

**Linn County Department of Health Services  
Public Health Programs**



**Annual Plan  
2008-2009**

## **I. Executive Summary**

The Linn County Department of Health Services, Public Health Program,(LCDHSPHP) commits itself to the health and well-being of all Linn County residents.

We:

- assure access to quality health and wellness services with a focus on prevention;
- assist individuals and families to make informed health choices;
- collaborate with community partners who share our interests;
- assess strengths, needs and risk factors affecting the individual's, family's and community's health ;and
- promote staff excellence through education, technology and mutual respect.

We subscribe to the Ten Essential Public Health Services and assess our progress based on the assessment of these ten essential health services.

### **Key Findings and Recommendations**

Linn County has 13 distinct communities within its boundaries. Each of these communities comes with a different perspective on the health and wellness challenges they face. These issues are impacted by the rural or urban nature of the community. Geography, economy and demographics change from community to community. The challenges we face as a county may be less or more in any given community but are, in general, similar. Some of these are:

- Low immunization rates for our youngest children
- Increasing rates of sexually transmitted infections, insufficient capacity to address this
- Obesity rates for our children and adults increasing rapidly
- Not enough physical activity for all of us, especially children and youth
- High health, social and economic impact of methamphetamine abuse
- Insufficiency of tobacco prevention programs in the schools and the rest of the community

- Insufficiency of chronic disease prevention programs and the capacity to address this issue
- Disparities in health care access, particularly for our Hispanic families
- Lack of access to health care for our school aged children and their families
- Lack of capacity to investigate increasing prevalence of communicable diseases
- High rate of preventable tobacco related deaths
- Growing senior population with related health care needs and the capacity to work with these issues

We have made progress in other issues:

- Partnership with Benton County and Samaritan Health services in opening an East County federally qualified health center. Our family planning, STI, BCC and immunizations are co-located at the site two days a week.
- Close grassroots working relationships among program areas ( public health, mental health, A&D)
- WIC caseload continues to increase

Linn County Public Health maintains a good working relationship with the Board of County Commissioners as they act as our Board of Health. The State Public Health Division knows us. We work well together and many staff participate in state level committees and groups.

## **II. Assessment**

The following indicators provide a description of the public health issues and needs in Linn County.

### **Geography**

Linn County is in the center of the Willamette Valley with the Willamette River as its western boundary and the crest of the Cascades as its eastern boundary. The climate and soil conditions provide one of Oregon's most diversified agriculture areas, allowing a wide variety of specialty crops. The Willamette Valley leads the nation in the production of common and perennial ryegrass. Linn County is also the home to major producers of rare primary metals, processed food, manufactured homes and motor homes. Our primary economy is agriculture, forest products, rare metals, manufacturing and recreation. We cover 2,297 square miles and our annual precipitation is 42.55". Access to health care is affected by the location of our communities as they relate to the larger communities and health care.

### **Population**

Linn County's population has grown 8.2% since the 2000 census. 5.9% of our residents speak a language other than English at home. 14.9% of our population is age 65 and over, compared to the statewide average of 12.5%. We are a predominantly white population, 94.9%. Our largest population center is Albany which is on the western edge of the county. There are 13 other incorporated areas in Linn County.

### **Children**

According to the 2007 Children First for Oregon report there are 22 indicators that are measured that define the status of children. Of those 22 indicators Linn County has 13 of them that are worse than the state average and 9 are better than the state average. Since last year we have improved in 9 of the indicators, 11 are worse than the previous year and 2 have stayed the same. Some of these are:

- Fully 23.3% of students have changed schools during the 2006-2007 school year;
- 44.7% of our public school children are eligible to receive free/reduced price lunches;
- On average, 5,832 children eat free/reduced price lunches during the school year. Only about 20% of those children take advantage of it during the summer;
- 46% of the 614 children who are victims of child abuse are under the age of 6;
- 53.5% of eighth graders have not had a medical check-up or physical exam in the previous year;
- 67.5 % children ages 6-10 have experienced tooth decay and of those, 42.4% have untreated decay;
- We are worse at getting women into prenatal care than the state average;
- We have a 24% worse rate of infant mortality than the state average (7.3/1000 births);
- We have over 4,000 children who are uninsured. 25% worse than the state average;
- We have over 6600 children (ages 0-17) who live in poverty. This is 47% worse than the state rate. **AND**
- **NO** children have access to School-Based Health Centers in this county.

### **Access to Health Care**

Linn County continues to struggle with getting its residents adequate access to health care. We have had the opportunity to work with Community Outreach, Inc. (COI) for at least 12 years and have donated clinic space, supplies and electronics for a weekly free clinic in both Albany and Lebanon. As the need increases in our communities we have seen the need for more space and more time manifest itself with these free clinics. People are showing up at our doors by 3 in the afternoon for a clinic that begins at 6 p.m. This can be disruptive to the Linn County clinic customers. We have seen a change in Samaritan Health leadership over the past few months and it appears a better organizational structure will take over.

In late January we opened up a Federally Qualified Health Center (FQHC) in East County in partnership with Benton County and Samaritan Health. The impact this could have on health care access for East County people is significant. At the time of this writing, it is too early to tell what that impact might be. A full time physician has just started practicing as of April 14, 2008) . Linn County Public Health is co-located in the building

with reproductive health services available 1 ½ days per week at that site. A mental health/primary care health integration model is being piloted at this site also.

### **Chronic Disease**

Chronic disease prevention is a traditional, enduring model of public health practice. Prevention has been the beginning of the public health system and continues today to be the mainstay for the public's health. Along with chronic disease management, prevention can keep people healthy and living well as opposed to illness and hospitalization. We currently do not have any county run or county convened programs for chronic disease management or prevention. We have partnered with Samaritan Health in their efforts to expand the program "Living Well with your Chronic Disease". It is a series of classes focusing on nutrition and exercise as a way to mitigate the effects of a chronic disease and to be more healthy. The data for chronic disease in Linn County is not good.

**Births:** In 2007 we had 600 first births.

**Prenatal Care:** Inadequate PNC = Less than 5 prenatal visits, or care which began in the third trimester was at 8.5%. This is a trend that is concerning us. The state rate is 6.4%.

**Parent and child health services, including family planning clinics.** Linn County provides these services in various formats. We utilize nurse home visiting to deliver Maternity Case Management, Babies First! and CaCoon services; Healthy Start provides services to pregnant women who are not at high risk for medical issues and to at risk first time parenting families. Comprehensive reproductive health services are offered at all clinic sites. We are staffed with nurse practitioners, public health nurses, medical assistants, bilingual health aid and family support workers. 414 unintended pregnancies were averted, including 162 to teens ( estimated tax savings in prenatal, labor and delivery, and infant healthcare costs for every unintended birth prevented by Oregon Family Planning Program is about \$7,500.) We provided family planning services to 31.7% of the

sexually active 15-17 year old females in Linn County. We provided services to 51% of the women in need of publicly supported family planning services in Linn County. 55 high need first birth families were given intensive home visits by a family support worker through the Healthy Start Program; 200 received welcome baby visits and family intakes. 200 pregnant women, children and families received home visits by a registered nurse. We served 220 women in our Breast and Cervical Cancer Program and another 91 with our Soroptomist funds. We average finding 4 cancers a year. Oregon Mothers Care helped 96 pregnant women access the OHP and linked with a prenatal provider

**Vital Statistics:** 1040 births and 986 deaths were processed through our vital records area.

**WIC:** More than 5,780 Linn County women, infants and children received nutrition education and supplemental food instruments.- in 2007. \$1.96M annually goes to Linn County grocers. Farmers in Linn County received \$11,366 through the farmer's market vouchers. 49% of pregnant women in Linn County are served by WIC.(compared to 40% in the state) 66% of WIC families have income at or below the federal poverty level.

**Dental:** Linn County continues to have difficulty addressing the dental needs of adults as well as children. Various communities within the county are more active in finding dental resources than others. Lebanon has brought the Northwest Medical/dental van to schools in conjunction with their Department of Human Services integration project which will no longer be funded. Helping Hands homeless shelter has been able to bring the dental van to its facilities with great success.

**Teen Pregnancy:** The preliminary rolling rate (Jan-Dec 2007) ) is 9.8 pregnancies per 1,000 females age 10-17. We are again above the state average of 8.8 pregnancies. Of great concern is the number of young teens, particularly in East County, who become pregnant.

**Tobacco Prevention:** Currently Linn County does not have a tobacco prevention program. We are pursuing working with Samaritan Health as well as Benton County to develop an acceptable program for Linn County.

Date taken from the **Linn County** Fact Sheet 2007 put out by the Tobacco Prevention Program include:

- 230 people die from tobacco use
- 4,495 people suffer serious illness caused by tobacco use
- 19, 746 adults regularly smoke cigarettes
- Over \$36.6 million is spent on medical care for tobacco related illnesses
- Over \$36.9 Million in productivity is lost due to tobacco related deaths.
- 11% of eighth graders smoke ( state 9%)
- 18% of 11<sup>th</sup> graders smoke cigarettes (17% state)
- 39% of non-smokers live with one or more people that smoke
- 16% are exposed to secondhand smoke in their homes
- 25% of adults smoke cigarettes(state 20%)
- 21% of babies are born to women who smoked while pregnant ( state 12%) (“The risk for perinatal mortality, both stillbirths and neonatal deaths, and the risk for sudden infant death syndrome (SIDS) are higher for the offspring of women who smoked during pregnancy”- 2001 Surgeon General’s Report)
- 82% of all Linn County adults- smokers and non-smokers alike- say that people should be protected from secondhand smoke
- 1,000 employees ( estimated) working in Linn County are not protected by Oregon’s Smokefree Workplace Law

### **III. Action Plans**

- A. Epidemiology and control of preventable diseases and disorders**
- B. Parent and child health services, including family planning clinics**
- C. Environmental Health**
- D. Health Statistics**
- E. Information and Referral**
- F. Other Issues**

## **A. Epidemiology and Control of Preventable Diseases and Disorders**

Linn County has experienced a significant increase in rates of Chlamydia in the last few years. Currently we are receiving double the number of cases over our 5 year average and a 25% increase over the last year. Because of our staffing limitations, we are able to follow-up with the positive case but not each of the case contacts as this would take a significant amount of nursing time that we are not able to spare.

In the last year, we have followed up on 5 gastroenteritis outbreaks involving residential care facilities and one medical practice. This is up from 3 the previous year. Our nurses assist with tracking of positive cases, education of staff and shipping of stool specimens. This is very time intensive especially when time must be prioritized between multiple needs. We have been fortunate to not have any recent food borne outbreaks in our county that required our direct follow-up.

We have been very busy with TB this year. In August we had a homeless man who was diagnosed with active TB. Because he was residing in a shelter, we were challenged with finding housing for him while he was contagious. We do have some older motels in our area that have an outside entrance and unit specific air handling however, these facilities often refuse to have the client once they are told that they need to be quarantined due to fears of infecting their staff. With some education and convincing, we did find a motel to accept the client at the county's expense. This client required housing from August through January at the county's expense along with daily DOT. In addition we went to the shelter to screen the potential contacts. 11 clients tested positive with 10 receiving LTBI treatment. In October, while rescreening the shelter clients, another client was found to have active TB. Her cultures showed positive in December and she was placed in a motel for isolation as well. She was in the motel for 2 weeks before having received effective treatment and was then able to return to the shelter for the remainder of her treatment. 5 of her contact tested positive. 2 are receiving LTBI. 2 symptomatic clients have sputum's pending before beginning LTBI Treatment and 1 is too mentally ill to complete a LTBI treatment program. During this past year we have treated 25 clients with LTBI meds.

As a result of the positive TB cases in the shelter, they have agreed to work with us on regular testing of homeless clients. We have worked with the state and the shelter to implement a TB prevention program. A policy was developed and shelter staff was trained. We worked with them to develop a tracking system. Now clients are required to receive a TB test at the Linn County Health Department within 5 business days of arriving at the shelter in order to continue to stay at the shelter. We issue the client a TB clearance card once the test has been read. The card will expire each year on the client's birthday. Staff at the shelter continues to

require training and encouragement to keep up with this process but both shelter staff and public health staff agree that it is to the benefit of all to keep the system in place.

<b>Time Period: 2008-2009</b>				
<b>GOAL: Provide current information to public regarding influenza prevention including access to information on vaccination clinics during influenza season.</b>				
<b>Objectives</b>	<b>Plan for Methods/Activities/Practice</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
<b>A.</b> Maintain influenza clinic information hotline.	A flu hotline will be maintained with influenza clinic info throughout Linn county	Clients will be able to access up-to-date flu vaccination information during flu season		
<b>B. Provide prevention information leases to media.</b>	Messages will be released to the media with information on cover your cough, wash your hands and stay home when sick.	Community will be aware of how to prevent illness from flu and other respiratory illnesses.		

<b>Time Period: 2008-2009</b>				
<b>GOAL: Promote prevention of disease transmission in care home settings.</b>				
<b>Objectives</b>	<b>Plan for Methods/ Activities/Practice</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
<b>A.</b> Assess educational needs of staff in Linn County Care Facilities.	Letters will be mailed out to care facilities in Linn County to offer basic infection control training and to determine the training needs of facilities. This will be followed-up with a phone call to be completed by a health educator requested for in our budget.	All care facilities will be mailed a letter and receive a follow-up phone call.		
<b>B.</b> Provide infection control trainings to care homes in the county	Care homes will be contacted by the health educator to arrange for training opportunities that include hand washing, standard precautions, and common disease transmission information.	All care facilities in Linn County will have an opportunity to receive training.		

<b>Time Period: 2008-2009</b>				
<b>GOAL: Provide TB Prevention in homeless shelters in Linn County</b>				
<b>Objectives</b>	<b>Plan for Methods/ Activities/Practice</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>

<b>Time Period: 2008-2009</b>				
<b>GOAL: Provide TB Prevention in homeless shelters in Linn County</b>				
<p><b>A. Homeless residents</b> residing in Linn County shelters will have initial TB screening within 5 business days of entering a shelter</p>	<p>Residents will call the LCHD to make an appointment for TB screening. Once resident is cleared for TB, they will be given a TB clearance card good for 1 year to expire on their birthday. LCPH will provide staffing to meet this goal.</p>	<p>All homeless clients will have TB clearance within 5 business days of entering the shelter.</p>		
<p><b>B. Homeless Shelter staff will maintain records of residents TB clearance and refer to LCPH for testing when appropriate</b></p>	<p>LCPH will give residents a clearance card as proof of TB clearance to be shown to the shelter. Shelter staff will maintain records and refer residents to LCPH when testing is needed.</p>	<p>TB clearance records will be current at the shelter.</p>		
<p><b>C. Shelter TB plan will be reviewed and updated as needed annually</b></p>	<p>Annual training for review and updates will be provided for shelter staff by LCPH. LCPH will be available for additional on-going support and training as needed.</p>	<p>Shelter staff will participate in initial and annual training.</p>		

## **Immunizations**

Our immunization program served 6% of the 2921 births in Linn County in the last year. Of those being served by Linn County, 59% are up-to-date, while 67% are fully covered by 24-35 months of age. Our immunization nurse had received a grant to purchase children's story books as one way to help increase our numbers. Each child that receives immunizations at Linn County Public Health receives a book with a reminder inside of the cover as to when they should return for their next set of vaccinations. She has also been making burp clothes which she rolls up with immunization information inside then ties a nice ribbon around it. These are handed out to new moms at Linn County hospitals at the time of birth. Birth records are compared to ALERT at around 3 months after birth to see if the babies are receiving needed immunizations. Babies not in ALERT receive a post card reminding the parent that immunizations are due.

Last year we began a new project to administer flu mist to school age children. Since it was a new program, we decided to stay with high school age students for the first year. We spent time at 3 school sites during registration to talk with parents about flu mist and get parent permission for the children to participate. Once the flu mist arrived at the county, we returned to the schools to vaccinate the children and the staff. Those who have health conditions that prevent them from being eligible for flu mist were offered injectable vaccine. We had great success in the Sweet Home School district and have decided to return there again this year and offer the program at other schools in the district. We will again participate in registration for any school that we have not offer this program to in the past to answer parent questions.

