos County deaths in the county are related to tobacco use**.** (2005 DHS Fact Sheet for Coos County) 80% of Coos County residents agree that people should be protected from secondhand smoke. Approximately 600 employees working in Coos County are not protected by Oregon's Smoke-Free Workplace Law. (2005 TPEP)

- **Suicide:** There were 24 suicides in 2004 (13 in 2003). There were 15 attempted suicides reported in teens during 2004.

Some Public Health successes are:

- ✓ The teen pregnancy rate (age 10-17) has declined over the past 5 years, with a rate of 10.2 in 2002, 7.8 in 2003, and 7.3 in 2004 (state rate 9.5 in 2004). However, preliminary data for 2005 show an increase in the teen pregnancy rate to 9.1.
- ✓ The rate of mothers who receive adequate prenatal care has improved. In 2003, Coos rate was 93.8% (state: 94.5%); in 2004, Coos 91.8% (state 94.2%).
- ✓ The rate of very low birth weight babies continues to improve from 15.5 per 1000 births in 1999 to 4.8 in 2003, although the rate increased to 17.2 for very low birth weigh in 2004, the rate for all low birth weight (59.6) remained below the state's rate for 2004 (60.5).

ADEQUACY OF the 5 BASIC SERVICES (Required by ORS 431.416)

1. Epidemiology and control of preventable diseases and disorders

Public Health staff (public health nurses, environmental health specialists, and the health officer) follow up on any confirmed or suspected cases of 42 diseases and 9 other conditions for which medical providers and labs in Coos County are required by law to report to the health department. We coordinate these reports with state public health. We work to identify the cause or source of any outbreak, identify those who have been exposed to communicable disease, provide health guidance and preventive measures, when appropriate and available (e.g., vaccines and medications) and work to prevent the spread or recurrence of disease. Our health department's lab also reports for any clients that we have diagnosed in our clinic. Staff in this program provide consultation to health providers in the community and education to the general public on communicable diseases. Investigation of all communicable disease reports is initiated within the current time lines provided to us under our state assurances. Completion of investigation forms and submission to DHS/HS is also within these time lines.

To respond to the CD pager calls on a 24/7 basis, all nurses in the department have been trained in basic CD investigation, as well as 2 environmental health specialists. A large outbreak or public health emergency would require far greater resources than this department has available.

2. Parent and child health services, including family planning clinics (ORS 435.205)

Nurses provide home visitation in Babies First!, Parents as Teachers, and CaCoon. Healthy Start in our county has been provided by a private non-profit agency. Parent educators, both nurses and public health aides, who are supervised by a nurse, use the Parents As Teachers curriculum, and nurses augment their visits with the Babies First! protocols. We have a limited staff in CaCoon, and we try to stretch our resources to serve the children with special health care needs. This past year we have increased our focus on adolescent clients.

Our maternity case management program will be provided by 1.6 FTE nurse this next year. Due to the poor Medicaid reimbursement rates, we are concerned about the ability to fund it in the future. Grant funds from the March of Dimes will help to provide services to some women this coming year.

We have contracted out a nurse to work .5 FTE in the DHS's Self Sufficiency JOBS Program to help their case managers with health assessments. We also contract with Coos County's Mental Health Department to provide .5 FTE nurse, who does infant and family mental health counseling. Our Field Services Supervisor serves on the DHS-SSP Conciliation Board and also the Multi-disciplinary team.

All Parent Educators provide parent education, advocacy, and support to parents. In addition, we focus on prevention of family violence, prevention of, or intervention for substance abuse, SIDS risk reduction, child nutrition, immunizations, child safety, developmental screening, and case management. All home visitors in the Healthy Beginnings program are supervised by an experienced Public Health Nurse with a Masters in Public Health. All of our home visiting programs work to prevent child maltreatment through the provision of services that strengthen families. Our home visiting programs are highly accessible as we provide services throughout Coos County. Our programs are in demand, and we usually have clients on a waiting list. For

this coming year, we will have 4 FTE nurses in home visiting, 1 FTE nurse contracted to other programs, and 1.1 FTE paraprofessional parent educator.

According to the service data for Oregon Title X Family Planning Agencies, there are 3,032 *women in need* (WIN) in our county between the ages of 13 and 44. We served 1,793 of those WIN clients in 2004, or 59.1%, (compared to 53.4% the previous year) *State average 2005: 34.8%*). Of the estimated number of teens in need of services (n=772) we served 81% (n=629). Our contraceptive services are estimated to have averted 338 pregnancies. The teen pregnancy rate in the county continues to decline and has been below the state average, although preliminary data for 2005 show an increase in the teen pregnancy rate.

3. Collection and reporting of health statistics.
We register all births and deaths in Coos County and forward the information to the state, as required by administrative rules. In addition to the County Registrar, our lead deputy registrar, who is available full time, has backup support from 3 other individuals who serve as deputy registrars.

4. Health Information and Referral Services.
All health department programs provide health information and referrals to programs within our agency and also to outside agencies that can help meet needs that are beyond the scope of our agency. Examples include referring a person with AIDS for housing, referring a pregnant woman to a medical doctor for prenatal care, referring a young parent for food stamps. Our support staff who answer the main switchboard spend significant time as a referral source. We strive to keep up-to-date on our community resources and our referral lists current. Health education, with a prevention focus, is also a key component of our public health programs.

5. Environmental Health Services
The Environmental Health program licenses and inspects restaurants, motels, RV parks, pools, spas, and organizational camps. Our environmental health specialists teach and certify food handlers and also provide food service manager training. To protect from food-borne illnesses, we license and inspect temporary food events that are open to the public. We also investigate reported cases of food-borne and water borne illnesses. We monitor small public water systems and perform septic loan inspections. We also inspect correction facilities, school kitchens, and daycare centers.

For the on site sewage disposal system within Coos County, the Oregon Department of Environmental Quality (DEQ) maintains all regulatory oversight. Our department is considering delegation for this function.

Solid waste is not regulated by this department. Individual cities have independent solid waste ordinances, as does Coos County. Our staff frequently receive nuisance complaints related to illegal dumping and make referrals to the applicable jurisdiction for code enforcement. Privately operated Sanitation/Garbage companies handle the majority of domestic solid waste within Coos County. Beaver Hill Disposal Site is the only solid waste disposal site within the county and is operated by Coos County. Regulatory oversight is provided by the DEQ.

Staff consist of two full time Environmental Health Specialists with .5 FTE clerical support.

The following describes the **adequacy of services the Health Department should include or provide for in programs, according to OAR 333-014-0054.**

1. Dental.
The water system serving our largest populated area has fluoridated water, but many others in our rural county are on small water systems or private wells. Dental awareness is conducted through WIC and home visiting programs, and nurses conduct visual "lift the lip" exams with children 0-5 during home visits. Care for children's teeth is discussed, and brochures on baby bottle tooth decay and toothbrushes are distributed.

2. Emergency Preparedness.
Our department's role in a declared emergency is to coordinate the health system response throughout the county. In response to a bioterrorist event or other public health emergency, we would also work to protect the public's health by preventing additional exposure to communicable agents and provide counter measures, such as vaccine and antibiotics. Staff have been working with the County Emergency Management staff to update the medical portion of the County's Emergency Response Plan and improve the emergency communication processes within the county. We meet monthly with community partners to work on health system issues in emergency response.

3. Health Education and Health Promotion.
Health education and promotion are components in all Health Department programs. Examples include breastfeeding support in WIC; food handler training; parent education for parents of newborns; refusal skills in the STARS abstinence program; correct use of child safety seats in vehicles; safer sex practices for persons with HIV; meal planning for persons with diabetes; and self-management techniques for persons with chronic diseases.

4. Laboratory Services.
Our department has a CLIA certified moderate complexity lab that we use to provide limited diagnostic and screening tests for our clients in the family planning and sexually transmitted disease programs.

5. Medical Examiner
The Medical Examiner in Coos County works out of the District Attorney's office.

6. Nutrition.
Nutrition education and counseling is the primary focus of the WIC program. Nutrition counseling is also a component in our maternal child services, family planning, diabetes project and Ryan White services. Funds have not been available to do community-wide promotion activities, e.g., for weight control and prevention of heart disease.

7. Older Adult Health.
This department provides flu shots and other immunizations to our older population. Eligible women age 50-64 receive mammograms and pap tests through our breast and cervical cancer screening program. We also provide a *Well Woman* exam, which includes a pap smear, for

women who are not seeking, or are not eligible for contraceptive services. Older adults may receive services through Ryan White (for those with HIV) and benefit from the community education targeting older adults in our diabetes project. Our department does not have funds to target other important health issues for elders, such as arthritis and cardiovascular health.

8. Primary Health Care.

Our department does not provide primary health care. We assist with the application process for the Oregon Health Plan, and we refer to local medical providers, including the local safety net providers in the Waterfall Clinic. We were successful in receiving a federal grant in a collaboration with Waterfall Clinic and other health provider to increase access to primary care (*Healthy Communities Access Program*). This grant, which is ending in August, has expanded the processes established through Oregon Mothers Care (in helping pregnant women get into prenatal care and apply for financial assistance) to all persons without insurance who are seeking medical care. The HCAP staff also help clients with prescription assistance programs. With the cutbacks on the Oregon Health Plan eligibility, however, the numbers without health insurance are increasing.

9. Shellfish sanitation.

Services are provided locally through the Oregon Department of Agriculture (ODA). Commercial shellfish harvesting is regulated by ODA under ORS 622 and standards set by U.S. Food and Drug Administration. ODA provides routine updates to the public and Coos County Public Health on status of shellfish harvesting in specific coastal areas. If circumstances warrant, Coos County Public Health may take additional steps to alert the public to related sanitation issues.

Action Plans

For

Each of the Five Basic Services

Control of Communicable Disease
Action Plan 2005/2006

Current Condition or Problem:

Oregon Vital Statistics show that Coos County had 211 reported cases of selected notifiable diseases during CY 2005. The counts and trends are as follows: AIDS – 1 case; HIV - 0 cases (4 in 2003); Chlamydia –115 cases, (130 in 2004); Gonorrhea – 2 cases, (7 in 2004); Hepatitis A - 0 cases (5 in 2004); Hepatitis B (acute) – 1 case (2 in 2004); Hepatitis C chronic – 48 cases; Pertussis – 5 cases (3 in 2004); Meningococcal disease – 3 cases; giardiasis – 8 cases.

1. Coos County Public Health (CCPH) continues to respond to communicable disease calls 24/7. We have trained 12 individuals in basic BT/CD Epidemiology (CD 101), and 4 have completed CD 303 also. Of the 12 with basic training, 9 have participated in the 24/7 emergency communicable disease communication system. Two Environmental Health Specialists are also trained in CD 101 and 103, and participate by responding to questions and concerns when it is applicable to their field.
2. Investigations of reportable conditions and communicable diseases are conducted, control measures are carried out, and investigation report forms are completed and submitted as per the CHLO & Oregon Communicable Disease Guidelines.
3. On-going training of staff is aimed at improving our ability to work in coordination with all of our community partners to improve communicable disease response. These partners include, but are not limited to: local hospitals, emergency medical services, fire, police, county emergency management, local volunteer agencies, local CERT teams, and state communicable disease personnel.
4. Immunizations for human target populations, such as those at risk for Hepatitis, are available here in the Health Department. Rabies immunizations for animal target populations are available within our jurisdiction, and rabies treatment inoculations are available locally at Bay Area Hospital.
5. We continue to receive and distribute public health alerts. Information is provided to the local providers via fax broadcast, e-mail and local media. We will continue to test this system periodically to identify any problem areas, and to keep all the contact information updated. This system is also in place for contacting City Municipalities, Public Safety Officers (fire & police), and veterinarians.
6. We are using the Oregon Alert system within our department to provide another means of communicating information for our emergency response.
7. CCPH continues to work closely with Oregon Health Services/ Acute & Communicable Disease Program (OHS/ACD). We have contacted the on-call epidemiologist after working hours on more than one occasion, and have had success using the OHS/ACD paging service. The epidemiologist on call has returned our call in a timely manner and has been able to assist us in the investigation via telephone consultation.

