



WASCO SHERMAN
PUBLIC HEALTH DEPARTMENT

419 E. 7th Street, The Dalles, OR 97058
Phone: (541) 506-2600 · Fax: (541) 506-2601 · www.wshd.org

2008 Comprehensive Plan

Table of Contents

- I. Executive Summary..... 1
- II. Assessment 2
- III. Action Plans 10
 - 1. Maternal and Child Health 10
 - 2. Immunizations 13
 - 3. Women Infants & Children (WIC) 20
 - 4. Family Planning 30
 - 5. Tobacco Education and Prevention..... 41
 - 6. Communicable Diseases 53
 - 7. Environmental Health Services..... 70
 - 8. Emergency Preparedness 74
- IV. Collection and Reporting of Health Statistics 81
- V. Health Information & Referral 82
- VI. Organizational Chart(separate document in back pocket)
- VII. 2007/2008 Adopted Budget 83
- VIII. Minimum Program Standards 83



WASCO SHERMAN
PUBLIC HEALTH DEPARTMENT

419 E. 7th Street, The Dalles, OR 97058
Phone: (541) 506-2600 · Fax: (541) 506-2601 · www.wshd.org

2008 Comprehensive Plan

“There is nothing men will not do, there is nothing they have not done, to recover their health and save their lives.”
- Oliver Wendell Holmes

I. Executive Summary

Historical Perspective:

Wasco Sherman Public Health is the only bi-county public health jurisdiction in Oregon and it was on April 26, 1950 that the two respective counties met together in the City of Moro for the purpose of forming a “District Health Unit”. The first official health unit was established in April, 1937 under the Wasco County Public Health Association even though public health work in Wasco County had its early beginnings following the influenza epidemic of 1918-1919. According to records, a group of health minded individuals went before the Wasco County Court on July 25, 1925 and \$500.00 was diverted from the general fund to the expense of a county nurse. In 1938, the Wasco County Health Unit was supplemented by its fourth public health nurse with an operating budget of just over \$15,000. And to think 50 years later with increased population-based health demands and commensurate expanded services, we currently operate with only 4 full-time and 2 part-time nursing positions. It would be remiss not to mention the public health services rendered in Gilliam County which includes licensed facility inspections, well child visits, tobacco prevention and education, and emergency preparedness including support for communicable disease investigations and amelioration.

Current Condition:

With respects to staffing disparities, this plan marks 14 months into a major financial course correction resulting in half the management and clerical support remaining. Specifically, the agency lost nearly a quarter of its staff (see organization chart) with no service reduction, leaving the existing 21 full time equivalent staffing capacity to promote and protect the public’s health represented by the work plans included in this plan. The most critical loss that impacts the agency’s ability to be in compliance with the State’s Minimum Program Standards (see page 91) is the Nursing Supervisor vacancy.

This position is integral to day-to-day clinical operations and staff management oversight. Currently, the Nurse Practitioner is serving in an interim capacity, but difficult burden to maintain on a permanent basis. Another vacancy is a .5 FTE Environmental Health Specialist that began services on January 1, 2005 to support Gilliam County licensed facility operations (in compliance with HB3156). The current Environmental Health Division is back to the original 2 staff, including the Supervisor. The number of restaurants, septic inspections, water supply systems, and other various sanitation needs continue to be on the rise, however funding to support continue to stay the same. It's amazing how far the world has come in providing a more sanitized environment noted by a leading medical journal as the most important milestone in the past century and a half that has reduced disease such as cholera. In fact, pollsters state sanitation as surpassing antibiotics, the discovery of DNA, and anesthesia, according to the British Medical Journal. We can only hope that sanitation will continued to be valued as a passive protection against health hazards in the future.

Meeting Unmet Needs:

This next year will be dedicated to a continued investigation into how to stimulate missed financial opportunities. Some of the major steps to address missed revenue opportunities has been to install a third window in the front office to ensure clients have an ability to pay for services, finding lower costs lab vendors, adopting an increase in both Environmental Health licensed facility fees, new administrative fees for clinical service, and conducting a cost analysis for higher staffed clinic service, Family Planning, that has been effected by the Deficit Reduction Act requiring extensive documentation for eligibility, and other various staffing efficiencies to maintain current service capacity.

The motto statement going into our future of recovery is being named, "Hopeful Optimism". With everything in life, there comes a season for expansion and contraction; the next season surely will be expansion to take on a more prominent role in social policy change or what is being coined as environmental engineering. This role is to work with community partners to create consciousness around the places people inhabit from homes, parks, offices, and vehicles that are conducive to living out the best quality of healthy living. This can come in the form of 'Walkable Communities' to a 'Greener Planet'. A very exciting future in deed!

II. Assessment

Funding from the Office of Rural Health Policy allowed Wasco Sherman Public Health (WSPH) to engage in a large scale community assessment process in 2006 with the inclusion of Gilliam County. Leading up to this project a demographic, economic, and overall county health profile was conducted that included Gilliam County. This health district serves the needs/problems facing both rural and 'frontier' rural population areas for the **27,190**¹ residents spread over 4,450² square miles of Wasco, Sherman, and

¹ Oregon State Office of Rural Health

² Wasco County GIS Division

Gilliam County, a land mass nearly 3 times the size of Rhode Island. The only urban community in Wasco County is The Dalles (population 12,503³), better known in the former days as *Le Grande Dalles de la Columbia* (The Great Falls of the Columbia) by French Canadian fur traders. The Dalles sits on the bank of the Columbia River dividing Oregon and Washington and is nestled between the Columbia River and the foothills of Mt. Hood. A beautiful area riddled with the same nation-wide problem of preventable disease and death, however set apart from the rest in socio economic determinants positively correlating to poor health outcomes. When compared to Oregon and the Nation, our residents are the most economically disadvantaged typified by low incomes, high poverty rates, consistent double-digit unemployment, and low educational attainment.

This community assessment process was initiated by a newly created ‘Rural Oregon Collaborative Consortium’ or ROCC that received a Planning Grant in March of 2006 to begin the commitment to the strategic planning model, “Mobilizing for Action through Planning & Partnerships” to address the most unmet needs/problems in this service area. The ROCC represents major health & human service agencies (see table following) coming together to develop a common set of priorities at the outset of the assessment efforts. Because accurate and timely health care information from both the provider standpoint and the community’s knowledge is foundational to better coordinated care and paramount to better health outcomes overtime, the ROCC plans to work together to address a lack of coordinated health services and relevant and accurate electronic health records available on the residents of its respective communities. The current health care environment in the 3 county service area lacks electronic health information exchange from one health care agency to another or rural health clinic to hospital. The only ROCC agencies that have recently purchased electronic equipment for internal tracking is Mid-Columbia Medical Center and La Clinica del Cariño Family Health Care Center that allows their own providers the ability to share information. Overtime, the ROCC foresees sensitively (HIPPA, and patient approved) sharing aggregated provider chronic disease knowledge through agreed upon data parameters for stakeholders and policy makers as well as the ROCC agencies to drive priorities in coordinated health promotion and disease prevention programming in the community and the incorporation of evidenced-based clinical interventions in patient-provider encounters.

This area as aforementioned is one of the most economically disadvantaged in Oregon and is typified by low incomes (median household income \$6,000 less than State,⁴) higher poverty rates with 4% higher rate of persons below 200% of poverty level than the State at 11.6% and double-digit unemployment in 2 of 3 counties with trends worsening in all 3. According to data found in the Oregon County Public Health Profiles, Wasco County has a high population living in low socio-economic conditions with 12% of the population classified as “economically disadvantaged,” and as shown in the Oregon State Office of Rural Health’s (SORH) Service Area Profiles, an unemployment rate for the area of 10.7%, higher than the state average of 6%. Sherman County is even higher with

³ City of The Dalles

⁴ Oregon Quick Facts

11.9% and Gilliam County 6.6% (Source: SORH). Not surprising when finding 67% of WSHD clients are at 100% of federal poverty level (Source: WSHD). The population demography is typical of rural America in that even though we have a high population rate of the younger generation which is averaged out for the region at 25%,⁵ our working population (ages 15-44) has declined from 1990 to 2004 by -7.4%⁶ for obvious reasons in search for education and jobs elsewhere. Then as explained later, an increasing proportion of retired age population (ages 45-64) have been moving in over the last 14 years: Wasco County showing 40% more 45-64 year olds; Gilliam showing a 52.5% increase; and Sherman at 20.1% all from a 1990 to 2004 trend. Of the tri-county area, Wasco County has a higher than average Hispanic/Latino population at 10.4%. This is largely due to the agricultural environment better known as the “Cherry Capitol of the Nation.” The major agricultural product of the The Dalles is sweet cherries with an excess of 6,000 acres of trees around the City. It is important to note that these numbers only represent Hispanic and Latinos who reside permanently in the area and substantially increase with the annual influx of migrant and seasonal farm workers during the harvest. The 2002 “Migrant and Seasonal Farm worker Enumeration Profiles Study” for Oregon states, “Estimating Migrant Seasonal Farm Workers is extremely difficult and no current source provides reliable information, particularly for population figures at the county level.” The second largest ethnic group in the tri-county area is Native Americans at 3.8% in Wasco County, 8% in Gilliam County, and 1.4% in Sherman County with the State of Oregon at 1.3%⁷. From a small geographically isolated community in Celilo, 20 miles away from The Dalles, there resides 1% of the 3.8% Native American population. In and around the town of Maupin there is a population density of 18.8% Native Americans where the Sovereign Nation of Warm Springs Reservation is located near in Wasco County.

This population is known to have disparities in health care and is cited in a report by the Oregon Health Science University;⁸ migrant farm workers are among the most disadvantaged, medically indigent persons and have the poorest health of any group in the US. The infant mortality among Migrant Workers is 25% higher than the general population, and the life expectancy is 49 compared to the national average of 73 (Centers for Disease Control, 1998). The only local population based health status survey that has ever been conducted in the tri-county area was in Wasco County in 2002 by La Clinica del Cariño that surveyed their target service population of Hispanic/Latino residents. This survey, which is statistically significant, found disparities around health care access in this population. The table below shows how Hispanics/Latinos have a need to increase access to health care whether through health insurance or simply access to providers.

Hispanic survey questions To Improve Health Services Wasco County Oregon (2002)	Percent answering Yes	Percent answering No	% 20 to over 60 minutes
Do you have health insurance?	43.1%	56.9%	
Do you have a Dr. in the area?	18.1%	81.9%	

⁵ Oregon Quick Facts 2003 (U.S. Census Bureau)

⁶ Oregon State Office Rural Health – Service Demography Profiles

⁷ Oregon Quick Facts 2003 (U.S. Census Bureau)

⁸ Report entitled ‘Reducing pesticide Exposure in Minority Families.’

Do you feel you need medical care now?	28.4%	67.2%	
Do you have a DDS in the area?	7.8%	92.2%	
Have you seen a Dr. in the past 12 months?	45.7%	54.3%	
Have you seen a dentist in the past 12 months?	25.9%	74.1%	
Do you feel you need dental care right now?	60.3%	39.7%	
Travel time to Dr. or Dentist			30%
Do you feel you need medical care?	28.4%	67.2%	
Do you get medical care?	17.2%	82.8%	

As the “Rural Healthy People 2010” companion document states, “Hispanics are more likely than other Americans under age 65 to be uninsured,” and the table above depicting the survey results evidences this disparity. Coupled with this deficit is the even more alarming research that states, “Since persons living in rural areas are more likely to have seasonal work and lower incomes, they are the most at-risk group of being both uninsured and living below federal poverty levels.” Many of the survey respondents were seasonal farm workers that come from California and Mexico to pick orchard fruit, specifically, 20.7% responded that they were a long way from home. According to the State of Oregon’s Children County Data Book of 2003, Wasco County has 223 children (ages 5-17) that live in ‘linguistically isolated’ households (i.e. where no person age 14 or over speaks English ‘very well.’)