**Time Period: 2008-2009**

**GOAL: Promote flu mist vaccination in targeted school age children**

Objective	Plan for Methods/ Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>A. LCPH will be available at selected school sites during school registration. This will be done the first year flu mist is offered at each school site.</p>	<p>Parents will be given information on flu mist and a chance to ask questions. Parents must sign a permission form in order for their child to be vaccinated.</p>	<p>% of all students who have parental consent for vaccination.</p>		
<p><b>B. Flu mist immunization clinics will be held at Sweet Home elementary and High Schools.</b></p>	<p>Children with parental permission will be given flu mist vaccination at the school site. Those unable to receive flu mist due to health concerns will be offered inject able vaccine</p>	<p>% of students who have parental consent and receive vaccination for flu.</p>		

**Time Period: 2008-2009**  
**GOAL: Promote flu mist vaccination in targeted school age children**

**Time Period: 2008-2009**  
**GOAL: All Linn county immunization providers will record immunizations in ALERT**

Objectives	Plan for Methods/ Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Assess participation in ALERT by all Linn County Providers	Immunization coordinator will run reports from ALERT to assess current use of ALERT by Linn County Providers.	Identification of providers not currently or consistently using ALERT.		
<b>B. Increase use of ALERT by Linn County Providers</b>	Bases on identified areas from assessment, we will work with individual providers to determine barriers to use of ALERT and help with possible solutions.	Increase in use of ALERT by Providers.		

**Time Period: 2008-2009**  
**GOAL: Increase rate of up-to-date immunizations for all Linn county children who receive immunizations from the LCPH.**

Objectives	Plan for Methods/ Activities/ Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. All babies born in Linn County will have 1 <sup>st</sup> set of immunizations at 3 months of age	Babies born in Linn County hospitals will receive a burp cloth with immunization information rolled up inside. Birth Certificate records will be checked at 3months against ALERT. Babies who do not have immunizations entered into ALERT will be sent a post card reminding the parent to immunize and have Linn County Contact info.	Increase in rate of immunization for Linn County 3 month olds from approximately 78%		

**Time Period: 2008-2009**

**GOAL: Increase rate of up-to-date immunizations for all Linn county children who receive immunizations from the LCPH.**

<b>B. All children will return to Linn County on time for next immunizations.</b>	Linn County has received a grant to purchase children's books. Each child who comes to Linn County for immunizations will receive a story book with a reminder inside of the cover indicating when to return for next set of immunizations.	Increase in up-to-date immunizations of Linn County Public Health immunized children at all bench mark ages.		
<b>C. All Seventh Grade students will have the newly required Tdap prior to exclusion dates.</b>	Linn County Public Health will provide free Tdap to 6 <sup>th</sup> graders in the spring at each school to prepare for the 7 <sup>th</sup> grade requirement. Information will be sent home to parents regarding the clinics and the new requirement.	No 7 <sup>th</sup> grade students will be excluded due to missing Tdap does.		

## Emergency Preparedness

We are currently working closely with a county multidisciplinary group to plan for special needs populations during an emergency event. The work group is made up of agency's who serve various Linn County residents. Our goal is to assess who our special needs populations are likely to be, assess what the needs of those populations may be and to develop plans to meet those needs. Our target date for completion is June 2009.

This year we have been able to secure funding to provide 24/7/52 coverage for our communicable disease services. This service will better serve our community by providing a trained person to answer infectious disease related questions and to be able to respond to communicable disease issues in a timely mater.

We will be completing our Cancellation of Classes table top exercise in May. We are hopeful that this encourages more partnerships to engage in meaningful planning activities. Planning will be taking place in the coming months with our county emergency manager, our city emergency managers and Linn County Public Health to develop a HSEEP training plan for exercising. This will promote collaboration with other agencies for planning and exercising.

<b>Time Period: 2008-2009</b>				
<b>GOAL: Complete work with key partners on the Linn County vulnerable populations plan.</b>				
<b>Objectives</b>	<b>Plan for Methods/ Activities/Practice</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
A. Assess who vulnerable populations in Linn County are and define in plan	A work group has been formed and is working on defining vulnerable populations through use of census data and agency input.	Completed definition of vulnerable populations in the plan.		

**Time Period: 2008-2009**

**GOAL: Complete work with key partners on the Linn County vulnerable populations plan.**

B. Compare current emergency plans to needs of vulnerable populations to assess for gaps	As vulnerable populations are identified, their special needs will be compared to the existing emergency plans. Areas where the general population plans do not meet the needs for special populations will be identified in the special needs plan.	Completion of the plan by June 2009		
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**Time Period: 2008-2009**

**GOAL: Linn County Public Health will participate in the county wide earth quake exercise April 2009**

Objectives	Plan for Methods/ Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Participate in planning and preparation for county wide exercise.	Attend planning meetings. Review policies and procedures in preparation for exercise. Update staff training on roles and responsibilities during an event. Update call down list and other critical contact information.	Plans and contact lists will be up-to-date for exercise. Public health will participate in the exercise planning using the HSEEP format as much as possible.		
B. Assist other county departments to prepare to participate in the exercise	Encourage and provide support to behavioral health, environmental health, roads department and other county departments to participate in preparing for and participating in the exercise.	County departments will prepare and participate in the exercise.		

## HIV Prevention

### Linn County Scope of Work

	YES	NO	Estimated # of Total Tests	Estimated # of Rapid Tests
HIV SCREENING	x		250	x
TARGETED TESTING	x		116	86

PROGRAM MODEL	INTERVENTION ACTIVITY	TARGET POPULATION(S)	PROJECTED NUMBER OF TESTS	SITES	If subcontracting this activity, name SUBCONTRACTOR
<b>CTRS FY 2009</b>	<i>Targeted</i> HIV Counseling & Testing	MSM	36	Linn County HD	
		IDU	80	Linn County HD	
		Partners of PLWH			

PROGRAM MODEL	INTERVENTION ACTIVITY	TARGET POPULATIONS	TARGET NUMBER TO REACH	SITES	If subcontracting this activity, name SUBCONTRACTOR
Outreach to CTRS	Venue-Based Outreach to Recruit into CTRS	MSM	60	Linn Benton Community College Gay Straight Alliance Other as indicated.	
		IDU	100	Alcohol & Drug Treatment Programs Street Outreach	
		Partners of PLWH			

<b>RECOMMENDATION</b>	<b>CONTEXT</b>	<b>ACTIVITIES / NEXT STEPS</b>
<p>1. Explore delivery of phone-based HIV test results.</p>	<ul style="list-style-type: none"> <li>• Resource issue: high number of clients not receiving HIV test results.</li> <li>• Purpose of this activity is to increase the percentage of results given to clients testing for HIV.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Work with DHS and/or other state and local partners to explore best practices in delivering HIV test results by phone. <ul style="list-style-type: none"> <li>○ Identify and resolve internal policy concerns;</li> <li>○ Identify organizational barriers, challenges and training needs.</li> </ul> </li> <li>➤ If appropriate, develop and implement procedures to deliver HIV test results by phone.</li> </ul>
<p>2. Identify best local practices to deliver HIV testing and prevention services to Hispanics.</p>	<ul style="list-style-type: none"> <li>• Collaboration, TA and Information issue:</li> <li>• County needs more and better information on how to effectively serve the HIV prevention needs of Hispanic residents.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Explore outreach options to Hispanic population by engaging health resources currently delivered at St. Mary's Congregation. <ul style="list-style-type: none"> <li>○ Revise FY2009 Program Plan (Outreach to CTRS and CTRS Program Models) as appropriate.</li> </ul> </li> </ul>

## B. Parent and child health services, including family planning clinics

### FAMILY PLANNING PROGRAM ANNUAL PLAN FOR COUNTY PUBLIC HEALTH DEPARTMENT FY'09

Agency: Linn County

Contact: Pat Crozier, R.N.

**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
Linn County only serving 48.8% of WIN compared to statewide (66.8%)	Outreach to County WIN with a focus on East Linn.	<p>Co-locate with new East Linn FQHC to provide family planning and STI services. Consider evening or weekend hours.</p> <p>Give WIC certifiers information for all clients.</p> <p>Advertise in community college newspaper for all clients</p> <p>Train home visitor nurses to provide FP services to isolated clients in rural areas.</p> <p>Advertise services on Hispanic radio stations and with newspaper ads.</p> <p>Conduct display table at local supermarket where Hispanic clientele visit-with materials and information.</p>	<p>Evaluate data Ahlers quarterly</p> <p>Look at numbers from FQHC on clients served.</p> <p>Count number of clients served at home visits.</p>

<p>Serving 18.5% Hispanic compared to statewide (19.5%)</p> <p>Serving only 10.8% teen population under the age of 19 yr.compared to statewide (28.4%)</p>	<p>Increase % of teen clients served</p>	<p>Connect with school counselors and school nurses to disseminate information and provide classroom presentations.</p>	<p>Evaluate Ahlers data quarterly</p>
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**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
<p>Lower percentage of eligible female clients receiving EC (14.4%) compared to statewide rate of (20.0%)</p>	<p>Increase by 5% the number of female clients who receive ECP</p>	<p>Review protocol with staff to dispense EC with each new start BC client.</p> <p>Review encounters form for accuracy of reporting.</p>	<p>Evaluate Ahlers data quarterly</p>
<p>Limited budget for high cost products to Title X clients</p>	<p>Look at budget and set budgetary limit on number of Title X provided Implanon and Mirena available.</p>	<p>Set number at start of fiscal year. Write into protocol.</p> <p>Train staff on system for Title X eligibility.</p>	<p>Review Ahlers data and budget to evaluate if stayed within limit.</p>

**Progress on Goals / Activities for FY 08**  
(Currently in Progress)

Goal / Objective	Progress on Activities
Serving 45% of WIN	<p>While we have made some progress – 3% over the current year, this continues to be a priority for our county. Since we will begin co-locating with the new FQHC we will watch the numbers of clients served and establish a good referral source for services.</p> <p>We continue to be in the process of updating our current web site with a new look and links to services.</p> <p>Bilingual staff gave presentation on Hispanic radio program of services available. This will be repeated in the future.</p> <p>We feel there has been a decrease in clients due to FPEP requirements-especially for teen clients. This continues to be a priority for us.</p> <p>We have had some staff transitions and hiring new staff for home visitors who will require FP training to provide at home visits.</p>
<p>Low percentage of eligible female clients receiving EC-7.3% compared to state rate of 20.2%</p> <p>No show rate too high</p>	<p>Linn County made good progress on this goal increasing our percentage to 14.5% - a 50% increase. While we have increased our percentage, this still remains a priority.</p> <p>We continue to see consistent high no show rate-We do reminder phone calls and text message reminders to clients if possible. We tried various schedule systems to allow slots for various clients, but went back to the original scheduler. We continue to monitor this number.</p>

Linn County: Family planning services are offered at three clinic sites in Linn County. Albany, Lebanon, and Sweet Home. In January 2008 we are co-locating in the new FQHC in Lebanon. Benton County is the administrator of the new clinic. Based on Ahlers data from 2007, our numbers are steady serving 2568 clients. [See attached annual plan for family planning and specific goals.](#)

**1. Please describe any plans you have for the upcoming fiscal year:**

- In January 2008 we started co-locating at the East Linn community Health Clinic. We will be watching our family planning numbers closely to see if we are increasing clients or merely shifting existing clients to this site. Data will be evaluated in 6 months. Will begin informal survey of clients served and site they typically go to.
- Clinic numbers are remaining at about 2568 unduplicated clients. Several factors are being looked at including citizenship verification process and clinic sites.
- Client satisfaction surveys- we will continue to conduct at least annual.
- Outreach to Hispanic community – Look at fairs, radio PSA, and local outreach where Hispanic population lives. Also work with WIC program to distribute information on programs.
- FTE – remain stable with current funding. May shift educational presentations and have nurses who work in clinic get out into community.
- Reminder phone calls – continue to assess the use of TXT messaging to clients for reminders on appointments.

**2. Please provide your plans for community education on family planning issues for the 2008-2009 fiscal year.**

- Continue to increase male services – Continue vasectomy referrals. In fiscal year 2007-2008 we had two physicians in East Linn who did vasectomy. Now only one contracted for vasectomy services. Currently working on establishing new provider in the Albany area for access with vasectomy procedure.
- Continue to increase ECP use for FP clients. Continue to offer to all clients and educate on need.
- Continue to provide class presentations on reproductive health topics.
- Update current Web site for Reproductive Health. Make easy to navigate topics with links for added information on birth control and STD information.
- Update SafeNet Website with corrected information on our clinics.
- Consider brief educational presentations on a routine bases to county commissioners as well as Health Advisory Board.
- Continue to do clinic display case in English and Spanish on health topics.

**3. Please identify any plans you may have to implement service improvement in the upcoming year. Such improvements could include any or all of the following, or others you might identify.**

- Continue to use customer satisfaction surveys to assess service delivery.

- Continue to be part of the BCCP (Breast and Cervical Cancer Program) work group and help move the program along in reorganization. Continue to be a contracted provider.
- Work with Soroptimist International of Albany on fund raisers as well as screening for services for Linn County women on use of grant funds.
- Monitor Teen Pregnancy rate – current rolling rate shows an increase by 2% from 2005 rate of 7.6 to 9.8 for 2007. Look to reestablishing teen pregnancy prevention work.
- Monitor high cost contraceptives. Assess need and set limit on number inserted for Title X clients within budget.
- Provide opportunity for staff to visit other FP clinics in neighboring counties for networking opportunities and idea gathering on service delivery.
- Continue to monitor data input and comparison to Ahlers data for our county data system – Raintree.
- Outreach to local businesses for referrals to our services for their employees who are low income or without insurance coverage.
- Assess immunization status for FP clients and missed opportunities to provide needed immunizations to adult population.
- Continue to work with local OB-GYN provider on colposcopy services offered at Linn County. Volunteers once per month.

**4. Please identify any additional women’s health services, activities or programs you will be working on in 2008-2009. Identify those areas that you would like more information or technical assistance.**

- Look at sending at least one Linn County Public Health nurse to the SANE training for sexual assault. Will help be more accessible to our community for this resource. ( **Technical help from state**)
- Continue to look at integrating HIV testing into Family Planning appointments based on time factor and cost.

**OFFICE OF FAMILY HEALTH**

**ADOLESCENT HEALTH PROGRAM PLAN**

**2008-2009**

County Agency \_\_\_\_ **Linn County**  
Person Completing Form **Pat Crozier**  
Phone **(541) 967-3888**

**Return this form attached to e-mail to: [robert.j.nystrom@state.or.us](mailto:robert.j.nystrom@state.or.us)**  
**Bob Nystrom, 503-731-4771**

*The Adolescent Health Program Plan is organized in three sections to provide updated information on your public health activities related to a wide range of adolescent health issues. For questions, contact Bob Nystrom, 503-731-4771, [robert.j.nystrom@state.or.us](mailto:robert.j.nystrom@state.or.us)*

- *Part 1. Plans for improvement where you have defined programs*
- *Part 2. Assessment of activity areas you are involved in regardless of whether you have a well defined plan or program in place*
- *Part 3. Assessment of your future interests*

Part 1. Program Plans

**Briefly describe your plan of involvement or improvement of services for the following focus areas over the next two years, where you have defined programs or new plans specific to adolescent or school-aged child populations (indicate no plan or program when appropriate):**

- **School-Based Health Centers**

Currently there are no school based health centers in Linn County. Even though our last attempt failed to engage a community in a school based health center, this area remains a priority. We will continue to explore different community interests in this quest. We will continue to keep the lines of communication open with the superintendents and consider a survey to identify local areas interest.

- **Coordinated School Health (Healthy Kids Learn Better) Schools**

No involvement

- **Teen Pregnancy Prevention & Contraceptive Access**

- We continue to do presentations at the schools on Birth Control and STD. We plan about 3 –4 presentations per year. We feel this is important and will maintain our focus in this area. We currently do not have a health educator dedicated to family planning, so rely on current staffing. Propose adding 1 FTE health educator for Linn County.
- Work with High School counselors to insure the teens are referred for appropriate services as needed.
- Working on updating our power point presentation for schools on birth control and STI information.
- Teen Maze – work with local CCF to participate in Teen Maze. Life skills experience for area Middle Schoolers. ( 500 –700) students. This years Teen Maze being held over two days and area teens are helping plan and be in the rooms for help as well as Linn Benton community college students. We are planning an interactive game related to STD's.
- Reestablish connecting with Teen Pregnancy Task Force in East Linn. Look at being a more active group on teen pregnancy prevention. Preliminary pregnancy rate in 2007 in Linn County shows an increase from 7.6 to 9.8. We will continue to watch data as well as look at plan to address this issue. Possibly look at Americorp worker. (TA from state)
- Co-locating at the new FQHC in Lebanon. Networking with physicians on a referral system for teen clients seen.
- Continue oversight and coordination of STARS contract and services in Linn County.

