

# **Coos County Public Health**

## **Annual Plan**

**2008-2009**

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**Coos County Public Health  
Annual Plan 08/09**

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## **Executive Summary**

Coos County Public Health Department continues to provide the 5 essential services required by Oregon law to meet the health needs of the community. Through these mandated services, we are addressing important social and health problems and state benchmarks: teen pregnancy prevention, child abuse prevention, adequate prenatal care, adequate immunizations for children, 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.

With a projected budget of \$2.466 million for FY 2008/2009, we expect to employ 27 staff. This is a 10% reduction in staff from FY 2007/08 and a 29 % reduction from FY 2006/07. Due to the loss of revenue from federal timber payments and subsequent cessation of county general funds for personnel and program expenses, we expect to have a further reduction in the level of services or number of clients served in this coming year. This is most evident in our maternal and child health programs. This comes at a time when many of our residents are facing health and economic challenges. With no discretionary funds, our department will provide only those services which are mandated or fully funded through dedicated sources. An increase in state support for public health would help to assure that public health remains viable in this county.

We continue to have concerns about the high rate of sexually transmitted diseases in young people (and the cessation of 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 diabetes affect the quality of life of our aging population.

We are receiving funds for a tobacco prevention project and have seen a reduction in smoking in adolescents. In our family health field services programs, we are continuing to make a difference, with an increase in our clients' parenting skills and the corresponding reduction in child abuse. We are seeing a decrease in teen pregnancy, as we continue to serve teens in our family planning program and through the school based health center, which receives funds from public health. The inspections and education by our environmental health staff help to assure prevention of food borne illness. Goals and objectives for these and other programs are described in the action plans, which guide the work of our dedicated staff. We 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

The **64,820** persons living in Coos County on the southern Oregon coast have a **median age of 43.1 years**. Residents in this mostly rural county live as part of one of the seven communities spread over **1629** square miles. In 2005, Coos County's ethnicity was comprised of:

- **93.6%** white, or **89.8%** white non-Hispanic,
- **4.3%** Hispanic or Latino,
- **2.3%** Native Americans,
- **1%** Asians,
- **0.5%** Black or African Americans, and
- **0.2%** Hawaiian/Pacific Islanders.

The largest population centers are the adjacent communities of Coos Bay (16,005) and North Bend (9,846), which border the largest deep-water port on the Oregon coast. The rich ocean and lush forests once supported thriving commercial fishing and timber harvesting industries whose importance to the economy has declined. Seasonal jobs dependent on tourism have replaced many family wage jobs.

- The per capita income (2004) is **\$26,953** (State: \$32,289), with a median household income of **\$33,178** (State: \$42,568).
- **16%** of the population lives below the poverty line (State: 12.9%).
- As of January 2007, **7.0%** of adults in Coos County were unemployed. (State: 6.0%)
- In 2005, **13.8%** of the population was enrolled in the Oregon Health Plan.
- On the Oregon Healthy Teens survey for 2005-2006, **21%** of eleventh graders reported physical health care needs that had not been met in the previous 12 months, because of financial restraints. The 2000 census showed that **14.6%** of the population of Coos County had no health insurance compared to 13.5% in Oregon, and **12%** of children under age 18 in our county had no health insurance compared to 11% Statewide.

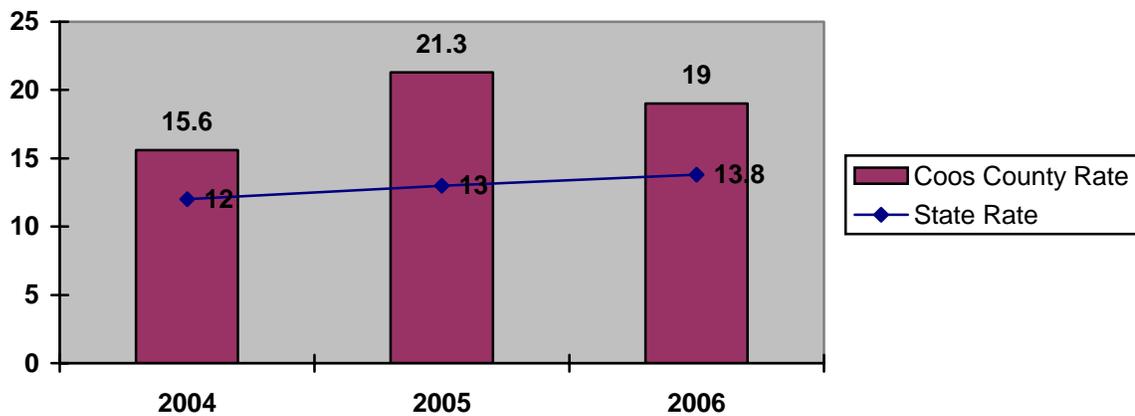
Public Health concerns in Coos County have multiple causes and are related in part to poverty, socioeconomic conditions, our aging population, the environment, and behavioral factors. Some major issues are:

**Alcohol and Drug Use:** On the 2005-2006 Oregon Healthy Teens survey (OHT), **35%** of 8<sup>th</sup> graders and **42.6%** of 11<sup>th</sup> graders reported having consumed beer wine or hard liquor in the previous 30 days. Amongst 11<sup>th</sup> graders, **26.3%** reported having 5 or more drinks in a short period of time during the last 30 days. On the OHT survey, **17.7%** of eighth graders and **26.4%** of 11<sup>th</sup> graders reported use of illicit drugs during the past 30 days. Less than 1% have used methamphetamines.

**Cancer:** Figures for 2000-2004 show an age adjusted cancer rate 2.6 percentage points lower than the previous years' report. **This puts Coos County third in the State (out of 36 counties) for high incidence cancers.** Much of this is a consequence of historically high smoking rates. Rates for high incidence cancers were **531.2** per 100,000 compared to 480.9 for the State. Coos County:

- Achieved age adjusted cancer mortality rates of **222.9** (State: 198.9), ranking third in the State.
- Ranked **highest** in the State for incidence of lung cancer at **91.9** per 100,000 (State:69.6) and **highest** for lung cancer deaths at **77.3** per 100,000 (State:56.4).
- Ranked **3<sup>rd</sup>** in the State for age adjusted rate of malignant melanoma with a rate of **28.8** per 100,000. (Douglas and Deschutes were 1<sup>st</sup> and 2<sup>nd</sup>.)
- Ranked **2<sup>nd</sup>** for oral and pharyngeal cancer with an average yearly rate of **14.4** per 100,000 (State: 11.3), from 1996-2004.
- Had the **18<sup>th</sup>** highest rates of breast cancer, at **136.4**, similar to the State levels of 138.8.
- Had the second lowest rate for colon and rectal cancers at 37 (State: 48.8).
- Had incidence rates of **169.5** (State: 157.8) for prostate cancer, with age adjusted mortality of **23** (State: 28.4).

**Rate of Child Abuse/Neglect**



**Child Abuse:** Coos County's rate of child abuse and neglect was slightly down in 2006 to **19.0** from 21.3 in 2005. The State rate was 13.8. In 2006, there were **649** reports of child abuse and neglect and **136** foster care entrants, compared to 781 and 154 in 2005 respectively. The high rate of child abuse and neglect is usually attributed to the high rates of several stress factors, including drug and alcohol abuse, crime, domestic violence and unemployment. In Oregon, mothers were involved in the abuse/neglect **43.9%** of the time, fathers **29.5%** of the time and stepfathers **4.5%** of the time, and live-in companions **5.1%** of the time. The major reasons for placement in foster care were drug and alcohol abuse, physical abuse, neglect, the child's behavior, inability to cope, and inadequate housing.

**Chronic Disease:** Asthma continues to present a health burden to residents of Coos County with a population prevalence of **8.7%** as measured by a combined 2002-2005 survey. This means over **5600 people in Coos County suffer from asthma**. The State asthma prevalence is 9.9%. The asthma rate for the Medicaid population is more than double that of privately insured persons. Of Oregon counties, Coos County has the **3<sup>rd</sup>** highest rate of hospitalization for asthma, at **13.5** per 10,000 residents, with a total of **438** hospitalizations for asthma from 2001-2005.