Goals:

- To continue to be prepared to identify and respond to reports of communicable disease outbreaks 24/7.
- To continue to complete and submit CD investigation documentation within the mandated timelines, > 90% of the time.
- To continue to provide education to the community on protection from potential illness and/or exposures.

Activities:

- Maintain "on call" pager schedule for trained CD staff for 24/7coverage.
- Distribute information received from CDC, Health Alert Network, and other sources to appropriate community partners.
- Continue active & passive surveillance of community illness/reportable diseases and/or syndromes.
- Update the county website with pertinent information on communicable diseases and/or public health preparedness topics.
- Train nurses new to the department in CD response, and provide continuing education to the public health staff about their duties and responsibilities during a communicable disease outbreak.
- Work with Tribal officials for a coordinated response to outbreak investigations.
- Investigate all reported communicable diseases/conditions within the guidelines provided by CHLO.
- Continue to test current communication capabilities, such as fax and email, with all local partners to ensure ability to distribute information during emergency situations.
- Make contact with the local laboratories and infection control practitioners on a periodic basis to encourage reporting.

Evaluation:

Meet the performance time lines for investigation and submission of forms to DHS/ACD.
Log the number of community outreach activities.
Tabulate the results of communications testing.

Tuberculosis – Action Plan 2006/2007

Current Condition or Problem:

One active case of Tuberculosis was identified in Coos County in 2005. We also had several cases that were suspicious for active tuberculosis and required investigation to rule out disease. Fortunately these were found to either be Mycobacterium Avium or other diseases which were not transmissible to others in the community.

Latent tuberculosis infection (LTBI) continues to be identified in the county. Last year we followed 1 patient with LTBI treatment. We currently have 3 patients on medication for this. These numbers are down from 2003 when we had 15 LTBI patients. Most cases have been identified during testing for purposes such as immigration, employment, and school admission.

Goals:

- Accurately identify active and latent TB cases in the community.
- Ensure that the active tuberculosis cases receive Directly Observed Therapy (DOT) for the duration of therapy appropriate to their case.
- Contact all persons with latent disease to discuss the appropriateness of antibiotic therapy.

Activities:

- Public health nurses and the Health Officer will continue to work cooperatively with Department of Human Services/Health Services and local medical providers to provide evaluation of positive PPD skin tests.
- Provide state supplied medication at no cost to those clients without medical insurance and/or limited resources when appropriate.
- Ensure that follow-up sputum testing is done at the appropriate intervals during treatment of active TB.
- Provide TB testing via the PPD method as requested and provide timely follow-up testing and treatment for any contacts to a person with known or suspected active TB, using the investigative guidelines.
- Submit appropriate completed forms to the state TB division at the initiation of therapy, as further information is available, and at the completion of therapy for both active and latent disease.

Evaluation:

- Timely investigation and identification of index cases and contacts.
- Accurate and complete documentation of completion of treatment and/or case management of clients, according to CCPH protocols.

Challenges:

Provision of DOT to active cases of TB is a challenge due to budget constraints at the local level, and minimal financial support for this work from the state. The state does continue to provide the appropriate medications for treatment of both LTBI and active TB to the county at no cost. The actual cost for follow up and management of active TB cases requiring DOT far exceeds the amount of funding provided. Patients with latent disease are seen and evaluated monthly, requiring allocation of nursing hours, and administrative costs. We will continue to provide services to the best of our ability. However, lack of resources may limit our response capability, eventually, and that will result in a risk to the community. Active tuberculosis, if untreated, could lead to an epidemic with devastating consequences.

Plan A - Continuous Quality Improvement: 4th DTaP rate at the Coos County Health Department
Fiscal Years 2006-2008

Year 1: July 2005 – June 2006				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Develop a plan to increase the 4th DTaP rate 10% over the next 3 years.	• Use AFIX to assess the baseline rate of the 4th DTaP. • Develop a P&P to increase the 4th DTaP rate. The P&P will include forecasting the 4th DTaP, when to administer the 4th DTaP, and a template letter about the increase of Pertussis in Oregon and the importance of the DTaP series. • Use AFIX to identify children ≥24 months of age who have not received the 4th DTaP, and mail a copy of the letter to their parents. • Use AFIX to reassess the 4th DTaP rate.	• Determine baseline rate of the 4th DTaP by July 1, 2005. • Develop and implement the 4th DTaP P&P by October 1, 2005. • Identify children ≥24 months of age, and mail a copy of the letter by October 31, 2005. • Reassess the 4th DTaP rate by April 30, 2006.	• The 4th DTaP rate in 2004 was 59%. • The 4th DTaP P&P was approved and implemented on March 29, 2006. • ~ 25 letters were mailed in Dec 2005. ~ 50 letters were mailed in Mar 2006. • The 4th DTaP rate in 2005 was 71%.	The P&P includes a reminder system for children 2-35 months. The system includes 248 children. Additional time was needed to review records in Ahlers, IRIS, and ALERT, the Oregon immunization registry. Some children had duplicate records in Ahlers, IRIS, and ALERT that needed to be merged. Before duplicates could be merged, data needed to be verified to determine that the records were for the same child and not two different children. If DTaP dose #2 or #3 is due, a reminder postcard is mailed. If DTaP dose #4 is due, the 4th DTaP letter is mailed. Reminders are mailed monthly. The Health Department increased the 4th DTaP rate over 10% during the last year.

Plan A - Continuous Quality Improvement: 4th DTaP rate at the Coos County Health Department

Year 2: July 2006 – June 2007				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results**	**Progress Notes**
A. Increase the 4th DTaP rate 5% in 2006.	• Evaluate the effectiveness of the 4th DTaP rate P&P and revise as needed. • Monthly reminders will be mailed to the parents of children 2-35 months of age who are due for a DTaP. • Obtain annual AFIX assessments of the 4th DTaP rate. • Use AFIX to reassess the 4th DTaP rate.	• Revise the 4th DTaP rate P&P as needed by December 31, 2006. • Reminders will be sent by the last business day of the month. • Annual AFIX assessments will be obtained during the annual Immunization Conference. • The 4th DTaP rate will increase 5% during 2006.	To be completed for the FY 2007 Report	To be completed for the FY 2007 Report

Plan A - Continuous Quality Improvement: 4th DTaP rate at the Coos County Health Department

Year 3: July 2007 – June 2008				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results**	**Progress Notes**
A. Increase the 4th DTaP rate another 5% in 2007.	• Hold a meeting with Maria Grumm, PHN, from the DHS IZ program to educate staff regarding dealing with parents opposed to multiple immunizations. • Obtain annual AFIX assessments of the 4th DTaP rate. • Use AFIX to reassess the 4th DTaP rate.	• The meeting to educate staff will be in September 2007. • Annual AFIX assessments will be obtained during the Annual Immunization Conference. • The 4th DTaP rate will have increased 5% in 2007.	To be completed for the FY 2008 Report	To be completed for the FY 2008 Report

Plan B - Chosen Focus Area: Vaccine Accountability with Private Providers Fiscal Years 2006-2008

Year 1: July 2005 – June 2006

Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Develop a plan to decrease the five private provider's VFC vaccine unaccountability rate to <5% over the next 3 years.	• Use ALERT to assess baseline vaccine unaccountability rates for each of the five private clinics that provide VFC vaccine. • Obtain Standard Operating Procedures (SOPs) from the DHS for vaccine management. • Work with each of the five private providers to develop SOPs for their clinic.	• Baseline unaccountability rates for the five private clinics will be assessed by October 1, 2005. • SOPs will be obtained by January 1, 2006. • All private clinics that provide VFC vaccine will develop SOPs by June 30, 2006.	• The HD is unable to access unaccountability rates due to the private clinics confidentially rights. • SOPs were obtained by January 1, 2006. Copies were mailed to the five private clinics on March 21, 2006. • On March 21, 2006, four of the five private clinics had written P&P regarding vaccine management.	During the 2005 Annual Immunization Luncheon, Jenne McKibben, DHS Health Educator, discussed storage and handling of vaccine. Also in 2005, the five private clinics that provide vaccine in Coos County completed an accountability check list. According to the results, all five clinics are in compliance with the DHS guidelines for vaccine storage and handling. Four of the five private clinics have written P&P in place for vaccine management. All five clinics have been provided copies of the DHS SOPs to update/develop their P&P for vaccine management as needed. Coos County Health Department had met its goal in educating the private clinics regarding vaccine management, and will be changing the focus for the next two years to developing an immunization coalition.

Plan B - Chosen Focus Area: Developing an Immunization Coalition

Year 2: July 2006 – June 2007				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results**	**Progress Notes**
A. Develop an immunization coalition.	• Identify agencies interested in participating in an immunization coalition. • Hold two immunization coalition meetings. • Identify the immunization coalition goals and action steps for the next two years.	• The immunization coalition will include participation from the Health Department, Bay Area Rotary Club, Bay Area Hospital, Coquille Tribe, North Bend Medical Center, Bay Clinic, and Powers Clinic. • The first immunization coalition meeting will be held by October 1, 2006. The second immunization coalition meeting will be held by April 1, 2007. • The immunization coalition goals will be identified during the first meeting. The goals will then be reassessed during the second meeting.	To be completed for the FY 2007 Report	To be completed for the FY 2007 Report

Plan B - Chosen Focus Area: Developing an Immunization Coalition

Year 3: July 2007 – June 2008				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results**	**Progress Notes**
A. Maintain the immunization coalition.	• Hold immunization coalition meetings biannually. • Develop an immunization resource list to distribute to coalition partners. • Reassess the coalition goals.	• Immunization coalition meetings will be held in October and April. • A list of immunization resources will be distributed to partners during the October meeting. • The coalition goals will be reassessed during the April meeting.	To be completed for the FY 2008 Report	To be completed for the FY 2008 Report

Outreach Activities: July 2005 – June 2006

Activity 1:

Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Educate three state-certified daycares and/or preschools staff regarding immunizations and Oregon state law.	• Perform three validation surveys with assistance from Amanda Timmons, DHS Health Educator on School Law.	• **Select three daycares and/or preschools by April 1, 2006.** • **Perform three validation surveys by May 2006.**	• Four daycares/preschools were selected by April 1, 2006. • Dates for the validation surveys are pending.	Amanda Timmons is currently scheduling dates for the validation surveys.

Activity 2:

Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results[1]	Progress Notes[2]
A. Educate public and private providers on ways to increase immunization coverage rates.	• Assist with the annual AFIX meeting to be hosted by the DHS IZ program AFIX team.	• The annual AFIX meeting will be held in June 2006.	• The annual AFIX meeting is scheduled for May 11, 2006.	Plans for the annual AFIX meeting are currently in progress. Amanda Timmons will also be present to discuss school law and the ACIP schedule.

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Increase Access to Early and Adequate Prenatal Care – Action Plan 06/07

Current Condition or Problem
In 2003, 6.2% of pregnant women in Coos County received inadequate prenatal care (defined as fewer than 5 visits before the third trimester), compared to the state rate of 5.5%; in 2004, 8.2% of the pregnant women received inadequate prenatal care, compared to the state rate of 5.8%. In 2003, 79.4% of all pregnant women in Coos county received prenatal care in the first trimester compared to the state rate of 81.1%, and in 2004, 78.2% of pregnant women in Coos County received prenatal care in the first trimester, compared to the state rate of 80.4%.

Of the women enrolled in our Maternity Case Management program this past year, 84% received prenatal care during their first trimester. This reflects a significant change from the previous year of 47%. Significant improvement in 2003-2005 may be attributed to our Health Communities Access Program (HCAP) and Oregon Mother's Care programs, helping women sign up for the Oregon Health Plan and access prenatal care earlier.