- **Youth Suicide Prevention**

*Our Health Administrator, Frank Moore, is very active in implementing the Youth Suicide Prevention Plan in Linn County.*

## 5. **Tobacco Use Prevention & Cessation**

Possibly subcontracting with Samaritan Health on TPEP.

**6. Alcohol & Other Drug Use Prevention**

Talk with clients in clinic and give information. We provide education at visits and during school presentations. Have handouts we use for educational purposes. A&D Program also experienced cuts.

**7. Nutrition & Physical Activity**

- Work with Diabetes Health Educator to look at obesity and physical activity issues as related to the “Healthy, Active Oregon” We have started a local coalition “Healthy Albany Partnership”(HAP) and are planning a symposium in May. HAP works with East County CHIP (Healthy Active Lebanon- HAL) projects in this area.
- Work with family planning state staff for possible pilot project for obesity in FP clients. Could target teens.

**Part 2. Assessment of Current Activities Related to Adolescent Health**

Please indicate (with “X”) any of the following activities specific to adolescent or school-aged child populations that you are currently involved in. Some areas have both general and specific activities. *Check all that apply for any topic area.*

*Individual client services* are those that are generally delivered one-to-one or in groups.

*Community activities* are those efforts that bring community members together to address a topic, or that provide health promotion or education to the community in general.

*Health delivery system* activities are those that result in linking individuals or communities to needed health care or other services, through coordination, collaboration, or communication.

<b>TOPIC OR HEALTH RISK AREA Current Activities/Involvement</b>	<b>Individual Services</b>	<b>Community Activities</b>	<b>Health Systems Delivery</b>
Access to care	<b>X</b>	<b>X</b>	<b>X</b>
Comprehensive screening (GAPS/Bright Futures)			
Parent/family involvement	<b>X</b>		<b>X</b>
Primary care services		<b>X</b>	<b>X</b>
Mental health services		<u><b>X</b></u>	<u><b>X</b></u>
Youth suicide prevention	<u>referral</u>		<u><b>X</b></u>
<b>Depression screening</b>	<u><b>X</b></u>		<u><b>X</b></u>
Teen pregnancy prevention	<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>

<b>TOPIC OR HEALTH RISK AREA Current Activities/Involvement</b>	<b>Individual Services</b>	<b>Community Activities</b>	<b>Health Systems Delivery</b>
Contraceptive access	<u>X</u>	<u>X</u>	<u>X</u>
<b>Condom distribution</b>	<u>X</u>		
<b>ECP promotion</b>	<u>X</u>	<u>X</u>	
STD/HIV prevention	<u>X</u>	<u>X</u>	<u>X</u>
<b>STD/HIV counseling</b>	<u>X</u>	<u>X</u>	<u>X</u>
<b>STD/HIV treatment</b>	<u>X</u>		
Tobacco prevention			
<b>Tobacco cessation</b>	<u>X</u>		<u>X</u>
Alcohol & Other Drug (AOD) Use Prevention	<u>X</u>		<u>X</u>
AOD Assessment/screening			

<b>TOPIC OR HEALTH RISK AREA Current Activities/Involvement</b>	<b>Individual Services</b>	<b>Community Activities</b>	<b>Health Systems Delivery</b>
<b>Nutrition promotion</b>	<u>X LIMITED</u>	<u>X</u>	<u>X</u>
<b>Physical activity promotion</b>			
<b>Motor vehicle safety</b>			
<b>    Seat belt use</b>			
<b>    DUI</b>			
<b>    Street racing</b>			
<b>Violence prevention</b>			
<b>    Harassment/Bullying</b>			
<b>    Physical fighting</b>			
<b>    Weapon carrying</b>			

**Part 3. Assessment of Future Interests Related to Adolescent Health**

For the topic areas or health risks for adolescents and school-aged children that you just responded to please indicate (with "x") what would you like to do in the future if resources could be identified? Some additional detail has been added.

<b>TOPIC OR HEALTH RISK AREA</b> <b>Future Interest/Needs</b>	<b>No plans to expand</b>	<b>Would like to expand</b>	<b>Would like more info or assistance</b>
	Select one		
Access to care		X	X
School-Based Health Centers			X
Comprehensive screening (GAPS/Bright Futures)			X
Coordinated School Health (Healthy Kids Learn Better)			
Parent/family involvement		X	X
Primary care services	X		
Mental health services			
Youth suicide prevention			X
<b>Depression screening</b>			
Teen pregnancy prevention		X	X
Contraceptive access		X	
<b>Condom distribution</b>		X	X
<b>ECP promotion</b>		X	X
STD/HIV prevention		X	X
<b>STD/HIV counseling</b>		X	X
<b>STD/HIV treatment</b>		X	X
Tobacco prevention			
<b>Tobacco cessation</b>			
Alcohol & Other Drug (AOD) Use Prevention			
AOD Assessment/screening			

	<b>No plans to expand</b>	<b>Would like to expand</b>	<b>Would like more info or assistance</b>
<b>Nutrition promotion</b>		X	X
<b>Physical activity promotion</b>		X	X
<b>Motor vehicle safety</b>			
<b>    Seat belt use</b>			
<b>    DUI</b>			
<b>    Street racing</b>			
<b>Violence prevention</b>			
<b>    Harassment/Bullying</b>			
<b>    Physical fighting</b>			
<b>    Weapon carrying</b>			

**A Continuum of Public Health home visit programs serves Linn County families with young children**

- 1. Maternity Case Management (MCM). Staffed by .4 FTE Public Health Nurse**
2. Oregon Mother's Care (OMC). Staffed by .2 FTE Bilingual Health Aid
3. Babies First (B-1<sup>st</sup>) {B-1<sup>st</sup>/CaCoon is staffed by 2.33 FTE Public Health Nurses
4. Care Coordination (CaCoon) {B-1<sup>st</sup>/CaCoon is staffed by 2.33 FTE Public Health Nurses
5. Healthy Start of Linn County (HSLC). Staffed by 2.6 FTE Family Support Workers.

**Four local collaborative projects in partnership with Linn County Public Health support families with young children 0-8 years.**

1. Linn County Post Partum Depression Project
2. Linn County Right from the Start Project
3. Linn County Juvenile and Adult Drug Court Project for Pregnant and Parenting Women – Mom's Support Group
4. Linn County Car Seat Program

**Program Criteria, Cost, Capacity and Hours.**

These Public Health Programs serving families and their children are

- 1. Available to serve all Linn County families.**
2. Voluntary and free.
3. Program capacity varies according to staffing level and program model requirements.
- 5. Hours of service are Monday through Friday, 8am – 5pm with some evening and weekend hours based on family need.**

Funding Sources by program

- 1. Maternity Case Management (MCM): County General Fund; Local Commission on Children and Families grant; Medicaid fee for service; Medicaid targeted case management; State General Funds through the Oregon Health Division for local Perinatal services, Child and Adolescent services.**

2. **Mothers Care: State General Funds through the Oregon Health Division for local perinatal services.**
3. Babies First (B-1<sup>st</sup>): County General Fund; Medicaid targeted case management and Medicaid administration funds; State General Funds through the Oregon Health Division for local Babies First services.
4. Care Coordination (CaCoon); County General Fund; Medicaid targeted case management and Medicaid administration funds; State General Funds through Child Development and Rehabilitation Center (CDRC) for local CaCoon services.
5. Healthy Start of Linn County (HSLC). State General Funds through the Oregon Commission on Children and families; Medicaid administration funds.

### Linn County Perinatal Programs

<b>Population Served by Program</b>	<b>Service Focus by Program</b>	<b>Referral Process by Program</b>	<b>Intake Period by Program</b>	<b>Staffing</b>
<p><b>1. (MCM) Maternity Case Management</b> serves women and the newborn during the perinatal period (prenatal through 8-weeks postpartum.</p> <p>50 Pregnant women are served annually.</p>	<p>1. Maternity Case Management (MCM) - The goals are to support and assist pregnant women through early access to quality prenatal care, to provide assistance with the OHP application, referral to a medical provider and on-going case management for at-risk pregnant women.</p> <p>Services include home visits, advocacy, case management, education and the skills of a public health nurse monitoring and assessing the health and needs of this family with potential for poor pregnancy and birth outcomes.</p> <p>MCM is offered to prenatal women who are at risk for poor health and birth outcomes. Teen pregnancy, women 40 + years of age, previous pregnancy problems, substance use, gestational diabetes and other chronic health problems that can cause a health problem for the pregnant woman and poor birth outcome of the child. This includes, low birth weight prematurity, drug effected infant, genetic problems.</p>	<p><b>1. MCM</b> prenatal referrals are received from community medical providers, hospital maternity care coordinators, from public health clinics, WIC, Mothers Care and Healthy Start.</p>	<p>1. <b>MCM intake is during the first and second trimester is the primary intake period.</b></p>	<p><b>1. MCM</b> is staffed by .40 FTE Public Health Nurse</p>
<p>2. Oregon Mothers</p>	<p>2. Oregon Mothers Care (OMC) The goal is to improve access to early prenatal care services in Linn County by providing referral for prenatal care and other related services to pregnant women as</p>	<p><b>2. OMC</b> referrals come from public health clinics and</p>	<p>2. <b>OMC intake</b></p>	<p><b>2. OMC is staffed</b></p>

<p>Care (OMC) serves pregnant women needing early access and referral to prenatal services.</p>	<p>early as possible in their pregnancy. Services of OMC also include on-going outreach to pregnant women and providers serving pregnant women; the use of the statewide Safe Net hotline and local access points within Linn County.</p>	<p>local physicians offices.</p>	<p>period for pregnant women supports early access to service</p>	<p>by a bilingual health aide.</p>
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Perinatal Programs

Problem	Issue	Goal	Activity	Evaluation
<p><b>Oral health among Oregon's children has deteriorated, especially in rural Oregon. Oregon Smiles 2007 DHS Public Health</b></p>	<p>It is important to see a dentist during pregnancy to prevent dental problems. The dental health of a pregnant woman is reflected in the unborn child. A pregnant woman with cavity-causing germs is likely to pass them on to the baby.</p>	<p><b>To build a foundation for a child's healthy teeth.</b></p>	<p><b>A dental appointment before the baby is born.</b></p>	<p><b>ORCHIDS Data</b></p>

## Linn County Child Health Programs

<b>Population Served by Program</b>	<b>Service Focus by Program</b>	<b>Referral Process by Program</b>	<b>Intake Period by Program</b>	<b>Staffing</b>
<p><b>3. Babies First (B-1<sup>st</sup>)</b> serves medically and socially high-risk infants and young children 0 to 4-years.</p> <p>150 families with young children 0-4 years are case managed annually</p>	<p><b>3. Babies First (B-1<sup>st</sup>)</b> - The goal of this program is for a Public Health nurse to engage, assess, monitor, case manage, and to connect high risk infants to a medical home because of actual or potential risks for poor birth outcomes, attachment problems, growth and developmental risks, and concerns about high risk social and behavioral issues within the family situation. Voluntary in-home nurse visits are offered to families with children 0-4 years. Services include case management, advocacy, health, growth &amp; developmental screening, health and parenting education, support and referral by a public health nurse.</p> <p><i>Children served may be alcohol &amp; drug exposed prenatally or within their environment; exposed to child abuse/neglect, failure to thrive, have poor attachment or behavioral problems, low birth weight, prematurity or showing developmental delay.</i></p>	<p><b>3. B-1<sup>st</sup></b> referrals are risk based and made by medical providers, hospital nurses and social worker, DHS child welfare and self-sufficiency staff, WIC, Maternity Case Management, Healthy Start and other community partners</p>	<p><b>3. B-1<sup>st</sup></b> Newborn through age 4 years.</p>	<p><b>3. B-1<sup>st</sup>/CaCoon</b> is staffed by 2.33 FTE Public Health Nurse.</p>
<p><b>4. Care Coordination (CaCoon)</b> serves infants and children 0-18 years with special health care needs.</p> <p>100 visits are made to children with special health needs annually</p>	<p><b>4. Care Coordination (CaCoon)</b> – Public Health nurses assist parents to be the case manager of their child’s special health care needs.</p>	<p><b>4. CaCoon</b> infants and children are referred by the CDRC, NICU’s, medical providers, hospital nurses and social worker, Healthy Start and other community partners.</p>	<p><b>4. CaCoon</b> Newborn through age 18-years.</p>	<p><b>4. B-1<sup>st</sup>/CaCoon</b> is staffed by 2.33 FTE Public Health Nurse.</p>
<p><b>5. Healthy Start</b></p>	<p><b>5. Healthy Start Of Linn County (HSLC)</b> - Offers a Welcome</p>	<p><b>5. HSLC</b></p>	<p><b>5. HSLC</b></p>	<p><b>5.HSLC</b> is staffed</p>

<p>(HSLC) serves first-time families, prenatally or shortly after birth.</p> <p><b>306 families were screened. 55 received intensive home visits</b></p>	<p>Baby telephone call with information and a visit to higher needs families in Linn County having their first baby. The goal is to promote positive parent-child interaction and relationship, readiness to learn, healthy thriving children, strong nurturing families and the prevention of child abuse and neglect.</p> <p>Families at higher risk receive intensive home visit services a trained family support worker who provides parenting support and education, developmental screening, access to health care and community resources.</p>	<p><b>Their health care provider, hospital nurses, WIC, Mothers Care, B-1st and the community, completes screening with a 1st time family.</b></p>	<p>First-birth families prenatally or shortly after the birth of their first baby.</p>	<p>by 2.6 FTE Family Support Workers</p>
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Child Health Programs

Problem	Issue	Goals	Activities	Evaluation
<p><b>Oral health among Oregon's children has deteriorated, especially in rural Oregon. Oregon Smiles 2007 DHS</b></p>	<p>Infants and children require special oral health care and attention. According to the Surgeon General, dental decay (cavities) is the most common chronic disease of childhood.</p>	<p><b>To build a foundation for a child's healthy teeth by providing information about oral health habits in the early years.</b></p>	<p><b>Staff Training</b>  <b>Parent Handouts</b>  <b>Preventing Baby Bottle Tooth Decay</b>  <b>Oral Hygiene</b>  <b>Weaning</b>  <b>Inform parents about fluoride prevention by providing information on</b></p>	<p><b>Staff Training</b>  <b>ORCHIDS Data</b>  <b>Program</b>  <b>Handouts</b></p>

<b>Public Health</b>			<b>city water supply or well water</b> <b>Support a Dental Visit at 1-year</b>	
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4 - Local Collaborative Projects in Partnership with Linn County Public Health support Perinatal & Child Health and Safety. These projects support families with young children 0-8-years and include:

- 6. Linn County Post Partum Depression Project
- 7. Linn County Right from the Start Project
- 8. Linn County Juvenile and Adult Drug Court Project for Pregnant and Parenting Women – Mom’s Support Group
- 9. Linn County Car Seat Program

Local Collaborative Projects in Partnership with Linn County Public Health support Perinatal & Child Health and Safety.