According to the 2004 Behavioral Risk Factor Surveillance System survey, **26.9%** of adult Oregonians suffered from diagnosed arthritis and another **22%** had chronic joint symptoms that were not formally diagnosed as arthritis. Coos County's rate was **26.4%**. Arthritis is the leading cause of disability in the U.S.

The death rate from diabetes in Coos County is 1.7 times the diabetes death rate in the State. Diabetes provides a significant contribution to poor health in Coos County. The diabetes rate from 2002-2005 was **7.0%**, compared to a State rate of 6%. It is estimated that **2.4%** of the residents have undiagnosed diabetes. **This means that currently at least 9.4%, or 6093, of the people in Coos County have diabetes.** This number is expected to grow markedly as a result of our high rates of smoking and overweight.

Cardiovascular disease is the number one cause of death in Coos County. From 2002-2005, the death rate from heart disease for the Coos County was **226.3** per 100,000 (State: 191.8). Deaths from strokes was 66.4 (State: 68.8). In 2002 heart disease and stroke combined accounted for **35%** of the total deaths. In Coos County, 5% of the population has suffered from heart attack, **7%** from coronary heart disease, and **3%** from stroke. Statewide, the prevalence rate for heart attack is about 4%, the rate for coronary heart disease is about 4% and the rate of stroke is 2%.

**Communicable Disease:** Chlamydia remains the most common reportable communicable disease in Coos County with **77** cases reported in 2006, compared to 115 cases reported in 2005. There were **2** cases of gonorrhea, and **3** cases of syphilis. Other reportable diseases include: **7** cases of salmonella; **5** cases of meningococcal disease; and **2** active cases of tuberculosis.

**Environmental Health Issues:**

- On **9** separate occasions alerts were issued for bacteria counts exceeding the maximum contaminant level in public water systems.
- **1** boil water notice for community water systems was issued.
- A harmful algae bloom closed recreational shellfish harvesting on the Coos County Coast for several weeks.
- **7** health advisories (ranging from 2-4 weeks) discouraged water contact on two ocean beaches as a result of Enterococcus bacteria levels.
- **4** municipal sewage treatment systems reported outflows of untreated sewage into fresh water.
- **5** properties remain catalogued on the "unfit for use list" due to methamphetamine drug lab contamination.

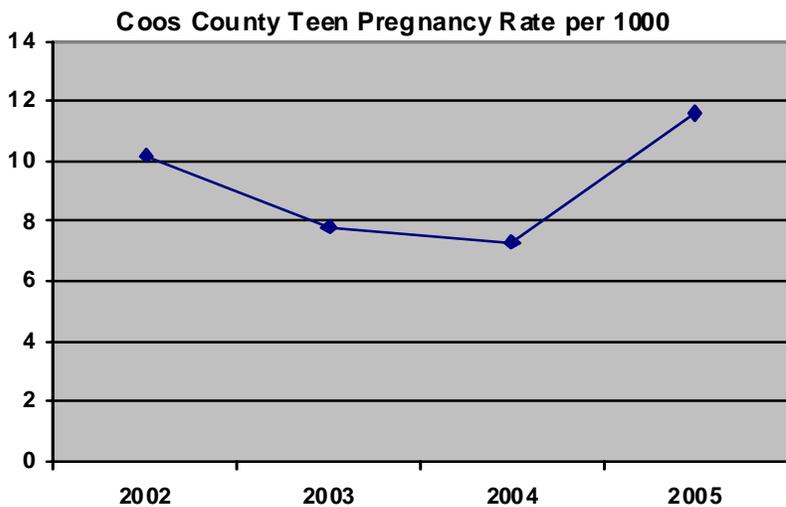
**Hunger:** Hunger is most often a direct consequence of poverty. The Coos County poverty rate was **16%** in 2004 compared to a State rate of 13%. Coos County had the fourth highest poverty rate in the State. Over 20% of children in our county live in poverty. Families with poverty level incomes in Coos County can only afford about half of a basic family food budget. In our county, **15.5%** of the population receives Food Stamps and **51.6%** of school children qualify for Free and Reduced Lunch Programs. Single parent families make up about **10%** of the population. Single mothers have a **38.7%** poverty rate. Eleven percent of eighth graders report that they or their family members skip meals or eat less because of financial restraints.

**Overweight and Obese:** Obesity has become the second most important preventable cause of disease, disability and death after smoking. The latest reported figures indicate **37.3%** of Coos County adults are overweight and **23.6%** are obese compared to 37.0% and 22.1% respectively for the State. **12.6%** of Coos County 8<sup>th</sup> graders are overweight and **11.9%** of 11<sup>th</sup> graders.

**Tobacco Use:** Coos County has a high rate of smoking, with **27%** of the adult population being smokers. Statewide, the rate is under 20%. The smoking rate in Medicaid clients in Coos County is **39%**. In Coos County, **24%** of pregnant women smoke, compared to the State smoking-in-pregnancy rate of just over 11%. On the Oregon Healthy Teens (OHT) survey, **15.9%** of eighth graders report living in a house where someone smokes inside the house. Smoking in young people continues to be relatively low, with only 4.2% of eighth graders and 9.6% of 11<sup>th</sup> graders reporting smoking on 10 or more days in the last month. Almost 70% of eighth graders have never smoked a cigarette. Almost **25%** of all deaths in our county are smoking related. The annual death rate from tobacco related diseases in Coos County from 2002-2005 was **243.6** per 100,000, sixth highest in the State. (State: 184.8)

**Birth:**

- Teen pregnancy rates (age 10-17) declined over 5 years from 10.2 per 1000 in 2002 to 7.8 in 2003 and continued to decline to 7.3 in 2004. The 2005 rates are 11.6 per 1000 females, ages 10-17. The State rate in 2005 was 9.5. The preliminary rolling rate for January through December 2007 shows the rate declining again, at 6.6 per 1000 females, ages 10-17.



- In 2004, the rate of low birth weight babies had improved, decreasing to 6.0% (38 babies) (State: 3.6%) from 7.3% in 2003. In 2005, the rate of low birth weight babies born in Coos County moved back up to 7.2%. The State rate for 2005 was 6.1%.
- Rates of inadequate prenatal care had declined to 7% in 2002 and then 6.2% in 2003. In 2004 the rate moved up to 8.2% and continued to rise in 2005 to 12.7% (State: 5.8%).

## **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 also reports 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.

Funding is insufficient to have staff dedicated solely to investigation of communicable disease reports. Completion of investigations by Fridays, especially when the case is reported at the end of the week, is an ongoing challenge. Nurses continue to respond to the CD calls and investigations 24 hours a day 7 days a week after hours, with calls relayed through our dispatch 911 service. An updated contact schedule is provided each Friday to dispatch. A large outbreak or public health emergency would require far greater resources than this department has available.

Our department has lost funding that we have had in past years to provide prevention programs for the chronic diseases of diabetes and asthma. We are a contract provider for the breast and cervical cancer screening program. We are pleased to have funding for a tobacco prevention program, as our rates of smoking continue to be higher than the state's rates. We have recently received funding to do community assessment and action planning for "tobacco related and other chronic diseases."

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

Nurses provide home visitation in Babies First! (aka Parents as Teachers) Healthy Start, and CaCoon programs. All Parent educators (nurses and public health aides) use the Parents As Teachers curriculum. Depending on the specific home visiting program, staff either follow State Commission on Children and Families Healthy Start Policies and Healthy Families America guidelines or 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.

**UPDATE:** For this coming year, we are projecting to have 2.4 FTE nurses providing services in the home visiting programs, including the manager who supervises the Healthy Start Program at .5 FTE. Additional nurse time is projected to be contracted at .6 FTE to work with DHS's Self sufficiency JOBS Program to help case managers with health assessments. In addition, we will have three full time paraprofessional parent educators, one who works in the Parents As Teachers program and 2 who will work in the Healthy Start program. All aides work under the supervision of a public health nurse.

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.

**UPDATE:** Due to the inadequate Medicaid reimbursement rates ( for Healthy Beginnings) we can no longer afford to provide maternity case management home visiting services to pregnant women. Instead, focus will shift to referring expectant mothers to other available services within the county and offering assistance in competing OHP applications through our Oregon Mothers Care program.