The following statistics reflect the 94 women served in our Maternity Case Management program for the 2004-2005 year:

- 78% received early prenatal care (within the first trimester of pregnancy)
- 76.1% were unplanned pregnancies
- 98.6% had nutritional risk factors
- 91.4% had oral health issues
- 66.2% were unmarried compared to the county rate of 42.9% and the state rate of 32.5%
- 36.0% of women were 19 years or younger, compared to the county rate of 12.2% and the state rate of 8.8%
- 29.0% had less than a high school education
- 39.3% were victims of domestic violence
- 40.9% had a current or history of mental health issue(s)
- 29.6% used tobacco compared to the county rate of 23.5% and the state rate of 12.6%. Of those MCM clients who smoked, 56.8% quit or decreased their smoking during their pregnancies.
- 19.4% admitted to using alcohol, compared to the county rate of .9% and the state rate of 1.5%. Of those MCM clients who drank, 100% quit during their pregnancies.
- 16.2 % admitted to using or having used drugs compared to the county rate of 3.9% and the state rate of 1.8%. Of those clients who admitted to using drugs, 72.7% quit during their pregnancies.
- 15.3% of births were premature.
- 15.4% of infants had birth weights < 2500 grams, compared to the county rate of 7.7% and the state rate of 7.1%

Client satisfaction surveys showed an average score of 4.9 out of a possible 5, achieving our 2005 goal.

Early prenatal care is important because:

- Complications to mother or fetus can be identified early and managed.

- There is adequate time to make referrals to smoking/drug/alcohol cessation programs, as substance use has been associated with low birth weight babies, preterm labor, sudden infant death syndrome, stillbirths, ectopic pregnancies, fetal alcohol syndrome, birth defects, and other conditions.
- Existing medical problems, such as hypertension and diabetes, can be better managed. (If uncontrolled, these have been associated with poor pregnancy outcomes for both mother and fetus.)
- It allows time to address psycho-social issues and make referrals to other agencies such as WIC, DHS-SSP, and the Housing Authority, to address a client's basic needs.

The identified barriers to early prenatal care include the following:

- Denial of pregnancy or lack of recognition of pregnancy until later into the gestational period.
- Procrastination.
- Low education levels.
- No medical insurance.
- Ignorance of the Oregon Health Plan requirements and difficulty with the application process.
- Drug/alcohol issues.
- Language barriers for Spanish speaking population (difficulty applying for OHP, communicating with prenatal care providers, few materials translated, few staff who speak Spanish).

Other access problems to prenatal care that have been identified include:

- Clinics requiring those without health insurance to pay 50% down of the total package cost before receiving prenatal care services.
- Lack of prenatal care providers in areas outside North Bend/Coos Bay; lack of prenatal care providers who speak Spanish.
- Lack of transportation to medical services, especially with the decrease in frequency of bus routes/stops.
- Late (after the first trimester) referrals to the Health Department for Maternity Case Management (MCM) and other services by other community providers.

Goals

- Increase access to comprehensive prenatal care by addressing barriers.
- Increase the percent of pregnant women who initiate prenatal care within the first trimester by 5% over the 2005-2006 baseline.
- High level outcome: **Strong nurturing families and healthy striving children.**

Activities

- Assist pregnant clients with applications to the Oregon Health Plan and facilitate pregnant women's first appointments with prenatal care providers, through the Healthy Communities Access Program (HCAP) and Oregon Mother's Care (OMC). To those women referred through OMC, providers have agreed to provide prenatal care without the 50% down payment.

- Refer pregnant clients from internal Public Health Department programs such as WIC and pregnancy testing to HCAP and MCM programs, and promote these services, as well as other agencies that serve pregnant women.
- Provide prenatal and postpartum home visits through the Health Department's MCM program. Home visiting nurses support pregnant women in maintaining prenatal care and healthy behaviors that support positive pregnancy outcomes.
- Coordinate distribution of prenatal vitamins to eligible women per March of Dimes grant guidelines.
- Continue to meet monthly and work with the Perinatal Task Force (PNTF) to assess and plan ways to improve the early prenatal care rates in Coos County. The PNTF includes representatives from Bay area Hospital, Public Health, DOCS – Independent Practice Association, A & D treatment, and several physicians..
- Assist with the Perinatal Task Force's new perinatal depression group, "Life with a New Baby in the Home," that provides 4 weeks of education to pregnant and postpartum mothers, and a follow-up support group.
- Continue to promote the importance of dental care during the second trimester of pregnancy to prenatal care providers and work with local dental providers in ensuring dental care is offered/provided to pregnant women in a timely fashion.
- Collect specific data on infant gestation, birth weight, birth defects, and maternal use of substances and their quit rates during pregnancy.
- Work with the Latino Outreach Committee to address barriers to providing services to the Spanish-speaking population.

Evaluation

- ✓ Improvement in the rate of pregnant women who receive first trimester prenatal care.
- ✓ Maintaining a score of 4.5 or better (out of a possible 5) on a satisfaction survey of clients served in the Maternity Case Management Program.
- ✓ Number of pregnant women served through Healthy Communities Access Program who have successfully initiated prenatal care.
- ✓ Log of the number of community outreach activities.

Challenges

- The state support for perinatal services is insufficient for the number of women who can be served with Maternity Case Management.
- The medicaid reimbursement rate for MCM services does not reflect the actual cost of providing these services.
- Barriers to access for adequate and timely oral health for pregnant women include: transportation; few dental providers accepting the OHP, resulting in long waits for an initial appointment; the requirement for the client to confirm the appointment the day before, or else it is cancelled; overall poor oral health status prior to pregnancy; and lack of oral health education prior to enrollment in the MCM program.

Infants and Children Will Have Nurturing Caregivers (and Decreased Child Abuse)
Action Plan 2006 - 2007

Current Condition or Problem

In 2003, Coos County was tied for 4th highest in Oregon for child abuse (Children's First County Data Book), with a rate of 22.1 per 1000 children, which was 189% worse than the state rate. This has improved since 1999 and 2000, when our county had the highest rate of child abuse per 1000 children under age 18. According to the 2004 statistics, the Coos County victim rate had improved to 15.6 per 1000. In the first quarter of 2006, Coos County has 167 children in foster care, with 81 of these children ages 0-5 years. About 26% of all children in foster care are placed with relatives, with this percent fluctuating up to 35% this past year.

Major family stressors that contribute to Coos County's child abuse/neglect rates are drug and/or alcohol abuse, parental involvement with a law enforcement agency, unemployment, and domestic violence. Other contributing factors are: low income, limited education, and poor parenting (the most prevalent factor according to the Child Welfare System). However, poor parenting is often generational and may be influenced also by the factors listed above.

Goals

Reduce child abuse and neglect.
High level outcome: **strong nurturing families and healthy thriving children.**

Activities

Research shows that early intervention into the lives of families, beginning in and including the prenatal period, has a high impact on parental success and lessens child maltreatment.

- Provide prenatal and postpartum home visits through the Department's Maternity Case Management (MCM) program. The visits by the nurse support pregnant women in maintaining prenatal care and healthy behaviors that support good outcomes in pregnancy and preparation for parenting.

- Educate mother in the MCM program about healthy lifestyle choices related to nutrition, importance of avoiding tobacco, drugs and alcohol.

- Educate mothers in the MCM program about common parenting topics such as parent-infant bonding during prenatal and postpartum periods, parental frustrations, sleep deprivation, child nurturing/protection, infant communication/bonding, and signs of postpartum depression.

- Educate mothers in the MCM program about key infant care topics such as well-child care, immunizations, safety/emergencies, lead exposure prevention, feeding/nutrition, sleep patterns/position, and child passenger safety.
- Provide home visits through the **Babies First!** program for children at risk of developmental delay due to a variety of risk factors including: premature birth; drug

exposed infant during pregnancy; low birth weight; age of the parent/caregiver; low income/ poverty and many other factors. **Babies First** targets children from birth to age three. Potential problems can be detected quickly and interventions started and monitored regularly. Public health nurses conduct in-home health and developmental screening for participating children on a regular basis. The nurses work closely with the families on parenting skills, health education, advocacy, and referrals to services in other agencies. **Babies First** focuses on helping families learn to care for and better understand their children. Case management activities help link families to needed community resources and providers.

- Provide monthly home visits (or more often if needed) after birth and up to age 5, in the **Parents as Teachers** program. Parent educators (nurses or paraprofessionals) use a best practices curriculum to help parents learn positive parent-child interactions, child development, realistic expectations, and coping skills. The program provides information and guidance to reduce child abuse and neglect and promote "readiness to learn." During the visits, educators help parents understand what to expect in each stage of their child's development, and offer practical tips on ways to encourage learning, manage challenging behavior, and promote strong parent-child relationships. Screening is done for overall development, language, hearing, and vision. Case management activities help link families to needed community resources and providers.
- Provide nursing case management for children with special health care needs through the **CaCoon** program. Nurses assist parent with medical, nutritional, and developmental issues and promote positive coping skills. Parents are helped to identify and prevent problems related to their child's special health condition. Screening is done for growth and development and referrals are made into early intervention when needed. Nurses also coordinate health care and specialty services.
- Assist with the newly formed perinatal depression group, which was recently formed through a collaborative effort of our local Perinatal Task Force. The depression group consists of a 4 week curriculum "Life with a New Baby in the Home," that is then followed by a support group for those who have graduated from the class. Since research shows that new moms who have a history of depression often miss or misinterpret their babies' cues, this intervention for the mothers' depression can be important for the ultimate development of the mother/child attachments.

Evaluation

For families served by **Maternity case Management:**

85% of the families surveyed and enrolled will state:

1. services helped them feel more confident about becoming a parent.
2. services provided them with information about what to expect during pregnancy and birth during the newborn period.
3. services resulted in their being informed of helpful resources in the community.

For families served by **Parents as Teachers:**

- Families needs will be identified in 100% of clients.

- 80% of parents will demonstrate positive child-rearing competencies and improved parenting skills
- 80% of parents will demonstrate positive parent-child interactions.
- 80% of parent s will demonstrate increased knowledge about child development.
- 80% of parents will demonstrate developmentally appropriate expectations.
- 90% of parents will have no confirmed case of abuse/neglect after enrollment into Parents as Teachers
- 90% of enrolled parents will self report improved access and utilization of services
- 90% of parents will report supportive relationships with others

For families served by **Babies First and CaCoon**:

- evaluations will be conducted by the state, and our staff will participate as needed.

Decrease Prenatal Tobacco Use – Action Plan 2006/2007

Current Condition or Problem

Smoking during pregnancy is a problem for the fetus, because nicotine passes the placental barrier and the carbon monoxide in tobacco smoke combines with hemoglobin to reduce the oxygen-carrying capacity of the blood. These factors contribute to complications such as slower fetal growth, low birth-weight, an increased risk of miscarriage, premature labor, an increased risk of stillbirth and pre-term delivery. These babies also have a greater risk of developing health problems within a few months after birth, such as asthma, allergies, ear infections, sudden infant death syndrome (SIDS), and lifelong disabilities. In addition, there is a possible link between smoking by a mother and attention deficit disorder (hyperactivity) in children.

According to the Oregon DHS Center for Health Statistics for 2004, 23.5% of pregnant women in Coos County used tobacco, nearly twice that of the state rate of 12.6%. Currently, Coos County is ranked 4th highest in the state for pregnant women who smoke. Although current figures are much lower than they were in 1997 when Coos County was ranked 1st in the state for pregnant women that smoked (with a rate of 36%), they are still alarmingly high.

Nearly 30% of the women enrolled in our Maternity Case Management (MCM) program in 2004-2005 used tobacco products during their pregnancies. While we may have had a disproportionate number of smoking women enrolled in our MCM program compared to the county, 56.8% of these women were successful in their efforts to quit or decrease their smoking.