<b>Population Served by Program</b>	<b>Service Focus by Program</b>	<b>Referral Process by Program</b>	<b>Intake Period by Program</b>	<b>Collaboration</b>
6. Linn County Post Partum Depression Project (LCPPD)  <b>100 women are provided</b>	<b>6. The Linn County Post Partum Depression Project (LCPPD) provides outreach, information and referral for women pregnant and parenting who are experiencing problems with mood and perinatal depression. Referral to Mental Health and other services is case managed.</b>	<b>6. LCPPD</b> Self-referral and provider referrals are made to the project.	<b>6. LCPPD</b> Pregnant and parenting women affected by mood or depression.	<b>6. LCPPD is a collaboration of Linn County Public Health, Mental Health and Alcohol and Drug Treatment and</b>

outreach services				hospital Maternity Care Coordinators.
<b>Population Served by Program</b>	<b>Service Focus by Program</b>	<b>Referral Process by Program</b>	<b>Intake Period by Program</b>	<b>Collaboration</b>
<b>7. Linn County Right from the Start Project.</b>  25 women are served annually.	<b>7. Linn County Right from the Start Project.</b> A prenatal program, that provides women affected by substance use receive additional support from a Public Health Nurse with special training in substance abusing pregnant women. The goals of the project are to assist the pregnant women to maintain a drug-free pregnancy through quick access to treatment and mental health counseling, and to provide ongoing support for her pregnancy needs.	<b>7. LC Right from the Start</b> referrals are made by medical providers, hospital nurses and social worker, WIC, Maternity Case Management, Healthy Start and other community partners.	<b>7. LC Right from the Start</b> Pregnant and parenting women affected by mood swings or depression.	<b>7. LC Right from the Start</b> is a collaboration with Linn County Mental, Linn County Alcohol and Drug Treatment and Linn County Public Health
8. Linn Juvenile and Adult Drug Court Project for Pregnant and Parenting Women – Mom’s Support Group	8, Mom’s <i>Having a Healthy Baby</i> support group <b>for Drug Court mothers who are pregnant or who have infants. Women in the existing Drug Court expressed a strong need for additional support during their pregnancy and after giving birth, this group provides participants with support and information on having a healthy pregnancy and raising a healthy infant.</b>	8. Mom’s Support Group referrals are made by the Juvenile and Adult Drug Court.	8, Mom’s Support Group Pregnant and Parenting women referred by the Juvenile and Adult Drug Court.	8, Mom’s Support Group is a collaboration with the Linn County Juvenile and Adult Drug Court, Alcohol and Drug Treatment and

<b>Up to 15 women annually</b>				<b>Public Health Nursing.</b>
<b>9. Linn County Car Seat Project.</b>  50 families are fitted with car seats annually	<b>9. Linn County Car Seat Project</b> provides car seat safety clinics, instruction on car seat safety and installation and low cost car seats for Linn County families.  The Albany Kiwanis Club donated \$1600 for convertible car seats over the past 2-years. A Grant through ODOT is provided through the Albany Fire Department.	<b>9. Linn County Car Seat Project</b> Self-referral and provider referrals are made to the project.	<b>9. Linn County Car Seat Project</b> Families with children needing car seats, information and training.	<b>9. Linn County Car Seat Project</b> is a collaboration of the Oregon Health Safety Division, ACTS Oregon, Linn County Public Health and Albany Fire Department.

Problem	Issue	Goals	Activities	Evaluation
<b>A funding cut in the Linn County Post Partum Depression Project (LCPPD)</b>	Depression in the perinatal period can lead to chronic depression in women. Depression in the perinatal period can also cause problems in the parent child interaction that may effect parent child attachment and a child's social emotional health.	<b>To restructure the project after the funding reduction.</b>	<b>Participate in the Office of Family Health Perinatal Depression Project</b>	<b>A plan, screen, and handouts for outreach will be developed.</b>

FY 2008 - 2009 WIC Nutrition Education Plan Form

**County/Agency:** Linn County  
**Person Completing Form:** Katey Stoll  
**Date:**  
**Phone Number:** April 17, 2008  
**Email Address:** (541) 967-3888 x2594  
kstoll@co.linn.or.us

Return this form electronically (attached to email) to: [sara.e.sloan@state.or.us](mailto:sara.e.sloan@state.or.us)  
by May 1, 2008  
Sara Sloan, 971-673-0043

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 one's 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:

By October 31, 2008 WIC certifiers, Nutritionist, Lactation Consultant and Coordinator will review the Oregon WIC Key Messages and discuss as a group which topics we feel we need training and/or clarification on. Then the Coordinator and Training Supervisor will prepare information and/or employee in-services to teach/clarify certain topics.

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:

During the July Employee In-Service, Linn County WIC staff will review the proposed food packages changes. By March 31, 2009 our group will select at least three of the modifications and connect the modifications with current nutrition education messages. As well, our staff (and as a state) will review past nutrition messages in effort to collaborate with the proposed food packages changes.

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

Implementation Plan and Timeline:

During the July Employee In-Service, Linn County WIC staff as a group, utilizing State provided guidance and assessment tool, will identify areas needing training and/or clarification in regards to the Dietary Risk Module assessment process by September 30, 2008, in effort to improve the certifiers confidence in documenting and handling client health risks in the WIC program.

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 include: State provided guidance and assessment tools.

Implementation Plan and Timeline:

During the October Employee In-Service, Linn County WIC staff as a group utilizing State provided guidance and assessment tool, will identify and select areas needing training and/or clarification regarding participant centered approach with the Dietary Risk Module process, in effort to evaluate and revise counseling modifications in the assessment process.

**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: [a\) To establish a work place event food policy, and b\) begin the process of establishing a countywide wellness program.](#)

Strategy: a) Propose a policy that requires healthy food choices be available during work place events (i.e. employee Birthday parties, Christmas parties, etc...).

b) Meet with various county officials/managers to gain an understanding of the interest regarding a countywide Wellness Program and then start initiating meetings and ideas to start creating the program.

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.

a) Based on employee interest in improving their health within Linn County Health Department, supporting the creation and enforcement of healthy practices in the work place is why this challenge was chosen. It seems many employees desire better health but don't have all the knowledge and/or support required for optimal success. Initially in July 2009, an employee survey (developed by the WIC Coord. and Training Supervisor) will be conducted in effort to determine challenges and/or weakness identified by employees regarding choosing healthier practices, especially in the work place. Once the surveys are reviewed, the WIC Coordinator will share during a department meeting (hopefully in July, maybe August) some shared challenges amongst employees (anonymously of course) and propose the healthy food policy for work events. At the end of at least a six month time frame, a evaluation survey will be conducted in effort to identify if changes proposed with the work place event healthy food policy made any difference to employees.

b) This challenge was selected since it was an evaluation set goal for the WIC Coordinator for the coming year, proposed by the Program Manager. Initially, will meet with Health Department Supervisor's to get ideas of what is legally, financially and realistically available as far as proposing a Wellness Program. This will be simply a start to something the WIC Coordinator foresees as a very large project, which will require the support of the Department Managers, Directors and eventually the Commissioners.

Activity 2:

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

Setting: Community

Objective: Continued nutrition promotion and education in the Linn County Health Departments.

Strategy: Quarterly Nutrition education displays in Linn County Health Departments. Continued promotion of the Fruits and Veggies More Matters™ campaign to individual WIC participants and during NE group activities.

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.

Within the health department and especially WIC, it is very important to be consistent and precise about the health information instructed and displayed, so having various up-to-date nutrition information available for clients at all times and at all clinics is the goal of this activity. Quarterly nutrition display boards in the WIC clinic areas, up-to-date client brochures continuously available, quarterly nutrition and health focuses at WIC Expos and on-going display and promotion of the Fruits and Veggies More Matters™ campaign. Assessing the effectiveness of the information provided is the biggest challenge regarding this type of activity. A possible solution again, would be conducting pre- and post-surveys to measure the knowledge increase on a randomly selected population of WIC clients.

**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, 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: Community/ Health Care

Objective: Continued partnership building amongst Breastfeeding Support professionals within Linn County.

Strategy: The WIC Coordinator and WIC Lactation Consultant will initiate meetings with other breastfeeding professionals within local hospitals, medical clinics, pregnancy centers and other maternal and infant care facilities, in effort to create a network of individuals consistently promoting and supporting breastfeeding mothers within the community.

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.

It is very common for mothers to have multiple care providers; the same is for lactation consultants as well, which can either be very helpful or very hurtful to the success of a breastfeeding mother. Creating a network between Breastfeeding professionals can help eliminate inconsistent breastfeeding instructions given to clients, and create a comfort amongst breastfeeding professionals within Linn County that as a whole will better the community. Assessing the effectiveness of this activity will involve assessing current breastfeeding trends and comparing those trends to future data. Overall this activity's success can be determined based on the relationships created amongst the breastfeeding support professionals within Linn County, because these relationships can only create good towards the promotion and support of breastfeeding mothers.

**Attachment A**  
**FY 2008-2009 WIC Nutrition Education Plan**  
**Goal 1, Activity 3**

**WIC Staff Training Plan – 7/1/2008 through 6/30/2009**

Agency: [Linn County](#)

Training Supervisor(s) and Credentials: [Leah Brunson, BS, IBCLC](#)

**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	<ul style="list-style-type: none"> <li>• Review and discuss Nutrition Ed Messages</li> <li>• Review and discuss the Dietary Risk Module process.</li> </ul>	<ul style="list-style-type: none"> <li>• Select Nutrition Ed Messages that staff needs training/clarification.</li> <li>• Identify areas needing training/clarification regarding the Dietary Risk Module process.</li> </ul>
2	October	<ul style="list-style-type: none"> <li>• Based on selected Nutrition Ed Messages</li> <li>• Based on areas needing training in regards to the Dietary Risk Module process.</li> </ul>	<ul style="list-style-type: none"> <li>• Review and/or learn about selected nutrition ed. topics.</li> <li>• Review and/or learn about selected areas in the Dietary Risk Module needing improvement/clarification.</li> </ul>
3	January	<ul style="list-style-type: none"> <li>• Proposed Food Package Review</li> </ul>	<ul style="list-style-type: none"> <li>• Review and/or learn about selected food package changes, in effort to understand and be able to explain the reason for the change(s) to clients.</li> </ul>
4	April	<ul style="list-style-type: none"> <li>• Review current client practices in regards to client-centered counseling and initiate any further training if needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Based on the confidence of the WIC staff, to continually improve staff's ability to apply the client-centered approach into the WIC certification process.</li> </ul>

## C. Environmental Health

### Problems, Goals, Activities, and Evaluations

All problems are manageable and managed. Our goals are to fulfill the contractual requirements between DHS and Linn County for Environmental Health Services. We conduct the activities necessary to provide program services in all areas of 333-014-0050(2)(e). Evaluations are in the form of the annual Environmental Health Statistics Report, DHS Triennial Review, and DEQ audit.

The goals and priorities of the DHS Environmental Services program are not clearly articulated. Activities and evaluations are not in alignment. For example, if one goal is to develop the food protection program in a manner consistent with the FDA Model Retail Food Program Standards, then the annual self review and triennial review should be aligned with and supportive of that goal. The Drinking Water Program provides a good example of well articulated goals, pertinent evaluation tools, alignment, and tight integration between state and local efforts.

2. A description of the problems, goals, activities, and evaluations related to your contract (program elements) with the DHS.

An opportunity for regular evaluation of significant state program activities (for example, rule making, training, technical assistance, program development priorities and efforts) by local health authorities would be welcomed and meaningful if appropriate changes are made as a result.

3. A description of how the program will accomplish the following program requirements. This will, in part, be a description of your management and staffing plan.

- a. Licensure, inspection and enforcement of facilities under ORS 624, 448, and 446: By complying with the requirements of the statutes.
- b. Consultation to industry and the public on environmental health matters: By responding to requests based on health significance and available resources.
- c. Investigation of complaints and cases of foodborne illness: By investigating, tracking and closing complaints, and by following the investigative guidelines for foodborne illness.
- d. Staff access to training and satisfaction of training requirements: Staff attend all mandatory training.
- e. Reduction of the rate of health and safety violations in licensed facilities and reduction of foodborne illness risk factors in food service facilities: Good question. These reductions will likely come as a result of more effective program management and development at the state level. We already faithfully implement the existing program requirements to the full extent allowed within the constraints of our contract with DHS.

4. We are implementing household hazardous waste and TMDL plans developed with assistance from DEQ.

## **D. Health Statistics**

Linn County births for 2007 were 1040 and deaths were 985. The Oregon Health Division web site has a preliminary 1st births at 600. In 2007 we issued 173 birth certificates to parents compared to 114 in 2006 which is almost a 52% increase in birth certificate issuance, which is over \$1,000 increase in birth certificate revenue in 2007 over 2006. We still hand register all Linn County death certificates as well as computer entry for all deaths for which we produce certified copies. Birth certificates are directly registered into the computer system by the hospitals through the State and we download any requested copies and enter intaglio information and orders for certified copies into the computer system. All billing is still done by hand as that phase of the computer system is still to come. The State computer system for vital stats is OVERS (Oregon Vital Events Registration System)

## **F. Information and Referral**

All of our site telephone numbers and addresses are listed in the various telephone books throughout the county. Staff is competent in triaging individuals who may have questions about services we do not offer as well as knowledgeable about program area services located within the department of health services. Many of our specific programs have brochures which speak to eligibility for that particular program. In addition, Linn County Department of Health Services has a brochure with all of its programs. (Alcohol and Drug, Mental Health, Developmental Disabilities, Environmental health, Commission on Children and Families and Public Health). Our website is well maintained with timely information and we are expanding the linkages within the site.

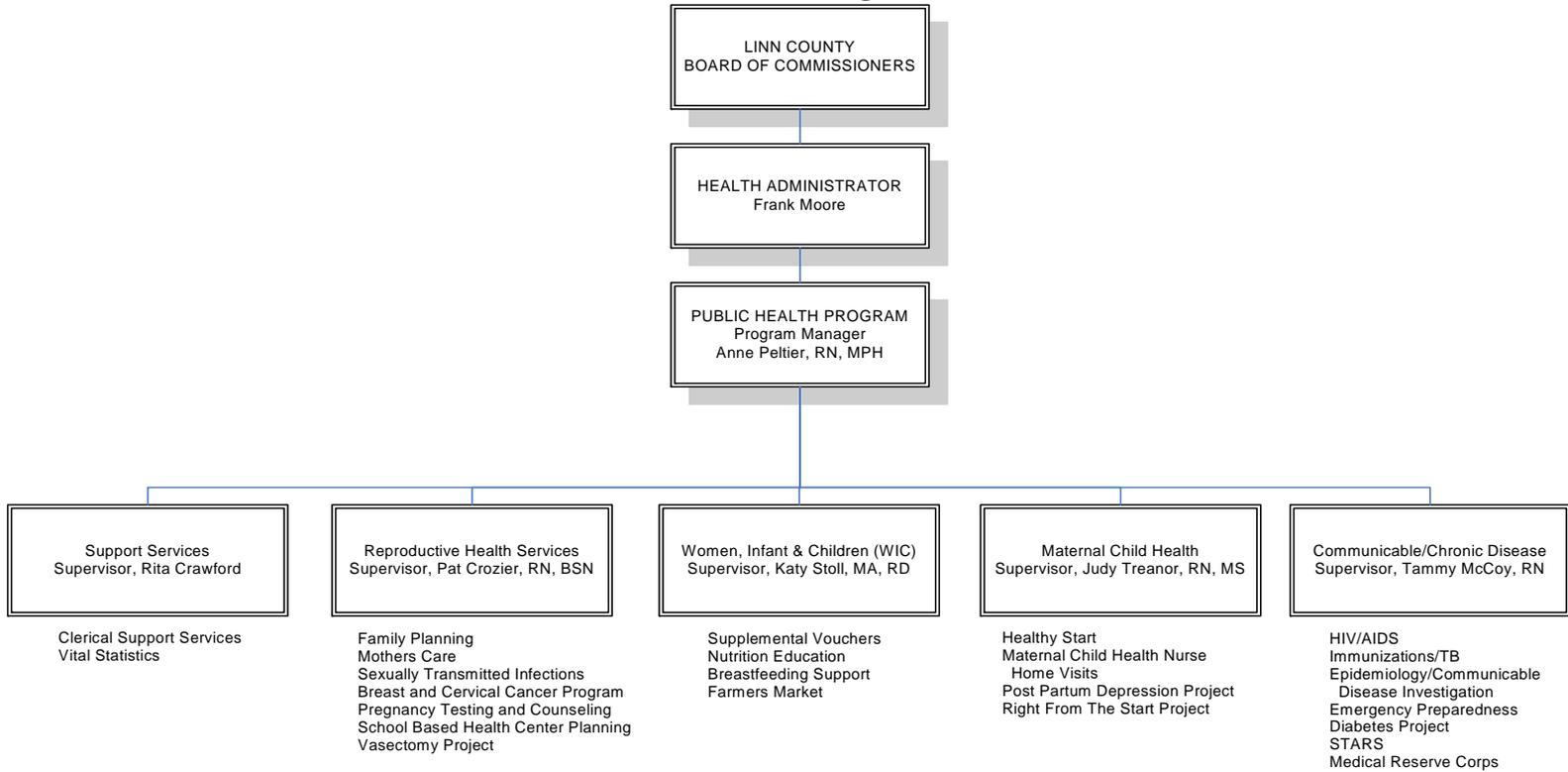
Love, Inc. is an information and referral agency that is nationwide with an affiliate in Benton County. Linn County has been pursuing an office which would pull together most of the faith communities in Linn County to work together on services for vulnerable populations.