Oregon’s rural populations exhibit demographic characteristics that create additional challenges for health care accessibility and delivery with rural Oregonians being older than their urban counterparts. The 1997 estimated census data shows that, while the average proportions of elderly (65 or older) population in Oregon is high (15.7%), it is highest in frontier and rural counties. In Frontier counties, the percentage of the population over 65 is 16.7%, while in urban counties the percentage is only 12.6%.

Rural Oregonians as a group have not attained the educational levels found in more urban areas of the state as reflected in the low educational attainment (area averages 9% less than state that possess bachelor’s degree or higher.⁹) According to the Oregon Progress Board, based on the last 3 year average (2001 – 2003) the tri-county area falls below the state by 4.7% for those having attained their high school degree and 8.3% lower than the state average for those having a bachelors degree.

The overall picture that emerges in Wasco, Sherman, and Gilliam counties is of a rural population that is older and has fewer resources than the population found in more urban areas. Rural Oregonians in general have less education, lower incomes, and are burdened by higher rates of unemployment than those in urban or even mixed areas. Many, due to factors such as low income, type of employment and unemployment, do not have health care benefits or the resources to purchase health care for themselves. A lack of understanding regarding what resources are available, and how to take advantage of

⁹ quickfacts.census.gov

critical resources compounds this lack of knowledge. Even if they do have some care provided, and seek to access that care, they may not have transportation available to allow them to that access. For example, there may be no provider locally, they may live out in a remote area, or they might be on a plan - such as the Oregon Health Plan – that is not accepted by any local providers. If they do not have a reliable car they are often unable to get to help. Public transportation essentially does not exist in most of rural Oregon. Towns are frequently 30 to 100 miles apart and many people live 15 miles or more from town.

The current situation in Wasco, Sherman and Gilliam Counties falls short of this hopeful endeavor to achieve Healthy People 2010. These counties are all dually designated as a **Medically Underserved Area and Health Professions Shortage Area (i.e. both mental and dental health professions shortages.**¹⁰) and are either “remote rural”, being more than 30 minutes average travel time from a population center of 10,000 or more, or less “remote rural”, being 30 minutes or less average travel time from a population center of 10,000 or more. To further emphasize just how rural this service area is; 2 of the 3 counties are designated as ‘frontier’ rural due to the low population density with 2.3 people per square mile in Sherman County and 1.6 in Gilliam.

Today, providers within the outpatient clinics and health department work independently of one another, relying upon phone calls and patient recall in order to deliver health care in the community. Services are duplicated and assumptions are made as to the services rendered without any means of verification outside of provider to provider phone and fax communication. **The need is for better real-time patient information through electronic information exchange.** More rural practitioners are often ill informed of improvements in billing practices or emerging infections and public health problems. Long distances between providers and the ‘local’ health department often make communication difficult and ways in which all health care providers might better communicate are often unheard due to such barriers. Patients in the community thus receive an often insufficient patchwork of health care services and would stand to substantially benefit from the creation of a network of outpatient providers whose goal is to overtime eliminate health disparities. As the table below depicts, the average round trip from the outlying medical clinics to the nearest urban source of health care (i.e. The Dalles hospital, Mid-Columbia Medical Center) is 118 miles.

Outpatient Medical Clinic	One Way Travel Distance	Round Trip Travel Distance
Arlington	64	128
Condon	73	146
Moro	40	80
Deschutes Rim	39.5	79
Average	59	118

Gaps in communication, exacerbated by the long distances between providers, have a detrimental effect on patient care due to irregular provider contact, poor coordination of

¹⁰ According to Oregon State Office of Rural Health

home visitation care and a lack of systematic data collection of vaccine patient data. At the present time, clients within the tri-county area bounce from site to site due to a lack of walk in access to most private clinics and first come first see availability in the health department. As a result, patients receive fragmented care from multiple providers who rely upon patient recall and inter-provider phone calls and faxes to piece together prior care received. Frustration abounds when the health department is closed and providers cannot access the medical histories of patients who appear after hours in the emergency room, or when the health department's consent forms are seen as inadequate thus preventing transmittal of vital patient information.

Further **barriers** to care for Wasco, Sherman, and Gilliam Counties include: 1) **Rural workers are less likely to have job-based insurance** coverage because they are less likely to be offered health insurance by their employers. In the *Journal of Rural Health*, researchers reported that more than 53% of the respondents noted that the inability to pay was one of the primary barriers to preventive health services; 2) The **perceived lack of confidentiality** by people in rural areas causes some to avoid or refuse health services that may be associated with stigmatizing situations and conditions. Therefore, patients may forego certain services such as HIV testing, treatment for sexually transmitted diseases, adolescent prenatal care, and treatment for behavioral or mental health issues to avoid the criticism of fellow community members. Rural populations of different cultural and ethnic backgrounds may hold differing views of disease, pain and illness. Therefore, it is not uncommon for patients in our rural Native American population areas to have a higher confidence in home remedies or folk healers; and 3) **Accessibility to health care** - patients in our rural and frontier rural areas have to overcome a variety of geographic and climatic barriers such as mountainous and rugged terrain and that is if they have an affordable means to travel in order to access their usual source of health care; and 4) **Affordability of health care** - the rising costs of health care coupled with the lower incomes presented above make it difficult for families to afford *acute, chronic and preventive health care*. Leading the ROCC to believe that our neighbors are more at risk of chronic disease evidenced by the socio-economic and demographic profile in paragraphs above The population-based health risk behavior status (local – State – Federal) data comparisons below are from August 2006's Behavioral Risk Factor Surveillance Survey (BRFSS) results made possible by the Federal Planning Grant. This represents only a handful of the many pervasive chronic disease risk factors that our North Central Oregonians are reporting.

Adult Risk Behaviors and Health Status compared to State and National Averages¹¹

% that responded as yes	Consumed less than 5 fruit & veggies a day	Current Smokers	Vigorous Physical Activity 3 or more days/wk	Doctor diagnosed Heart Disease	Doctor diagnosed as having Heart Attack	Doctor diagnosed Asthma	Doctor diagnosed Diabetes	General Health is excellent
Local	80.55	19	46 (10 min.)	5	8	12	10	18
State of Oregon	74.1	18.5	69.3 (20 min.)	3.8	3.6	10.1	6.7	19
National	76.8	20.5	72.6 (20 min.)	NA	NA	8.0	7.3	20.3

The ROCC understands the need to take advantage of economies of scale and work together to more intensely build a seamless continuity of care for its collective residents to prevent and ameliorate chronic disease.

The profile table below represents the self-governance board for the ROCC. A new member since receiving the Planning Grant is Deschutes Rim Health Clinic that has opened their new clinic in the town of Maupin. When more than one name appears in contact column it is because the first listed contact has requested an alternate contact to serve as their voting member when their busy schedule curtails them from being present.

Organization Name	Address	Key Contact/Self-governance Board Member	Current Role in Agency
Wasco Sherman Public Health Department	419 E 7 th Street The Dalles, OR 97058	Lynnette Benjamin	Director
Mid Columbia Medical Center	1700 E. 19 th St. The Dalles, OR 97058	Duane Francis or Catherine Whalen, Vice-Chair	President & CEO/Community Initiatives Director
Moro Medical Center	110 Main St, Moro, OR 97039	Linda Thompson	Clinic Manager
Arlington Medical Center	120 On The Mall Arlington, OR 97812	Carmen Gronquist	Clinic Manager
Gilliam County Medical Center	422 N. Main Condon, OR 97823	Cindy Hess	Clinic Manager, Chair
Deschutes Rim Health Clinic – As of 9/27/06	P.O. Box 266 1605 Blue Rock Road, Maupin, OR 97037	Jerri Parman or Dennis Beechler	Clinic Manager/Board Member

¹¹Source BRFSS Results: Local – Gilmore Research /State -Oregon Website/National –Centers for Disease Control

Fellowship of Churches	1525 E. 9 th St. The Dalles, 97058	Bob McNary	President
Mid-Columbia Center for Living	419 E. 7 th , Rm 207 The Dalles, OR 97058	Sharon Guidera or Rodney McDowell	Director/Clinical Services Manager
Oregon Department of Human Services	700 Union St., Room #216 The Dalles, OR 97058	Carri Ramsey	Community Development Coordinator
La Clinica del Cariño Family Health Care Center, Inc.	425 E. 7 th The Dalles, OR 97058	Frank Vasquez	Director

Obviously, the ROCC cannot change the climate, terrain, and job market, but overtime proposes to impact the availability and coordination of relevant health promotion and disease prevention services by developing a collective work plan to address accomplishing the stated objectives in Healthy People 2010 goals & objectives. In the meantime, the following pages reflect the action plans working to meet the immediate public health service needs.

III. Action Plans

1. Maternal and Child Health Programs:

Wasco Sherman Public Health offers service to pregnant women, young children and families by providing a public health nurse with special training to visit homes. There is no charge for these services, but the Oregon Health Plan may be billed for some services. Maternity Case Management (MCM), Babies First (BF), and Community-Based Care Coordination (CaCoon) are overseen by Lori Treichel, Public Health Nurse. These home visiting-based service are rendered by 2 Public Health Nurses and one bi-lingual Community Outreach Worker.

The goal of Maternity Case Management is to reduce poor birth outcomes augmenting traditional prenatal care by communicating with providers to assist with coordination of care services. These services conducted in the home include: evaluating strengths and needs to make healthy lifestyle choices; identifying pregnancy changes needing intervention; screening and referring for substance abuse; providing tobacco cessation interventions; evaluating environment and relationships; education on several topics (i.e. healthy eating, immunizations, lead exposure, fetal alcohol syndrome, oral health, labor and delivery, etc.); and counseling for possible referral to appropriate services from psychological to social-economic needs.

The goal of Babies First is to improve the physical, developmental, and emotional health of high-risk infants and is a commitment to on-going Home-Based Care. All newborns are vulnerable, but some face tougher odds than others. Low birth weights, medical conditions, single-parent families, poverty, and drug exposure are reasons to have provider referrals for home visiting. The program targets children from birth through age three so potential problems are detected quickly and interventions can be monitored with regular visits. Home visits start shortly after birth to 4-6 month intervals and can be scheduled more frequently if needed. Issues besides health and developmental screening are addressed and include: parenting skills; health education; case management; advocacy, and agency referrals. Families learn how to care for and better understand their children in the relaxed and comfortable setting of their homes.

The Community-Based Care Coordination or CaCoon, not reflected in the action plan is for families who have children with special health needs from birth to age 20 that result in special medical, educational, vocational and social needs. This program provides local support for families by helping parents find financial services for which the child may qualify for and working with the primary care physician to coordinate health care and specialty care. The overall goal is to help the family learn new skills to become as independent as possible in caring for their child.