Goals

- Decrease the number of pregnant women who use tobacco from 30% to 25% or less
- Increase the number of tobacco interventions given by health care providers to women of childbearing age
- Continue to offer 5As cessation trainings to health care providers
- Promote the use of the Oregon Tobacco Quitline by Coos County residents as well as other quitlines (such as Great Start) and smoking cessation resources (such as Fresh Start Family)

Activities

- Continue to use the 5As of cessation protocol in home visiting programs, WIC, and during family planning visits for women of childbearing age.

- Continue to offer/provide 5As cessation and motivational counseling trainings to various community partners including the Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians, Bay Area Hospital, prenatal care providers, and other health care providers who request assistance

- Continue to participate in the Clean Air Coalition and work with community partners to increase awareness and knowledge of the dangers / consequences of tobacco use during pregnancy.

- Continue to promote established cessation programs to prenatal care providers, case management providers, and healthcare personnel.

- Continue to refer to the Oregon Tobacco Quit Line, and local cessation programs.

Evaluation

- WIC, Family Planning, MCM, and other home visiting programs will track the smoking status of their clients
- The 2005 Oregon DHS Center for Vital Statistics database will show a decrease in the number of pregnant women in Coos County who use tobacco

Family Planning -- Action Plan 06-07
Reduce the Risk of Unintended Teen Pregnancy
Assure High Quality Family Planning Services

Current Condition or Problem

Coos County Public Health Department may be the only place in Coos County that many women and teens can obtain correct information about sexuality issues and confidential, quality care and contraceptives at no cost to them. In 2005, there were 3,032 *women in need* (WIN), ages 13-44, according to Region X data, and our family planning clinic served 1,793 unduplicated clients (ages 10-44), or 59.1% of the WIN, compared to 34.8% served by the state as a whole. The data also showed that there were 772 teens 13-19 year olds in need of services, and our clinic served 629 teens, or 81%. Teen clients comprised 31% of the total clients that were seen in the Family Planning Clinic, without considering WIN statistics.

Our teen pregnancy rates have decreased over the past few 5 years, with a rate of 10.2 per 1000 girls age 10-17 in 2002, 7.8 in 2003, and 7.3 in 2004 (state rate 9.5 in 2004). The rolling rate for 2005, however, shows an increased rate of 9.1. The rolling rate for 2005 rises sharply to 21.2 per 1000 if only 15-17 year olds are counted, compared to the rate of 16.5 in 2004. Many of these late adolescent/young adults seem ill equipped for life and parenthood because of low paying jobs and limited ability to improve their earnings in the future because of lack of opportunity and education. The U. S. Census Bureau tells us that in 2000, about 82% of our county young people graduated from high school, but only 15% of persons in the county age 25 plus have a bachelor's degree or higher.

Funding to sustain our family planning services is becoming more challenging. Each year we are serving more clients who are not eligible for FPEP, or Oregon Health Plan and who do not pay for services. Both Title X and county funds have decreased, as have the reimbursement rates from Medicaid.

Goal: ***Reduce the Risk of Unintended Teen Pregnancy***

Activities:

1. Increase the community's knowledge of public health family planning services and the availability of contraceptives to teens.

- Place public service announcements in local papers, radio, and teen school newspapers; provide information on the 5 minute talk shows on TV.
- Encourage staff to join community organizations that relate to public health issues where they can share information about family planning services.
- Participate in programs that target teens, such as Teen Maze, Youth Summit, and provide information about contraceptive services.
- Provide educational programs to schools, when invited.
- Ask teens to describe the best ways to market information to them.

2. Assure clinic services are customer friendly for teens.

- Remove much of the baby-oriented information in the waiting room and decorate it with posters depicting non-pregnant young people doing healthy things.

- Hang a bulletin board that displays teen-friendly posters and education relative to teen issues.
- Obtain magazines that are oriented towards teens and young men.
- Provide appointments for teens within 2 weeks of their attempt to schedule.
- Provide contraceptives through delayed pelvics and at pregnancy testing clinic.

3. To decrease teen pregnancy rates, promote abstinence education and refusal skills.

- Students Today Aren't Ready for Sex (STARS) program will be provided to at least 3 school districts in Coos County.
- Teen leaders will be trained in the curriculum.
- Over 400 middle school students will be reached through the program.

Evaluation: Observe Title X statistics for number of clients served and DHS statistics for number of teen pregnancies. Survey clients to determine how they heard about family planning services.

Goal: ***Assure High Quality Family Planning Services***

1. Continue with the COPE process to address concerns with clinic operations that have been identified by either staff or clients.
2. Conduct chart reviews for quality assurance on a regular basis.
3. Review family planning policies and procedures and assure that staff understand how to implement them.
4. Enable staff to attend family training offered by Region X, through webcasts, conference calls or other means to enhance and assure training in family planning

Evaluation: Compliance with family planning requirements, as determined through state review, scheduled for February, 2007; chart review process; client surveys.

FY 2006 - 2007 WIC Nutrition Education Plan Form

County/Agency: Coos

Person Completing Form: Phyllis Olson
Date: 4-10-2006
Phone Number: 541-756-2020 x520

Email Address: polson@co.coos.or.us

Direct questions to: Sara Goodrich, 971-673-0043

This section asks you to write the nutrition education plan(s) for the fiscal year 2006 – 2007.

Goal 1: Decrease the risk of obesity among WIC participants by increasing physical activity awareness.

Activity 1: **Required**
Assess your community's resources for safe, developmentally appropriate physical activity opportunities for families and their young children and provide a list of these resources to WIC clients.

Implementation Plan: Clients will be given a map of local parks, and free or low cost physical activity opportunities

Timeline: 8-01-2006

Activity 2: **Required**
Make available to clients a 2nd nutrition education opportunity to increase physical activity.

Implementation Plan: The class "Being Active as a Family" will be offered in May and at least 3 more months in 2006.

Timeline: September, 2006.

Activity 1: **Required**
Assess activities and resources in the community to promote fruits and vegetables and provide a list of these activities and resources to WIC clients.

Implementation Plan: We will provide a list of community gardens and farmers markets in the area. We will participate in issuing Farm Direct coupons.

Timeline: September, 2006

Activity 2: **Required**
Develop and implement client-centered activity or event by June 2007 in recognition of 5 A Day.

Implementation Plan: Develop a clinic Bulletin Board devoted to 5 A Day.

Timeline: September 2006

Activity 1: **Required**
Explore options for developing innovative partnerships for providing nutrition education to clients in your agency.

Implementation Plan: Contact OSU Extension and explore cooperating in additional nutrition education using their resources.

Timeline: December, 2006

Activity 2: **Required**
Assess your agency's 2nd nutrition education offerings and make changes as needed to improve your show rates.

Implementation Plan: Offer classes more than once a month and vary times.

Timeline: Evaluate November, 2006

Goal 4: Increase breastfeeding duration rates among WIC participants.

Activity 1: **Required**
Assess breastfeeding resources available in your community and create and/or update a resource list for clients.

Implementation Plan: A breastfeeding resource list for Coos County will be updated and available for clients.

Timeline: October, 2006

Activity 2: **Required**
Implement at least one new strategy to support clients' breastfeeding goals.

Implementation Plan: In coordination with the Coos County Breastfeeding Coalition, 3 major area employers will be contacted with the benefits of breastfeeding and becoming Breastfeeding Friendly Employers.

Timeline: March 2007

Annual Report Form - WIC
Evaluation of Nutrition Education Plan FY 2005-2006

WIC Agency:_Coos
Person Completing the Form ___Phyllis Olson
Date:__4-10-2006

Phone:___541-756-2020

Direct questions to: Sara Goodrich, 971-673-0043

This section asks you to evaluate the nutrition education plan(s) you implemented during fiscal year 2005 - 2006. Answer the questions in "Outcome Evaluation" where a "response" is requested.

Please use the outcome evaluation criteria to assess the activities your agencies did for each Year 2 (i.e. 2005 – 2006) Objective. If your agency was unable to complete an activity, please indicate why.

Goal 1: Decrease the risk of obesity among WIC participants by increasing physical activity awareness.

Year 2 Objective:
During plan period, all WIC families will be provided information on the increasing rates of overweight children and adults and be able to make positive lifestyle choices to decrease the risk of overweight.

Activity 1: Assess client awareness regarding physical activity and identifying client barriers to getting adequate physical activity by using state provided assessment tool. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- What is one result from the client assessments that you have applied in your agency?

Response: Not enough free or low cost physical activity programs for families with young children.

Activity 2: Using results from staff and client surveys, identify or develop, and implement at least one clinic activity to promote increased physical activity and increase awareness of the prevalence of overweight among staff and clients. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- Identify 3 barriers or ideas you learned from the staff and client surveys.
- What clinic activities did you develop to promote physical activity?
- How did the activities address the barriers or concerns identified in the surveys?

Response: Barriers to physical activity were:

Time, expense, and lack of safe areas to be active.
Coos WIC participated in a FIT WIC grant. Classes were held using the "Being Active as a Family" video. Clients from 3-5 years old were given activity bags, a booklet of fun indoor, inexpensive physical activities, lists of local parks, South Slough activity schedule, local swimming pool schedule and fees, and a free pass to Outdoor In (a private indoor play area). These were low cost options in safe places. We focused on short activities, not taking a great deal of time, and activity fitting in with a daily routine.

Goal 2: Increase the percentage of WIC participants who consume at least five daily servings of vegetables and fruits.

Year 2 Objective:

During plan period, staff will assess and promote client consumption of fruit and vegetables.

Activity 1: Assess client attitudes and behaviors regarding fruit and vegetable consumption using state provided tool. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- What is one result from the client assessments that you have applied in your agency?

Response: Fruits and vegetables are expensive. WIC Farmers Market coupons were promoted with ideas on choosing the best values.

Activity 2: Develop and implement a client centered activity or event during September 2005 in recognition of 5 A Day Month. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- What client centered activity or event did your agency implement for 5 A Day month?
- How did your agency decide on this activity or event?
- What went well and what would you do differently?

Response: We displayed a bulletin board with information on fruits and vegetables and ideas on using seasonal produce. We also displayed recipes using fruits and vegetables. We chose this activity due to staff time restraints and because it was highly visible to all clients. The information was well received and we are still hearing requests for more recipes.

Activity 3: Use client fruit and vegetable survey results to develop or modify individual or group nutrition education activities to promote fruit and vegetable consumption. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- Identify 3 client attitudes or behaviors you learned from the surveys.
- What nutrition education activities did your agency develop or modify to promote fruit and vegetable consumption?
- How did the activities address the results from the surveys?

Response: Three identified attitudes were: The expense of fruits and vegetables; whether they are offered frequently or seldom; and response to children's refusal to eat them. We offered a class on Fruits and Vegetables for 2 months. This included the division of responsibility (parents choose what is offered and when and children choose if or how much to eat) and actively involving other family members in produce selection and preparation. We promoted participation in Farmers Market and discussed ideas on choosing the best values.

Goal 3:Increase client participation in 2nd nutrition education contacts.

Year 2 Objective:

Assess clients' attitudes, wants, needs and barriers regarding attendance to nutrition education opportunities; develop guidelines for nutrition education in your agency; and develop strategies to increase client participation in nutrition education. During the planning process, consider the impact of implementation of multiple month food instrument issuance (FLPP).

Activity 1: Assess client attitudes, needs, and barriers to attendance related to 2nd nutrition education using state provided tool.

Outcome Evaluation: Please address the following questions in your response. This activity was required.

- What is one result from the client assessments that you have applied in your agency?

Response: Clients would like to choose day and time for 2nd nutrition education. Classes will be offered twice a month and at varied times. Clients will be advised that they may reschedule for a time convenient for them.