## **IV. Additional Requirements**

### **A. Organizational Chart**

### **B. CCF Comprehensive Plan Coordination**

# Linn County Department of Health Services Public Health Programs



**B. Linn County Local Public Health Authority is the governing body that oversees the local commission on children and families.**

## V. Unmet Needs

1. **Physical activity and nutrition**- we are not doing enough to address these issues. I would like us to work with the YMCAs, the schools, Boys and Girls Clubs, CHIP, Healthy Albany Partnership and Samaritan Health to explore ways to address this on a county level. Need a health educator.
2. **Chronic disease prevention**- not nearly enough being done in Linn County. This is what county public health programs should be dealing with. We have no county programs that address the needs of this population much less focus on the prevention of chronic disease. Need a health educator.
3. **School Based Health Centers**- We are shamefully unable to provided school based access to health care for any of our children in Linn County. This is even in light of the alarming rate of asthma in our school aged children. I would like to see us explore pumping up community support for at least one SBHC in Linn County. Need a health educator.
4. **Senior Services**- % of our population is over age 65 yet all we offer to seniors is maybe a flu shot every year. How can we help them manage their chronic disease? How can we help them stay fit and healthy? Let's work with Senior and disabled Services, our cities senior centers, the YMCA and Samaritan Health to make sure our seniors don't fall through the cracks. Need a health educator.

## **VI. Budget**

Shirlee Wertz is the keeper of our budget information. She can be reached at (541) 924-6914 ext. 2035 and [swertz@co.linn.or.us](mailto:swertz@co.linn.or.us).  
Our address is P.O. Box 100  
Albany, Or 97321

## VII. Minimum Standards

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

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

### Organization

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

13. Yes \_\_\_ No  Written performance evaluations are done annually.(After 5 ½ years, we do every two years)
14. Yes  No \_\_\_ Evidence of staff development activities exists.
15. Yes  No \_\_\_ Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes  No \_\_\_ Records include minimum information required by each program.
17. Yes  No \_\_\_ A records manual of all forms used is reviewed annually.
18. Yes  No \_\_\_ There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes  No \_\_\_ Filing and retrieval of health records follow written procedures.
20. Yes  No \_\_\_ Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes  No \_\_\_ Local health department telephone numbers and facilities' addresses are publicized.
22. Yes  No \_\_\_ Health information and referral services are available during regular business hours.
23. Yes  No \_\_\_ Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.
24. Yes  No \_\_\_ 100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.
25. Yes  No \_\_\_ To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes  No \_\_\_ Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes  No \_\_\_ Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.

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

### **Control of Communicable Diseases**

37. Yes  No  There is a mechanism for reporting communicable disease cases to the health department.
38. Yes  No  Investigations of reportable conditions and communicable 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.
48. Yes  No \_\_\_ Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes  No \_\_\_ Training in first aid for choking is available for food service workers.

50. Yes  No  Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
51. Yes  No  Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
52. Yes  No  Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.
53. Yes  No  Compliance assistance is provided to public water systems that violate requirements.
54. Yes  No  All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
55. Yes  No  A written plan exists for responding to emergencies involving public water systems.
56. Yes  No  Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes  No  A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.
58. Yes  No  Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes  No  School and public facilities food service operations are inspected for health and safety risks.
60. Yes  No  Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes  No  A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes  No  Indoor clean air complaints in licensed facilities are investigated.
63. Yes  No  Environmental contamination potentially impacting public health or the environment is investigated.

64. Yes  No  The health and safety of the public is being protected through hazardous incidence investigation and response.
65. Yes  No  Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes  No  All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

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

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

### **Nutrition**

73. Yes  No  Local health department reviews population data to promote appropriate nutritional services.
74. The following health department programs include an assessment of nutritional status:
- a. Yes  No  WIC

- b. Yes  No  Family Planning
- c. Yes  No  Parent and Child Health
- d. Yes  No  Older Adult Health
- e. Yes  No  Corrections Health

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

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

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

### **Older Adult Health**

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

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

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

81. Yes  No  Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education.

### **Parent and Child Health**

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

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

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

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

### **Primary Health Care**

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

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

*Cultural Competency*

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

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

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

102. Yes  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:**

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

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

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

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

AND

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

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

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

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

OR

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

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

**106. Yes  No  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.

## VIII. Capacity Assessment

### Operational Definition of a Functional Local Health Department (LHD) Metrics LHD Capacity Assessment Tool

**Directions:**

- **Using the scale below, score each indicator based on the capacity within your LHD; including both capacity provided by your HD staff and through contracts that you have with outside entities.**
  
- **In the comment section, following each focus area indicators, please identify any outside entities (non-contract) at the local, regional or state level that provide capacity to fulfill the indicators in that section.**
  
- **The items in the shaded boxes to the right of the scoring column are supplemental information (Illustrative Evidence) to help clarify the focus areas being evaluated.**

Score	Description
<b>0</b>	<b>No capacity</b>
<b>1</b>	<b>Minimal capacity (&lt; 25%)</b>
<b>2</b>	<b>Moderate capacity (25% - 50%)</b>
<b>3</b>	<b>Significant capacity (51% - 75%)</b>
<b>4</b>	<b>Optimal (76%-100%)</b>

County \_\_\_\_\_ Linn County Department of Health Services\_\_ Date \_\_\_\_\_ 3/18/08 \_\_\_\_\_

Name of person completing survey \_\_\_\_\_ Anne Peltier RN, MPH \_\_\_\_\_

## ESSENTIAL SERVICE I: Monitor health status and understand health issues facing the community

**STANDARD I-A** Obtain and maintain data that provide information on the community's health (e.g., provider immunization rates; hospital discharge data; environmental health hazard, risk, and exposure data; community-specific data; number of uninsured; and indicators of health disparities such as high levels of poverty, lack of affordable housing, limited or no access to transportation, etc.).

### FOCUS: DATA COLLECTION, PROCESSING and MAINTENANCE

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff has expertise and training to collect, manage, integrate and display health-related data	4	<ul style="list-style-type: none"> <li>▪ A data set from a major data system</li> <li>▪ Written documentation of process to contribute/maintain to register</li> <li>▪ Report that demonstrates health assessment data being collected; or minutes or presentation to a meeting in which a profile of community health status is presented</li> <li>▪ Listing of key staff names and degrees; conduct assessment of training and provide assessment results;</li> <li>▪ Written description of current computer equipment and technology including brand, model, year</li> </ul>
2. LHD uses appropriate equipment and technology	4	
3. LHD maintains and uses an information system(s) (e.g. email, shared electronic database files, intranet)	4	
4. LHD demonstrates an electronic linkage with local and statewide databases	4	
5. An electronic disease reporting system exists between the LHD and health care providers	1	
6. LHD has a process and protocols in place to maintain a comprehensive collection, review, and analysis of data from a variety of reliable sources	4	
7. LHD collects and reviews primary data (e.g. community surveys; disease reporting) and secondary data (state health department data; census data; hospital discharge data) from a variety of reliable sources	4	
8. LHD contributes to and/or maintains a registry (e.g. log of all known events of certain type in the community--immunization; violence; communicable disease)	4	

**Comments regarding non-contract entities providing services for this focus area:**

**STANDARD I-B.** Develop relationships with local providers and others in the community who have information on reportable diseases and other conditions of public health interest and facilitate information exchange.

**FOCUS: DISEASE REPORTING RELATIONSHIPS; MAKE DATA AND INFORMATION FLOW ROUTINE**

Operational Definition Indicators	Score	Illustrative Evidence
2. LHD maintains a user-friendly (preferably electronic) system for reporting of data	4	<ul style="list-style-type: none"> <li>▪ List of providers and log of reports made</li> <li>▪ Feedback provided on data reports</li> <li>▪ Written summary that details on percentage of reports that are from providers</li> <li>▪ Presentations, evidence of meetings held or conference organized (e.g. agenda), or educational materials distributed to promote provider relationships and reporting</li> </ul>
3. LHD maintains a written and electronic list of health care providers and public health partners who may be disease-reporters	4	
4. A written policy/procedure exists that describes the method to assure that LHD staff can be contacted at all times	4	
5. Providers are educated and trained on collecting and reporting data to the LHD	4	
6. LHD uses a quality improvement process between LHD and providers to make it easy for providers to report	4	
7. Health care providers and other public health partners receive reports and feedback on disease trends and clusters	3	

**Comments regarding non-contract entities providing services for this focus area.**

**STANDARD I-C.** Conduct or contribute expertise to periodic community health assessments.

**FOCUS: CONDUCT OR CONTRIBUTE EXPERTISE TO PERIODIC COMMUNITY HEALTH ASSESSMENTS**

Operational Definition Indicators	Score	Illustrative Evidence
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1. LHD staff have the appropriate knowledge of standards and processes for conducting community health assessments	1	<ul style="list-style-type: none"> <li>▪ A Community Health Plan (CHP) with community health assessment</li> <li>▪ Summary of community health assessment findings</li> <li>▪ Community health assessment update</li> </ul>
2. LHD staff are trained in the application of assessment methods	1	
3. LHD staff can organize and manage an assessment process	2	
4. A structured process for conducting the community health assessment is reviewed and adopted (i.e. APEX/PH, MAPP, etc.)	0	
5. LHD organizes community health data (e.g. mortality, disease prevalence, risk factors, and other data) for assessment purposes	3	
6. Broad participation of community stakeholders in the assessment process is secured.	0	
7. A community health assessment process is conducted every five years	0	

**Comments regarding non-contract entities providing services for this focus area:**

**STANDARD I-D.** Integrate data with health assessment and data collection efforts conducted by others in the public health system.

**FOCUS: INTEGRATING DATA/DATA SHARING WITH COMMUNITY PARTNERS**

Operational Definition Indicators	Score	Illustrative Evidence
1. A written protocol to integrate data exists	0	<ul style="list-style-type: none"> <li>▪ LHD or other agency report indicating diverse participation in assessment process</li> <li>▪ Minutes demonstrating convening diverse groups in health assessment process</li> <li>▪ Written documentation of membership in other groups that are conducting health assessment or data collection efforts</li> </ul>
2. LHD develops and maintains relationships with community and public health system partners	1	
3. Assessment processes by community agencies include the LHD and community partners as participants	0	
4. LHD uses an electronic system to integrate assessment data from a variety of sources (e.g. database software)	0	

		<ul style="list-style-type: none"> <li>Meeting minutes showing health data and community health assessments are shared</li> <li>Written protocol or description of the process used to share data</li> <li>Evidence that health assessment and data are available for public use (e.g. website, reports on how data is shared)</li> </ul>
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▪ **Comments regarding non-contract entities providing services for this focus area above.**

▪ **STANDARD I-E** Analyze data to identify trends, health problems, environmental health hazards, and social and economic conditions that adversely affect the public’s health.

▪ **FOCUS: DATA ANALYSIS**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has a process in place to analyze and identify patterns in data	4	<ul style="list-style-type: none"> <li>Evidence of an internal process reflecting data analysis (e.g., policies and procedures, meeting minutes, agency management team minutes, etc.)</li> <li>Documentation of having reported analysis findings to state (e.g., emails/logs of phone calls, analysis of local infectious disease data)</li> <li>Report and/or a presentation that demonstrates a comprehensive understanding of the health status and health problems most meaningful for the community in logical data groups</li> <li>Other documentation such as asset map of the community, Community Health Profile, GIS map detailing trends, health problems etc</li> </ul>
2. LHD staff are competent in methods of data analysis and interpretation	4	
3. LHD draws inferences from data to identify trends over time, health problems, environmental, health hazards, and social and economic conditions that adversely affect the public’s health	2	
4. LHD graphs health data to indicate whether the problems identified by the community health assessment are improving or worsening	0	
5. LHD compares local data to other jurisdictions and/or the state or nation	2	
6. LHD conducts a small area analysis using GIS	0	
7. LHD conducts gap analysis of the needs of populations who may encounter barriers to services	1	
8. LHD makes data analysis usable to others	1	

**Comments regarding non-contract entities providing services for this focus area above.**

**ESSENTIAL SERVICE II: Protect people from health problems and health hazards.**

**STANDARD II-A. Investigate health problems and environmental health hazards**

**FOCUS: ROUTINE OUTBREAK INVESTIGATIONS**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD expertise to carry out an investigation can be demonstrated	4	<ul style="list-style-type: none"> <li>▪ Report showing review process of health problems and environmental health hazards</li> <li>▪ Electronic database is used with standardized case investigation protocols</li> <li>▪ Information on leading industry in the community and any associated risks</li> <li>▪ Information on local employment and related occupational risks</li> <li>▪ Evidence of an appropriately conducted, documented and reported outbreak investigation (if applicable)</li> </ul>
2. LHD uses a surveillance system to trigger investigations	4	
3. LHD has written protocols to document the investigation process, including identifying information about the disease, case investigation steps, reporting requirements, contact and clinical management, use of emergency biologics, and the process for exercising legal authority for disease control	4	
4. Data on health problems and environmental hazards are collected at regular intervals	1	
5. Data collected on health problems in the community are analyzed for trends and clusters	1	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD II-B. Prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food, water, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities.**

**FOCUS: MITIGATION OF HEALTH PROBLEMS AND ADVERSE HEALTH EVENTS**

Operational Definition Indicators	Score	Illustrative Evidence
1. HLD staff are trained to mitigate adverse health events	4	<ul style="list-style-type: none"> <li>▪ Copy of an electronic disease reporting template</li> <li>▪ Quarterly self-assessment of investigation and reporting process</li> <li>▪ Policies, procedures, or a detailed flow chart that describes the roles and responsibilities for local response.</li> <li>▪ LHD internal log of disease reports not otherwise reported in an electronic form (e.g. well water, lead) with disposition of LHD activities to mitigate problem</li> <li>▪ Demonstrate use of prevalence of conditions to target interventions, personal and community health interventions to mitigate chronic disease and injuries</li> <li>▪ Evidence of public health response such as information releases on disease prevention and control</li> </ul>
2. LHD has protocols for minimizing and containing adverse health events	4	
3. The appropriate number and type of staff (i.e. epidemiological capacity, clinical capacity) are available at the LHD or can be accessed to carry out protocols effectively	3	
4. LHD informs and educates the about adverse health events, including information such as the nature of the situation, how to respond, and where to find resources	4	
5. LHD implements the established epidemiological protocol for mitigation, including disease-specific procedures for mitigating an outbreak, such as providing prophylaxis, and conducting follow-up documentation and reporting	4	
6. LHD conducts routine programs to protect the public from vaccine preventable conditions, such as pneumonia and influenza	4	

**Comments regarding non-contract entities providing services for this focus area above:**

**STANDARD II-C. Coordinate with other governmental agencies that investigate and respond to health problems, health disparities, or environmental health hazards.**

***FOCUS: FOCUS: WORKING WITH OTHER GOVERNMENTAL AGENCIES ON ROUTINE INVESTIGATION AND RESPONSE***

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has protocols with other governmental agencies for mutual assistance in responding to specific health problems or hazards	4	<ul style="list-style-type: none"> <li>▪ List of governmental agencies that investigate and response to health problems and evidence</li> </ul>

		<b>of coordination, including meeting notes, agendas, logs of phone calls etc.</b> <ul style="list-style-type: none"> <li>▪ <b>Copies of memorandums of understandings with other governmental agencies</b></li> <li>▪ <b>Written protocols/policy detailing the process for investigating/responding to health problems</b></li> </ul>
2. LHD establishes a planning committee with diverse partners	1	
3. LHD identifies partners in advance and protocols are developed to engage partners during an event	3	
4. LHD routinely communicates with other governmental agencies on health problems in the community	4	
LHD coordinates action with other governmental agencies		

**Comments regarding non-contract entities providing services for this focus area above:**

**STANDARD II- D. Lead public health emergency planning, exercises, and response activities in the community in accordance with the National Incident Management System, and coordinate with other local, state and federal agencies.**

**FOCUS: TAKE LEAD IN EMERGENCIES THAT ARE PUBLIC HEALTH IN NATURE**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD staff demonstrate competency in preparing for and responding to public health emergencies	4	<ul style="list-style-type: none"> <li>▪ <b>Local preparedness quarterly reports detailing preparedness activities and coordination with government agencies</b></li> <li>▪ <b>Copy of LHD response plan</b></li> <li>▪ <b>Evidence of LHD preparedness meetings with other government agencies including planning meetings minutes, calendar of meetings, email exchanges, logs of phone calls etc.</b></li> <li>▪ <b>Evidence of real event or exercise that evaluates policies, including meeting minutes from debriefing or After-Action Report</b></li> <li>▪ <b>Evidence of use of Project Public Health</b></li> </ul>
2. There is a protocol in place to engage volunteers during an event	2	
3. Emergencies that trigger use of the response plan are defined	4	
4. LHD develops a plan with emergency response partners that outlines responsibilities, communication networks, and evacuation procedures	4	
5. LHD leads the annual testing of its emergency response plan, through the use of drills and exercises.	4	
6. LHD leads in an annual revision of its emergency response plan	4	

7. LHD identifies volunteers and trains them	1	<b>Ready Criteria</b>
8. LHD coordinates public health response capacity with local, state and federal agencies	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD II-E. Fully participate in planning, exercises, and response activities for other emergencies in the community that have public health implications, within the context of state and regional plans and in a manner consistent with the community’s best public health interest.**

**FOCUS: PARTICIPATE WHEN OTHER AGENCIES ARE IN THE LEAD**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD is competent in emergency preparedness for public health and other types of emergencies that may have public health implications	3	<ul style="list-style-type: none"> <li>▪ Evidence of LHD participation in partner planning for emergencies including planning meetings minutes, calendar of meetings, email exchanges, logs of phone calls etc.</li> <li>▪ Invitation to participate in partner exercises or evidence of participation in emergency response when LHD was not in the lead (e.g. press release, newspaper story)</li> <li>▪ Evidence of real event or exercise that evaluates policies, including meeting minutes from debriefing or After-Action Report</li> <li>▪ Evidence of use of Project Public Health Ready Criteria</li> </ul>
2. LHD staff attends preparedness planning meetings and exercises sponsored by other organizations (e.g. regional exercises, state planning groups, local emergency management drills, etc.)	4	
3. LHD participates in local, regional and state all-hazards response planning	4	

Comments regarding non-contract entities providing services for this focus area above:

**STANDARD II- F.** Maintain access to laboratory and biostatistical expertise and capacity to help monitor community health status and diagnose and investigate public health problems and hazards.