Goals	Objectives	Plan for Methods / Activities / Practice	Outcome Measures Results (Data source)
<p><u>Maternity Case Management</u> HP2010 #16D Health Status Improvement for Pregnant Women</p> <p>1a. No prenatal tobacco use</p> <p>-----</p> <p>2a. Culturally appropriate, early and adequate prenatal care for Hispanic women</p>	<p><u>MCM</u></p> <p>1a. Decrease the number of babies born to mothers that smoke tobacco during pregnancy</p> <p>-----</p> <p>2a. Provide early and adequate, quality culturally appropriate prenatal services</p>	<p><u>MCM</u></p> <p>1a. Provide MCM services</p> <p>1b. 100% of MCM clients are offered the 5A's counseling</p> <p>1c. Collaborate with the Tobacco Prevention coordinator for current written resources</p> <p>1d. Provide community education about the dangers of smoking tobacco during pregnancy</p> <p>-----</p> <p>2a. Collaborate with La Clinica Del Carino's newly opened local prenatal services program and the Home Visiting Network (HVN) activities</p> <p>2b. Community Health Worker will provide interpretation services weekly to the private Prenatal Care clinic for Hispanic Women</p> <p>2c. The HVN will track the number of MCM referrals received from La Clinica Del Carino</p>	<p><u>MCM</u></p> <p>1a. The number of women who smoke at the beginning of pregnancy and quit during pregnancy</p> <p>(PRAMS data, WIC data)</p> <p>-----</p> <p>2a. The number of MCM clients referred by La Clinica Del Carino's prenatal services program that accepted MCM services</p> <p>2b. The percentage of Hispanic women receiving prenatal care in the first trimester</p> <p>(Home Visiting Network data, Oregon Mother's Care data)</p>
<p><u>MCM</u></p> <p>HP2010 # 16-10, 16-12</p> <p>Prevention of Low Birth weight (LBW)</p>	<p><u>MCM</u></p> <p>All pregnant women will have adequate nutrition during pregnancy</p>	<p><u>MCM</u></p> <p>Provide MCM services</p> <p>Collaborate between the WIC program and MCM nurses</p> <p>MCM nurses will be</p>	<p><u>MCM</u></p> <p>The percentage of MCM nurses trained in WIC recertification</p> <p>The number of WIC home visit recertification's</p>

		trained to provide WIC recertification's at home visits	completed Percentage of LBW infants (Birth certificate data)
<u>Babies First</u> Increase the percentage of infants diagnosed with early hearing loss that are enrolled in Early Intervention (EI) before 6 months of age	<u>BF</u> All babies referred to home visiting services will be offered Babies First (BF) services	<u>BF</u> Collaborate with EI around goals for hearing screens Home visit nurses will conduct hearing screenings on infants by 4 months of age	<u>BF</u> Documented hearing screens Timely referrals to audiology services and EI (Babies First chart review)
<u>Child Health</u> Decrease the death rate from unintentional injuries due to motor vehicle crashes among children aged 10 and under	<u>CH</u> Increase the knowledge and accessibility of child restraints to low income families enrolled in Health Department home visiting programs	<u>CH</u> Provide updated child restraint information to families receiving home visits Provide car seat class information to home visiting clients and their families	<u>CH</u> Track car seat class registration and follow-through (WIC data)

Statement of Maternal Child Health unmet needs:

There are still many unmet needs in the two counties. With state and local budgets shrinking, along with local health department staffing cuts, we have lost all flexible funding dollars and manpower to put toward unmet needs. We are thus limited in our ability to provide injury prevention services such as bike helmet promotion, but we are an active referral source for the county car seat program and every Oregon Mother's Care (OMC) client is educated on proper seatbelt placement during pregnancy and the use of car seats for infants and children. We are an OMC access site, but we are not funded for prenatal care services, so refer clients to area primary care providers. We are happy to report the recent opening of a prenatal care clinic through La Clinica del Carino that is hoped that collaborative efforts will increase access to early prenatal care for low income and non-English speaking members of the community. We are still lacking services for women and families experiencing the effects of post-partum depression and there is little access to pediatric specialty care for undocumented children.

2. Immunizations Program:

The health department provides immunizations for approximately 40% of children born in our county. Our up to date immunization rates for 24 month olds has decreased in the last year. One factor for this decrease is parents opting only for certain vaccines or limiting the number of shots child receives per visit. Many private providers in our area are also limiting the number of vaccines given per visit. The health department will focus on increasing our up-to-date (UTD) rates for 24 months olds in the next three years. We also plan to work with the sexually transmitted disease and communicable disease programs to increase the vaccination for Hepatitis A and B protection in the high risk population. Diane Kerr, our Public Health Nurse for 35 years now, is the person responsible for tracking the immunization rates for the health district. She also provides rural school-based health services, home visiting, and other various clinic and community-based initiatives.

**Plan A - Continuous Quality Improvement: Increase To Date rate by 24 mo. of age
Fiscal Years 2008-2011**

Year 1: March 2008 – Feb 2009			
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Results
Increase the UTD rate at 24 mo. of age by 4% each year for the next three years	<ul style="list-style-type: none"> • Assess AFIX data for UTD rates at 24 mo. in 2007 data • Staff training for forecasting. (Clinic will utilize IRIS forecast for 100% of client immunization visits.) • Assure every shot is entered into Alert/Iris system within 14 days. • Train staff for give all shots forecasted unless truly contraindicates • Policy and procedures created for giving all shots due at every visit. • Develop and distribute written educational materials to parents who are hesitant to vaccinate their child. • Develop and implement a reminder system for immunization clients. 	<ul style="list-style-type: none"> • AFIX reviewed and plan created to increase UTD rates. UTD will increase 4% and missed shots will decrease by 2% within Health Department. • Training for vaccine forecasting for all staff by September 2008. • Run a performance measure report for end of the year. Timelines of data entry should be greater than or equal to 80%. • Training about true contraindications for all staff by Sept. 2008. • Distribution of educational material for parents will begin on July 1, 2008. • Reminder system will begin on July 1, 2008. 	

Year 2: March 2009 – Feb 2010

Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Results
<p>Continue to increase UTD rate at 24 mo of age by 4% this year</p>	<ul style="list-style-type: none"> • Assess AFIX data for UTD rates at 24 mo. in 2008 data • Continue to use IRIS forecast for 100% of client immunization visits. • Continue to assure every shot is entered into Alert/Iris system within 14 days. • Assess use of written educational materials for hesitant parents. • Evaluate the reminder system for immunization clients. 	<ul style="list-style-type: none"> • AFIX data shows a 4% increase on UTS and a 2% decrease in missed shots. • Run a performance measure report for end of the year. Timeliness of data entry should be greater than or equal to 80%. • Written educational materials were assessed on July 1, 2009. Will meet with RNs as to whether parents were willing to accept forecasted immunizations after educational materials were presented & discussed. • Reminder system was evaluated on July 1, 2009. Will access Alert/Iris system one month after reminder sent, to check if immunizations were received. 	

Year 3: March 2010 – Feb 2011			
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Results
Continue to increase UTD rate at 24 mo of age by 4% this year	<ul style="list-style-type: none"> Continue to reassess AFIX data for UTD rates and missed shots at 24 mo. in 2009 data Continue to use IRIS forecast for 100% of client immunization visits. Continue to assure every shot is entered into Alert/Iris system within 14 days. Upgrade immunization materials for hesitant parents. Implement the upgraded reminder system for immunization clients. 	<ul style="list-style-type: none"> AFIX data shows 4% increase on UTD and a 2% decrease in missed shots. Run a performance measure report for end of the year. Timeliness of data entry should be greater than or equal to 80%. Distribution of upgraded educational material for parents will begin on July 1, 2009. The upgraded reminder system will begin on July 1, 2009. 	

**Plan B – Outreach Activities
Fiscal Years 2008-2011**

Year 1: March 2008 – Feb 2009				
	Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Results
ACTIVITY 1: Focus on High Risk Population	Due to increase reporting of Hepatitis C cases and STD cases to the health dept., the health dept. will work to increase the vaccination rates by 10% for Hep A & B within high risk populations	<ul style="list-style-type: none"> • Determine baseline • Continue to screen all STD clients accessing care at health dept. • Provide written information to all private providers in the service area about Hep A & B vaccination programs at health dept. Currently, the CD nurse verbally provides information to the client who is reported and to his private provider. • Work with community partners who work with high risk clients to offer training for staff about the Hep A & B program 	<ul style="list-style-type: none"> • Hep A & B disease rates in our service area will be maintained at our current low rates. <ul style="list-style-type: none"> - Hep A – 4 cases since 2000 - Hep B – 1 case since 2000 • Increased use of Hep A & B vaccine at the health dept. • Hep A & B rates will increase by March 2009. • Provided written information to all private providers in the service area about Hep A & B vaccination programs at health dept. by Sept. 2008. 	

ACTIVITY 2: Ability to bill for adult immunizations	Explore and expand ability to bill for adult immunizations with Medicare or private insurance. Currently all adult clients must pay cash then bill their insurance for immunizations given.	<ul style="list-style-type: none"> ○ Business Manager will explore obtaining a Medicare billing account for health dept. ○ Have correct CPT and billing codes for adult immunizations. ○ Train staff for correct use of CPT and billing costs. ○ Work with insurance providers to set up accounts. 	<ul style="list-style-type: none"> ● Will obtain Medicare billing account ● Will be able to bill correctly for adult clients ● Conducted training for staff about correct use of CPT and billing costs by Feb. 2009. ● Account will be set up with insurance providers. 	
---------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

Year 2: March 2009 – Feb 2010				
	Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Results
ACTIVITY 1: Focus on High Risk Population	Continue to increase vaccination rates of Hep A & B in high risk population	<ul style="list-style-type: none"> ● Continue screening ● Provide written information to new private providers ● Offer additional trainings to community partners if needed. 	<ul style="list-style-type: none"> ● Hep A & B rates in our service area will be maintained at our current low rates ● Increased use of Hep A & B vaccine at the health dept. 	

ACTIVITY 2: Ability to bill for adult immunizations	Explore and expand ability to bill for adult immunizations with Medicare and private insurance.	<ul style="list-style-type: none"> • Business manager will have obtained a Medicare billing account. • Front office staff will be correctly billing for adult vaccines. 	<ul style="list-style-type: none"> • Will have obtained Medicare billing account • Will be able to offer billing for adult immunizations for correct payment • Will order and maintain vaccines such as shingles, PPV 23 to give adult clients. Currently, clients are referred to their PCP or local pharmacies to obtain these vaccines. 	
---------------------------------------------------------------	-------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

Year 3: March 2010 – Feb 2011				
	Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Results
ACTIVITY 1: Focus on High Risk Population	Continue to increase vaccination rates of Hep A & B in high risk population	<ul style="list-style-type: none"> • Continue screening • Provide written information to new private providers • Offer additional trainings to community partners if needed. 	<ul style="list-style-type: none"> • Hep A & B rates in our service area will be maintained at our current low rates. • Increased use of Hep A & B vaccine at the health dept 	
ACTIVITY 2: Ability to bill for adult immunizations	Continue to explore and expand ability to bill for adult immunizations with Medicare and private insurance.	<ul style="list-style-type: none"> • Will have ability to bill for all adult vaccines. 	<ul style="list-style-type: none"> • Will be billing for adult vaccines. • Will have all adult vaccines, such as shingles, available. 	

3. Women Infant's & Children (WIC) Program:

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a free nutrition education program that teaches families how to make healthy nutrition choices for their families. To qualify you just need to be pregnant and/or breastfeeding and have infants and children under 5 who meet the income guidelines which is 185% of poverty. Studies have shown that children in low-income families have a higher incidence of inadequate dietary intake, and that most of their foods that are high in calorie and low in nutritional value. The intake of fruits and vegetables in Wasco, Sherman, and Gilliam was also noted to be far below recommendations for good health.

In an effort to increase nutritional consumption and raise awareness of the importance of eating more fruits and vegetables every day, the WIC program is working with the State Nutrition Action Plan (SNAP) program, the More Matters campaign and the Oregon Extension office to promote education and information to WIC clients. Networking with these agencies is key to offering new, simple to use education materials, recipes and even samples of fresh fruits and vegetable to expose families to new tastes and smells of produce they may not have tried before. The Farmers Direct Program also is another way WIC offers families the opportunity to increase their consumption by providing \$200.00 vouchers that can be redeemed at local farm stands. Wasco-Sherman WIC's goal is to increase the number of servings of fruits and vegetable to 6-8/day.

- a. **Current condition or problem:** Wasco-Sherman County WIC Program has not reached assigned caseload requirements for fiscal year 2007-2008.
- b. **Goals:** To meet or exceed caseload within 6 months
- c. **Activities:** Strategies for how we will address the caseload issue:
 - 1. Ongoing outreach to local community partners.
 - 2. Utilize our local radio contact more frequently for WIC outreach and to spread the message that we are looking for additional customers at WIC.
 - 3. Monitor the migrant clinic, which is starting the month of June, to see if the fluctuation in caseload helps push our overall caseload numbers up. Monitor the change in the numbers from last year to see if the season's produce limitation may have an effect on caseload numbers from last year's season. The fruit crops have been less productive the past few years which also may have an impact on our overall caseload.
 - 4. Outreach to current clients and use of a "tell a friend campaign" to spread the message that our county is seeking customers for those that may be eligible for WIC services.
- d. **Evaluation:** The plan for evaluating our strategies will be weekly review of caseload numbers; closely monitoring and calling clients that have not brought proofs; documenting and continuing outreach strategies; continuing to talk with Vernita Reyna, our Nutrition Consultant, regarding monthly caseload trends and suggestions if caseload remains to decrease.