Activity 2: Compare results of client and staff surveys to state nutrition education minimum standards and develop guidelines for quality nutrition education in your agency. Minimum standards will be set in the areas of availability, accessibility, topic, content, delivery methods, marketing, assessment, and evaluation. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- Identify 5 attitudes, needs, and or barriers you learned from the surveys.
- What guidelines did you develop for quality nutrition education?
- How did the guidelines address the results of the surveys?

Response: The client surveys indicated:

1. **Breastfeeding class was indicated as one of the favorite. It will be offered twice a month at varied times.**

2. **Choosing time and day is important. Classes will be offered twice a month and clients will be encouraged to reschedule for a time convenient for them.**
3. **Hands-on workshops were popular and the frequency will be increased.**
4. **Almost half the respondents value videos for nutrition education and they will continue to be offered with group discussion.**
5. **Picky eaters-fruits and vegetables were a choice for more education. These classes will be offered and we will participate in Farmer's Market with an emphasis on child involvement in helping choose and prepare the produce.**

Guidelines for quality nutrition education:

Assessment: Client surveys were administered and sent to state for collation. The results were reviewed and analyzed.

Availability: Class times will vary and clients will be encouraged to reschedule for convenient appointments.

Topic and Content: Client preferences have been noted and these will be addressed in the offerings for the following year. Nutrition education offerings are available for all categories of clients.

Methods: Clients preferred hands on and video format classes and these will be the methods most commonly used.

Marketing: All current staff completed the "Marketing Nutrition Education" module. The new certifier will complete by July 1, 2006. WIC intake staff are reviewing classes offered so they can understand and encourage attendance.

Evaluation: WIC local agency Individual Education attendance from April, 2005 to February 2006 was 61%, Group Nutrition Education attendance was 51%.

After each nutrition education class the participants are asked to fill out an evaluation and these are reviewed and considered for changes that could be made.

Activity 3: Contact your Nutrition Consultant to review your agency's guidelines, then plan and schedule 2nd nutrition education offering in preparation for multiple month food instrument issuance. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- When did you and your Nutrition Consultant review your guidelines?
- How did your 2nd nutrition education plan offerings meet these guidelines?
- Have your 2nd nutrition education offerings been scheduled?

Response: Guidelines were reviewed in September, 2005.
Local 2nd nutrition education offerings met these guidelines.
2nd nutrition education offerings are scheduled on a rotating basis depending on season and interest.

Activity 4: Assure staff who teach nutrition education classes complete the Providing Group Nutrition Education module and the appropriate Level 2 training modules. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- Have all staff who teach nutrition education completed the Providing Group Nutrition Education module and the appropriate Level 2 training modules?

Response: All staff who teach nutrition education have completed the Providing Group Nutrition Education module and the appropriate Level 2 training modules. The new Certifier will complete these modules by October, 2006

Goal 4: Increase breastfeeding duration rates among WIC participants by decreasing barriers to breastfeeding.

Year 2 Objective:

During plan period, WIC staff will assess client attitudes, beliefs, and barriers regarding continuing breastfeeding to at least 6 months of age, and implement strategies to support client breastfeeding goals.

Activity 1: WIC staff will have completed role-appropriate sections of the revised Breastfeeding Module. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- Have all staff completed role-appropriate sections of the revised Breastfeeding Module?

Response: All staff have completed role-appropriate sections of the revised Breastfeeding Module.

Activity 2: WIC staff will assess client beliefs, attitudes and barriers regarding continuing breastfeeding to at least 6 months of age by using state provided assessment tool. This activity was required.

Outcome Evaluation: Please address the following questions in your response.

- What is one result from the client assessments that you have applied in your agency?

Response: The client survey indicated mothers believed returning to work would mean a need for using formula. Efforts are being made to encourage mothers returning to work to continue to breastfeed. Breast pumps are available to mothers so they may pump breastmilk on their breaks and take home to the infant.

Activity 3: The WIC agency will implement at least one strategy to support client breastfeeding goals. This activity was required.

Examples of possible strategies:

- WIC Certifiers will use the 3-Step Counseling Strategy to help mother's identify their barrier(s) to breastfeeding 6 months.
- Effective open-ended questions.
- Affirming statements.
- Education/counseling strategies.
- Include a goal setting objective that all prenatal women who indicate they plan to breastfeed will identify a goal related to breastfeeding 6 months.
- Include a participant activity during the Breastfeeding Class wherein participants identify at least one barrier they face to breastfeeding at least 6 months. As a group, identify strategies to address these barriers.
- Institute a system for follow-up calls or written messages at critical periods of time when breastfeeding challenges may arise.

Outcome Evaluation: Please address the following questions in your response.
- Did your agency implement at least one strategy to support breastfeeding goals?
- How did the strategy address the identified issue?

Response: Open-ended questions are used to identify and address barriers to breastfeeding. This allows us to explore the issues of family support and public attitude.

Health Statistics – Action Plan 2006/07

Current condition or problem
As one of the services required by Oregon law, our department registers all births and deaths in the county. We also review the health statistics which have been compiled by the state related to program areas that we provide. In some of our programs, we have not had a systematic approach to collecting health data or outcome measures that have not otherwise been required by the funding source.

Goal
Continued improvement in departmental statistics gathering on health indicators or outcome objectives.

Activities

- Each program supervisor will review tools and methods for collecting outcome data related to targeted program objectives.
- Where there are gaps in data collection, supervisors will develop tools or processes for measuring program effectiveness.

Evaluation
Achievement of improved data collection in program areas.

Health Information and Referral Services - Action Plan 2006/07

Current Condition or Problem

Public Health clients often have needs that are out of the range of services offered within our department. Some are aware of the information or services they are seeking, and call asking for contacts and phone numbers. Many, however, are unaware of services available, and therefore do not inquire. These clients are dependent on Coos County Public Health staff to take the initiative and suggest services and opportunities that might be beneficial to them.

All Department programs are currently involved in providing information and making referrals to clients for services offered at the Health Department, as well as services of other agencies. The following are examples of common information and referrals provided by our department. The Family Planning Clinic provides options counseling to clients who become pregnant, and refers the client to the appropriate agency. The Healthy Communities Access Program and Oregon Mothers Care outreach specialists assist clients in applying for publicly funded health insurances, and in locating affordable primary healthcare services. They set up pregnant clients with prenatal care providers and also specialty providers outside the community. The Healthy Communities Access Program case management nurse follows the care of clients with special or complex healthcare needs and also links the clients to organizations offering services that will meet their social, environmental, and financial needs. WIC ensures that client's vaccinations are current by referring to the Coos County Public Health Immunization Clinic when scheduled immunizations are due. Home visiting nurses regularly refer parents of young children and pregnant women to free stop smoking classes offered by the local hospital.

Goals

Coos County Public Health has the goal to assure those who qualify become connected with the many services available through public and private agencies designed to improve their quality of life. We plan to improve our already extensive referral program to provide even better, more prompt and complete information to members of our community. We want to see information of importance to the community passed on in the most effective way, to keep them informed and prepared in the case of an emergency, such as an outbreak of a communicable disease, a natural disaster or terrorist attack.

Activities

To enable our staff to continue to improve their abilities to successfully refer our clients to other agencies for appropriate services:

- We will continue to invite individuals from other agencies, such as Red Cross and Child Welfare Services, to make presentations at our monthly all-staff meetings, so that our staff will become familiar with services provided by other agencies.
- We will participate in agency health fairs.
- New employee orientation will include an emphasis on the importance of our information and referral service, to ensure that new staff coming in will catch the vision of holistically meeting the needs of the community through interagency cooperation.

To facilitate the public's need to access accurate and pertinent information in a prompt manner:

- We will continue to enhance our website to include more links to state and federal agencies, such as the CDC.

- We will continue include our website address in all public information campaigns we make in other media, such as newspaper, radio or television.
- We will post health information and our department's services on our electronic sign.

Evaluation

We will track who has attended the agency presentations made at our staff meetings. We will review orientation checklists to see that the proper emphasis on information and referral services has actually been included in all incoming staff orientations.

We will monitor our website with regularly scheduled inspections to track the condition and progress being made, checking for completeness and currency of the information. We will make needed adjustments or training to enable staff in our respective programs to update information relevant to their program. We will review all advertising to insure the website address is included.

Licensed Facilities (& Other Institutions) – Action Plan 2006/2007

Current Condition

What happens when…
-restaurant patrons become ill from food poisoning?
-a tourist complains about a dirty hotel room?
-a swimmer at the public pool gets burning, irritated eyes?

When such incidents occur, the Environmental Health staff investigates and takes steps as warranted to prevent recurrence.

Most such conditions are preventable. Prevention is the real aim for the Environmental Health Program for the 191 licensed temporary restaurants, 374 annually licensed facilities and 64 other inspected institutions operating within Coos County in 2005. Restaurants, public pools, bed and breakfasts, RV parks, overnight lodging, organization camps, schools, child care centers, are inspected and have education and consultation services available.

The Environmental Health Program benefits virtually every person residing in or traveling through Coos County. Consider the sheer numbers of meals served, nights stayed by RV campers and nights stayed in hotel/motels within Coos County at licensed facilities:

An estimate of the number of meals served by Coos County restaurants annually:

(Total # of Restaurant Seats)	X	*(Seats Filled 3 Times Weekly)	X	(52 Weeks)	=	Number of Meals Served
11,392	**x**	**3**	**x**	**52**	**=**	**1,777,152**

*Gross underestimate, as most restaurants bank on filling each seat more than once a day.

An estimate of the number of nights RV campers spend annually in Coos County:

(Total # of RV Sites)	X	*(Sites Filled 3 Times Weekly)	X	(52 Weeks)	=	RV Sites Occupied Yearly
1301	**x**	**3**	**x**	**52**	**=**	**202,956**

An estimate of the number of nights travelers spend annually in Coos County:

(Total # of Rooms)	X	*(Rooms Filled 3 Times Weekly)	X	(52 Weeks)	=	Rooms Occupied
1,333	**x**	**3**	**x**	**52**	**=**	**207,948**

Added together, on more than **2 million** separate occasions, consumers in Coos County benefited from Environmental Health Services. Considering this sum, a disease and incidence rate of one tenth of one percent would result in more than 2,000 annual illnesses or injuries. The fact that in 2005 Coos County Public Health documented only 22 consumer complaints regarding all licensed establishments in Coos County, lends credibility to the idea of maintaining a proactive Environmental Health Services approach.

Goals

Environmental Health Services provide education, consultation and inspection services to assure:

- Community visitors have clean safe traveler's accommodations,
- Public pools and spas are free of disease causing germs,
- Food workers know how to keep food safe
- Restaurants, schools and day cares serve safe food
- Day care facilities are free of environmental injury risks.

Activities

- License and inspect food service facilities as required by OAR 333 Division 12, Inspection frequency may increase based on epidemiological risks
- Provide Food Manager Certification Training
- Provide Food Handler Training at least twice monthly
  Provide Food Handler Training outreach in Bandon, Myrtle Point, and Coquille
- Follow-up on all allegations of food borne illness
- Initiate communicable disease epidemiological investigations of confirmed food borne illness outbreaks in concert with communicable disease nurses immediately upon notification
- License and inspect temporary food vendors primarily notable at special events and festivals
- License & inspect Tourist Accommodations for health and safety risks as required by OAR 333 Division 12
- License and inspect Public Pools for health and safety risks as required by OAR 333 Division 12
- Investigate complaints regarding legitimate environmental concerns at Public Pools relating to public safety and health
- Investigate complaints regarding legitimate environmental concerns relating to public safety and health at Tourist Accommodations

Evaluation

The Licensed Facility Statistics Report provides a statistical evaluation for work done over the year. Prominent points from 2005 include:

License Type	Inspections Performed	Closures	Misc. Complaints
Public Pool	100%	0	2
Lodging	100%	0	1
RV Camp	99%	0	1
Food Service	104%	1	11

Food Complaints	11
Confirmed Food Borne Illness	0
Food Handler Training Cards Issued	999
Food Service Mangers Certified	37

Safe Drinking Water – Action Plan 2006/2007

Current Condition
Everyone takes for granted the quality of Oregon's drinking water. But nationally, several water borne disease outbreaks have provided a reminder that drinking contaminated water can cause illness and even death. A keen interest in protecting drinking water has been renewed by the recognition that public water systems provide an easy conduit for a terrorist's threat into many homes. Our services provided in the Drinking Water Program are intended to assure good quality water.