According to the service data for Oregon Title X Family Planning Agencies, in 2007 there were 2,824 *women in need* (WIN) in our county between the ages of 13 and 44. We served 1,467 of those WIN clients in 2007, or 51%, (compared to 56% the previous year) *State average 2007: 58.5%*). Of the estimated number of teens in need of services ages 15-17, we served 26% (n=222). Our contraceptive services are estimated to have averted 228 pregnancies. The teen pregnancy rate in the county continues to decline after a rise in the previous year.

This past year we received funding for a certified school based health center, located on the Marshfield High School Campus. Public Health was instrumental as a pass through agency for funds to supplement the SBHC budget needs.

### **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 well women over 40 years of age to local resources for primary care, 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.

To enlighten the community about public health services, we continue to publish an annual report, post messages on our electronic sign on the front of the County Annex, send public

service announcements regarding services and new developments, post educational bulletins and general information on our newly developed My Space account, speak to groups about “*Public Health in Our Communities*,” upon request, and strive to complete our website.

## 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 (this year monitoring will include the additional systems with 4-14 connections) and perform a limited number of septic loan inspections. We also inspect correctional 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 may consider delegation for this function at a future date.

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 a full time Environmental Health (EH) Specialist trainee and an EH Program Manager, with .9 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. Many others in our rural county are on small water systems without fluoridation or have 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. The maternal / child health staff are continuing to work with local dentists and community partners to increase access to dental care for pregnant women and children. We share educational resources with the dental hygiene society and provide “lift the lip” screening/referral services to children and parents in Healthy Start, WIC, SSP/TANF, and the Southern Oregon Community College’s Family Center.
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 worked with the County Emergency Management staff to update the medical portion of the County's Emergency Response Plan and have drafted the emergency communication plan for the department and the pandemic influenza response plan. 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 that we will continue to provide include breastfeeding support in WIC; food handler training; parent education for parents of newborns; correct use of child safety seats in vehicles; safer sex practices for persons with HIV.
4. **Laboratory Services:** Our department has a CLIA waived lab, currently licensed as a PPM lab. We 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, and family planning services. Funds have not been available to do community-wide promotion activities, e.g., for weight control and prevention of heart disease. Although we expect to include these topics in our community assessment funded by the "tobacco related and other chronic disease" project.
7. **Older Adult Health:** This department provides flu shots and other immunizations to our older population. We currently are a contracted provider for the Breast and Cervical Prevention Program, which serves women (and men) ages 40-64 who meet the eligibility criteria. Our department does not currently have funds to target other important health interventions 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 continue to provide limited assistance to persons seeking publicly funded insurance, and prescription assistance. Through Oregon Mothers Care, we help pregnant women get appointments for prenatal care and apply for financial assistance. 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 2008/2009**

### **Current Condition or Problem:**

1. Coos County investigated 346 reports of communicable disease during FY 2006/2007; including the following:

**AIDS/HIV** – 0 case, (1 case in 2005)  
(4 in 2003)

**Hepatitis C** - processed 191 lab reports,  
(159 in 2005)

**Chlamydia** –77 cases, (115 in 2005)

**Pertussis** – 2 cases, (5 in 2005)

**Gonorrhea** – 2 cases, (2 in 2005)

**Meningococcal disease** – 5 cases, (3 in 2005)

**Hepatitis A** - 1 cases, (0 in 2005)

**Giardiasis** – 14 cases, (8 in 2005).

**Hepatitis B** – 8 cases, (7 in 2005)

2. Coos County Public Health (CCPH) continues to respond to communicable disease calls 24/7. We have trained individuals in basic BT/CD Epidemiology (CD 101), and also CD 303. One Environmental Health Specialist is also trained in CD 101 and 303, and the other EH specialist will also be trained to respond to questions and concerns when it is applicable to their field.
3. 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 Investigative Disease Guidelines.
4. 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.
5. 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.
6. 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.
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 emergency call back of trained CD staff via 911/dispatch service for 24/7 coverage.
- 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, as funding and support permits.
- Train any 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 investigative guidelines.
- 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.
- Hold additional meetings with Bay Area Hospital department heads (from nursing, medical records, lab, client care supervisor) and public health staff (environmental health, communicable disease nurse, and clinic manager).

**Evaluation:**

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

**Challenges:**

Funding continues to be inadequate to meet the requirements of this contract program element.

## **Tuberculosis**

### **Action Plan 2008/2009**

#### **Current Condition or Problem:**

In FY 2006/2007, our nurses investigated 4 possible cases of tuberculosis, of which 2 were found to be active cases. Latent tuberculosis infection (LTBI) continues to be identified in the county. During the past fiscal year, 7 individuals received antibiotic treatment and monthly evaluation for latent tuberculosis. These numbers are up from 2005 when we had 4 LTBI patients. Most cases have been identified during testing for purposes such as immigration, employment, and school admission. Nurses performed skin testing for 137 individuals.

#### **Goals:**

- Accurately identify active and latent TB cases in the community.
- Ensure that the active tuberculosis cases receive Directly Observed Therapy (DOT), as necessary, for the duration of therapy appropriate to their cases.
- 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 often 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.

Local Health Department: Coos County Public Health

**Plan A - Continuous Quality Improvement: 4:3:1:3:3 Immunization Series Coverage Rate**

Fiscal Years 2007-2010

Year 1: July 2007 – June 2008		
Objectives	Methods / Tasks	Outcome Measure(s)
<p><b>A.</b> Increase the 4:3:1:3:3 immunization series coverage rate by 1% and decrease the missed shots rate by 1%</p>	<ul style="list-style-type: none"> <li>• Quarterly reminders will be mailed to the parents of children 12-35 mo. who are due for a 4th DTaP and children 2-35 mo. who are late starters (received their first shot after 3 months of age).</li> <li>• Use IRIS and ALERT to forecast. Recommend to parents that the child receive all shots due at the time of visit.</li> <li>• Assess the 4:3:1:3:3 immunization rates annually.</li> <li>• Assess the missed shots rate annually.</li> </ul>	<ul style="list-style-type: none"> <li>• Reminders will be sent by the last business day of the quarter (i.e. Sep 30).</li> <li>• With each visit, an IRIS and ALERT forecast will be printed 100% of the time for children 2 years of age and younger.</li> <li>• The 4:3:1:3:3 immunization rates will increase by 1%.</li> <li>• The missed shots rate will decrease by 1%.</li> </ul>

Outcome Measure(s) Results	Progress Notes
<ul style="list-style-type: none"> <li>• Reminders sent:  <b>First quarter</b> – 32 reminders sent on 9/21/07 for the 4<sup>th</sup> DTaP due. 7 reminders sent on 10/7/07 for late starters due for a DTaP.  <b>Second quarter</b> – 31 reminders sent on 1/11/08 for children 12-35 months due for a DTaP.  <b>Third quarter</b> – 20 reminders sent on 4/8/08 for children &lt;35 months of age due for a DTaP</li> <li>• IRIS and ALERT forecasts are printed at 100% of visits for children 2 years of age and younger.</li> <li>• The 4:3:1:3:3 rate increased from 69% in 2006 to 76% in 2007</li> <li>• <b>The missed shots rate decreased from 16% in 2006 to 15% in 2007.</b></li> </ul>	<p>During the end of the <b>1<sup>st</sup> quarter</b>, there were problems retrieving the 4<sup>th</sup> DTaP report from IRIS. An IRIS 4<sup>th</sup> DTaP report was finally obtained from IRIS on 9/21/07. A list of “late starters” was received from ALERT in October. The list was largely children with a status of “WIC Only”. After excluding the “WIC Only” children, reminders were sent for “late starters” who were due for a DTaP.</p> <p>At the end of the <b>2<sup>nd</sup> quarter</b>, there were problems retrieving the IRIS 4<sup>th</sup> DTaP report and data was unable to be obtained. A list of “late starters” was received from ALERT on 12/4/07. The list only had children with a status of “Active”, but should also have included children with a status of “Change in medical home, Provider pending, etc. On 1/2/08, a second report was received from ALERT with children 12-35 months of age due for a DTaP.</p> <p>For the <b>3<sup>rd</sup> quarter</b>, a list of children less than 35 months due for a DTaP and “late starters” due for anything was received from ALERT on 4/8/08. There are children on the 2<sup>nd</sup> quarter list who did not return for their DTaP, but were not included on the 3<sup>rd</sup> quarter list.</p> <p>In order to reach this objective, the list received from ALERT must include children with the same status and age groups as the list of children used for the <i>Annual Assessment of Immunization Rates and Practices</i>. This will ensure that reminders are sent to the same children which the <i>Annual Assessment of Immunization Rates and Practices</i> data will reflect at the end of the year. Coos County Public Health continues to work with ALERT to obtain the appropriate list of children each quarter.</p> <p>Even with the difficulty in obtaining reports of children due for a DTaP, Coos County Public Health was able to increase the 4:3:1:3:3 rate and decrease the “missed shots” rate.</p>