**WOMEN INFANTS AND CHILDREN (WIC)
WASCO SHERMAN COUNTY PUBLIC HEALTH DEPARTMENT**

Agency: Wasco Sherman Health Department

Contact: Karen Lyon

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

Objective(s)	Planned Activities	Outcome Evaluation	Response
<p>During plan period, all WIC families will be provided information to help them make positive lifestyle choices to decrease the risk of overweight</p>	<p><u>Activity 1.</u> Using the state provided tool, assess your community's resources for safe, developmentally appropriate physical activity opportunities for families and their young children and provide a list of these resources to WIC clients.</p>	<ul style="list-style-type: none"> • Was the community assessment completed and a list of resources provided to WIC clients? • How did clients respond to the resource list? 	<ul style="list-style-type: none"> • The community assessment tool provided by the state was used as a guide to begin the process of assessing the resources in our local community. However, after initial research was done, it was found that the Northern Wasco County Parks and Recreation District has already done an extensive job at researching appropriate and safe resources and has put together a comprehensive program guide. These guides offer physical activity opportunities for all age levels, infant to adult, and many of them are family focused. Some of the programs have a minimum cost, other are free. The program guide also has a wonderful list of community parks and what facilities are available at each site. Wasco-Sherman County WIC program, through this goal, now has a partnership with the Parks and Recreation District and will receive a free allocation of these program guides to provide to our WIC clients each fall and summer season as the guides are updated. We have been distributing the guides at Health Expo's, classes, and at individual and recert appointments as appropriate. • Clients have responded positively to the program guides and appreciate the information.
	<p><u>Activity 2.</u> Make available to clients a 2nd NE opportunity to participate in physical activity.</p>	<ul style="list-style-type: none"> • Was a 2nd nutrition education opportunity to increase physical activity made available to clients? If yes, describe what it was. 	<ul style="list-style-type: none"> • Yes, 2nd nutrition education opportunities to increase physical activity were made available to clients. Every other month, (starting mid-2006 and continuing through 2007), we had an instructor from the International Loving Touch Foundation, Judy Shinn, who donated her time and taught the infant massage class. In

		<ul style="list-style-type: none"> • How/why did your agency choose this particular 2nd nutrition education opportunity? • Did your agency create a new opportunity or modify an existing opportunity? • How did clients respond to this opportunity? • Will you continue to make this opportunity available in the future? 	<p>July we partner with the Wonderworks Children Museum to utilize their play station. We organize a “walk to Wonderworks” where WIC families had the opportunity to take a short walk down to the museum and experience the play station free of charge. Families were also offered membership to join the playroom at a discounted rate. Another opportunity provided to our clients during the month of July was with our Celebrate Summer Classes which focused on physical activity. During this class we gave ideas on easy and fun activities that families could participate in and passed out free frisbees and small sized blow-up balls for older children. On February 2, 2007, WIC also partnered with the Health Promotion team and other community players, and participated in the ‘GO RED’ Day for Women’s Heart Health. Prior to this event, information was provided to clients encouraging them to join in the walk.</p> <ul style="list-style-type: none"> • Our agency chose these particular opportunities because they utilized community agencies and partners, they were easy to incorporate with the second education schedules, and they were a fun way to motivate clients to make physical activity part of everyday. • Our agency did both, created a new opportunity as well as modified an existing opportunity. The ‘GO Red’ Day was a new collaboration and we expanded on the Celebrating Summer Class and walk to Wonderworks event. • Clients responded positively to all opportunities. The most successful was the classes that had the physical activity focus and provided the free exercise giveaways. • Yes, we will continue to provide these opportunities and hope to network more with the community when they have things such as the
--	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

			‘GO Red’ Day, or fun walks, to encourage ongoing participation. As budget allow, we will also continue to provide fun activity centered give-a-ways so after the class, families can continue to ‘play’.
--	--	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Objective(s)	Planned Activities	Outcome Evaluation	Response
During plan period, staff will promote client consumption of fruits and vegetables.	<u>Activity 1.</u> Using state provided tool, assess activities and resources in the community to promote fruits and vegetables and provide a list of these activities and resources to WIC clients.	<ul style="list-style-type: none"> Was the community assessment completed and a list of resources provided to WIC clients? How did clients respond to the list? 	<ul style="list-style-type: none"> Yes, the community assessment tool was used as a guide to development of the list. Clients were appreciative of the information and wished there were more services/resources in the community of The Dalles that offered lower priced fruits and vegetables.
	<u>Activity 2.</u> Develop and implement a client centered activity/event by June 2007 in recognition of 5 A Day. Examples include: Bulletin Boards, Newsletters, and Classes.	<ul style="list-style-type: none"> What client centered activity/event did your agency implement in recognition of 5 A Day? 	<ul style="list-style-type: none"> Our agency was part of the Fruits and Vegetable More Matters launch event. We partnered with Fern Wilcox from the OSU Extension Service whom we had not previously had a chance to work with yet this year. Although we had different populations of the community we each focused on, the message of More Matters was the same. Fern Wilcox provided information to the Department of Human Services, and the Senior Citizens program and our focus was WIC families. Our agency developed two new bulletin boards in both English and Spanish promoting and informing clients of the new campaign and importance of eating more fruits and veggies every day. We held two Health Expo’s with the theme of Fruits and Veggies More Matters where we displayed the bulletin boards,

		<ul style="list-style-type: none"> • How did your agency decide on this activity/event? • What went well and what would you do differently? 	<p>gave out the handouts provided by the state for the campaign, had a food demo on making “awesome applesauce”, and educated clients as they came in for the expo. In addition, our agency spoke on KODL radio on the topic of the importance of eating fresh fruits and vegetables and educating the community of the new More Matters launch campaign.</p> <ul style="list-style-type: none"> • Our agency decided on these activities because they allowed us to network with other local community partners while incorporating the message into things we already have established; the health expo and our media connection. Currently, each month the Health Department is given time to talk on the KODL radio during the Coffee Break morning show. For March, it worked out perfect for WIC to use this slot and discuss the new campaign message, reminding the community of the importance of eating fruits and vegetables, and continuing our outreach as a health department • We thought everything went well and nothing different would be done. If we had not had initial media connections, that piece would have been much harder to have accomplished. The process of working with OSU Extension was a great way to network and we will continue to work together as we continue this message in the future.
	<p><u>Activity 3.</u> (Optional) Develop and implement a staff activity/event that promotes fruit and vegetable consumption.</p>	<ul style="list-style-type: none"> • Did your agency implement a staff activity/event that promotes fruit and vegetable consumption? • How did your agency decide on this activity/event? 	<ul style="list-style-type: none"> • Yes, in association with the Fruits and Veggies More Matters theme, on March 26th (the day of our second health expo) we provided staff samples of fresh fruits along with the giving out the new handouts of what makes a serving of fruit/vegetables and updating the Public Health staff about the new campaign theme. • We decided on this activity as it was a great way to share the information with staff and continue to Fruit and Veggie

		<ul style="list-style-type: none"> • What went well and what would you do differently? 	<p>More Matters campaign launch. Staff was thankful to hear about the change in the message since many of them were not aware of it.</p> <ul style="list-style-type: none"> • We felt this time of sharing and education of staff was a quick and easy activity that was still helpful and informative. <p>In addition to this special targeted activity, it is an ongoing request of our Program Manager to have nutritious foods (along with fun foods) available when there are any meetings held by the Health Department. Usually these foods are in the form of fruits and vegetables. We really do a great job here at Wasco-Sherman County Public Health of “walking the talk” when it comes to healthy foods –and lots of it!</p>
--	--	-------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Objective(s)	Planned Activities	Outcome Evaluation	Response
<p>During plan period, develop strategies to increase client participation in nutrition education.</p>	<p><u>Activity 1.</u> Explore options for developing innovative partnerships for providing NE to clients in your agency.</p>	<ul style="list-style-type: none"> • Did your agency begin a process for developing innovative partnerships for providing NE? • What did you use to begin the process? • What will you need to continue? 	<ul style="list-style-type: none"> • Yes, our agency began a process for developing partnerships for providing NE. • To begin the process, we meet with the Mid-Columbia Children’s Council (Head Start) to discuss options that would work for both organizations and increase clients choices for their second education opportunity. We customized the state samples of the forms for WIC Nutrition Education Agreement and NE Documentation to be specific between MCCC Head Start and WIC. The agreement was signed and copies given to both agencies. Since the NE topics may be diverse, and since the number of clients utilizing this opportunity is small, we decided to document in the client progress notes the topic that was covered. As we implement this opportunity, the actually documentation or an off-site NE template may need to be developed to better document this contact. • It is too soon to say what we will need to continue this process since we will only be able to implement this activity by April 2007. We will monitor our progress and see if there is something that we are in need of in the future.
	<p><u>Activity 2.</u> Using state provided tool, assess your agency’s 2nd nutrition education offerings and make changes as needed to improve your show rates.</p>	<ul style="list-style-type: none"> • What nutrition education offerings were identified as most and least attended? 	<ul style="list-style-type: none"> • The nutrition education offerings that were identified as the most attended were the health expo’s. The least attended was not able to be determined due to changes in the class schedules and the addition of more individual education appointments and less variety of specific topics. The more specific the topic, time and day seemed to have the least attended rates.

		<ul style="list-style-type: none"> • What changes were made based on the results of your assessment? 	<ul style="list-style-type: none"> • The changes that will be made based on the assessment results are that we will continue to offer and work to expand the health expo's we are currently offering. Survey results show that clients like the new idea of the expo and really appreciate that they can come during a flexible time period and have a few different days of the week to choose from. We will be continuing to change/updates the bulletin boards we have created and add more food and physical fitness demonstration to this successful second education activity. We have found that clients are much more relaxed when they are free to browse materials and often begin conversations not only with the staff but with other clients which was not noticed to be done in our 'class' settings. The WIC staff greets each participant and asks individually how they or their children are doing, and checks to see if there is any particular need or question they may have. The biggest change we completed this year was relocating the classes and expos to the building next door which is more conducive for larger groups. • We did note a trend that during busy months of the year, our show rates decreased; such as July, September, November (short month) and in show rates were the best in October. We will follow this trend and make adjustments to our schedules during higher no show months to help maintain normal show rates.
--	--	---------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Goal 4: Increase breastfeeding duration rates among WIC participants.