Approximately 50,000 Coos County residents live where they are served by 74 public water systems. Most of the remaining 12,000 county residents (20%) live where they rely on private water supplies. These private drinking water systems range from small clusters of homes sharing a common source to a single residence with a source independent of any other users. Federal dollars exist to provide regulatory oversight for EPA designated public water systems. No funding for oversight is available for non EPA water systems, private or otherwise, to assure that residents are obtaining good quality water.

Services provided for Public Water Systems are covered in the Drinking Water Systems Assurances as per delegation agreement (and contract) between Coos County Public Health and the State Drinking Water Program. This leaves the Environmental Health Program to provide services for 84% of the County's public water systems and the remnant of service is performed by the State Drinking Water Program office and by the Oregon Department of Agriculture.

Environmental services are primarily directed toward helping public water system operators sort through a seemingly never ending maze of rules relating to assuring the quality of the drinking water and may include encouraging operators to take steps to physically protect the water and regularly sample for potential contaminants. Dozens of potential contaminants may need to be sampled, but the following table notes some important contaminants of concern.

Contaminate	**Examples**		**Implications**
Chemical	Nitrates		Blue Baby Syndrome
	Trichloroethylene		Solvent linked to cancer, birth defects, reproductive problems
	Lead		Effects central nervous system and child development
Microbial	Bacteria	Escherichia coli O157:H7	Acute bloody diarrhea, abdominal cramps - occasionally leads to kidney failure
	Viruses	Hepatitis A	Fever, abdominal pain, fatigue, jaundice, loss of appetite, intermittent nausea, dark urine
	Parasites	Cryptosporidium	Symptoms include diarrhea, abdominal cramps, nausea, occasionally vomiting, low-grade fever

The potential for health problems from drinking water is illustrated by localized outbreaks of water borne disease. For example, in 1993 and 1994, there were 30 renowned disease outbreaks associated with drinking water - 23 were associated with public water systems and 7 with private systems. Many of these outbreaks have been linked to contamination by bacteria or viruses, probably from human or animal waste.

Goals
To assure the availability of safe drinking water meaning - "water which is sufficiently free from biological, chemical, radiological, or physical impurities such that individuals will not be exposed to disease or harmful physiological effects."

Public Water Systems: Increase to at least 95% the percentage of people who receive a supply of drinking water from public water systems that meet all EPA health based safe drinking water standards.

Private Water Systems: When called upon, make information available to water users that will empower them to obtain safe drinking water.

Activities
Public Water Systems
- Consult with system operator on steps to correct any water quality violations
- Work with system operators with water quality noncompliance and sampling issues
- Assist system operators in assuring preparation of an adequate emergency response plan
- Physically survey each water system no less often than every 5 years

Private Water Systems
- Make available brochures about ensuring and developing safe drinking water sources. This information is also available from OSU Extension and from private consultants.
- Consult with suspected victims of water borne illness regarding ensuring drinking water safety as they are referred by Communicable Disease investigation staff.

Evaluations:
The following data tables represent work done in 2005 to ensure safe drinking water.

Public Water Systems

Measure	Value
Number of consultations for water quality violations	**4**
Number of contacts to assist in correcting chronic noncompliance	**14**
Number of emergency response plan preparation consultations	**3**
Number of water system sanitary surveys conducted	**4**
Percentage of [EPA] public water systems in compliance with water quality standards	**86%**

Private Water Systems

Measure	Value
Number of consultations	**5**
Investigations into suspected water borne illness complaints	**0**
Number of Water Borne Disease Outbreaks–confirmed	**0**

Action Plans

For

Other Public Health Concerns

Public Health Emergency Preparedness – Action Plan 2005/2006 and 2006/2007

Current Condition:

Coos County Public Health (CCPH) continues to work towards coordination of emergency planning with our partners within the county, within Region 3 (Coos, Curry, Douglas, and Lane Counties), and the state. The Public Health Administrator continues to chair the local Health Emergency Response Team (HERT) that has met monthly since October 2001 for emergency response planning. The Administrator also participates on the Regional Preparedness Advisory Board, which coordinates the HRSA preparedness activities with hospitals and providers in Region 3, and with the Public Health Preparedness Leadership Team, which makes recommendations for the state's public health preparedness program. Due to staff attrition last year, a new Public Health Preparedness Coordinator (PHP) was hired and a new Public Information Officer was assigned to fill that role.

Accomplishments 04/05

1. CCPH staff and community partners attended training for mass casualty and mass injury incidents, and strategic national stockpile (SNS) coordination.
2. CCPH arranged training for staff and community partners in incident command.
3. A procedure for a mass casualty incident was drafted.
4. A smallpox vaccination plan was drafted.
5. A medical response plan to a radiological incident was also drafted.
6. Procedures for 24/7 notification and response to communicable disease reports have been completed and distributed to staff.
7. The earthquake drill procedure was developed and reviewed with the CCPH staff.
8. The department's Public Information Officer (PIO) was instrumental in bringing together a regional PIO group that continues to meet every 2-3 months. This group has participated in exercises to identify areas where more cooperative work between agency PIOs can help to present a single message to the community and the region during a crisis.
9. Two flu clinics were organized and exercised as model mass immunization clinics, using CCPH staff, volunteers and community partners.
10. CCPH participated in a community exercise that involved mass injury, mass casualty, an incident command system, and a significant health risk to the community.

Accomplishments 05/06

1. CCPH facilitated and participated in a functional exercise focusing on the inter/intra-agency emergency communication in a Pneumonic Plague event.

2. November 1, 2005 the BT Coordinator orientated the Public Health Staff to their incident command roles, prior to participating in the modified full-scale Pneumonic Plague exercise on November 2nd, 2005.

3. November 2nd, Coos County Public Health participated in the state and regional Pneumonic Plague interagency communications modified full-scale exercise.

4. In accordance with the Program Element #12, a Base Plan and a Natural Disaster Response Plan are currently being drafted.

5. The Mass Prophylaxis Plan, the Emergency Communications Plan, and the Strategic National Stockpile plan are currently being updated and modified.

6. Tribal representation has been included in our emergency planning work groups.

7. April 25th, 2006, the PHP Coordinator presented CCPH's Base Health and Medical Emergency Response Plan activation procedures to CCPH staff at a staff meeting.

8. April 25th, 2006, the PHP Coordinator facilitated an Emergency Communications Plan orientation and tabletop exercise to CCPH's Public Information Officer, Assistant PIO, Internal Communications Officer, and other Command Staff.

Response Capability

We currently have 8 nurses and an environmental health specialist (EHS) trained in CD 101 and 4 nurses and an EHS trained at the CD 303 level to increase the ability of our department to respond to an outbreak/incident. This has also increased the number of individuals available to be on-call 24/7 for reporting purposes.

We continue to follow our policies and procedures for 24/7 reporting. The pager number for emergencies is available to the public on our answering machine and has been distributed to the local care providers, hospitals, ambulance services, fire & police departments, and veterinarians. We continue to provide a direct phone line into the desk of one of the Public Health Nurses. When the pager is being carried after regular hours by any of the nurses who do not normally provide communicable disease response, then one of the regular CD nurses is available by pager and/or telephone to back them up.

Training Opportunities

In September of 2005, the PHP coordinator attended a WMD training. In November, our department participated in the full-scale exercise, and in November, the PHP Coordinator attended several online trainings including the updates on Influenza and SARS. The PHP coordinator continues to attend the OrEpi conferences and trainings offered by the state, to stay up to date with preparedness for new and existing diseases and public health threats.

In December, the new Public Information Officer attended the PIO Crisis and Emergency Risk Communication Course in Roseburg.

All staff have been trained in NIMS 700, and have been oriented to their roles in a public health emergency.

Goals:

To be prepared to respond to reports of unusual events, either man-made or naturally occurring, in an efficient and organized manner.

To provide education to the community on how they can best protect themselves from both known and emerging diseases or from an act of willful destruction to health or property, such as use of a weapon of mass destruction (WMD) or an act of bioterrorism (BT).

To continue to participate in the ongoing revision of our County Emergency Operations Planning to ensure that Public Health is prepared to respond to incidents in a coordinated manner with our county government, and with our community and state partners.

To continue to improve communications between local emergency 1st responder agencies, local healthcare agencies, regional partners, and state partners to effectively respond to an emergency event while keeping the public safe and informed with up-to-date information

To continue to develop relationships with businesses, schools, faith-based organizations, tribal agencies, social service agencies, and other community members to facilitate community-wide public health emergency preparedness and response.

Activities:

Continue to provide 24/7 access to nurses trained in communicable disease for those in the local health system, first responders, and Oregon State Public Health.

Update emergency planning for medical response annually, and integrate the medical response procedures into the Coos County Emergency Operations Plan.

Update the county website with pertinent information on communicable diseases and/or public health preparedness topics.

Continue to facilitate the local HERT meetings, monthly.

Provide continuing education to the Public Health staff on potential duties and/or responsibilities during a communicable disease outbreak, BT incident, and/or natural disaster health recovery.

Encourage participation by our local tribal officials, schools, faith-based organizations and social service agencies in planning for incidents regarding communicable disease and/or other public health emergencies and bioterrorist events.

Continue to test current communication capabilities, including alternate communication devices, with all local partners to ensure ability to distribute information during emergency situations.

Complete the staff training on respiratory protection and fit testing.

Participate in regional and statewide exercises.

Complete necessary public health emergency response and health recovery plans, annexes and attachments, with a focus on pandemic flu.

Work with local businesses and schools to facilitate the preparation of emergency response health plans, with an emphasis on pandemic flu response.

Evaluation

Evaluation of our progress will be done quarterly using the assurances provided by program element 12 of the IGA with DHS-State Public Health. Records of activities will be maintained.

Oregon Breast & Cervical Cancer and Komen Programs
Annual Program Improvement Plan: July 1, 2006- June 30, 2007

Organization: Coos County
Program Staff: Renee Johnson

1. General Program Management

Perform program management functions, including meeting requirements in the following areas: staffing and contracting, provider networks, fiscal management, record keeping, data collection, and reporting. Maintain communication with internal and external partners regarding the Program.

A. Maintain adequate staff (program coordinator, community educator, case manager and clinical consultation) and resources for the Program.
B. Develop and maintain a network of Screening Service Providers to provide Screening Services in the Service Area in a timely manner.
C. The Program must be accessible, acceptable and available to the community and meet the needs of medically underserved individuals in the Service Area.
D. Maintain communication with DHS staff, Screening Service Providers and other Program staff.
E. Maintain a fiscal management system to assure appropriate use of funds.
F. Collect Minimum Data Elements, clinical reports and documentation relating to Screening Services delivery and maintain medical records.
G. Deliver at least 75% of Screening Services in a primary care setting.
H. Meet annual Screening Goals (at least 90%) for the BCC and Komen Awards.

Submit required reports and other documentation that are complete and on time.

Objectives	**Activities Planned to Meet Objectives**	**Who Is Responsible** (Local Program and/or Community Collaborators)	**Evaluation/Outcome** (Measures of Success)
From 7/1/06 through 6/30/07 meet or exceed goals A through I listed above	Maintain systems already in place that have made BCC program successful. Revise as indicated. Continue to monitor program through either the Clackamas Data Base or the new Web-based database Network with Fiscal Manager	**BCC Coordinator** **BCC Supervisor** **BCC Fiscal Manager** **BCC Billing and Receiving Specialist** **BCC Administrator**	BCC data will meet or exceed Protocols outlined above. Monitor monthly expenditures with Fiscal Manager.