Local Health Department: Coos County Public Health

**Plan A - Continuous Quality Improvement: 4:3:1:3:3 Immunization Series Coverage Rate**

Fiscal Years 2007-2010

Year 2: July 2008 – June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p><b>A.</b> Increase the 4:3:1:3:3 immunization series coverage rate by 1% and decrease the missed shots rate by 1%</p>	<ul style="list-style-type: none"> <li>Quarterly reminders will be mailed to the parents of children 12-35 mo. who are due for a 4th DTaP and children 2-35 mo. who are late starters (received their first shot after 3 months of age).</li> <li>Use IRIS and ALERT to forecast. Recommend to parents that the child receive all shots due at the time of visit.</li> <li>Assess the 4:3:1:3:3 immunization rates annually.</li> <li>Assess the missed shots rate annually.</li> </ul>	<ul style="list-style-type: none"> <li>Reminders will be sent by the last business day of the quarter (i.e. Sep 30).</li> <li>With each visit, an IRIS and ALERT forecast will be printed 100% of the time for children 2 years of age and younger.</li> <li>The 4:3:1:3:3 immunization rates will increase by 1%.</li> <li>The missed shots rate will decrease by 1%.</li> </ul>		

Local Health Department: Coos County Public Health

**Plan A - Continuous Quality Improvement: 4:3:1:3:3 Immunization Series Coverage Rate**

Fiscal Years 2007-2010

Year 3: July 2009 – June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p><b>A.</b> Increase the 4:3:1:3:3 immunization series coverage rate by 1% and decrease the missed shots rate by 1%</p>	<ul style="list-style-type: none"> <li>Quarterly reminders will be mailed to the parents of children 12-35 mo. who are due for a 4th DTaP and children 2-35 mo. who are late starters (received their first shot after 3 months of age).</li> <li>Use IRIS and ALERT to forecast. Recommend to parents that the child receive all shots due at the time of visit.</li> <li>Assess the 4:3:1:3:3 immunization rates annually.</li> <li>Assess the missed shots rate annually.</li> </ul>	<ul style="list-style-type: none"> <li>Reminders will be sent by the last business day of the quarter (i.e. Sep 30).</li> <li>With each visit, an IRIS and ALERT forecast will be printed 100% of the time for children 2 years of age and younger.</li> <li>The 4:3:1:3:3 immunization rates will increase by 1%.</li> <li>The missed shots rate will decrease by 1%.</li> </ul>		

Local Health Department: Coos County Public Health  
**Plan B - Chosen Focus Area: AFIX Exchange Luncheon**  
 Fiscal Years 2007-2010

Year 1: July 2007 – June 2008				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p><b>A.</b> Educate public and private providers on ways to increase immunization coverage rates.</p>	<ul style="list-style-type: none"> <li>• Assist with the annual AFIX Exchange Luncheon to be hosted by the DHS IZ program AFIX team.</li> <li>• Staff from all private and public clinics that provide immunizations will be invited to attend the AFIX Exchange Luncheon.</li> </ul>	<ul style="list-style-type: none"> <li>• The annual AFIX meeting will be held in the Spring 2008.</li> <li>• There will be attendance from Bay Clinic, NBMC-Bandon, NBMC-Coos Bay, NBMC-Coquille, NBMC-Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC.</li> </ul>	<ul style="list-style-type: none"> <li>• The annual AFIX meeting will be held May 6, 2008.</li> <li>• Invitations were mailed to Bay Clinic, NBMC-Bandon, NBMC-Coos Bay, NBMC-Coquille, NBMC-Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC.</li> </ul>	

Local Health Department: Coos County Public Health  
**Plan B - Chosen Focus Area: AFIX Exchange Luncheon**  
 Fiscal Years 2007-2010

Year 2: July 2008 – June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p><b>A.</b> Educate public and private providers on ways to increase immunization coverage rates.</p>	<ul style="list-style-type: none"> <li>• Assist with the annual AFIX Exchange Luncheon to be hosted by the DHS IZ program AFIX team.</li> <li>• Staff from all private and public clinics that provide immunizations will be invited to attend the AFIX Exchange Luncheon.</li> </ul>	<ul style="list-style-type: none"> <li>• The annual AFIX meeting will be held in the spring 2009.</li> <li>• There will be attendance from Bay Clinic, NBMC-Bandon, NBMC-Coos Bay, NBMC-Coquille, NBMC-Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC.</li> </ul>		

Local Health Department: Coos County Public Health  
**Plan B - Chosen Focus Area: AFIX Exchange Luncheon**  
 Fiscal Years 2007-2010

Year 1: July 2009 – June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p><b>A.</b> Educate public and private providers on ways to increase immunization coverage rates.</p>	<ul style="list-style-type: none"> <li>• Assist with the annual AFIX Exchange Luncheon to be hosted by the DHS IZ program AFIX team.</li> <li>• Staff from all private and public clinics that provide immunizations will be invited to attend the AFIX Exchange Luncheon.</li> </ul>	<ul style="list-style-type: none"> <li>• The annual AFIX meeting will be held in the Spring 2010.</li> <li>• There will be attendance from Bay Clinic, NBMC-Bandon, NBMC-Coos Bay, NBMC-Coquille, NBMC-Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC.</li> </ul>		

## **Increase Access to Early and Adequate Prenatal Care Action Plan 08/09**

### **Current Condition or Problem:**

In 2006, 14.6% 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 6.2%. In 2006, 69.8% of all pregnant women in Coos County received prenatal care in the first trimester compared to the state rate of 79.2. Of the women enrolled in our Maternity Case Management program this past year, 77.6% received early prenatal care during their first trimester.

The following statistics reflect the 34 women served in our Maternity Case Management program for the 2006-2007 year:

- 75% received early prenatal care (within the first trimester of pregnancy)
- 79% were unplanned pregnancies
- 100% had nutritional risk factors
- 99% had oral health issues
- 63% were unmarried
- 29.8% of women were 19 years or younger. Over 13 percent (13.5%) were 17 years or younger, compared to the 2006 county rate of 4.6% and the 2006 state rate of 2.8%
- 31% had less than a high school education
- 22% were victims of domestic violence
- 44% had a current or history of mental health issue(s)
- 46% used tobacco compared to the 2006 county rate of 26.3% and the 2006 state rate of 12.3%. Of those MCM clients who smoked, 56% quit and 11% decreased smoking during their pregnancies.
- 24% admitted to using alcohol. Of those MCM clients who drank, 92.9% quit during their pregnancies.
- 18 % admitted to using or having used drugs compared to the 2004 county rate of 3.9% and the 2004 state rate of 1.8%. Of those clients who admitted to using drugs, 95% quit during their pregnancies.
- 13.7% of births were premature.
- 8% of infants had birth weights < 2500 grams

Client satisfaction surveys showed an average score of 4.5 out of a possible 5, achieving our 2006 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)
- Mental health issues/conditions
- Previous involvement with Child Welfare Protective Services

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

- 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.
- Lack of smoking cessation support groups
- Lack of easy access and treatment for dental care during pregnancy
- Due to the inadequate Medicaid reimbursement rates and lack of County general fund support, this program can no longer afford to offer home visiting services to pregnant women living in Coos County.