Objective(s)	Planned Activities	Outcome Evaluation	Response
<p>During plan period, staff will promote exclusive breastfeeding for 6 months of age and implement strategies to support client's breastfeeding goals.</p>	<p><u>Activity 1.</u> Assess breastfeeding resources available in your community and create and/or update a resource list for clients.</p>	<ul style="list-style-type: none"> • Was an assessment done of the breastfeeding resources available in your community? • Was a community breastfeeding resource list created and/or updated? 	<ul style="list-style-type: none"> • Yes, an assessment was done of the breastfeeding resources in the community. • The breastfeeding resource list was updated with the addition of me, Karen Lyon, as a Certified Lactation Educator. The breastfeeding resource in The Dalles remains limited.
	<p><u>Activity 2.</u> The WIC agency will implement at least one new strategy to support client's breastfeeding goals.</p>	<ul style="list-style-type: none"> • Did your agency implement at least one new strategy to support client's breastfeeding goals? • How did the strategy address the identified issue? 	<ul style="list-style-type: none"> • Yes, our agency implemented one new strategy to support client's breastfeeding goal by hiring a new WIC Coordinator who has successfully completed Advanced Breastfeeding Training as a CLE. We are in the process of completing a second strategy of Wasco-Sherman County Health Department becoming certified as a Breastfeeding Mother Friendly Employer. The final policies are being drafted and the goal is to have the application send to the State for final approval by June 30th, 2007. • The strategy addressed the identified issue of needing an additional staff member in WIC who could help counsel mothers with breastfeeding questions, concerns, and make appropriate referrals when necessary. The second strategy addresses the need that as a Public Health Department, it is essential that we are the pioneers in becoming a Breastfeeding Mother Friendly Employer before we take the idea and message to other agencies.
	<p><u>Activity 3.</u> (Optional) The WIC agency will participate in World Breastfeeding Week to raise the awareness of the importance of exclusively breastfeeding for the first</p>	<ul style="list-style-type: none"> • Did your agency participate in World Breastfeeding Week? If yes, describe what you did. How did it go? 	<ul style="list-style-type: none"> • Yes, our agency participated in World Breastfeeding Week. Throughout the month of August we celebrated breastfeeding! First, we created breastfeeding friendly bulletin boards which provided

	<p>6 months of life and continue as long as the mother and baby mutually desire.</p>	<ul style="list-style-type: none"> • What advice might you give to other WIC agencies if they were to try this 	<p>pictures, information and materials to support breastfeeding moms and their families. We made “thank you for breastfeeding” gift bags to give to our breastfeeding moms which included a variety of nice goodies, all breastfeeding friendly. Staff wore breastfeeding friendly pins and we decorated the front office WIC window with things that were included in our breastfeeding kit. We also utilized our Health Departments’ monthly media time on KODL Coffee Break Talk Show to talk about World Breastfeeding Week (month), which provided education to the community about the importance of breastfeeding and how the WIC program supports moms who are breastfeeding as well as provide outreach for the WIC program. We put a lot of time and effort into this campaign and felt it was a successful.</p> <ul style="list-style-type: none"> • The only advice I have to give other agencies is that any participation in the World Breastfeeding Week is beneficial. The easy thing to do was decorate the lobby and bulletin boards. The most fun thing to do was making and giving out the gift bags; the moms were surprised and thankful to be acknowledged for their efforts to breastfeed.
--	--------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

4. Family Planning Program:

Current Condition:

Unintended Pregnancy: The state wide purpose of the Family Planning Program is to assist families in the timing and spacing of pregnancies by providing contraceptive services to women of childbearing age who are in need of services; in other words, to provide services to women and men who do not have health insurance, who may not be able to afford contraceptive services, or who experience any other barrier preventing them from obtaining contraceptive services elsewhere in the community. The Wasco Sherman Family Planning Program is doing an excellent job of meeting the contraceptive needs of the counties, as demonstrated by the State data for fiscal year 2007. See below:

- 94.5% of women in need (WIN) in Wasco Sherman Counties were served at our clinic.
- The total number of women served increased by 7.5%
- The number of teens served increased by 9.0%
- 95.2% of our clients report incomes below 150% of the Federal Poverty Level
- 25.7% of our clients are Hispanic
- 255 pregnancies were prevented; 70 of those prevented were among women under the age of 20

Laboratory Services: The Wasco Sherman Public Health Department operates a CLIA waived laboratory. On-site we are able to offer waived lab testing such as:

- Glucose monitoring
- Hemoglobin
- Urine analysis
- Pregnancy testing
- Fecal occult blood testing
- Wet mount

Additional testing for the Family Planning and the Sexually Transmitted Infections Programs is offered at one of 3 off-site laboratories. Within the past year we have negotiated with our lab providers for discounted prices, and have been very satisfied with their price reductions and quality of service. We are currently contracted with Cyto Laboratory in Texas to perform standard pap smears, liquid based pap smears, and HPV (Human Papillomavirus) testing.

We are currently contracted with Interpath Laboratory, a regional lab in Pendleton, for a variety of testing including but not limited to:

- Gonorrhea
- Chlamydia testing not covered by the Infertility Prevention Project
- urine culture and sensitivity
- Herpes culture and typing
- lipid panel

- Serum HCG (Human chorionic gonadotropin)

We utilize the Oregon State Public Health Lab for the provision of the following lab tests:

- HIV (Human Immuno Deficiency Virus)
- RPR (Syphilis)
- Chlamydia
- Hepatitis B
- Hepatitis C

Sexual Behavior: Data from the Oregon Healthy Teens Survey for the combined years 2007-2008 will be released late fall 2008. The 2005-2006 Oregon Healthy Teen Survey reported the following data for 8th and 11th grade students:

Variable measured	8 th grade response	11 th grade response
% students who have ever had sexual intercourse	19.7%	34.8%
Age at first intercourse		
• 11 or younger	2.9%	1.5%
• 12	2.9%	0.8%
• 13	8.0%	5.3%
• 14	5.6%	5.4%
• 15	0.2%	8.8%
• 16	NA	11.1%
• 17 or older	NA	1.8%

Variable measured	8 th grade response	11 th grade response
Number of lifetime sexual partners		
• 1 person	8.4%	12.2%
• 2 people	4.3%	8.7%
• 3 people	2.0%	3.8%
• 4 people	0.9%	1.4%
• 5 people	1.2%	3.9%
• 6 or more people	2.6%	4.7%
For those who have had sex, use of alcohol or drugs before most recent sexual intercourse	20.5% yes	27.5% yes
For those who have had sex, use of condom with most recent sexual intercourse	69.9% yes	63.8% yes
For those who have had sex, use of birth control method at time of most	71.4% yes	81.7% yes

recent sexual intercourse		
Forced to have sexual intercourse	5.4% yes	9.8% yes

The Wasco Sherman Health Department has recently fielded a number of calls from community partners regarding their perception of an increase in the number of teen pregnancies within the county. Please refer to the following table for data:

Year	Wasco Sherman Number of Teen Pregnancies	Wasco Sherman Teen Pregnancy Rate	State of Oregon Average Teen Pregnancy Rate
2003	13	9.4	10.5
2004	12	8.5	9.5
2005	9	6.6	9.5
2007	13	9.4	8.8

*teen pregnancy rate is a calculation of the number of teen pregnancies per 1,000 females age 10 to 17

Although the numbers of teens pregnant in any given year since 2003 has ranged from 9 to 13, we have remained below the State average rate until 2007. At this point in time it is too early to determine if the community perceptions reflect a relative stable rate over the past 4 years, or is part of a much more serious tendency of an upward swing. Part of our 3 year plan is to re-establish High School field trips to the Health Department which allows us to showcase all of our services including Family Planning and Sexually Transmitted Infection Prevention.

**FAMILY PLANNING PROGRAM THREE YEAR PLAN FOR
WASCO SHERMAN COUNTY PUBLIC HEALTH DEPARTMENT
FY'09**

July 1, 2008 to June 30, 2011

Agency: Wasco Sherman Public Health

Contact: Connie Clark NP

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
Staff changes and FPEP enrollment changes have resulted in higher cost and decreased reimbursement that threatens the sustainability of the program over time	Completely assess current financial status of the program for the 2006-2007 FY, completing the assessment by June 30 th , 2008	<ul style="list-style-type: none"> • Enter final time use data • Compare final cost analysis for level of service provided with current fees • Adjust fees to reflect cost to provide service for changes of 10% or less • For services with greater than 10% discrepancy in cost to provide versus current fee, evaluate each step in the provision of service for opportunities to reduce cost, and adjust fees to reflect a 10% adjustment • Develop long range plan for fee adjustment items with >10% discrepancy 	<ul style="list-style-type: none"> • Continue quarterly and FY end revenue reports • Continue quarterly and FY end tracking of clients served • Review results of cost analysis with Leadership Team • Track meetings with County Court

	Increase number of clients served by at least 10% by the period ending June 30 th 2008	<ul style="list-style-type: none"> • Continue with Clinic Services meetings based on COPE (client-oriented, provider-efficient services) model to evaluate client recruitment & retention • At least quarterly Clinic Services meetings • Reinstigate the High School field trips to the Health Department 	<ul style="list-style-type: none"> • Continue quarterly and FY end tracking of clients served • Track number of field trips
	Rehire a part time nursing supervisor	<ul style="list-style-type: none"> • NP will drop time to 30 hours per week • Evaluate need to increase days exams offered by June 2009 	<ul style="list-style-type: none"> • Staff feedback • Continue quarterly and FY end tracking of salary expenditures • Continue tracking number of clients served and to monitor length of wait time for exams

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
Appointments for exams are limited by having only one part-time clinician	Nursing staff will be trained to perform STD exams for male and female clients by June 30 th , 2008	<ul style="list-style-type: none"> • Add walk-in STD/repap exams to our services • Develop a policy and procedure for nurse preformed STD/repap exams 	<ul style="list-style-type: none"> • Track number of nurse performed exams • Client and staff feedback • Approval of revised policy and procedures
	Develop a system for cross coverage for nurse practitioner leave time by June 30 th , 2008	<ul style="list-style-type: none"> • Meet with community and regional partners/providers • Assess need for a coverage system • Agree on a system for coverage if needed • Implement the coverage system as needed 	<ul style="list-style-type: none"> • Track usage of coverage system • Client and staff feedback

<p>Estimated percent of sexually active teens served by clinic has decreased since 2005</p>	<p>Reestablish High School Health Class fieldtrips to the Health Department</p>	<ul style="list-style-type: none"> • Clinic RN's to arrange schedule of fieldtrips with High School staff by September 2008 • Fieldtrips to resume by October 2008 • Clinic RN's to review and possibly edit slideshow presentation by September 2008 	<ul style="list-style-type: none"> • Track number of field trips • Student and staff feedback • Track estimated percent of sexually active teens served in clinic
---------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

Goal / Objective	Progress on Activities
Completely assess current financial status of the program for the 2006-2007 FY, completing the assessment by June 30 th , 2008	The cost analysis is nearly complete. We have entered all of the data except for the second time analysis collected 12/07. New lab pricing was negotiated for pap smears decreasing our cost. We have continued with quarterly tracking of clients served, revenue generated, and program costs. Our cost for supplies is below what was projected, but salary cost more than projected.
Nursing staff will be trained to perform STD exams for male and female clients and repaps by June 30 th , 2008	Our full time nurse completed the didactic training for STD exams as well as STD training offered by region X and has her certificate. She is currently being precepted by our nurse practitioner, and will soon be able to perform exams independently. We decided to expand the role to include the performance of repaps. Our specimen collection policy and procedure has been revised to reflect her role, and the remainder of our policies and procedures are undergoing revision.
Increase number of clients served by at least 10% by the period ending June 30 th , 2008	Total clients served has increased 9.0% from FY06 to FY07 nearly meeting our goal of a 10% increase. With the dissolution of COPE (client-oriented, provider-efficient services) at the state level, we have opted to create a Clinic Services group comprised of nursing staff working in clinic and front office staff and have modeled it on the COPE system. This group has been meeting at least monthly over lunch to review policies & procedures, and client flow. Morale has increased and areas of contention decreased
Develop a system for cross coverage for nurse practitioner leave time by June 30 th , 2008	A brief discussion with the director of our neighboring county took place, and she did not view this as a need at this time. I checked with the Oregon State Board of Nursing and the Washington State Board of Nursing regarding rules governing NP's providing coverage in outside their practice state, and both organizations require licensure for each state. The only exception would be in the event of a disaster or Public Health emergency at which time the NP or nurse would be allowed temporary practice privileges. I would still like to discuss this issue with the clinicians themselves to assess if there is interest on their part.