II. Recruitment of Priority Populations

Recruit individuals with low incomes who are medically underserved and are not currently accessing health services, and encourage them to return for re-screening at recommended intervals. Priority populations are women ages 50–64, women of color, women who live in rural areas, women with disabilities, and lesbians; all of whom may be at risk of not getting screened.

A. Review program data provided by the Department to determine demographics of individuals receiving Screening Services.
B. Identify the Priority Populations for program services on an annual basis for the Service Area.
C. Involve Priority Populations in planning and implementing recruitment activities.
D. Conduct recruitment activities to reach Priority Populations using a variety of media and education strategies.
E. Monitor enrollment information to determine referral sources and effectiveness of recruitment activities.
F. Collaborate with community organizations with direct access to Priority Populations to define and conduct culturally appropriate recruitment activities.
G. Develop and deliver recruitment messages that are consistent with recruitment priorities.
H. Increase the percentage of women receiving BCC Screening Services who are age 50-64 (goal is 75%).
I. Increase the percentage of women re-screened, with a focus on age 50-64 (goal is at least 50% of each prior year's breast Screening Services with normal results).
J. Increase the percentage of women served who have a history of being rarely or never screened for cervical cancer (goal is at least 20% of initial cervical Screening Services).

Activities Planned to Meet Objectives	**Who Is Responsible** (Local Program and/or Community Collaborators)	**Evaluation/Outcomes** (Measures of Success)
Continue to provide educational events in the community focusing on Breast and Cervical Health. **Collaborate with Community partners to provide culturally appropriate recruitment activities.** **Deliver recruitment messages that are consistent with the priority populations in Coos County.** **Increase the number of women who are considered "true re-screens".**	Bcc Coordinator Women's Health Coalition BCC Supervisor	**Evaluations from educational events.** News releases, PSA's Enrollment form will show true re-screen

III. Screening Services

Conduct enrollment activities, deliver complete, timely and clinically appropriate Screening Services, maintain Tracking and Follow-up Systems, and provide Case Management for clients with abnormal screening test results.

A. Maintain a system to assess eligibility and special needs and to schedule appointments.
B. Assure that Screening Services are complete, timely and clinically appropriate, according to program guidelines and protocols.
C. Establish and utilize Tracking and Follow-up Systems to assure timely and complete services.
D. Provide Case Management services to all individuals with abnormal screening or diagnostic test results.
E. Assure that all mammograms are conducted in facilities that meet the Mammography Quality Standards Act (MQSA) certification.
F. Assure that all cytology services are delivered in facilities that meet the standards and regulations for the Clinical Laboratory Improvement Act (CLIA).
G. Ensure that a final diagnosis is made for at least 90% of all Screening Services with an abnormal test result.
H. Ensure that less than 10% of all individuals with abnormal test results refuse further Screening Services or are lost to follow up.

Objectives	**Activities Planned to Meet Objectives**	**Who Is Responsible** (Local Program and/or Community Collaborators)	**Evaluation/Outcomes** (Measures of Success)
From 7/1/06 through 6/30/07 meet or exceed goals A through H listed above.	Maintain systems already in place that have made BCC program successful. Revise as indicated. Continue to network with BCC staff, and providers to ensure all protocols are understood and met. Visit all providers' sites. Educate new office staff, and review procedures with current staff to ensure all staff are updated on program guidelines and protocols.	BCC Coordinator BCC Supervisor BCC Administrator	End of year data for Coos County will show BCC protocols and guidelines are met according to CDC guidelines.

IV. Community Education and Community Collaborator Activities

Establish and maintain collaborative relationships with health care providers, community organizations and individuals who participate in the promotion of early detection education and screening activities and have contact with the priority populations in the service area. Through the Program, these relationships can reduce duplication of effort, expand networks and combine resources for maximum benefit to increase screening among all Oregonians.

A. Analyze demographic data and community feedback from the Service Area to determine education priorities.
B. Coordinate with Community Collaborators to conduct education activities to promote early detection of breast and cervical cancer.
C. Evaluate education activities to determine effectiveness and outcomes to enhance decision-making about future use of limited resources.
D. Develop and maintain mechanisms to communicate with Community Collaborators on a regular basis.

Objectives	**Activities Planned to Meet Objectives**	**Who Is Responsible** (Local Program and/or Community Collaborators)	**Evaluation/Outcomes** (Measures of Success)
From 7/1/06 through 6/30/07 continue to focus on A through D listed above.	Continue to meet monthly with the Women's Health Coalition. Strategize/ Analyze on how to provide educational events focused on Breast and Cervical Health. Network with HCAP (Healthy Communities Access Program) to promote and educate the women of Coos County, the importance of maintaining a "whole well being".	BCC Coordinator BCC Supervisor Coos County Women's Health Coalition HCAP Case Mgt. R.N.	Provide evaluation forms at each educational event to determine effectiveness and outcomes to enhance future educational events. Continue to keep minutes from monthly Women's Health Coalition meetings. Promote/provide information about health topics of the month to family planning clients to initiate the idea of whole well being.

Tobacco Use Prevention – Action Plan 2006/2007

Every year in Coos County…

- **229 people die from tobacco use**
- **4,476 suffer from serious illness caused by tobacco use**
- **$27.8 million is spent on medical care for tobacco-related illnesses.**
- **$28.5 million is lost from decreased productivity due to tobacco-related disability and death.**

Coos County ranks 1st in the State of Oregon for incidence of deaths related to lung cancers, and 2nd in the State for all cancers combined!

(Oregon State Cancer Registry (OSCaR – data from 1998 – 2002)

- **27% of adults in Coos County smoke (the state average is 21%)**
- **6% of 8th graders and 19% of 11th graders smoke**
- **25% of county residents are exposed to secondhand smoke in a typical week**
- **23% of pregnant women smoke – compared to the state rate of 12%**
- **25% of all deaths in Coos County are tobacco related**

(Oregon Tobacco Prevention and Education Program – Coos County Fact Sheet – 2005 - http://www.oregon.gov/DHS/ph/tobacco/docs/Coos.pdf

Goals

2006-07 Tobacco Prevention and Education goals focus on **countering pro-tobacco influences, and creating tobacco-free environments.** We will be working with specific populations to help reduce their exposure to secondhand smoke in homes and cars, as well as increasing youth awareness to the dangers of using tobacco products.

Activities

- Our Clean Air Coalition will work with TPEP and other Coos County tobacco programs to collect sample policies from other cities that address **banning tobacco industry sponsorship and promotion at public events.**

- Members of the Clean Air Coalition will make presentations to local governing bodies about tobacco **industry tactics targeting youth**, and urge them to adopt policies that ban tobacco sponsorship of public events and tobacco promotion at such events.

- Our Clean Air Coalition will partner with **local schools** in developing a monitoring system for enforcement of the new school policies banning tobacco sponsorship and promotion on local campuses.
- Our Tobacco Prevention Coordinator will coordinate with the **tribes to implement the goals in our project. A summit style meeting is being planned for August 2006 to bring the tribes and CCPH to the table to discuss and exchange ideas and resources.**
- A **smoke-free homes and cars campaign that targets the low socio-economic population** and diverse groups in Coos County will be implemented. The Smoke-Free Environment sub-committee will periodically monitor Coos County businesses listed as smoke-free in the state registry.
- **Presentations at public meetings** will be filmed and shown on Channel 14, the local government educational channel.
- Members of the Clean Air Coalition will **meet with at least half of the local governing bodies in Coos County** to distribute sample policies, educate them about second-hand smoke, and promote the benefits of smoke-free public events.
- We will work with community partners to disseminate information on secondhand smoke and continue to **promote the Oregon Tobacco Quit Line.**

Challenges: Achievement of the stated goals is contingent upon the receipt by this county of funding from the Oregon Tobacco Prevention and Education Program, which has been funded by the Measure 44 cigarette tax.

HIV Client Services – Action Plan 2006/07

Current condition or problem:

There are approximately 40,000 new cases of HIV infection in the United States each year[a]. 30% of people infected with HIV are not aware of their seropositive status. 25% of those infected carry the Hepatitis C virus as well. According to the most current State reports, there was one new case of AIDS reported in Coos County in 2005. Estimates indicate that there are approximately 60 individuals with HIV/AIDS currently living in Coos County. Of these known cases, 40% also carry the Hepatitis C virus. Coos County Public Health is currently serving 34 clients. Clients include 23 males, 10 women and one child age 12 years. Fortunately, there were no deaths locally on the Ryan White caseload this year.

People living with HIV/AIDS (PLWHA) face multiple challenges. Employment is difficult, access to support services can be confusing, maintaining a complex prescription regimen for years is frustrating, and the psychological shift from productive citizen to patient on a long slow death spiral causes many to suffer from depression. Social stigmatization continues to isolate PLWHA. The dementia that HIV causes leaves many people unable to understand the forms and procedures required to access services.

Existing barriers to the access of life saving prescriptions continue to be problematic. Budget shortfalls have eliminated programs that provide necessary medications. The highly touted Patient Assistance Programs offered by drug manufactures are time consuming, confusing, and labor intensive. The federally funded Aids Drug Assistance Program is not the panacea needed to ensure prescription coverage for PLWHA.

Poverty caused by job loss and disability coupled with social misconceptions make independent living problematical for HIV infected people.

Goals

The goals of Coos County Public Health's Ryan White Title II case management program are to provide a comprehensive continuum of primary care and supportive services that promote the mental, physical, and social well being of PLWHA

Activities

Psychosocial case management services:

Client identification and outreach: The Ryan White case manager shall collaborate with local outpatient medical clinics informing practitioners of the scope of services available to PLWHA. The Ryan White case manager will encourage word of mouth communication about local Ryan White services from existing clients to others who may benefit from Ryan White services.

Assessment: The Ryan White case manager will conduct a one on one discussion with the client at least annually (more often if necessary), about their goals and objectives, presenting problems or issues. The client and the case manager will complete a written care plan that lists prioritized issues and problems to be addressed. This written care plan will provide a framework for both the case manager and the client. A designated staff R.N. will monitor disease status and progression and will conduct routine health assessments.

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[a] Osmond, Dennis H PhD Epidemiology of HIV/AIDS in the United States HIV InSite (UCSF). March, 2003

Planning: Agreement through discussion shall occur between the client and the case manager, assigning responsibility for completion of each task listed in the care plan. Timelines and specific activities may be used as a guide. The case manager will broker services for the client as needed, and provide assistance to the client as needed in filling out forms and advocating for services. Authorizations of RW funds by the case manager shall be made to assist the client with unforeseen emergencies that may otherwise compromise the client's access to routine medical care and disrupt their day-to-day stability.

Monitoring: Monitoring the RW case load will occur to ensure that the case manager is aware of changes of client health status and obstacles faced by the client that hinder his or her ability to function in a maximally independent capacity in the community. The case manager, with input from the client, shall determine the degree to which a client shall be monitored. The client's level of acuity (or ability to function independently in many facets of daily living) may also determine the level of monitoring to be done. Monitoring will consist of telephone contact, Public Health office visit, home visit or contact in other community-based settings. Reassessment, care plan revision and modification occurs semi-annually, annually or as needed.

Additional Functions The case manager will provide ongoing documentation in the client file of all contacts, actions, authorizations or other pertinent information that promotes continuity of care. Other activities identified as being provided on an as-need basis include direct service (assistance with obtaining food for example), group education and socialization activities, crisis intervention, system advocacy, resource development and discharge planning.

Evaluation:

Measurement of meeting the above-mentioned objectives occurs in several ways:

- Clients are asked periodically to evaluate the level of services they receive. They are encouraged to point out any shortcomings or obstacles that they have faced.
- Routine chart reviews are done to ensure that the most current information is available and that all necessary forms are in place. This will facilitate accessing necessary resources and services.
- Care plans are reviewed periodically. As client goals are achieved, the issue is eliminated. Success can be measured in terms of goals accomplished and to a greater extent, when they are accomplished within the timelines stated.
- Clinical and psychosocial outcomes are measured by using the acuity scale provided by the Department of Health Services. The scale ranges from 1 (independent) to 4 (dependent). Movement among the scale is indicative of client progress or regression.