**FOCUS: ACCESS TO LAB AND BIOSTATS RESOURCES**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has current written protocols and/or guidelines for handling clinical and environmental laboratory samples based on standards	4	<ul style="list-style-type: none"> <li>▪ <b>Quarterly reports/assessments indicating that staffing requirements are met</b></li> <li>▪ <b>Written protocols/procedures for access to state lab services</b></li> <li>▪ <b>Records, indicating appropriate requests for and response of monitoring, diagnosing and investigating health problems and hazards</b></li> <li>▪ <b>List of individuals fulfilling this capacity, job description for personnel (if applicable) or copy of consulting/contracting (if applicable)</b></li> </ul>
2. LHD maintains a call-up protocol of epidemiological resources	4	
3. LHD maintains epidemiological and statistical expertise, including access to and consultations with appropriately trained epidemiologists	4	
4. LHD has a written procedures for surge capacity, with descriptions of how expanded lab capacity is made readily available when needed for outbreak response	1	
5. There is a current list of local and regional laboratories having the capacity to analyze specimens	4	
6. LHD assesses the availability of epidemiological expertise on a regular basis	4	
7. LHD implements a state-wide laboratory protocol for reporting, collecting, handling and transporting laboratory specimens	4	
8. LHD assesses the availability of laboratory expertise on a regular basis	4	
9. LHD uses epidemiologic, biostatistical and laboratory expertise when needed	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD II- G. Maintain policies and technology required for urgent communications and electronic data exchange.**

**FOCUS: CAPACITY FOR EMERGENCY COMMUNICATIONS AND DATA EXCHANGE**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD maintains appropriate technology for 24/7 communications	4	<ul style="list-style-type: none"> <li>▪ Preparedness quarterly reports with checklist on emergency communication capacity</li> <li>▪ Sample of written policy describing data exchange/urgent communications, including protocol of 24/7 communications policies</li> <li>▪ Evidence of real event or exercise that evaluates policies, including meeting minutes from debriefing or After-Action Report</li> </ul>
2. LHD maintains appropriate technology for electronic data exchange	4	
3. LHD updates protocols and contact information at least annually and makes readily available to staff.	4	
4. LHD uses multiple methods for dissemination of public health messages	4	
5. LHD tests its emergency data exchange capabilities annually	4	
6. Meeting minutes from debriefing or After-Action Report	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**ESSENTIAL SERVICE III: Give people information they need to make healthy choices.**

**STANDARD III a. Develop relationships with media to convey information of public health significance, correct misinformation about public health issues, and serve as an essential resource.**

**FOCUS: DEVELOP AND IMPLEMENT MEDIA STRATEGIES**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD develops and maintains a database of media partners and outlets available	4	<ul style="list-style-type: none"> <li>▪ <b>List of current media contact</b></li> <li>▪ <b>Notes from meetings with media</b></li> </ul>
2. LHD maintains a written protocol for communicating	4	

with the media		<b>representatives on current and emerging public health issues</b> <ul style="list-style-type: none"> <li>▪ <b>Log of calls from media about public health events or stories</b></li> <li>▪ <b>Logs of calls to media about public health event or story</b></li> <li>▪ <b>Health reports disseminated to media</b></li> <li>▪ <b>LHD press releases and associated media news stories</b></li> <li>▪ <b>Written media strategy</b></li> </ul>
3. LHD builds staff competency in working with the media	2	
4. LHD conducts an environmental scan and assessment of media outlets	0	
5. LHD develops a media strategy that includes formal (press releases) and informal opportunities for communicating with the media and responding to media requests	1	
6. LHD communicates routinely with media to raise awareness of public health and public health issues in the community	3	
7. LHD communicates with media on emerging events and situations to inform the public	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD III-B. Exchange information and data with individuals, community groups, other agencies, and the general public about physical, behavioral, environmental, social, economic, and other issues affecting the public’s health.**

***FOCUS: GENERAL DATA AND INFORMATION EXCHANGE ON ISSUES AFFECTING POPULATION HEALTH***

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD establishes a network to share data with stakeholders	1	<ul style="list-style-type: none"> <li>▪ <b>Notes from meetings with community stakeholders (e.g. open forums, topical health issue meetings, such as infectious disease, preparedness MCH, etc.) demonstrating communication and exchange with key community partners (e.g. evidence that LHD staff presentation of report)</b></li> <li>▪ <b>Report identifying organizational roles and responsibilities for service delivery</b></li> </ul>
2. LHD continuously develops current information on health issues that affect the community	1	
3. LHD has protocols and/or strategies in place to communicate health information periodically	1	
4. LHD has a written protocol in place to respond to specific information requests	1	
5. LHD uses its stakeholder network to gather information and to provide data and information on	0	

community health issues		
6. LHD uses principles of social marketing to understand the information needs of specific populations	1	<b>(e.g., preparedness roles)</b> <ul style="list-style-type: none"> <li>▪ Health reports disseminated by LHD</li> <li>▪ Topical communication (e.g. in blast faxes, health alerts, etc.)</li> <li>▪ LHD newsletters</li> <li>▪ LHD web site with tracking capabilities</li> <li>▪ Protocols for communication with target audiences (i.e. individuals, community groups, other agencies, and the general public)</li> </ul>
7. LHD informs the public about how to obtain health data and information from the department	4	
8. LHD responds to data requests in a timely manner	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD III -C.** Provide targeted, culturally appropriate information to help individuals understand what decisions they can make to be healthy.

***FOCUS: PROVIDE HEALTH INFORMATION TO INDIVIDUALS FOR BEHAVIOR CHANGE***

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. Accurate and current information is available in formats that are culturally appropriate, linguistically relevant and accessible to target and special populations	4	<ul style="list-style-type: none"> <li>▪ Publications of health information in different languages represented in the community including brochures, hand-outs etc.</li> <li>▪ Evidence of cultural competency training provided for LHD staff and contractors, including copy of training, schedule of training, agenda, attendance, or evaluation</li> <li>▪ LHD annual report demonstrating how services are targeted to at risk populations</li> <li>▪ Evidence of use of local media for health messages including press release, health story</li> <li>▪ Log tracking health education meeting attendance for reach into target populations</li> <li>▪ Protocols for testing health messages with target audiences</li> <li>▪ Surveys conducted to evaluate whether target</li> </ul>
2. LHD staff demonstrates capacity to develop materials and conduct education campaigns designed to improve health behaviors	3	
3. LHD uses the community health assessment to develop health education information	1	
4. LHD assesses the target population for how they accept information	1	
5. LHD provides health education services in the language used by, and within the cultural context of, the target population	4	
6. Members of the target population participate in the	3	

development and distribution of health education materials

- audience understood health messages
- Tracking system for program participants by race, ethnicity, gender, sexual orientation

Comments regarding non-contract entities providing services for this focus area above.

**STANDARD III-D. Provide health promotion programs to address identified health problems.**

**FOCUS: HEALTH PROMOTION PROGRAMS FOR BEHAVIOR AND ENVIRONMENTAL/COMMUNITY CHANGE**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has an overall strategy/plan for its delivery of population-based health promotion and disease prevention programs (e.g. which programs are developed, how they are implemented, and when they are evaluated)	1	<ul style="list-style-type: none"> <li>Report/justification that details how health promotion programs are linked to community health assessment and health improvement plan</li> <li>Health promotion program reports</li> <li>Inventory all health promotion programs, including free-standing programs and programs that are embedded in other programs</li> <li>Written procedures describe the systematic approach to health promotion information, including the development, distribution, evaluation, and revision process</li> <li>Records indicating training and/or materials for health promotion have been provided to community organizations.</li> <li>Program evaluation summaries, progress reports, or summaries of analysis demonstrate that key measure data are used as part of the process to improve the programs or to revise health promotion curricula</li> <li>Log or summary of technical assistance efforts</li> <li>Document the source of proven intervention</li> </ul>
2. LHD staff has health promotion knowledge and skills (e.g. social marketing)	2	
3. LHD staff are available to offer technical assistance to the community in development of health promotion programming	1	
4. LHD involves a variety of disciplines in the design and implementation of health promotion programs (e.g. Educators, Faith Institutions, Nursing, Environmental, Community-development for the built environment)	1	
5. LHD identifies populations at risk as potential target populations for health promotion programming	4	
6. LHD assesses the target population for how they accept information	1	
7. LHD demonstrates that program designs use proven intervention strategies	1	
8. LHD implements the appropriate program for identified target populations	2	
9. LHD evaluates health promotion efforts every two	0	

years, the results of which are used to improve programs.		<b>strategies</b>
10. LHD develops and revises performance measures, goals and objectives for annual program planning based on information obtained through evaluation of health promotion activities.	1	
11. LHD provides technical assistance to communities and community agencies on health promotion activities	1	

**Comments regarding non-contract entities providing services for this focus area above.**

**ESSEMTIAL SERVICE IV: Engage the community to identify and solve health problems.**

**STANDARD IV-A. Engage the local public health system in an ongoing, strategic, community-driven, comprehensive planning process to identify, prioritize, and solve public health problems; establish public health goals; and evaluate success in meeting the goals.**

**FOCUS: COMMUNITY PLANNING PROCESS ENGAGING SYSTEMS PARTNERS**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD has a community health planning structure in place	0	<ul style="list-style-type: none"> <li>▪ <b>Community health needs assessment and community health plan</b></li> <li>▪ <b>Meeting minutes, membership lists, and attendance frequency for coalitions focused on public health topics (e.g. pandemic flu, cardiovascular disease prevention, etc.)</b></li> <li>▪ <b>Written description of the planning process and effort to engage the community and system partners</b></li> <li>▪ <b>A community health plan with at least one measurable outcome objective covering a 5-year time frame related to each priority health need and at least one measurable impact objective related to each outcome objective.</b></li> </ul>
2. LHD has the capacity to manage the planning process (e.g., trained staff, organized unit, assigned responsibilities)	1	
1. LHD recruits a broad range of community partners, stakeholders and constituents to participate in the community planning process	0	
2. LHD reviews and adopts a structured process for conducting community health planning (i.e. APEX/PH, MAPP, etc.)	0	
3. The planning team uses the community health assessment to inform the selection of priorities	0	

4. Community assets are identified	1	<ul style="list-style-type: none"> <li>▪ <b>Local performance assessment using NPHPS</b></li> </ul>
5. Gaps are identified through analysis of the results with periodic surveys and other assessment information	0	
6. Community satisfaction is assessed and gaps are identified.	0	
7. Partnership effectiveness in improving community health is assessed	0	
8. Partnership effectiveness in improving community health is assessed	0	
9. The performance of the public health system is assessed (in relationship to targets)	0	
10. Goals and objectives are established in the plan	0	
11. Plan identifies emerging issues which may require investigation	0	
12. Strategies and best practices are selected to increase potential for success	0	
13. Information about public health needs and priorities is disseminated to elected officials	2	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD IV-B. Promote the community’s understanding of, and advocacy for, policies and activities that will improve the public’s health**

**FOCUS: RAISE AWARENESS AND GAIN GENERAL PUBLIC SUPPORT FOR THE PLAN AND A DEEPER UNDERSTANDING OF PUBLIC HEALTH ISSUES**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD has current information on health issues that affect the community readily accessible	3	<ul style="list-style-type: none"> <li>▪ <b>Needs assessment and community health plan</b></li> <li>▪ <b>Presentations at public meetings, meeting agendas, or meeting notes</b></li> <li>▪ <b>Press release, newspaper clippings about community health priorities and public health</b></li> </ul>
1. LHD conducts a community education and marketing	0	

process to increase the awareness of the community health improvement plan and its recommendations		<ul style="list-style-type: none"> <li>▪ Evidence of plan distribution including LHD website, newsletter, or distribution list</li> </ul>
2. LHD uses a variety of methods (e.g. media, website) to disseminate the plan to the community	0	
3. LHD leads a process to assess and analyze effectiveness of public policy and community environment to improve health and shares the results publicly	0	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD IV-C. Support, implement, and evaluate strategies that address public health goals in partnership with public and private organizations.**

**FOCUS: SUPPORT PARTNERS TO IMPLEMENT ACTION**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff are familiar with program planning methods	2	<ul style="list-style-type: none"> <li>▪ Grant proposals to fund community priorities developed/supported by LHD and other community agencies</li> <li>▪ Letters of support for grant proposals</li> <li>▪ Topic oriented coalitions: Lists of members, meeting frequency, meeting notes, etc.</li> <li>▪ Media reports of partnerships/coalition implementation activities</li> <li>▪ Linkage agreements among strategic partners</li> </ul>
1. LHD staff is identified to establish and maintain partnerships and perform collective work	2	
1. LHD identifies community organizations that contribute to the Essential Public Health Services/program implementation	2	
2. System partner organizations' work plans, action plans and program plans to address public health goals	1	
3. A policy agenda is developed	0	
4. System partner organizations align their program activities and/or organization plans with community objectives	0	
5. Resources are marshaled (e.g., human and financial) to conduct program activities	0	

6. Implementation progress is systematically monitored	0	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD IV-D. Develop partnerships to generate interest in and support for improved community health status, including new and emerging public health issues.**

**FOCUS: DEVELOP PARTNERSHIPS TO SUPPORT PUBLIC HEALTH**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD maintains a directory of community organizations and systems partners	1	<ul style="list-style-type: none"> <li>▪ <b>Community assessment and plan, including a description of the community participation process, a list of community groups involved in the process and method the community group uses to establish priorities</b></li> <li>▪ <b>Document direct and in-kind contributions from community agencies to support planned public health efforts</b></li> <li>▪ <b>Letters of support for grant proposals</b></li> <li>▪ <b>Lists of members of topic-oriented coalitions</b></li> <li>▪ <b>Linkage agreements among strategic partners</b></li> <li>▪ <b>Annual report listing external relationships maintained by the LHD</b></li> <li>▪ <b>Document use of best practices in evaluating partnerships</b></li> </ul>
2. LHD marshals the resources needed to maintain partnerships (e.g. personnel, funding, policy changes, system change)	0	
3. LHD encourages constituent participation in community health activities	0	
4. LHD forms alliances or coalitions around specific public health policy issues	1	
5. LHD recruits individuals and organizations to play leadership roles on public health issues	0	
6. LHD participates in coalitions led by other community partners	2	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD IV- E. Inform the community, governing bodies, and elected officials about governmental public health services that are being provided, improvements being made in those services, and priority health issues not yet being adequately addressed.**