### **Goals:**

- Continue to be an active participant in the Coos County Perinatal Task Force to identify perinatal issues and solutions that help to improve outcomes for both mother and baby
- Refer pregnant women to locally available services
- High level outcome: **Strong nurturing families and healthy thriving 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 Oregon Mother's Care (OMC) Program.
- Refer pregnant clients from internal Public Health Department programs such as WIC and pregnancy testing to Oregon Mothers Care (OMC) and outside agencies which provide support during the prenatal period such as The MOMS program through Bay Area Hospital, Coquille Valley Hospital's perinatal outreach program, and Pregnancy Resource Center.
- 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, DHS Food Stamps/Temporary Aid to Needy Families, and physicians and other organizations.
- Continue to assist with the Perinatal Task Force's new perinatal depression group, "Parenting Survival Skills: Adjusting to Your New Baby," that provides 4 weeks of education to pregnant and postpartum mothers, and a follow-up support group.
- Continue to meet with the Coos County Breastfeeding Coalition.
- Attempt to locate additional sources of funding to help support the MCM program.
- Encourage state nursing consultants to work with OMAP and other policy makers to increase MCM reimbursement rates, considering that service to an MCM client actually is benefiting the health and wellness of 2 clients (mother and unborn child).

### **Evaluation:**

- Number of pregnant women served through Oregon MothersCare 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. Lack of financial support has resulted in our phasing out this crucial service.

## **Infants and Children Will Have Nurturing Caregivers & Decreased Child Abuse Action Plan 2008-2009**

### **Current Condition or Problem:**

The statistics for child abuse showed that Coos County is now ranked 14<sup>th</sup> in the state (an improvement from 7<sup>th</sup> in the state) with a rate of 19.0 per 1000, down from 21.3 per 1000 in 2005. The state rate is 13.8 per 1,000. 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. The major reasons for placement in foster care were drug and alcohol abuse, physical abuse, neglect, the child's behavior, inability to cope, and inadequate housing.

One participant in our Babies First! (Parents As Teachers) program stated:

*"I just have a really hard time with this [parenting and discipline] because I was so abused as a child. I'm afraid that I will lash out like when it happened to me."*

The following statistics reflect a sampling of the 436 children served in our Babies First (Parents As Teachers) and CaCoon programs for the 2006-2007 fiscal year:

- 100% of parents stated their needs were identified
- 100% of parents stated their parent educator helped them understand how their child grows and develops
- 100% of parents stated they felt comfortable discussing their concerns with their parent educator
- 100% of parents stated they felt more confident as parents
- 91% of parents stated their parent educator connected them to useful resources
- 90% of parents stated their parent educator helped them strengthen their relationship with their child
- 100% of parents stated their parent educator helped them learn and use positive discipline methods

### **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 regularly scheduled home visits through the **Babies First! (AKA Parents As Teachers)** 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 through age four. 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. Using the Parents As Teachers best practice curriculum, and following the Babies First protocols, nurses and public health aides (under the supervision of a nurse) help parents learn positive parent-child interactions, child development, realistic expectations, and coping skills. This parenting 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. The CaCoon Nurse will participate in Community Connections as needed and as able, considering the limitations of funding.
- Provide the **Healthy Start** program to first time families identified as eligible to receive Healthy Start services. This program was transferred to CCPH in fiscal year 06-07. Policies and procedures have been developed that adhere with the state Healthy Start policies and procedures, Healthy Families America best practice guidelines and state/county CCF protocols. This program fits well into CCPH’s existing continuum of home visiting programs.
- Consider expending Healthy Start into the prenatal period to help offset the phasing out of our Healthy Beginnings (Maternity Case Management) program and/or developing a Supervisor/FSW position to expand services to families in the postpartum period.
- Assist with the perinatal depression group, “Parenting Survival Skills: Adjusting to Your New Baby,” which was recently formed through a collaborative effort of our local Perinatal Task Force. The depression group consists of a 4 week curriculum 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.

- Continue to participate in the Coos County Breastfeeding Coalition to promote breastfeeding and improve breastfeeding rates among county residents.
- Continue to partner with Bay Area Hospital through their Community Development Grant to provide parenting education services to families who may not be eligible for Targeted Case Management billing.
- Continue to develop rapport with local and regional dental community to improve access and treatment of pregnant women and young children to promote early childhood cavities prevention.
- Seek funding opportunities through grants and/or contracts to help support our maternal child health services.
- Work with regional dental consultants to possibly plan for setting up a dental clinic to assess our Family Health home visiting clients as well as WIC clients.
- Maternal Child Health Home Visiting Supervisor will continue to participate in local MDT and Child Fatality Review Board.
- Maternal Child Health staff will continue to participate in DHS: Child Welfare Services's System of Care meetings, Family Decision Meetings, etc. as appropriate.
- Maternal Child Health staff will continue to participate in Family Violence Council meetings.
- Continue to be active participants on the Coos County *Zero to Three Court Team* pilot program, providing administrative support as well as direct services to enrolled families via our Healthy Start, Babies First! and CaCoon programs.
- Consider sending the Maternal Child Health Home Visiting Supervisor or other delegate to "Circle of Security" training to then be able to provide more in depth training to remainder of staff on issues related to attachment.
- Plan on sending at least 1-2 field staff to annual Child Abuse Summit, if funding available.
- Continue to offer inservice training to staff, on topics such as domestic violence and child abuse.

### **Evaluation:**

For families served by **Babies First! (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 parents 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
- Additional evaluations will be conducted by the state, and our staff will participate as needed.
- For families served by **CaCoon**:
  - Evaluations will be conducted by the state, and our staff will participate as needed.
- For families served by **Healthy Start**:
  - Evaluations will be conducted by the state and local Commission on Children and Families. Staff will participate as needed.

## **Decrease Prenatal Tobacco Use Action Plan 2008/2009**

### **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 2006 statistics, 26.3% of pregnant women in Coos County used tobacco, reflecting a significant increase from the previous year and more than twice that of the state rate of 12.3%. Coos County is now ranked 2<sup>nd</sup> highest in the state for pregnant women who smoke.

Nearly 46% of the women enrolled in our Healthy Beginnings (MCM) program in 2006-2007 used tobacco products during their pregnancies. While we may have had a disproportionate number of smoking women enrolled in our prenatal program compared to the county, 56% of these women were successful in their efforts to quit and 11% were able to decrease their level of smoking.

### **Goals:**

- Continue to offer 5As cessation trainings to health care providers
- Promote the use of the Oregon Tobacco Quitline by Coos County residents and smoking cessation resources (such as Fresh Start Family and classes by DOCS)

### **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. If funding is available, bring in speaker to provide local training for health care providers focusing on the 5 A's, motivational counseling, and stages of change.
- Continue to participate in the Chronic Disease 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 case management providers, and healthcare personnel.

- Continue to refer to the Oregon Tobacco Quit Line, and local cessation programs.
- Collaborate with Tobacco Prevention Program's Public Health Educator in tobacco related projects for pregnant women

**Evaluation:**

- WIC, Family Planning, and other home visiting programs will track the smoking status of their clients
- The 2007 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**  
**Reduce the Risk of Unintended Teen Pregnancy &**  
**Assure High Quality Family Planning Services**  
**Action Plan 08-09**

**Current Condition or Problem:**

In 2007, there were an estimated 2,824 *women in need* (WIN), ages 13-44, according to Region X data. Our family planning clinic served 1,457 unduplicated or 50.8% of the WIN, compared to 1,647 clients served in 2006. According to the Healthy Teens Survey, 57.3% of the 15-17 year old females in the county are sexually active, and 25% of those were served by our agency in family planning. Of the total 476 teens served, 222 were in the age range of 10-17, and 254 in the age range of 18-19. Teen clients comprised 32% of the total clients that were served in the Family Planning Clinic, which is consistent with the previous year.

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 2005 rates were **11.6** per 1000 females, ages 10-17, compared to the state rate of 9.5. However, the **preliminary rolling** rate is 6.6 for January through December 2007, which is good news.

Funding to sustain our family planning services is becoming more challenging, with the loss of county general fund support and the eligibility requirement for citizenship in order to receive Medicaid payment through the family planning expansion project. The local Waterfall Clinic became an FPEP provider in 2006, and provides FPEP services to the same client pool that we serve. Teens are also served by Waterfall Clinic through the school based health center in Coos Bay, which receives public health funding.

Outreach activities have occurred on the local community college campus and at special community events for teens (Teen Summit and Teenopoly), and presentations in 2 school districts. Family planning clinic days at the Coquille satellite office are offered twice a month. The Students Today Aren't Ready for Sex (STARS) abstinence program was discontinued in 2007/08 due to lack of funds, and any outreach/education will be limited in FY 2008/09 due to the decrease in funding.