**FAMILY PLANNING PROGRAM THREE YEAR PLAN FOR
WASCO SHERMAN COUNTY PUBLIC HEALTH DEPARTMENT
FY'09**

July 1, 2008 to June 30, 2011

Agency: Wasco Sherman Public Health

Contact: Connie Clark NP

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
Staff changes and FPEP enrollment changes have resulted in higher cost and decreased reimbursement that threatens the sustainability of the program over time	Completely assess current financial status of the program for the 2006-2007 FY, completing the assessment by June 30 th , 2008	<ul style="list-style-type: none"> • Enter final time use data • Compare final cost analysis for level of service provided with current fees • Adjust fees to reflect cost to provide service for changes of 10% or less • For services with greater than 10% discrepancy in cost to provide versus current fee, evaluate each step in the provision of service for opportunities to reduce cost, and adjust fees to reflect a 10% adjustment • Develop long range plan for fee adjustment items with >10% discrepancy 	<ul style="list-style-type: none"> • Continue quarterly and FY end revenue reports • Continue quarterly and FY end tracking of clients served • Review results of cost analysis with Leadership Team • Track meetings with County Court
	Increase number of clients served by at least 10% by the period ending June 30 th 2008	<ul style="list-style-type: none"> • Continue with Clinic Services meetings based on COPE model to evaluate client recruitment & retention • At least quarterly Clinic Services meetings • Reinstitute the High School field trips to the Health Department 	<ul style="list-style-type: none"> • Continue quarterly and FY end tracking of clients served • Track number of field trips

	Rehire a part time nursing supervisor	<ul style="list-style-type: none"> • NP will drop time to 30 hours per week • Evaluate need to increase days exams offered by June 2009 	<ul style="list-style-type: none"> • Staff feedback • Continue quarterly and FY end tracking of salary expenditures • Continue tracking number of clients served and to monitor length of wait time for exams
--	---------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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
Appointments for exams are limited by having only one part-time clinician	Nursing staff will be trained to perform STD exams for male and female clients by June 30 th , 2008	<ul style="list-style-type: none"> • Add walk-in STD/repap exams to our services • Develop a policy and procedure for nurse preformed STD/repap exams 	<ul style="list-style-type: none"> • Track number of nurse performed exams • Client and staff feedback • Approval of revised policy and procedures
	Develop a system for cross coverage for nurse practitioner leave time by June 30 th , 2008	<ul style="list-style-type: none"> • Meet with community and regional partners/providers • Assess need for a coverage system • Agree on a system for coverage if needed • Implement the coverage system as needed 	<ul style="list-style-type: none"> • Track usage of coverage system • Client and staff feedback
Estimated percent of sexually active teens served by clinic has decreased since 2005	Reestablish High School Health Class fieldtrips to the Health Department	<ul style="list-style-type: none"> • Clinic RN's to arrange schedule of fieldtrips with High School staff by September 2008 • Fieldtrips to resume by October 2008 • Clinic RN's to review and possibly edit slideshow presentation by September 2008 	<ul style="list-style-type: none"> • Track number of field trips • Student and staff feedback • Track estimated percent of sexually active teens served in clinic

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

Goal / Objective	Progress on Activities
<p>Completely assess current financial status of the program for the 2006-2007 FY, completing the assessment by June 30th, 2008</p>	<p>The cost analysis is nearly complete. We have entered all of the data except for the second time analysis collected 12/07. New lab pricing was negotiated for pap smears decreasing our cost. We have continued with quarterly tracking of clients served, revenue generated, and program costs. Our cost for supplies is below what was projected, but salary cost more than projected.</p>
<p>Nursing staff will be trained to perform STD exams for male and female clients and repaps by June 30th, 2008</p>	<p>Our full time nurse completed the didactic training for STD exams as well as STD training offered by region X and has her certificate. She is currently being precepted by our nurse practitioner, and will soon be able to perform exams independently. We decided to expand the role to include the performance of repaps. Our specimen collection policy and procedure has been revised to reflect her role, and the remainder of our policies and procedures are undergoing revision.</p>
<p>Increase number of clients served by at least 10% by the period ending June 30th 2008</p>	<p>Total clients served has increased 9.0% from FY06 to FY07 nearly meeting our goal of a 10% increase. With the dissolution of COPE at the state level, we have opted to create a Clinic Services group comprised of nursing staff working in clinic and front office staff and have modeled it on the COPE system. This group has been meeting at least monthly over lunch to review policies & procedures, and client flow. Morale has increased and areas of contention decreased</p>
<p>Develop a system for cross coverage for nurse practitioner leave time by June 30th, 2008</p>	<p>A brief discussion with the director of our neighboring county took place, and she did not view this as a need at this time. I checked with the Oregon State Board of Nursing and the Washington State Board of Nursing regarding rules governing NP's providing coverage in outside their practice state, and both organizations require licensure for each state. The only exception would be in the event of a disaster or Public Health emergency at which time the NP or nurse would be allowed temporary practice privileges. I would still like to discuss this issue with the clinicians themselves to assess if there is interest on their part.</p>

Within the past year and a half, the Wasco Sherman Public Health Department Family Planning Program has experienced multiple internal and external forces that have negatively impacted the sustainability of the program. With the changes imposed by the Deficit Reduction Act, less of our clients qualify for reimbursement through the Family Planning Expansion Project (FPEP), thereby reducing the amount of revenue generated by the program. The cost of birth control methods increased substantially in the fall of 2005 (some methods more than doubling in price), resulting in higher supply costs for the program. The decrease in revenue from the Family Planning Program, in conjunction with decreased revenue for almost all health department programs, resulted in the layoff of 6.1 FTE's or the equivalent of 20% of the health department workforce. This lay off has increased staff work load to the point that continued provision of basic services is threatened and expansion of services is out of the question. Given the facts that: 1) the Family Planning Program is federally mandated to serve all clients seeking services, 2) it is more difficult for clients to qualify for reimbursement, 3) clients who do not qualify for reimbursement are assessed at a fee scale that extends to zero, long term sustainability of the program is threatened.

5. Tobacco Prevention and Education Program (TPEP):

Tobacco use is the single most preventable cause of death and disease in Oregon and Wasco County. Nearly 70% of smokers want to quit smoking, but only 2.5% are able to quit permanently each year.

It is not active tobacco use alone that causes morbidity and mortality in Oregon. Secondhand smoke has been causally linked to lung cancer, childhood asthma, sudden infant death syndrome, lower-respiratory tract infections, and contributes significantly to heart disease, the nation's leading cause of death.

The objective of the Oregon Tobacco Prevention and Education Program is to make **sustainable environmental change**. We do that by working to create policies that protect people from the hazards of tobacco use, which effectively will “reframe” the social norm. The Wasco Sherman Health Department has a tobacco program plan that addresses the following six goal areas:

- *Eliminating or reducing exposure to secondhand smoke
- *Countering pro-tobacco influences
- *Reducing youth access to tobacco
- *Promoting quitting among adults and youth
- *Enforcement tobacco-related local and state laws
- *Reducing the burden of tobacco-related chronic disease

<p>Objective #1: By June 30, 2009, four of the six school districts in Wasco, Sherman and Gilliam Counties will have a Gold Standard Tobacco Policy. Presently, two of the six of the districts have a Gold Standard Policy.</p>				
<p>Primary Objective: Reduce Exposure to Secondhand Smoke</p>				
<p>Secondary Objective: Promote Quitting</p>				
<p>Coordination/ Collaboration</p>	<p>Assessment/ Research</p>	<p>Community Education and Media</p>	<p>Policy Development and Implementation</p>	<p>Notes</p>
<p>1/1/08-6/30/09 Engage students, parents, Site Council /PTA/PTO/Wellness Committee members, athletes, educators, administrators, support staff, and superintendents to assist in promoting a strong and well-enforced policy.</p>	<p>1/1/08-12/31/08 Use the Oregon Healthy Teen Data as support for the need for a good school policy.</p>	<p>4/1/08-6/30/09 Assist Coalition Members with a presentation to each School Board on the benefits of a strong and well-enforced tobacco policy. This may result in Earned Media.</p>	<p>9/1/08-6/30/09 We will promote the ease of using the Gold Standard Policy as presented, and assist schools who want to customize the language by interfacing with the expertise of American Lung Association of Oregon (ALAO)staff.</p>	
<p>1/1/08-6/30/09 Partner with Commission offices in all three counties to share resources and optimize efforts</p>		<p>2/1/08-2/28/08 Obtain Tobacco World curriculum for middle schools to use.</p>	<p>1/1/08-6/30/09 The implementation plan will include well-placed signage to promote the policy and continual coalition support for regular announcement of the policy at school events and in the student handbook.</p>	
<p>1/1/08-6/30/09 Work with the ALAO to insure submitted policies meet State requirements and to obtain signage for school properties.</p>				

<p>1/1/08-6/30/09 Work with the Healthy Kids Learn Better Committee in School District #21 to maximize efforts to enforce a strong tobacco policy.</p>				
<p>2/1/08-3/31/08 Coordinate with District #21 Superintendent Candy Armstrong to identify ways to communicate with neighboring superintendents.</p>				
Critical Questions:				
<p>What sectors of the community will this objective reach? Students, Parents, Employees, Educators, Support Staff, Administration, Grandparents, Athletic Supporters, and other Visitors. Private school students and families who do not have a school age member or friend will not be reached.</p>				
<p>What types of technical and /or data assistance do we anticipate needing from TPEP? We would like to know whether data shows a strong tobacco policy leads to a higher graduation rate. We believe this information would help gain support from school officials and parents, and could lead to better enforcement of school policy.</p>				
<p>What types of technical and/or data assistance will we need from Statewide capacity building programs for eliminating disparities? We have a large Latino population, so it is imperative we provide signage and literature in both English and Spanish.</p>				

Objective #2: By January 1, 2009, Mid-Columbia Medical Center (Wasco County) will have a tobacco free policy covering all corporate properties.

Primary Objective: Reduce Exposure to Secondhand Smoke

Secondary Objective: Promote Quitting

Coordination/ Collaboration	Assessment/ Research	Community Education and Media	Policy Development and Implementation	Notes
<p>1/1/08-6/30/09 A committee of medical staff and physicians (and Wasco Sherman Health Dept. Prevention Coordinator) have been meeting since 11/07. The committee is chaired by a Medical Librarian and has representation from Nursing, Human Resources, Facilities Management, and Medical Staff.</p>	<p>1/1/08 to 3/31/08 Review survey results from Employee Survey. Survey was given to 750 employees to obtain input on whether smokers/chewers were interested in quitting, whether additional medical benefits are needed to quit, the level of exposure to secondhand smoke in the home; whether they are comfortable w/ an enforcement role, and whether training would help.</p>	<p>6/1/08-6/30/09 Prepare the community at large of upcoming policy change with MCMC newsletter and other media, notify patients upon admission and scheduling of procedures.</p>	<p>3/1/08-12/31/08 Committee will develop the policy timeline based on findings in assessment and research. We want to be mindful of employee ownership of the change and provide the community resources and information prior to the aggressive new policy. Implementation details to be determined.</p>	<p>FYI Presently the hospital has a tobacco free policy that is not well-enforced. The MCMC Tobacco Free Committee is working toward a comprehensive tobacco policy prior to working toward strengthened enforcement.</p>
	<p>1/1/08-4/28/08 Review Tobacco Policies for OHSU and Asante Health System. Chairperson and TPEP Coordinator will research effectiveness by contacting staff at each facility.</p>			<p>FYI TPEP staff coordinated a conference call with MCMC tobacco committee chairperson and MCMC marketing department employee to discuss marketing strategies with Metro One.</p>

	<p>1/1/08-5/28/08 Evaluate cost savings to institution by funding cessation services for employees and families. TPEP staff will work w/ the committee to research information.</p>			<p>Summer '07 Committee member Keith Stelzer, M.D., who oversees the Celilo Cancer treatment center, made a presentation to the Medical Staff and obtained support to eliminate practice of allowing patients to smoke outside of the hospital.</p>
	<p>1/1/08-6/30/08 Review the Step-Up Campaign and determine whether information may be integrated in the MCMC process of policy development.</p>			<p>December '07 The committee made a presentation to the Management Team and has received an endorsement to forward the proposal to the Hospital Board.</p>
<p>What Sectors of the Community will this Objective Reach? In addition to being the major employer in the region with many corporations including physician practices, Mid-Columbia Medical Center is also the only hospital in the tri-county area. The impact of a strong tobacco policy will be significant in the community at large.</p>				
<p>What types of technical and/or data assistance do we anticipate needing from TPEP staff? Unknown at this time.</p>				
<p>What types of technical and/or data assistance do we anticipate needing from the Statewide Capacity Building Programs for Eliminating Disparities? We have a large Latino population, so we may need assistance to communicate with non-English speaking persons.</p>				

Objective #3: By January 1, 2009, Columbia Gorge Community College will review the present tobacco policy and determine whether a stronger policy is necessary.