***FOCUS: REPORTING PROGRESS, ADVOCATING FOR RESOURCES TO IMPLEMENT PRIORITIES***

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD monitors its progress in implementing public health services and interventions	3	<ul style="list-style-type: none"> <li>▪ <b>Dissemination list for community assessment and community health plan</b></li> <li>▪ <b>Newspaper articles, progress reports, website postings, LHD annual reports etc.</b></li> <li>▪ <b>Minutes of meetings at city councils, county boards sharing information about services provided</b></li> <li>▪ <b>Testimony and/or letters to elected officials about needed policy changes</b></li> <li>▪ <b>Summary of LHD evaluation of progress in achieving performance goals, including how budget was altered and needed change</b></li> </ul>
2. LHD maintains a good working relationship with governing/legislative bodies	3	
3. LHD maintains capacity to interact with the legislative process	2	
4. LHD analyzes information to compare to performance to plan targets or benchmarks	1	
5. LHD generates and disseminates performance reports on public health services	1	
6. LHD provides testimony and information to governing body on public health policy	2	
7. LHD submits a budget justification that reflects program priorities and community needs	4	
8. LHD engages in public health policy development, identifying, prioritizing and monitoring public health policy issues	2	

**Comments regarding non-contract entities providing services for this focus area above.**

**ESSENTIAL SERVICE V: Develop public health policies and plans**

**STANDARD V-A. Serve as a primary resource to governing bodies and policymakers to establish and maintain public health policies, practices, and capacity based on current science and best practices.**

***FOCUS: PRIMARY SCIENTIFIC RESOURCE FOR POLICY CHANGE IN PUBLIC HEALTH***

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD staff are up to date with current public health topics	2	<ul style="list-style-type: none"> <li>▪ <b>Letter to state from Board of Health confirming adoption of the community health plan</b></li> </ul>
2. LHD staff are knowledgeable about the legislative	2	

process		
3. LHD maintains a written protocol for working with the legislative process	4	<ul style="list-style-type: none"> <li>▪ <b>Board of Health meeting minutes on presentation and discussion of community health assessment and plan</b></li> <li>▪ <b>A representative sample of Board of Health, City Council and/or County Board meeting minutes indicating discussion of public health policy issues</b></li> <li>▪ <b>Reports on LHD activities, press releases, annual reports, indicating major health policy, practice and capacity issues</b></li> <li>▪ <b>Evidence/logs of calls from elected officials, and other government officials</b></li> <li>▪ <b>LHD staff serving on legislative or topical ad</b></li> </ul>
4. LHD maintains formal and informal relationships with legislative and governing body(s)	2	
5. LHD maintains a database of legislative and governing bodies	2	
6. LHD has a tracking system in place to monitor public health issues under discussion by governing and legislative bodies	0	
7. LHD communicates routinely with legislative and governing bodies to raise awareness of current public health issues and emerging issues affecting the community	2	
8. LHD provides expertise to legislative and governing body(s) in setting public health priorities and planning public health programs	1	
9. LHD staff attends appropriate legislative events	1	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD V-B. Advocate for policies that lessen health disparities and improve physical, behavioral, environmental, social, and economic conditions in the community that affect the public’s health.**

***FOCUS: POLICY ADVOCACY FOR HEALTH IMPROVEMENT***

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD staff has the competencies/skills to advocate effectively for public health policy	2	<ul style="list-style-type: none"> <li>▪ <b>Schedule of staff training on policy/advocacy development, copy of training, or list of</b></li> </ul>

2. LHD maintains a directory of potential policy partners	0	<b>trainings staff attended</b> <ul style="list-style-type: none"> <li>▪ <b>Directory of potential policy partners</b></li> <li>▪ <b>Community health assessment and plan showing populations at risk, differences in health status among various population groups, health disparities</b></li> <li>▪ <b>LHD annual reports presenting issues of special populations and root causes of health problems</b></li> <li>▪ <b>Special reports on health disparities</b></li> <li>▪ <b>Grant applications targeted at programs to reduce disparities</b></li> <li>▪ <b>Written summary or meeting minutes of governing body's approval of resources to address disparities</b></li> <li>▪ <b>Meeting attendance list showing participation in local committees working on community development or environmental issues, etc.</b></li> <li>▪ <b>Document that LHD engages local partnerships, state and national associations in advocacy/policy development</b></li> <li>▪ <b>Documentation of meetings or contact with state or local legislators (e.g. keep copy of electronic form letters)</b></li> </ul>
3. LHD engages community partners in policy development process	0	
4. LHD conducts advocacy for local, state, and national policies and legislation that protect and promote the public's health	0	
5. LHD develops a legislative strategy to reflect community needs and priorities	0	
6. Constituency support is built around the LHD legislative agenda	0	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD V-C. Engage in LHD strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs.**

**FOCUS: LHD ROLE IN IMPLEMENTING COMMUNITY HEALTH IMPROVEMENT PLAN**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD leadership recognizes need for strategic planning	1	<ul style="list-style-type: none"> <li>▪ <b>Organizational Capacity Self-Assessment</b></li> </ul>

2. LHD allocates resources for strategic planning	0	<p>(e.g., using APEX/PH Part I)</p> <ul style="list-style-type: none"> <li>▪ Organizational strategic plan document or documentation of strategic priorities</li> <li>▪ Annual budget forecast</li> <li>▪ LHD mission or guiding principles statement</li> <li>▪ Meeting minutes or agendas</li> </ul>
3. LHD staff has expertise to lead and facilitate the strategic planning process	0	
4. LHD conducts a formal strategic planning process that considers its mission, vision and role in the community in relation to the assurance of the ten essential public health services	0	
5. LHD uses assessment data on community health problems and emerging health threats to develop annual program goals to develop policy	0	
6. LHD identifies new strategic opportunities for promoting public health activities	2	
7. The LHD widely disseminates its strategic plan and shares with the public and key stakeholders.	0	
8. LHD develops or updates the agency strategic plan every 24 months.	0	

**Comments regarding non-contract entities providing services for this focus area.**

**ESSENTIAL SERVICE VI: Enforce public health laws and regulations**

**STANDARD VI-A. Review existing laws and regulations and work with governing bodies and policymakers to update them as needed**

**FOCUS: REVIEW AND MODERNIZE PUBLIC HEALTH AUTHORITY**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has legal expertise available to assist in the review of laws and regulations	2	<ul style="list-style-type: none"> <li>▪ Dates of any formal code review by the County Board or City Council</li> <li>▪ Review of compliance of the local jurisdiction with state laws and regulations</li> <li>▪ Minutes from meetings with policymakers on keeping public health laws up-to-date</li> <li>▪ Participation in legislative committees of one of the local public health administrators</li> </ul>
2. The LHD, with the participation of its governing body, reviews policies and procedures within its existing legal scope of authority on a regular and periodic basis	1	
3. LHD evaluates the need for changes in rules, regulations, and ordinances	2	

4. LHD identifies its legal authority to develop, implement and enforce public health policy.	2	<b>associations</b> <ul style="list-style-type: none"> <li>▪ <b>List of access to legal counsel</b></li> <li>▪ <b>Dates of and written procedure for systematic planned review of local ordinances</b></li> </ul>
5. LHD and governing body drafts modifications and/or formulations of laws and regulations.	1	
6. LHD uses a model public health emergency act in reviewing the local public health authority for managing emergencies	3	
7. LHD applies knowledge of disease trends, best practices and current public health science to legal reviews	1	
8. LHD and governing body inform policy makers of needed statutory and regulatory updates	2	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD VI-B Understand existing laws, ordinances, and regulations that protect the public’s health.**

**FOCUS: LINK LHD PRACTICE TO EXISTING LAW AND REGULATION IN AN APPROPRIATE WAY**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD has legal and program planning expertise available to assist in the review of laws and regulations.	3	<ul style="list-style-type: none"> <li>▪ <b>Dates of any formal code review by the County Board of City Council</b></li> <li>▪ <b>Review of compliance of the local jurisdiction with state laws and regulations</b></li> <li>▪ <b>Minutes from meetings with policymakers on keeping public health laws up-to-date</b></li> <li>▪ <b>Participation in legislative committees of one of the local public health administrators associations</b></li> <li>▪ <b>List of access to legal counsel</b></li> <li>▪ <b>Dates of and written procedure for systematic planned review of local ordinances</b></li> </ul>
2. LHD studies laws and identifies public health issues that can only be addressed through laws.	2	
3. LHD understand the intent of law and regulations with policy makers, legal counsel and other legislative bodies	3	
4. LHD reviews its programs to determine whether program changes are needed to better carry out legal mandates	3	
5. LHD identifies organizations with regulatory and	4	

enforcement authority.

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD VI-C Educate individuals and organizations on the meaning, purpose, and benefit of public health laws, regulations, and ordinances and how to comply**

**FOCUS: COMMUNICATION AND EDUCATION ON HOW TO COMPLY WITH LAWS**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD staff is competent to provide education to regulated entities.	4	<ul style="list-style-type: none"><li>▪ <b>Trainings held for regulated entities (e.g. restaurants)</b></li><li>▪ <b>Job descriptions of inspectors indicating education is part of their performance expectations</b></li><li>▪ <b>Inspection case notes indicating education provided at time of inspection</b></li><li>▪ <b>Formal, intentional education process incorporated into regulatory practice and documented in annual reports, inspection reports, etc.</b></li></ul>
1. LHD makes written policies, local ordinances, administrative code, and enabling laws accessible to the public	4	
2. LHD provides appropriate education to regulated facilities at the time of inspection.	4	
3. LHD invites regulated entities to education programs on new and/or updated regulations as appropriate.	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD VI-D Monitor, and analyze over time, the compliance of regulated organizations, entities, and individuals.**

**FOCUS: TRACKING AND UNDERSTANDING PATTERNS OF COMPLIANCE WITH REGULATION**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD has a system to track compliance records over time by each regulated organization.	4	<ul style="list-style-type: none"><li>▪ <b>Updated lists of regulated entities in the jurisdiction</b></li><li>▪ <b>LHD Quality Assurance reports with summaries of most critical violations and</b></li></ul>
2. LHD staff is capable of analyzing data trends over time	4	

3. The LHD conducts inspections of regulated entities as appropriate (e.g., CD, animal control, environmental health) and monitors compliance	4	<b>most frequently-occurring violations</b> <ul style="list-style-type: none"> <li>▪ <b>Violations trends report examining level of violations over time in the jurisdiction</b></li> <li>▪ <b>Violations trends report examining level of violations over time by regulated entity</b></li> </ul>
4. LHD evaluates a selected number of enforcement actions each year to determine compliance with and effectiveness of enforcement procedures	4	
5. LHD conducts analysis of complaints, violations and enforcement activities to determine patterns, trends and latent problems at least annually	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD VI-E Conduct enforcement activities.**

**FOCUS: COMPETENT AND FAIR ENFORCEMENT ACTIONS**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD workforce is skilled in enforcement procedures and credentialed as appropriate	4	<ul style="list-style-type: none"> <li>▪ <b>Timeframes and frequencies of formal enforcement activities</b></li> <li>▪ <b>Enforcement intervention reports, including administrative interventions and legal interventions</b></li> <li>▪ <b>LHD annual report summarizing enforcement activities by type.</b></li> <li>▪ <b>Quality assurance activities incorporated into all regulatory activities</b></li> </ul>
1. LHD uses a risk analysis method (i.e., identify restaurants with frequent violations) and a work plan to guide the frequency and scheduling of inspections of regulated facilities	4	
2. Written procedures and protocols for conducting enforcement actions are maintained.	4	
3. LHD routinely conducts enforcement activities according to procedures and protocols and rules are applied consistently.	4	
4. LHD promptly conducts enforcement activities needed in response to an emergency	4	

**Comments regarding non-contract entities providing services for this focus area above.**



**STANDARD VI-F. Coordinate notification of violations among other governmental agencies that enforce laws and regulations that protect the public’s health.**

**FOCUS: NOTIFY OTHER GOVERNMENT AGENCIES OF ENFORCEMENT VIOLATIONS**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. Rapid communication capability can be demonstrated between the LHD and other enforcement entities	2	<ul style="list-style-type: none"> <li>▪ <b>A chart or map of government agencies with enforcement responsibilities and contact information</b></li> <li>▪ <b>File/log of “inter-organizational” notifications with back-up notification forms</b></li> <li>▪ <b>Procedures for inter-agency communication</b></li> <li>▪ <b>Memorandum of Understanding or other formal written inter-agency agreements</b></li> </ul>
2. LHD has a comprehensive knowledge of other agencies involved in enforcement in the protection of the public health	2	
3. LHD develops and executes communication protocols for the notification of other enforcement agencies	2	

**Comments regarding non-contract entities providing services for this focus area above**

**ESSENTIAL SERVICE VII: Help People receive health services**

**STANDARD VII a. Engage the community to identify gaps in culturally competent, appropriate, and equitable personal health services, including preventive and health promotion services, and develop strategies to close the gaps.**

**FOCUS: COMMUNITY-ORIENTED PROGRAM PLANNING**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD staff has a working understanding of access issues	3	<ul style="list-style-type: none"> <li>▪ <b>Program assessments and plans, (e.g. HIV plans, MCH plans)</b></li> <li>▪ <b>Community forums report identifying access issues</b></li> <li>▪ <b>Community Health Assessment that identifies cultural competency and access as issues or community priorities</b></li> <li>▪ <b>Risk factor and other community surveys, including consumer satisfaction surveys, every two years</b></li> </ul>
2. LHD staff are competent in program planning and community development methods	3	
3. LHD engages a diverse set of community partners, representing communities of color, tribal representatives and specific populations, to identify program gaps and barriers	1	
4. LHD, in partnership with community partners, interprets qualitative and quantitative information on program gaps,	0	

developed through surveys, focus groups, interviews or other means of primary data collection.		<ul style="list-style-type: none"> <li>▪ <b>Surveys targeted to special population groups, such as Hispanic populations</b></li> <li>▪ <b>Staff have education and/or training in program planning and community development methods and/or staff have conducted program planning or community development activities (e.g. Program staff have gone through MAPP training).</b></li> </ul>
5. LHD uses criteria periodically to evaluate access, quality, appropriateness and effectiveness of preventive and personal health services in the community.	2	
LHD identifies community health and prevention priorities to reduce access barriers every five years.	0	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD VII-B Support and implement strategies to increase access to care and establish systems of personal health services, including preventive and health promotion services, in partnership with the community**

**FOCUS: PREVENTION AND PERSONAL HEALTH CARE SYSTEM BUILDING**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. A plan is in place for prevention and health promotion which identifies efforts to link public and private partnerships into a network of personal health and prevention services	1	<ul style="list-style-type: none"> <li>▪ <b>Partnership meeting notes on implementation strategies</b></li> <li>▪ <b>Memorandum of Understanding</b></li> <li>▪ <b>Subcontracts in the community to implement services</b></li> <li>▪ <b>Community planning processes/plans</b></li> <li>▪ <b>Grant applications by members of community partnerships</b></li> <li>▪ <b>Letters of support for grants to other community agencies</b></li> <li>▪ <b>Community assessment data demonstrates an increase in access to care.</b></li> </ul>
2. LHD maintains the capacity to provide health care services when local needs and authority exist, and the appropriate agency capacity and adequate additional resources can be secured.	2	
3. LHD convenes or participates in a collaborative process with community health care providers, social services organizations, and community stakeholders to coordinate service delivery and to reduce barriers to accessing primary and preventive services.	3	
4. LHD develops and implements strategies to increase utilization of public health programs and services	2	
5. LHD, in partnership with other community agencies,	3	

identifies gaps in access to critical health services through analysis of the results of periodic surveys and other assessment information.