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
Changes in FPEP enrollment have led to increased staff time without additional reimbursement, threatening the ability of the agency to maintain current level of service.	1) Increase revenue from donations by 10% for the period ending June 30, 2008	<ul style="list-style-type: none"> <li>Develop a donation policy and procedure consistent with Title X guidelines.</li> <li>Train staff in positions to make the donation requests.</li> <li>Implement donation request policy.</li> <li>Evaluate policy for consistency, fairness and effectiveness</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly and fiscal year end revenue reports</li> <li>Customer feedback</li> <li>Staff feedback</li> </ul>

*Update:* Objective was met in 2006/07. Four new sources of donations have been established, in addition to an increase in client donations. A customer satisfaction survey reveals positive comments from over 90% of the respondents.

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
Unable to offer IUDs due to untrained staff.	1 NP will be able to offer IUD insertions by September 30, 2007	<ul style="list-style-type: none"> <li>Identify IUD training events and resources.</li> <li>Paragard has been contacted and we expect a return call from the representative for our area.</li> <li>A local physician has been contacted and is willing to do some precepting.</li> <li>Support NP to attend an IUD training and preceptorship.</li> <li>Add IUD as a birth control option for clients</li> </ul>	<ul style="list-style-type: none"> <li>IUD training certificate</li> <li># of IUDs inserted/removed</li> </ul>

*Update:* Objective was met in 2006/07. NP received IUD training and since the training has inserted 17 IUDs. See new objective below.

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Continuing education on contraceptive methods is costly due to distance required to drive, and time out of clinic, with resulting loss of revenue.	Obtain FP education and CEUs without going out of town.	Register staff for phone and web conferences.	6 FP/Title X conferences will have been attended via phone conferencing.

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

**Goal 1:**      **Oregon WIC staff will have the knowledge to provide quality nutrition education.**

**Year 1 Objective:**

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

**Activity 1:**

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

**Outcome evaluation:**

- All certifiers successfully completed the Nutrition Risk Module.
- Competency achievement checklist was filed for each certifier.
- Dates were entered into TWIST .

**Activity 2:**

All certifiers will complete the revised Dietary Risk Module by March 31, 2008.

**Outcome evaluation:**

- All certifiers successfully completed all the activities of the Dietary Risk Module.
- Completion dates were entered into TWIST.
- Competency achievement checklist filed for each certifier.

**Activity 3:**

Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2007-2008.

**Outcome evaluation:**

- Staff in-services were held as planned.
- The objectives were met and these addressed the need for staff to be current in module completion.

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

**Year 1 Objective:**

During plan period, each agency will implement strategies to provide targeted, quality nutrition education.

**Activity 1:**

**Outcome evaluation:**

- State provided resources were used to conduct a needs assessment of our community to determine relevant health concerns and assure that our nutrition education activity offerings meet the needs of our WIC population.
- Smoking, obesity, dental care and breastfeeding duration were relevant concerns in our area.
- The information was used to plan client classes and shared with other Public Health teams.

**Outcome Evaluation:**

- Group nutrition education schedule was submitted for 2007-2008.
- Child nutrition classes included information on obesity, screen time, dental health. Breastfeeding class stressed continuation, and prenatal individual education addressed smoking cessation. These were topics determined relevant to our community by the needs assessment.

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

**Year 1 Objective:**

During plan period, each local agency will develop at least one specific objective and activity to help facilitate healthy behavior change for WIC staff and at least one specific objective and activity to help facilitate healthy behavior change for WIC clients.

**Activity 1:**

Local Agency Objective to facilitate healthy behavior change for WIC staff. Local Agency Staff Activity.

**Outcome Evaluation:**

- Increasing consumption of fruits and vegetables at agency activities was the activity chosen.
- This was chosen because of observation of items historically offered.
- A department policy is now in place that at any activity a healthy choice will be available.
- This has gone well with little resistance.

**Activity 2:**

Local Agency Objective to facilitate healthy behavior change for WIC clients. Local agency Client Activity.

**Outcome Evaluation:**

- Our goal was to increase physical activity. A bulletin board was developed and handouts on activity and screen time made available. We chose this activity due to the obesity rate in this county. We would not do anything differently.

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

**Year 1 Objective:**

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

**Activity 1:** Local Agency Breastfeeding Objective. Local agency Breastfeeding Activity: Coos WIC will partner with local Breastfeeding coalition to visit 3 major county employers with information of advantages of being Breastfeeding Friendly Employers.

**Outcome Evaluation:**

- Our coalition partners did not meet for months due to changes in personnel. The coalition is regrouping and this will be a goal for the next year. We did have employer information available.
- We did participate in World Breastfeeding month with posters and client handouts.

WIC Nutrition Education Plan Form  
FY 2008 – 2009

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

Year 2 Objective:

During plan period, through informal discussions, staff in-services and/or targeted trainings, staff will be able to describe the general content of the new WIC food packages and begin to connect how these changes may influence current nutrition education messages.

**Activity 1:**

By October 31, 2008, staff will review the Oregon WIC Key Nutrition Messages and identify which ones they need additional training on.

Resources: American Academy of Pediatrics, MyPyramid.gov, Maternal and Child Health Oral health website – <http://www.mchoralhealth.org/Openwide/> Information from the 2008 WIC Statewide meeting.

Implementation Plan and Timeline: During the August Staff meeting, we will review the Oregon WIC Key Nutrition Messages and identify the ones on which staff need additional clarification. For those messages that need clarification, the training supervisor will prepare additional information to share with staff at the October meeting.

**Activity 2:**

By March 31, 2009, staff will review the proposed food packages changes and:

- Select at least three food packages modifications (for example, addition of new foods, reduction of current foods, elimination of current foods for a specific category),
- Review current nutrition education messages most closely connected to those modifications, and
- Determine which messages will remain the same and which messages may need to be modified to clarify WIC's reasoning for the change and/or reduce client resistance to the change.

Resources: WIC Works Website WIC food package materials, Information from the 2008 WIC Statewide meeting, State provided materials.

Implementation Plan and Timeline: In January 2009 we will begin to share WIC food package resource information with all staff including “WIC Food Packages...Time for a Change” on the WIC Works website. We will review the Fresh Choices 2009 Status Report updates. At our February 2009 staff meeting we will discuss the food package modifications and how they fit with our education messages.

**Activity 3:**

Identify your agency training supervisor(s) and projected staff in-service training dates and topics for FY 2008-2009. Complete and return Attachment A by May 1, 2008.

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

**Year 2 Objective:**

During Plan period, each agency will assess staff knowledge and skill level to identify areas of training needed to provide participant centered services.

**Activity 1:**

By July 30, 2008, staff will review the diet assessment steps from the Dietary Risk Module and identify ones on which they need additional training.

Implementation Plan and Timeline: By July 30, 2008, staff will review the diet assessment steps from the Dietary Risk Module to determine if staff need additional training and or practice. The training supervisor will assess results and provide training on these steps at our November staff meeting.

**Activity 2:**

By November 30, 2008, staff will evaluate how they have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules.

Resources: State provided guidance and assessment tools.

Implementation Plan and Timeline: Using state guidance and tools, during our November staff meeting, staff will share how they have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules. We plan to have staff observe each other for the next several months and provide feedback.

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

**Year 2 Objective:**

During Plan period, in order to help facilitate healthy behavior change for WIC staff and WIC clients, each local agency will select at least one objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

**Activity 1:**

Identify your setting, objective and strategy to facilitate healthy behavior change for WIC staff.

Setting: Worksite

Objective: By 2012, increase by five percent the number of employees who consume five servings of fruits and vegetables per day.

Strategy: Increase the availability and promotion of fruits and vegetables at worksites, break rooms, meetings and events.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Implementation Plan and Timeline: This objective was chosen because it is an ongoing goal for our department. We will review the Healthy Meeting Guidelines and increase staff consumption of fruits and vegetables.

**Activity 2:**

Identify your setting, objective and strategy to facilitate healthy behavior change for WIC clients.

Setting: Home

Objective: By 2012, decrease television and other screen time for children. Reduce by two percent the number of children ages 2-18 who have more than two hours a day of screen time and work to ensure children 2 years and younger have no screen time,

Strategy: Pediatricians and other health professional will teach parents that children 2 years and younger should have no television or other screen time.