Challenges:

Through implementation of the federal Ryan White grant, we have been instrumental in meeting the diverse needs of person with HIV in our community. Our greatest challenge continues to be our efforts to prevent new cases of HIV infection, as we did not receive any intervention funds this past year. Our focus has been primarily presenting HIV/AIDS information at community forums and the Coos County Public Health clinic, advertising, anonymous and confidential counseling and testing services. With a small increase in prevention funding for this upcoming fiscal year, we will be training our staff in rapid testing and assessing the feasibility of offering testing through venues other than our Health Department clinic.

Accomplishments:

- Client files are routinely reviewed to facilitate the provision of timely psychosocial and clinical case management services.
- The transition to the new Medicare part D program was completed for clients who qualified prior to the May 16, 2006 deadline.
- Increased utilization on local services, such as food boxes, and fraternal organizations (such as the Lions Club for vision and hearing aids) occurred, reducing the fiscal burden on the local Ryan White program.
- The local Ryan Program is the privileged benefactor of charitable contributions of a local church that donated approximately $200 to client services.

Unmet Needs
2006/07

The unmet needs are generally the same as have been discussed the past two years. The health issues that receive our focus and action continue to be the ones that have a funding stream. Our discretionary funds continue to be extremely limited. The *State Support for Public Health* per capita allotment for our county remains static at about 59 cents per person per year. Our county's general fund support was less than 10% in 2005/06. These two sources of discretionary funds are used to fill the spending gaps for the program elements that we commit to in our contract with DHS-Health Services, and funds are not available to tackle other health issues.

The primary causes of death in our county are cardiovascular disease and cancer, and both cancer and cardiovascular disease are related to the high use of tobacco that we have locally. During 1998-2002, the age adjusted rate showed that Coos County ranked highest in the state for *high incidence* cancers, and Coos has the highest death rate in the state for lung cancer. Also, our rates for obesity are higher than the state rates. We have been fortunate to receive some state funds for the resumption of a tobacco prevention project, and we hope to be successful in competing for some of the limited federal funds offered by the state for a diabetes/asthma/cardiovascular disease project. Otherwise, we have no funding to address this need.

Although our teen pregnancy rate has steadily decreased over the past few years, we are seeing a reverse trend in the latest statistics. Our cases of sexually transmitted diseases have been consistently high, and funds to educate teens about safer sex practices are limited. We are receiving a small increase in our HIV prevention funds provided by the state, although an additional $4,000 per year does not go far.

State funding for the TB case management at less than $600 per year does not begin to pay for the investigation and case management of latent or active cases.

Public Health Nurse Home Visitation continues to be a much needed program in Coos County, and we are achieving positive outcomes in preventing child abuse. Although research has proven that **nurse** home visitation is the most effective type of home visiting to high risk clients, this model continues to lack financial support statewide. It is a challenge to provide a strong public health home visiting program, which is very much sought after by clients, agencies, hospitals, and the medical community, with limited funds. Our nurse home visiting program is built on the infrastructure of Medicaid billing, funding that is based on decisions at the federal level. An increase in the Medicaid reimbursement rates specific for the maternity case management (MCM) program, or an alternative source of funding, would help to cover the cost of providing the MCM service. Providing intervention during the prenatal and early postpartum period is very cost effective way of preventing problems with a very high risk population.

Oral health care remains a challenge in the maternal child health program. Our nurses have been diligent is assessing and referring pregnant women and young children to dentists for exams and treatment as recommended by the Early Childhood Cavities Prevention program, sponsored both by DHS and OMAP. We have received several complaints and concerns from parents that dentists were not accepting their young children at the ages that were recommended, or that clients, especially on the Oregon Health Plan, were being treated appropriately. After our field

services staff have communicated with the oral health coordinators at OMAP and locally with the local director of one of the dental providers, we have seen some improvement in the access of care.

And finally, we must recognize that there are many more individuals and families who are now ineligible for the Oregon Health Plan, and are essentially without health care. Our efforts to assist our constituents in their quest for affordable health care have become more challenging than ever.

Budget Statement

Contact to receive a copy of our approved budget document:

Sherrill Lorenzo
Business Operations Manager
Coos County Public Health
541-756-2020, ext. 539
slorenzo@co.coos.or.us

Comprehensive Plan Statement
Senate Bill 555

The Coos County Board of Commissioners, who are the Local Public Health Authority, also oversee the Coos County Commission on Children and Families, which was responsible for coordinating the comprehensive planning process in Coos County.

Health Department staff have participated in the most recent update to the comprehensive plan. Annual plan topics which are also included in the comprehensive plan include: prenatal care, immunizations, child abuse, use of alcohol, tobacco and other drugs, and teen pregnancy.

VII. Minimum Standards -- Coos County Public Health

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

2. Yes _x_ No ___ The Local Health Authority meets at least annually to address public health concerns.

3. Yes _x_ No ___ A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.

4. Yes _x_ No ___ Current local health department policies and procedures exist which are reviewed at least annually.

5. Yes _x_ No ___ Ongoing community assessment is performed to analyze and evaluate community data.

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

7. Yes _x_ No ___ Local health officials develop and manage an annual operating budget.

8. Yes __x No ___ Generally accepted public accounting practices are used for managing funds.

9. Yes _x_ No ___ All revenues generated from public health services are allocated to public health programs.
10. Yes __x No ___ Written personnel policies and procedures are in compliance with federal and state laws and regulations.

11. Yes _x_ No ___ Personnel policies and procedures are available for all employees.

12. Yes __x No ___ All positions have written job descriptions, including minimum qualifications.

13. Yes _x_ No ___ Written performance evaluations are done annually.

14. Yes __x No ___ Evidence of staff development activities exists.

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

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

17. Yes ___ No _x_ A records manual of all forms used is reviewed annually. (There is not a single manual for all forms.)

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

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

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

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

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

23. Yes _x_ No ___ Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.

24. Yes __x No ___ 100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.

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

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

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

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

29. Yes _x__ No __ Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.

30. Yes ___ No _x_ Health department administration and county medical examiner review collaborative efforts at least annually. (Only as needed.)

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

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

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

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

35. Yes _x__ No ___ Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.

36. Yes __x_ No ___ A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

Control of Communicable Diseases

37. Yes _x_ No ___ There is a mechanism for reporting communicable disease cases to the health department.

38. Yes _x__ No ___ Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.

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

40. Yes _x__ No ___ Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.

41. Yes _x__ No ___ There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.

42. Yes __x_ No ___ There is a mechanism for reporting and following up on zoonotic diseases to the local health department.

43. Yes _x_ No ___ A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
44. Yes __x_ No ___ Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.

45. Yes _x__ No ___ Immunizations for human target populations are available within the local health department jurisdiction.

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

Environmental Health

47. Yes _x__ No ___ Food service facilities are licensed and inspected as required by Chapter 333 Division 12, or more frequently based on epidemiological risk.

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

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

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

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

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

53. Yes _x__ No ___ Compliance assistance is provided to public water systems that violate requirements.

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

55. Yes _x__ No ___ A written plan exists for responding to emergencies involving public water systems.

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

57. Yes _x__ No __ A program exists to monitor, issue permits, and inspect on-site sewage disposal systems. (DEQ)

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

59. Yes __x_ No ___ School and public facilities food service operations are inspected for health and safety risks.

60. Yes _x__ No ___ Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.

61. Yes _x__ No ___ A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.

62. Yes _x__ No ___ Indoor clean air complaints in licensed facilities are investigated.

63. Yes _x__ No ___ Environmental contamination potentially impacting public health or the environment is investigated.

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

65. Yes x___ No ___ Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.

66. Yes _x__ No ___ All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448. (Added per G.S. request, not in program indicators)

Health Education and Health Promotion

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

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

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

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

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

72. Yes _x__ No ___ All health department facilities are smoke free.

Nutrition

73. Yes _x__ No ___ Local health department reviews population data to promote appropriate nutritional services.

74. The following health department programs include an assessment of nutritional status:
    a. Yes _x__ No ___ WIC
    b. Yes _x__ No ___ Family Planning
    c. Yes _x__ No ___ Parent and Child Health
    d. Yes __x_ No ___ Older Adult Health
    e. Yes _-__ No _-__ Corrections Health (n/a)

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

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

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

Older Adult Health

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

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

80. Yes _x__ No ___ Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.

81. Yes ___ No _x__ Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education. (Funds are lacking for some of these topics.)

Parent and Child Health

82. Yes _x__ No ___ Perinatal care is provided directly or by referral.

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

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

85. Yes _x__ No ___ Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.

86. Yes _x__ No ___ Child abuse prevention and treatment services are provided directly or by referral.

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

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

89. Yes __x_ No ___ There is a system in place to follow up on all reported SIDS deaths.

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

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

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

Primary Health Care

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

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

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

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

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

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

Cultural Competency

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

100. Yes x__ No ___ The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.

101. Yes _x__ No ___ The local health department assures that advisory groups reflect the population to be served.

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 ___ No _x__ The local health department Health Administrator meets minimum qualifications: The Administrator has a bachelor's degree in community health and 19 years of public health experience.

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.

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.

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.

106. Yes x___ No ___ The local health department Health Officer meets minimum qualifications:

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

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.

__John Griffith_________	_Coos__	__May 3, 2006
Local Public Health Authority	County	Date

Coos County Public Health

Charles Holloway, MD

Sherrill Lorenzo, BS
Business Operations

Kara Breuer, ARS
Stacie McNeill, HAP/Lead

Rick Ha ark
Super g
Environme Health
Coord or

Lilo Isenl , EH
Specia II
Rachel Th e, OS
III (
Peter C ey,
EH Spe st II
(Extra lp)

Stacey Hastings
Prevention Services Coordinator

STARS/Teen Pregnancy Prevention
Amie Arnold
(AmericCorps Volunteer)

Diabetes Prevention
Stacey Hastings (.5)

Tobacco Prevention
Karen Devereux (.5)

Asthma Prevention
Kathy Cooley (.2)

Karin Kenney, Aide (.9)
Susan Thurman, Aide (.9)
Rosa Johnson, Aide (.45)
Jan Low, OS III (.5)
Lily Mills, OS II

Sylvia Mangan, RN
Field Services Supervisor

PAT, Babies 1st, CaCoon
Lauren Sproul, PHN II (.5)
Angie Moore, Aide
Anne Hudson, PHN II (.5)
Susan Thurman (.1)
Josephine Kuehn, PHN II (.8)
Maria Wartnik, PHN II (.3)
(Extra Help)
Sarah Dement, PHN II (.1)
(Extra Help)

MCM
Kathy Cooley, PHN III (.8)
Josephine Kuehn, PHN II (.2)

SSP– Jobs Program
Anne Hudson, PHN II (.5)

Vacant
Clinic Program Manager

Family Planning
Louise Whitehead, NP

HIV - Ryan White
K. Devereux, MHA II (.45)
Patty Flett (.1)

Clinic Services
Lena Hawtin, PHN III (.4)
Patty Flett, PHN II (.7)
Kathy Sisson, PHN II
Joyce Smith, PHA III
PHA I Vacant

Immunizations
Lena Hawtin, PHN III (.4)

Support Services
Lisa Hermann, OS III
Gloria Marone, OS III
Jan Low, OS III (.5)
Rachel Thorne, OS III (.5)
(Extra Help)
Sheila Carlstrom
Shelly Johnson

Public Health Preparedness
Kristi Kauffman, PHE
Lena Hawtin, PHN III (.2)
Patty Flett, PHN II (.2)
Karin Kenney, PHA II (.1)

Breast & Cervical Cancer
R. Johnson, PHA III (.45)

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April 28,)6