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD VII-C Link individuals to available, accessible personal health care providers (i.e., a medical home).**

**FOCUS: INDIVIDUAL-FOCUSED LINKAGES TO NEEDED CARE**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD maintains a current inventory of available personal health care resources	4	<ul style="list-style-type: none"> <li>▪ Reports on outreach and case management services</li> <li>▪ Logs of referrals to care and/or reports from referral tracking system.</li> <li>▪ Inventory of safety-net programs providers</li> <li>▪ FQHC's operated by LHD or LHD an integral partner with FQHC</li> <li>▪ Minutes of community meetings addressing concerns about outreach and/or tracking</li> </ul>
2. LHD uses a tracking system for health care referrals	1	
3. LHD engages indigenous lay health advocates for outreach to special populations in need of health care.	2	
4. LHD provides community outreach and linkage services	2	
5. LHD disseminates or makes referrals to a current, comprehensive list of community health and wellness resources.	3	
6. LHD enrolls or links to enrollment agents potential beneficiaries in Medicaid or Medical Assistance Programs	43	
7. LHD informs the public, through a variety of methods, about services and resources available through LHD to reduce specific barriers to access to care		

**Comments regarding non-contract entities providing services for this focus area above.**

**ESSENTIAL SERVICE VIII: Maintain a competent public health workforce**

**STANDARD VIII. A. Recruit, train, develop, and retain a diverse staff.**

**FOCUS: OVERALL HUMAN RESOURCES FUNCTION/ WORKFORCE CAPACITY**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has formally organized human resources function.	3	<ul style="list-style-type: none"> <li>▪ <b>APEX Part I - Organizational Capacity Self-Assessment</b></li> <li>▪ <b>Organizational assessment within a larger agency strategic plan</b></li> <li>▪ <b>LHD organizational chart that includes the functional elements of the organization and their relationship to each other</b></li> <li>▪ <b>Job descriptions with minimum qualifications for each position</b></li> <li>▪ <b>Public Health Competencies incorporated into all LHD job descriptions</b></li> <li>▪ <b>Written plans or policies regarding staff recruitment, selection, development, and retention</b></li> <li>▪ <b>Affirmative action plan</b></li> <li>▪ <b>Statement on equal opportunity</b></li> </ul>
2. LHD has policies that promote and facilitate staff access to training	4	
3. LHD has a non-discriminatory employment policy	4	
4. LHD develops, uses, and revises job standards and position descriptions.	4	
5. LHD determines needed competencies, composition, and size of its workforce and seeks job applicants to fill those needs	4	
6. LHD periodically assesses its capacity (staff size, staff education and experience requirements, financial resources, and administrative capacity) in relation to the needs of the population it serves.	4	
7. LHD conducts periodic studies of workforce needs and the effect on critical health services.	3	
8. LHD provides new employee orientation, employee-in-service and continuing education experiences where appropriate.	4	
9. LHD provides for staff training in cultural sensitivity and cultural competency.	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD VIII-B Evaluate LHD staff members' public health competencies, and address deficiencies through continuing education, training, and leadership development activities.**

**FOCUS: PUBLIC HEALTH COMPETENCIES OF EXISTING WORKFORCE**

Operational Definition Indicators	Score	Illustrative Evidence
1. A learning management system is in place to organize competency assessments and training and educational	4	<ul style="list-style-type: none"> <li>▪ <b>Report on annual reassessment of all staff competency levels and training needs</b></li> </ul>

opportunities to address deficiencies		
2. Training and leadership opportunities are available.	4	<ul style="list-style-type: none"> <li>▪ Performance evaluations including worker objectives and continuing education and training plans, based in part on worker self-assessments</li> <li>▪ LHD tracking system for staff participation in training and education</li> <li>▪ Written policy on staff development</li> <li>▪ LHD training plan based on self-assessment data</li> <li>▪ Staff training and development plans</li> <li>▪ List of LHD staff who have participated in workforce development activities including web-casts, online trainings, workshop etc. and list of these events</li> </ul>
3. LHD assesses its staff members to identify deficiencies in knowledge, skills and authority; and remedial action is taken when required.	4	
4. LHD provides incentives for the workforce to pursue education and training	4	
5. LHD provides opportunities for continuing education, training,	4	
6. LHD provides opportunity for leadership development for its staff	4	
7. LHD encourages or requires relevant certification and credentialing programs for individuals, not otherwise licensed or monitored by the state and whose activities can affect the health of the public	4	
8. LHD assures that each staff member has attended training within the past 24 months to maintain competency.	4	
9. LHD provides a coordinated program of continuing education for staff which includes attendance at seminars, workshops, conferences, in-service training, and/or formal courses to improve employee skills and knowledge in accordance with their professional needs	4	
10. LHD supports staff conference attendance and peer exchange opportunities	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD VIII- C Provide practice- and competency based educational experiences for the future public health workforce, and provide expertise in developing and teaching public health curricula, through partnerships with academia.**

**FOCUS: DEVELOPING THE FUTURE WORKFORCE**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD has partnership agreements in place with universities, schools or programs of public health and/or colleges to enrich public health practice and academic settings	4	<ul style="list-style-type: none"> <li>▪ <b>Internships/preceptorships at the LHD for students at multiple levels (e.g. high school, college and graduate school)</b></li> <li>▪ <b>Guest lectures for public health classes</b></li> <li>▪ <b>List of LHD staff that have served as faculty (e.g. making presentations) at conferences, workshops, trainings, or school career orientation programs</b></li> </ul>
2. LHD partners with academic institutions to provide clinical sites for training programs (e.g. internships) and for joint appointments for its staff.	4	
3. LHD implements plans for developing training and research focused interactions with academic institutions, including teaching courses, and faculty exchanges.	1	
4. LHD provides field training or work-study experiences for students enrolled in institutions of higher education.	4	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD VIII-D Promote the use of effective public health practices among other practitioners and agencies engaged in public health interventions.**

**FOCUS: EFFECTIVE PUBLIC PRACTICED BY EXTERNAL WORKFORCE**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD has agreements in place with public health systems partners for workforce assessment, training and professional education.	0	<ul style="list-style-type: none"> <li>▪ <b>Presentations at community groups</b></li> <li>▪ <b>Annual reports to Board of Health on basic evaluation of programs, target groups, reach into the population at risk</b></li> <li>▪ <b>Meeting notes indicating LHD communication of best practices with other public health practitioners</b></li> <li>▪ <b>Consultations with other agencies on effective public health practices are documented</b></li> <li>▪ <b>Presentations at conferences</b></li> <li>▪ <b>Participation on advisory committees</b></li> </ul>
2. LHD shares best public health practices with community partners at meetings in the community (e.g. hospital meetings to plan a community health promotion initiative, Chamber of Commerce meetings to promote workplace wellness, etc.)	3	
3. LHD makes presentations at public health and health care conferences	2	

		<ul style="list-style-type: none"> <li>▪ developing best practices</li> <li>▪ Participation in Grand Rounds at local hospitals with physician committees</li> <li>▪ Agreements with partner providers LHD makes presentations at public health and health care conferences</li> </ul>
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Comments regarding non-contract entities providing services for this focus area above.

**STANDARD VIII-E Provide the public health workforce with adequate resources to do their jobs**

**FOCUS: ADEQUATE RESOURCES FOR JOB PERFORMANCE**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has identified funding sources for workforce job support activities	0	<ul style="list-style-type: none"> <li>▪ LHD budget has job support line items (e.g. basic office supplies and equipment, maintenance, provisions for a safe work environment, workforce safety, violence prevention, etc.)</li> <li>▪ Inventory of computer and other equipment to assist staff in efficiently carrying out work tasks</li> </ul>
2. LHD provides up-to-date computer hardware, software and internet access for each staff member	4	
3. LHD routinely makes public health and discipline-specific journals available for staff to stay updated in the field	4	

Comments regarding non-contract entities providing services for this focus area above.

**ESSENTIAL SERVICE IX: Evaluate and improve programs**

**STANDARD IX. A. Develop evaluation efforts to assess health outcomes to the extent possible.**

**FOCUS: OVERALL LHD EVALUATION STRATEGY FOCUSES ON COMMUNITY OUTCOMES**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has data on community health outcomes and risk	4	<ul style="list-style-type: none"> <li>▪ Community health assessment examine a</li> </ul>

2. LHD staff or external evaluation expertise is in place	4	<p>wide scope of health outcomes and inform future service delivery</p> <ul style="list-style-type: none"> <li>▪ Examples of monitoring health outcomes that result in redirected program efforts</li> <li>▪ Annual reviews of progress in reaching outcome and impact (addressing risk factors) objectives</li> <li>▪ Annual report cards on progress in improving health outcomes</li> </ul>
3. LHD has assigned responsibility for evaluation within the organization	0	
4. LHD has plans in place to reduce specific gaps in access or make other improvements in public health services	3	
5. LHD develops and executes an internal policy to guide its overall evaluation efforts, including frequency and scope of program evaluations, organizational evaluations, use of health outcomes as benchmarks for evaluations	2	
6. LHD conducts evaluation activities that include an analysis of local data (e.g., analyzing age-specific participation in preventive services) with established community health goals, objectives and performance measures.	2	
7. LHD uses community health outcome targets (e.g. Health People 2010) as benchmarks for evaluating the effectiveness of public health services	3	
8. LHD assures that population-based services are provided according to established standards and guidelines	4	
9.		

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD IX-B Apply evidence-based criteria to evaluation activities where possible**

<b>FOCUS: EVIDENCE- BASED METHODOLOGY FOR EVALUATION</b>		
<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD has evaluation expertise readily available	4	<ul style="list-style-type: none"> <li>▪ <b>Protocol(s) for LHD program evaluation</b></li> </ul>
2. LHD uses an acceptable evaluation framework that	3	

connects the public health intervention with health outcomes produced, based on the collection and use of evidence		<b>describing reasonable evaluation frameworks, including use of externally-developed standards, benchmarks, baseline data</b> <ul style="list-style-type: none"> <li>▪ <b>References for research, such as literature search, or use of experts in evaluation process</b></li> <li>▪ <b>Use of <i>CDC's Framework for Program Evaluation</i></b></li> <li>▪ <b>Documentation that evidence based methodology has been applied</b></li> </ul>
3. LHD periodically evaluates its key processes of service delivery for efficiency and effectiveness, using established criteria (e.g., from research literature, management literature, etc.)	2	
4. LHD makes formal efforts to identify best practices or benchmarks for evaluation purposes.	2	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD IX-C Evaluate the effectiveness and quality of all LHD programs and activities and use the information to improve LHD performance and community health outcomes.**

**FOCUS: EVALUATE LHD PROGRAMS**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD has a systematic process for assessing consumer and community satisfaction with agency services	4	<ul style="list-style-type: none"> <li>▪ <b>Reports, summaries of analysis, or meetings minutes or materials that demonstrate program monitoring activities</b></li> <li>▪ <b>Report of an evaluation findings</b></li> <li>▪ <b>Program review documents that demonstrate LHD compliance with applicable professional and regulatory standards</b></li> <li>▪ <b>Use of a performance management system to improve the quality of programs</b></li> <li>▪ <b>References for research, such as literature search, or use of experts in evaluation process</b></li> <li>▪ <b>Documentation that evaluation has resulted in program modification</b></li> </ul>
2. LHD monitors program performance measures and analyzes data to document the progress toward goals and grant/funding requirements	4	
3. LHD evaluates the quality of clinical and preventive population based programs	4	
4. LHD program evaluations identify need for change in policies and/or programs.	4	
5. LHD employs a quality assurance/quality improvement process that uses evaluation findings	2	
6. LHD uses data on customer needs and service delivery to improve processes and/or in the design and delivery of new programs/services	4	
7. LHD changes its program activities to improve effectiveness, based on evaluation findings	4	

**Comments regarding non-contract entities providing services for this focus area above**

**STANDARD IX-D Review the effectiveness of public health interventions provided by other practitioners and agencies for prevention, containment, and/or remediation of problems affecting the public’s health, and provide expertise to those interventions that need improvement.**

**FOCUS: EXTERNAL EVALUATION OF OTHER’S PROGRAMS**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD maintains data systems for capacity, availability, quality, cost and utilization of health services	4	<ul style="list-style-type: none"> <li>▪ <b>Written protocols or summary of CHP process, indicating level of coordination among community organizations in providing services that improve the health of the public</b></li> <li>▪ <b>Monitoring of progress of local public health system towards meeting community health objectives as stated in the community health plan</b></li> <li>▪ <b>Examples of reviews of the effectiveness of community agencies and coordination with LHD to improve service delivery</b></li> </ul>
2. Agreements between LHD and external agencies for evaluation are in place	0	
3. LHD provides consultation and technical assistance on program implementation and evaluation of prevention services provides by other community agencies	1	
4. LHD evaluates the accessibility, quality, and effectiveness of personal health services	4	
5. LHD assures that a systematic process for assessing consumer and community satisfaction with external agency services is in place.	2	
6. LHD assures that a systematic process for assessing consumer and community satisfaction with external agency services is in place.	2	

**Comments regarding non-contract entities providing services for this focus area above.**

**ESSENTIAL SERVICES X: Contribute to and apply the evidence base of public health**

**STANDARD X a. When researchers approach the LHD to engage in research activities that benefit the health of the community,**

**i. Identify appropriate populations, geographic areas, and partners;**

- ii. Work with them to actively involve the community in all phases of research;
- iii. Provide data and expertise to support research; and,
- iv. Facilitate their efforts to share research findings with the community, governing bodies, and policymakers.

**FOCUS: PARTICIPATE IN RESEARCH ACTIVITIES**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has access to the resources to participate in research (e.g., data and expertise)	4	<ul style="list-style-type: none"> <li>▪ LHD policy on data sharing</li> <li>▪ Participation in public health surveys</li> <li>▪ Collecting data that can be used in research (e.g. West Nile data)</li> <li>▪ Relationship with a university, where available, such as meeting notes, agendas etc.</li> </ul>
2. LHD has policies which endorse participatory research and ensuring the rights of participants in local public health research programs.	0	
3. LHD partners with academic/research institutions of higher education that are interested in conducting public health research. (e.g., provide data, content expertise)	4	
4. LHD proposes public health issues for research agendas, as appropriate.	0	
5. LHD convenes community members and key community partners, as appropriate, to identify opportunities for community participatory research that would benefit the community	0	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD X- B Share results of research, program evaluations, and best practices with other public health practitioners and academics**

**FOCUS: DISSEMINATE RESEARCH FINDINGS**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has access to expertise to evaluate current research and participate in research dissemination activities	4	<ul style="list-style-type: none"> <li>▪ Presentations at community groups</li> <li>▪ Annual reports to Board of Health on basic evaluation of programs, target groups, reach into the population at risk</li> </ul>
1. LHD disseminates research findings to public health colleagues	0	

2. LHD disseminates research findings to the community, partners and policy makers.	1	<ul style="list-style-type: none"> <li>▪ <b>Documentation of LHD communication of best practices with other public health practitioners</b></li> <li>▪ <b>Documentation of consultations with other agencies on effective public health practices</b></li> </ul>
3. LHD provides expertise, based upon research into innovative solutions, to elected officials and community organizations involved in developing and analyzing public policy and in planning implementation of population-based strategies.	2	

**Comments regarding non-contract entities providing services for this focus area above.**

**STANDARD X-C Apply evidence-based programs and best practices where possible**

**FOCUS: APPLY RESEARCH RESULTS IN LHD ACTIVITIES**

<b>Operational Definition Indicators</b>	<b>Score</b>	<b>Illustrative Evidence</b>
1. LHD has access to expertise to evaluate current research and participate in research translation activities.	4	<ul style="list-style-type: none"> <li>▪ <b>Inventory of intervention strategies by source (e.g. evidence-based approaches and/or best practices from grants, CDC's Guide to Community Preventive Services, Guide to Clinical Preventive Services, etc.)</b></li> <li>▪ <b>Meeting notes documenting participation a Best Practices Committee</b></li> <li>▪ <b>Program/policy examples from LHD that are based on best practices (e.g. State-determined best practice)</b></li> <li>▪ <b>Written summary or protocol of how LHD evaluates research for applicability to practice</b></li> </ul>
2. LHD seeks information about applicable evidence-based programs before implementing interventions	2	
3. LHD evaluates research efforts for applicability in practice	2	
4. LHD implements, on a priority basis, newly developed and innovative strategies, methodologies, programs, and projects, which have been demonstrated to be effective in improving public health.	2	
5. LHD provides technical assistance to external organizations in applying relevant research results.	1	

**Comments regarding non-contract entities providing services for this focus area above.**