State and local community coalitions should urge parents to be role models by encouraging them to increase their physical activity, limit their time in front of television and provide children with resources that foster active behavior.

Coos WIC will use individual counseling and group meetings/classes to emphasize these points.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

We chose this objective because we want to encourage families to be physically active. We would like parents to understand the effects of excessive screen time.

We will update our list of free or low cost resources in our community for physical activity by October, 2008.

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

Year 1 Objective:

During Plan period, in order to help improve breastfeeding outcomes for WIC participants, each local agency will select at least one setting, one objective, and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

**Activity 1:**

Setting: Home

Objective: By 2012, maintain the current level of breastfeeding initiation and increase by two percent a year the number of mothers who breastfeed exclusively for the first six months of a child's life.

Strategy: Health plans, health systems, hospitals and others shall promote breastfeeding campaigns targeting the entire family.

Implementation Plan and Timeline: We chose this hoping to be able to prolong exclusive breastfeeding.

We will reactivate the area breastfeeding coalition and celebrate World Breastfeeding Week in August.

By January, 2009, with the aid of the breastfeeding coalition, we will offer to educate local businesses concerning the new legislation on pumping breastmilk at work.

**Attachment A**  
**FY 2008-2009 WIC Nutrition Education Plan**

**Goal 1 - Activity 3 WIC Staff Training Plan – 7/1/2008 through 6/30/2009**

**Staff Development Planned:**

Based on planned new program initiatives (for example Oregon WIC Listens, new WIC food packages), your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2008 – June 30, 2009. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July	Review Diet Risk Food Module	Review Diet Risk steps and begin practicing new techniques.
2	October	Oregon WIC Key Nutrition Messages	Review messages and determine if additional information is needed.
3	January	New WIC Food Packages	Review Fresh Choices Status Report and new food packages.
4	May	Review Breastfeeding Module and new info.	To refresh knowledge of breastfeeding and review local breastfeeding statistics.

## **Health Statistics Action Plan 2008/09**

### **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 2008/09**

### **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 Oregon Health Plan / Oregon Mothers Care outreach specialist assists clients in applying for publicly funded health insurances, and in locating affordable primary healthcare services. 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 strive to enhance our website to include more links to state and federal agencies, such as the CDC.
- We will continue to 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.
- We will publish an annual report describing our services.

**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 2007/2008**

### **Current Condition:**

Safety and prevention of illness are the goals for the Environmental Health Program for the 241 licensed temporary restaurants, 387 annually licensed facilities and 48 other inspected institutions operating within Coos County in 2007. Restaurants, public pools, bed and breakfasts, RV parks, overnight lodging, organization camps, schools, and 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:

**12,397** Seats in licensed Restaurants exist in Coos County.

If all of these seats are filled only 3 times a week that means:

**1,933,932** meals were served by Food Service establishments licensed and regulated by the Coos County Environmental Health Office.

**1185** Sites licensed for overnight RV camping exist in Coos County.

If all of these sites were occupied only 3 nights a week that means

**184,860** nights of camping accommodation were provided by RV Parks licensed and regulated by the Coos County Environmental Health Office.

**1101** Rooms licensed for Overnight Lodging exist in Coos County.

If all of these rooms were occupied solo for only 3 nights a week that means

**171,756** nights lodging were provided by Traveler's Accommodations licensed and inspected by the Coos County Environmental Health Office.

Added together, on approximately **2.3 million** occasions, consumers in Coos County benefited from Environmental Health Services. The fact that in 2007 Coos County Public Health documented only 27 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 with a live at least monthly
- Provide periodic 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 together with communicable disease nurses immediately upon notification
- License and inspect temporary food vendors
- 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
- Provide an annual Safe Pool Operator’s Class
- 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 2007 include:

<b>License Type</b>	<b>Inspections Performed</b>	<b>Closures</b>	<b>Misc. Consumer Complaints</b>
Public Pool	100%	7	0
Lodging	100%	0	2
RV Camp	98%	0	2
Food Service	109%	0	12

Food Complaints	23
Confirmed Food Borne Illness	0
Food Handler Training Cards Issued	599
Food Service Mangers Certified	46

## Safe Drinking Water Action Plan 2008/2009

### 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 known water systems. Most of the remaining 12,000 county residents (20%) live where they rely on private water supplies. Among the 79 recognized water systems in Coos County, 50 are designated by EPA as public water systems. Oregon Revised Statutes expand the definition of public water system to include regulation for another 29 smaller water systems.

County services provided for Public Water Systems are covered in the Drinking Water Systems Assurances as per delegation agreement between Coos County Public Health and the State Drinking Water Program. This means the Environmental Health Program has direct responsibility to work with approximately 86% of the county's public water systems. The remnant of service is the responsibility of either the State Drinking Water Program office or the Oregon Department of Agriculture.

Environmental services are primarily directed toward helping public water system operators sort through the rules that relate to assuring the quality of the drinking water and may also include encouraging operators to take steps to physically protect the water and regularly sample for potential contaminants.

Though there are many potential contaminants for which water could be sampled, the following table provides examples of some contaminants with obvious health implications.

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 Oregon 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.

**Goals:**

Assure the availability of safe drinking 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.

EPA Designated 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.

Non-EPA Public Water Systems: Seek to provide public outreach to operators of water systems including applicable health based standards for operation.

Public Water Systems:

- Consult with system operators on steps to correct any water quality violations
- Work with system operators with water quality noncompliance and sampling issues
- Physically survey each water system no less often than every 5 years
- Identify previously unrecognized [Non-EPA] public water systems and their operators

Non-Regulated/Private Water Systems:

- Refer users of private water to education sources such as OSU Extension.
- 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 2007 to ensure safe drinking water.

<b>Measure</b>	<b>Value</b>
Number of consultations for water quality violations	16
Number of contacts to assist in correcting chronic noncompliance	6
Number of water system sanitary surveys conducted	9
Percentage of "EPA regulated" public water systems in compliance with water quality standards	68%
Public Water Systems added (or reactivated) to the State's Inventory	1

**Drinking Water Systems Not Regulated by EPA**

<b>Measure</b>	<b>Value</b>
Number of referrals	2
Investigations into suspected water borne illness complaints	0
Number of Water Borne Disease Outbreaks—confirmed	0

**Action Plans**

**For**

**Other Public Health Concerns**

## **HIV Client Services**

### **Action Plan 2006/07**

**This action plan has been deleted for 2008/09 because Coos County Public Health no longer offers this program.**

#### **Current condition or problem:**

According to the most current State reports, there was 1 new case of AIDS reported in Coos County in 2005. Estimates indicate that there may be 60 individuals with HIV/AIDS currently living in Coos County. Coos County Public Health has recently been serving 24 clients, in the Ryan White case management program, with several additional intakes recently.

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.

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 persons with HIV disease in our community. Our greatest challenge this past year has been staff attrition. In order to meet the training requirements, staff must travel to Salem or Portland, which is a financial burden on our department.

**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.

## **Public Health Emergency Preparedness Action Plan 2008/2009**

### **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 in 2007, a new Public Health Preparedness Coordinator (PHP) was hired at the end of December.

Response Capability: We have had a reduction in staff since FY 06/07—4 nurse full time positions—which will decrease this department's ability to respond to an outbreak/incident of significant size. This staff reduction also has decreased the number of individuals available to be on-call 24/7 for reporting purposes.

We continue to have designated staff for on-call response to 24/7. However, we now have reports relayed to us after hours through the Sheriff's dispatch center, as we have discontinued the use of a 24/7 pager for disease reporting.

### **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 1<sup>st</sup> 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 for 08-09:**

- Continue to provide 24/7 response to the health care system for reportable diseases

- Update procedures for CD investigation , quarantine, isolation, and restriction of movement, and procedures for surge capacity of paid and volunteer staff during a public health emergency event.
- Update the county website with pertinent information on communicable diseases and/or public health preparedness topics.
- Continue to facilitate the local Health Emergency Response Team meetings, monthly.
- Provide continuing education to the Public Health staff on potential duties and/or responsibilities during a communicable disease outbreak, pandemic illness, 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.
- 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 incidence command training for all staff, based on their response roles, according to the National Incidence Management System requirements.
- Complete staff training in the use of the Health Alert Network system, and test the local use of the system.
- Participate in local/regional exercises with community partners.
- Complete and update the necessary public health emergency response and health recovery plans, annexes and attachments, with a focus on chemical and radiation.
- Continue to work with law enforcement, hospitals, health care agencies, emergency management, local businesses, other government agencies, and other client-services based agencies to address needs of vulnerable populations during an emergency event.
- Work with local businesses and schools to facilitate the preparation of emergency response health plans, with an emphasis on pandemic flu response.
- Work with emergency response agencies on development and review of current emergency response plans and procedures for the proposed Liquid Natural Gas facility terminal.
- Continue to participate in all monthly LHD Public Health Preparedness conference calls, as required.