Primary Objective: Reduce Exposure to Secondhand Smoke

Secondary Objective: Promote Quitting

Coordination/ Collaboration	Assessment/ Research	Community Education and Media	Policy Development and Implementation	Notes
9/1/08-12/31/08 Schedule a meeting with CGCC President Dr. Frank Toda, CGCC Facilities Manager Robb Van Cleave, and the Student Body President to propose an upgraded tobacco policy discussion.	6/1/08-9/30/08 Review Tobacco Policies at community colleges throughout Oregon to prepare for initial meeting w/ Dr. Toda, Van Cleave, and ASB President.	4/1/09-6/30/09 The primary audience will be staff, students, and administration. We will communicate internally with this audience based on assessment of communication channels.	4/1/09-6/30/09 Host a forum with students, staff, administration, board members and community members to discuss whether the existing policy is sufficient or if there is support for a stronger policy.	FYI Presently, CGCC has a tobacco free campus policy that excludes the parking lot and personal vehicles.
12/1/08-3/31/09 Enlist board support by meeting individually with three or more board members to obtain their input and ownership in a stronger policy.	12/1/08-3/31/09 Determine what avenues are available to communicate with staff and students, be it newsletter, school newspaper, list serve, staff meetings, etc.		4/1/09-6/30/09 Help facilitate a decision by stakeholders on how to better enforce the policy, whether it is the existing one or an upgraded policy.	
9/1/08-6/30/09 Work in partnership with the TPEP staff person at Hood River County as CGCC serves Hood River County and has facilities in both counties.	9/1/08-12/31/09 Meet with CGCC Human Resource Manager to determine what cessation benefits are available for employees.			
	9/1/08-12/31/08 Determine the trouble-spots on campus where smoking occurs by visiting campus on four occasions and tracking results.			

<p>What sectors of the community will this objective reach? The average CGCC student is 36 years old, and many high school students take advanced placement classes. Many of the students are parents (either single or married) and many are working and taking classes. Some are dislocated employees. The influence of a strict tobacco policy at CGCC would extend to a wide variety of people. CGCC has facilities in both Wasco and Hood River Counties.</p>
<p>What types of technical and/or data assistance do we anticipate needing from TPEP staff? A universal no tobacco logo would be particularly helpful on a community college campus.</p>
<p>What types of technical and/or data assistance do we anticipate needing from the Statewide Capacity Building Programs for Eliminating Disparities? We have a large Latino population. If there were additional funds to pay for signs specific to the Spanish speaking population that would be a big help toward eliminating disparities.</p>

<p align="center">Objective #4: By January 1, 2009, we will distribute at least 30 "Property Managers Guide to Smokefree Housing" to stakeholders in Wasco, Sherman and Gilliam Counties.</p>				
<p align="center">Primary Objective: Reduce Exposure to Secondhand Smoke</p>				
<p align="center">Secondary Objective: Promote Quitting</p>				
<p align="center">Coordination/ Collaboration</p>	<p align="center">Assessment/ Research</p>	<p align="center">Community Education and Media</p>	<p align="center">Policy Development and Implementation</p>	<p align="center">Notes</p>
<p>6/1/08-6/30/09 Compile a list of landlords by contacting realtors and property managers in the tri-county region.</p>	<p>6/1/08-6/30/09 Track information on the landlord list of who is presently smokefree, who is willing to go smokefree, and who is resistant to a smokefree policy.</p>	<p>6/1/08-6/30/09 Speak at the Renter's Association Meeting in The Dalles on the benefits of Smokefree Multi-Unit Housing. Distribute Guides to Smokefree Housing at forum.</p>	<p>6/1/08-6/30/09 Determine whether there are landlords in the Tri-County Region who may be willing to spearhead a Smokefree Housing Campaign.</p>	
<p>6/1/08-9/30/09 Meet with Ruby Mason, Executive Director of Mid-Columbia Housing to build a relationship of mutual support for smokefree housing, obtain landlord information, and ideas on how to interface with Columbia Cascade Housing Corporation and Umatilla Housing Authority.</p>	<p>6/1/08-6/30/09 Determine who are the key (influential) landlords in the tri-county region by interviewing realtors Jim Wilcox, Mike Woodside, and Vicky Ellett. Distribute Guides to Smokefree Housing to each realtor.</p>			

	6/1/08-6/30/08 Review resources from: smokefreehousingNW.com			
	6/1/08-6/30/09 Determine the most effective methods to communicate with landlords by asking them personally.			
What sectors of the community will this objective reach? Property Owners and Managers. We will not reach people who do not rent or are landlords.				
What types of technical and/or data assistance do we anticipate needing from TPEP staff? On-going support.				
What types of technical and/or data assistance do we anticipate needing from the Statewide Capacity Building Programs for Eliminating Disparities? Unknown at this time.				

Objective #5: Local Agreement for Enforcement of the Smokefree Workplace Law
Wasco County has an Intergovernmental Agreement for enforcement of the Indoor Clean Air Act in both Wasco and Sherman Counties.
Wasco County will be responsible to enforce the Indoor Clean Air Act in Gilliam County. Gilliam County Judge Pat Shaw is in support of the Gilliam County Tobacco Control Program being in partnership with Wasco Sherman Health Department. We will provide Judge Shaw with a copy of the submitted application. Judge Shaw plans to send a letter of acknowledgement to the State.

Objective #6: By 4/1/08, Wasco Sherman Health Department will develop a written protocol on how to respond to Smokefree Workplace Violations and complaints.

Primary Objective: Reduce Exposure to Secondhand Smoke

Secondary Objective: Promote Quitting

Coordination/ Collaboration	Assessment/ Research	Community Education and Media	Policy Development and Implementation	Notes
<p>1/1/08-3/31/08 Meet with Environmental Health Inspectors at Wasco Sherman Health Department, who do sanitation inspections for restaurants, bars, childcare centers, and other kitchens in Wasco, Sherman and Gilliam Counties, to brainstorm necessary procedures.</p>	<p>1/1/08-3/31/08 Call Janet Jones at Umatilla County and Jane Stevenson in Jackson County to ask what procedures they employ for complaints and violations.</p>	<p>4/1/08-4/30/08 Submit a press release to media throughout the tri-county region to educate the public about the smokefree workplace law and to provide contact information for complaints.</p>	<p>3/1/08-3/31/08 Submit a recommended policy to WSHD Executive Director Lynnette Benjamin for review and approval prior to sending to the State.</p>	
<p>1/1/08-3/31/08 Meet with tobacco prevention partners in all three counties (Debby Jones in Wasco, Theresa Mobley in Sherman, and Michelle Geer in Gilliam) to request their ideas in creating a protocol.</p>		<p>9/1/08-12/31/08 Send educational materials to all Chamber of Commerce's throughout the tri-county region to educate business owners on the smokefree workplace law and to provide contact information for complaints.</p>		

Objective #7: by 6/30/09, Wasco Sherman Health Department will Compile a profile of the prevalence of all tobacco-related chronic diseases in Wasco, Sherman, and Gilliam Counties.

Primary Objective: Countering Exposure to Secondhand Smoke

Secondary Objective: Promote Quitting

Coordination/ Collaboration	Assessment/ Research	Community Education and Media	Policy Development and Implementation	Notes
<p>9/1/08-6/30/09 Coordinate with Mid-Columbia Medical Center, physician offices, and clinics throughout the Wasco, Sherman and Gilliam Counties to gather data about tobacco-related diseases.</p>	<p>9/1/08-6/30/09 Determine what information Oregon Public Health Division may be able to provide about tobacco-related diseases in Wasco, Sherman, and Gilliam Counties.</p>			
<p>9/1/08-6/30/09 Contact staff at TPEP (Diana) to obtain information specific to the Latino population.</p>	<p>9/1/08-6/30/09 Compile data into a profile of tobacco-related chronic disease.</p>			

Objective #8: By 12/31/08, Wasco Sherman Public Health Department will send literature out to Bar and Bar/Restaurant owners in Wasco, Sherman, and Gilliam Counties to provide support for the policy change, offer to meet and be a resource, and to encourage them to adopt a smokefree policy prior to 1/1/09.

Primary Objective: Countering Pro-Tobacco Influences

Secondary Objective: Promote Quitting

Coordination/ Collaboration	Assessment/ Research	Community Education and Media	Policy Development and Implementation	Notes
<p>1/1/08-8/31/08 Meet with Environmental Health Inspectors at Wasco Sherman Health Department, who do sanitation inspections for restaurants and bars in Wasco, Sherman and Gilliam Counties, to brainstorm the best way to approach business owners. The inspectors have a relationship with most owners and/or managers presently.</p>	<p>1/1/08-8/31/08 Compile a list of bars and restaurant/bar combinations located in Wasco, Sherman, and Gilliam Counties.</p>	<p>7/1/08-11/30/08 Provide the Why Wait campaign educational materials for restaurant and bar owners, including information about fines for violations, in a mass mailing. Offer to meet personally with each business owner/manager at their convenience.</p>	<p>1/1/08-12/31/08 Assist managers and owners who want to develop a written policy by customizing a policy for their purpose. Assist with communication to employees and the general public.</p>	<p>FYI Jorge Barragon joined our editorial board visit w/ The Dalles Chronicle on 1/9/08. He is a member of the Mid-Columbia Medical Center Board of Directors.</p>
	<p>1/1/08-12/31/08 Promote the Oregon Quitline as a valuable service for employees who work in bars and restaurants affected by the new law by providing posters, brochures, and contact information at each facility.</p>	<p>1/1/08-12/31/08 Utilize the Why Wait Materials for both internal and external communication.</p>		

Objective #24: By June 30, 2009, 50% of the Head Start/Early Intervention programs in Wasco, Sherman, and Gilliam Counties will have a tobacco policy to protect students from exposure to second hand smoke.

Primary Objective: Reduce Exposure to Secondhand Smoke

Secondary Objective: Promote Quitting

Coordination/ Collaboration	Assessment/ Research	Community Education and Media	Policy Development and Implementation	Notes
1/1/08-6/30/08 Meet with Head Start Director Janelle Wyatt in The Dalles to build repore and find out who the Directors are in the other Head Start Programs in Wasco, Sherman, and Gilliam Counties.	1/1/08-6/30/08 Determine what is the most effective way to communicate with and influence Head Start Directors by asking Janelle Wyatt.	1/1/09-6/30/09 Promote specific cessation programs available to employees at each Head Start Program by providing information at staff meetings.	9/1/08-6/30/09 Assist Head Start Directors in writing a tobacco policy for their facility in conjunction with the ALAO.	
1/1/08-6/30/08 Contact the regional Head Start office to determine whether they are able to support the promotion of a smokefree policy at individual programs.	6/1/08-12/31/08 Determine what cessation benefits employees at each Head Start Program have as a benefit to employment.			
2/1/08-6/30/09 Collaborate with ALAO to review any current policies to identify elements that may be missing.	1/1/08-9/30/08 Review the "Fresh Air for Little Noses" program thru the American Lung Association in order to communicate the effects of secondhand smoke on readiness to learn.			

What sectors of the community will this objective reach? This work will reach staff and administrators at Head Start Programs, students, and parents. It will not reach people who do not utilize the Head Start or Early Intervention Program Services.

What types of technical and/or data assistance do we anticipate needing from TPEP staff? It would be helpful to obtain further information about the influence of secondhand smoke on readiness to learn.

What types of technical and/or data assistance do we anticipate needing from the Statewide Capacity Building Programs for Eliminating Disparities? We have a large Latino population. If there were additional funds to pay for signs specific to the Spanish speaking population that would be a big help toward eliminating disparities.