### **Evaluation**

Evaluation of our progress will be done semi-annually and by participation in the Annual . Review with other preparedness coordinators in Region 3.

### **Challenges**

The contractual expectations in this program are challenging and exceed what is funded.

## Unmet Needs 2008/09

The unmet needs are generally the same as have been discussed in recent years. Due to the loss of federal timber payments, our county no longer provides any general fund money for public health personnel or program supplies. The County continues to provide the public health department with facilities, utilities, janitorial service and maintenance, legal counsel, information technology and human resources support. Thus the health issues that receive our focus and action continue to be the ones with a funding stream from the state and federal government. We have had to cease any services which are not mandated by law or which do not have full funding from grants or fees. The mandated services, such as the federal Title X Family Planning Program, which rely on fees that cannot be collected, are especially a challenge. Although the *State Support for Public Health* per capita allotment for our county was doubled to \$1.18 for this past fiscal year, it does not completely fund one nurse position. An additional increase in base funding for public health from the state general fund and/or federal sources will be essential in the near future if we are to continue to administer a county health department at the local level.

The primary causes of death in our county continue to be cardiovascular disease and cancer, and both cancer and cardiovascular disease are related to the high use of tobacco that we have locally. The 2000-2004 average rate for *high incidence cancers* showed that Coos County continues to rank 3<sup>rd</sup> highest in the state. Coos County continues to have the highest incidence for lung cancer and the highest rate for lung cancer deaths. Also, 60% of our population are overweight or obese. We have been fortunate to receive some state funds for a part time health educator to work with community partners to assess the burden of chronic diseases in our county. We anticipate that additional funding will be necessary to put any plans into action.

Our cases of sexually transmitted diseases have been consistently high. Without state or federal funding, we must now require that persons seeking exams for these infections pay the full cost of the service. We have received some grant funds from the Coquille Tribal Community Fund for vouchers to help low income clients pay for STD exams; otherwise we have to turn people away from this traditional public health service if they cannot afford to pay. We are expecting to receive no funds from the state for HIV testing and counseling services this next year. Although our rates of HIV are low in Coos County, this loss of funding will reduce the outreach and education that can have an impact on other sexually transmitted infections. Staff time to do outreach and education for teen pregnancy prevention is extremely limited because of funding, or the lack thereof.

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 in the families we serve (99% free of abuse after enrollment). 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. Our nurse home visiting program is built on the infrastructure of Medicaid billing. Due to the low Medicaid payment for the maternity case management (MCM) program, which does not cover the cost of the nurse's time, we are discontinuing this home visiting service. We hope to reinstate it if funding is increased, because providing intervention during

the prenatal and early postpartum period is a 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 as well as the many individuals and families who are without health care. Because of the economy and increasing energy prices, we expect hunger to increase, resulting in more families seeking enrollment in the WIC program. Although our WIC program received a small increase for this next fiscal year, it is not enough to increase staffing and service levels.

With the demise of County general fund support, our environmental health staff no longer provide consultation on resolution of nuisance complaints and other environmental issues, such as household mold and pests.

And finally, with reduced staff and increased workloads, we are finding it increasingly difficult to participate in community assessments, planning, partnerships, and community projects where we have historically contributed our expertise and advocacy for health and social issues. Further, the workload and instability of funding is taking a toll on the resiliency of public health professionals. We are seeing a greater incidence of illness, and retention is an ongoing issue.

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

15. Yes  No  Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes  No  Records include minimum information required by each program.
17. Yes  No  A records manual of all forms used is reviewed annually. (There is not a single manual for all forms.)
18. Yes  No  There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes  No  Filing and retrieval of health records follow written procedures.
20. Yes  No  Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes  No  Local health department telephone numbers and facilities' addresses are publicized.
22. Yes  No  Health information and referral services are available during regular business hours.
23. Yes  No  Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.
24. Yes  No  100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.
25. Yes  No  To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes  No  Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes  No  Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.
28. Yes  No  A system to obtain reports of deaths of public health significance is in place.
29. Yes  No  Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.

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

### **Control of Communicable Diseases**

37. Yes  No \_\_\_ There is a mechanism for reporting communicable disease cases to the health department.
38. Yes  No \_\_\_ Investigations of reportable conditions and communicable 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  No \_\_\_ Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.
40. Yes  No \_\_\_ Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.
41. Yes  No \_\_\_ There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
42. Yes  No \_\_\_ There is a mechanism for reporting and following up on zoonotic diseases to the local health department.

- 43. Yes  No  A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
- 44. Yes  No  Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
- 45. Yes  No  Immunizations for human target populations are available within the local health department jurisdiction.
- 46. Yes  No  Rabies immunizations for animal target populations are available within the local health department jurisdiction.

### **Environmental Health**

- 47. Yes  No  Food service facilities are licensed and inspected as required by Chapter 333 Division 12, or more frequently based on epidemiological risk.
- 48. Yes  No  Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
- 49. Yes  No  Training in first aid for choking is available for food service workers.
- 50. Yes  No  Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
- 51. Yes  No  Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
- 52. Yes  No  Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.
- 53. Yes  No  Compliance assistance is provided to public water systems that violate requirements.
- 54. Yes  No  All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
- 55. Yes  No  A written plan exists for responding to emergencies involving public water systems.
- 56. Yes  No  Information for developing a safe water supply is available to people using on-site individual wells and springs.
- 57. Yes  No  A program exists to monitor, issue permits, and inspect on-site sewage disposal systems. (DEQ)

58. Yes  No  Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes  No  School and public facilities food service operations are inspected for health and safety risks.
60. Yes  No  Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes  No  A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes  No  Indoor clean air complaints in licensed facilities are investigated.
63. Yes  No  Environmental contamination potentially impacting public health or the environment is investigated. **(by DEQ)**
64. Yes  No  The health and safety of the public is being protected through hazardous incidence investigation and response. **(by DEQ)**
65. Yes  No  Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control. (other agencies contribute to regulation)
66. Yes  No  All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448. (Added per G.S. request, not in program indicators)

### **Health Education and Health Promotion**

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

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

### **Nutrition**

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

74. The following health department programs include an assessment of nutritional status:

- a. Yes  No  WIC
- b. Yes  No  Family Planning
- c. Yes  No  Parent and Child Health
- d. Yes  No  Older Adult Health
- e. Yes  No  Corrections Health (n/a)

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

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

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

### **Older Adult Health**

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

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

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

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

### **Parent and Child Health**

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

83. Yes  No  Immunizations are provided for infants, children, adolescents and adults either directly or by referral.
84. Yes  No  Comprehensive family planning services are provided directly or by referral.
85. Yes  No  Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.
86. Yes  No  Child abuse prevention and treatment services are provided directly or by referral.
87. Yes  No  There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.
88. Yes  No  There is a system in place for identifying and following up on high risk infants.
89. Yes  No  There is a system in place to follow up on all reported SIDS deaths.
90. Yes  No  Preventive oral health services are provided directly or by referral.
91. Yes  No  Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.
92. Yes  No  Injury prevention services are provided within the community.

### **Primary Health Care**

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

### Cultural Competency

99. Yes  No  The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.
100. Yes  No  The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.
101. Yes  No  The local health department assures that advisory groups reflect the population to be served.
102. Yes  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  The local health department Health Administrator meets minimum qualifications: **The Administrator has a bachelor's degree in community health and 20 years of public health experience, including 11 years in public health management.**

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

If the answer is "No", submit an attachment that describes your plan to meet the minimum qualifications. **A waiver is requested.**

104. Yes  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  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  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 this Comprehensive 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, BOC Chair**  
*Local Public Health Authority*

**Coos**  
*County*

**5-6-2008**  
*Date*

# Coos County Public Health

## Organizational Chart

Proposed 2008-2009