6. Epidemiology and Control of Communicable Diseases

We meet minimum standards for Communicable Disease Control and provide 24/7 response to emergent CD calls via pager. The pager used to be carried by RN's on a rotating basis, but due to budget constraints, the burden of the CD pager has fallen to the director. We promptly investigate outbreaks of illness in our county with CD nurse, and as needed, Environmental Health as well. In urgent communicable disease events, we stop most other programs and go into Incident Command mode, where half or more of the staff may gather to respond to the event at hand. The person responsible for overseeing the control of communicable disease is Allyson Smith, Public Health Nurse and author of the action plan provided. The following is a snapshot of the current communicable disease program:

- Has a communicable disease nurse who traditionally covered communicable disease control and STD investigation, but now also covers the Tuberculosis program and HIV Ryan White Case Management and HIV/AIDS Prevention Programs as well.
- Public health emergencies can be responded to promptly via 24/7 pager coverage.
- Environmental Health works collaboratively with CD nurse in outbreak settings to evaluate the need for more stringent environmental controls to stop the spread of disease.
- Outbreak reports are responded to promptly and appropriately and involve the state Epi staff; reports are completed in a timely manner as much as time permits. This has become more challenging as nursing hours have been cut in our health department.
- Communicable Disease Trends are followed and periodically analyzed to detect potential links between various cases. Education activities are aimed at reducing trends.
- Follow up on animal bite complaints by Environmental Health staff. Rabies testing is done as needed.
- Communicable disease outreach includes several facets: frequent faxes of information to area providers in three counties, and often to neighboring counties as well; promoting complimentary twin rix (Hepatitis A&B immunization) for high risk county residents (i.e. those diagnosed with Hep C or HIV infection); STD prevention counseling to at risk populations in classroom settings.
- West Nile Virus dead bird surveillance and West Nile Plan.

- We are currently working towards generic press releases and fact sheets for outbreak response. We have only begun this process and hope to generate more press releases and fact sheets on additional diseases as time permits.

Communicable Disease Current Conditions:

In Wasco and Sherman Counties, Chronic Hepatitis C cases outnumber all other reportable communicable diseases. Chronic Hepatitis C reporting has more than doubled the reporting burden in the communicable disease program since it became reportable in 2005. This reporting requirement has not been accompanied by any increase in funding; to the contrary, CD and PHEP funding has sustained a significant cut in recent months. We have had 68 cases of Chronic Hepatitis C reported to us for Wasco, Sherman & Gilliam Counties (64 for Wasco, 2 ea. For Sherman and Gilliam Co.'s) and this year we had two cases of Acute Hepatitis C reported, which is a vivid reminder that transmission is still occurring via needle sharing and other risky behaviors.

We have identified a need to do more follow up on Hepatitis C infections, including immunization against vaccine preventable illness, and chronic disease management training. Because of recent budgetary constraints, we have not yet been able to begin this process in earnest. We feel that self management skills are essential to individuals living with this disease, especially since the majority of affected individuals lack health insurance or other financial resources. We offer Hepatitis C screening in our family planning and walk in clinic, but unfortunately do not do as much screening as we would like due to the costs of screening. As time allows we counsel individuals how to make liver-healthy lifestyle choices.

We've had a number of outbreaks in our community over the past year, including Norovirus in various settings: (organizational camps, nursing homes & schools), and Shigellosis in individuals, primarily linked to school children and their contacts. Most of our outbreaks of illness are not due to contaminated food or water, but are spread person to person by poor hygiene and inadequate disinfection. We've done a fair amount of education to administrators of the various organizations as well as to individuals involved in these settings to promote good hygiene and empower people to stop the spread of disease. There is still much to be done in this arena. The challenge is in raising awareness and in forming new habits. Methicillin Resistant Staphylococcus Aureus, more commonly referred to as MRSA, though not a reportable infection, has raised concern in school settings particularly, and the health department has responded to this concern, offering information and educational tools.

We have responded to prevent outbreaks of Meningitis and Mumps in the past couple years as well: meningitis due to a death in a Klickitat County Washington child with contacts in our county, and Mumps due to a case identified in a local health care worker. (Mumps has also only become reportable to public health just recently, and presents some unique challenges, as recent cases in Oregon have been diagnosed with great difficulty, and required involvement from the CDC in cooperation with Oregon DHS.)

Sexually Transmitted Disease (STD):

Chlamydia is a close second communicable disease in terms of numbers affected in our counties, and we do an excellent job of confidential partner identification and referral or treatment, (Contingent upon cooperation from those who are infected, of course.) We encourage community partners to screen sexually active women under the age of 25, but have found that some do not do so. This may be one area where we could make some progress, since so many people who have sexually transmitted infections do not have symptoms. It becomes very important to screen sexually active young women when they present for routine gynecological care, as that is how many of these silent infections are discovered. Since we know that STD's are the most common cause of infertility, we need to follow the standard of care by routinely screening. Our nurse practitioner routinely screens all sexually active women according to State of Oregon Region X guidelines: all women less than 25 years of age, as well as women over that age with other indicators (i.e. exposure to STD, pregnant, IUD insertion, etc.). In spite of the work we do in this area, the incidence rate of Chlamydia infection is rising every year, as it is in the rest of the state, and we have traditionally been below the state average, but in that regard, the gap is closing.

This past year we had a small outbreak of Gonorrhea early in the year, and were able to identify a large number of contacts and get all of them in for testing and treatment. Success is measured by the relative absence of ongoing cases. In 2007, we identified only one case in the 7 months following the outbreak, but it was geographically and temporally isolated from the original outbreak. Our Gonorrhea outbreak catapulted our incidence just above that of the State of Oregon in cases per 100,000 population, which was notable since usually our incidence is half or less than that of the rest of the state. We are managing to bring over 75% of STD partners in for testing and treatment, but increasing rates of infection point to the need for more intervention. While this percentage seems low, it is difficult to improve upon it, as success hinges on cases being able and willing to give information sufficient for follow up, and on contacts being willing to accept the testing and treatment that is offered.

Ongoing STD incidence is naturally affected by drug use, especially Methamphetamines, and it is doubtful that rates will drop dramatically until or unless the rates of drug use go down. A community wide effort to combat drug use and risk behaviors will likely be needed to change the trends.

HIV/AIDS:

HIV/AIDS have entered the arena of chronic disease, now that medications are capable keeping the HIV virus at bay. With our Ryan White program, the health department offers confidential medical case management to individuals who qualify. Case management assists individuals in obtaining services, insurance, medical referrals, coordination between various health care entities, and assistance with housing and medication access and adherence. Case management strives to assist HIV or AIDs infected individuals in maintaining independence and optimal health as long as possible. Our health department is continuing to offer this program, in spite of having taken a large cut in nursing hours in the department. We feel this program is important, as rural

counties lack many of the supportive services that the larger counties offer, and maintaining optimal care for these clients is very challenging in rural Oregon. Prevention is always the best for clients as well as the community and is also less costly than acute care, hence promoting self management is of utmost importance.

HIV/AIDS incidence is up in 2007, with the yearend total being 4, and the previous 8 years have averaged 1.4 cases annually. This emphasizes the importance of prevention activities, which is the other HIV program our health department is involved in. Prevention can be accomplished in many ways, including education, one on one risk reduction counseling, confidential screening and counseling. Outreach activities, including confidential IV needle exchange and outreach to high risk populations, have been useful in many larger communities, but is more difficult to institute by smaller rural health departments such as ours. Wasco Sherman Health Department has gone to the NORCOR correctional facility in the past to do periodic screening there, but with the drastic cut in nursing staff, this has not been possible in recent months.

It is very important to promote screening, especially amongst those at greatest risk of contracting HIV, in order that the infected person can obtain medical help, and also in order for the individual to take additional precautions not to spread the illness to others. Our health department offers confidential HIV screening on a walk in basis, and we offer this service regardless of ability to pay. We are hoping to add rapid screening to the services we offer, so that results can be given the same day the testing is done. With our increased state award for HIV prevention, we feel rapid testing may appeal to some people who felt uncomfortable waiting for results, as well as those who for one reason or another are unlikely to return for conventional screening results. Looking back to recent months screening efforts, 1/3 or more of those screened fail to return for their results; this reveals an unfortunate waste of effort, and is something that would be easily remedied by HIV rapid testing. In high risk individuals being evaluated for possible Tuberculosis infection, knowing the HIV status with rapid testing will allow us to better evaluate and treat someone who may be dually infected with TB and HIV.

Success in HIV prevention would be manifested by the numbers of individuals who are tested and given results and by ensuring that the high risk population is adequately tested. Success might also be evidenced by a flat growth in numbers of new cases, but of course, the more you test, the more cases you are likely to uncover, so this can be interpreted in various ways.

Tuberculosis:

Tuberculosis has been one of the most poorly funded communicable disease programs for several decades. This potentially deadly disease has received media attention this past year, and funding priorities may change because of that.

In Wasco, Sherman, and Gilliam counties, incidence of the contagious, “active,” form of TB known as “Tuberculosis Disease” has fortunately remained quite low. It is typical for us to have a few false alarms (Suspect Cases) each year, with people who at first appear to have active tuberculosis, and in those cases, we rally to evaluate the patient and to

protect the public until evaluation determines the public is not at risk. In the end, we usually have zero cases per year and only occasionally have one or two active cases. What we usually see on an ongoing basis are people who have been exposed in TB endemic areas like Mexico, and commonly will present with the **non**-contagious “dormant” form of the disease known as “Latent TB”, or “TB infection”. Our health department efforts are generally to evaluate these individuals medically and treat them with 6-9 months of medication to prevent active cases of TB Disease. We have in years past had only a handful of clients taking this medication at any given time, but with our new health officer and a change in protocols, we have been increasing the number of clients being treated. It is too early to say how great the burden of Latent TB treatment will become, but with an expanding immigrant population, this trend towards an increasing case load is likely to rise significantly. It should be noted, the state provides medication to treat Latent TB (or active TB) and also Chest X-rays for those who qualify, but it does not provide the health department substantial revenues to cover nursing hours.

The greatest challenges in Tuberculosis will no doubt arise when and if we have an active case in our county, as evaluating and treating the people with significant exposure has been a tremendous task for health departments statewide. Active cases also require “Directly Observed Therapy”: the person with active disease must take their doses of medication witnessed by a health department employee, usually an RN. This is standard of care for active tuberculosis. Needless to say, this is very labor intense for any health department.

To summarize our tuberculosis program, we screen people who are likely to have been exposed to Tuberculosis, occasionally for immigration purposes, more often for school attendance, work attendance, pregnancy, and sometimes because it is part of a medical evaluation of an individual. We treat latent cases if medically indicated, with 6-9 months of medication, and in the rare case of active TB, we investigate to identify and protect those who were exposed to TB and we treat the active cases with Directly Observed Therapy. Success in TB is measured by the percentage of those being treated for Latent TB Infection who complete their regimen of medication, and by successful investigation and treatment of active cases as they arise. The following table reflects measures to improve the overall communicable disease monitoring and surveillance for the health district.

Condition	Goals	Objectives	Outcome Measures
Communicable Disease: 1. Reporting: The numbers of communicable diseases, including STD’s have more than tripled since the year 2000. In the five years prior to	Communicable Disease 1. Reporting: Respond to disease reports with timely investigations and timely reports to state 95 % of the time. WSHD will begin to use the	Communicable Disease 1. Reporting: Accurate data will be available re. the extent of the disease burden for our region and transmission of disease will be limited. Individuals with reportable diseases will	Communicable disease 1. Reporting: 95 % or greater investigation and reporting rates maintained. Absence of ongoing transmission evidenced by

<p>Hepatitis C becoming reportable, our county averaged just over fifty reports per year. We have now had two full years of Chronic Hepatitis C reporting, and in 2007, Hepatitis C accounted for sixty percent of the increase in reportable diseases.</p> <p>2. <u>Outreach to Providers:</u> Providers seldom report diseases to public health, and seem unaware of their responsibility to report prior to lab confirmation of certain illnesses.</p> <p>3. <u>Hepatitis C</u> Hepatitis C is our most frequently reported communicable disease. 65 Cases were reported for Wasco County in 2007. Many of the population affected by this disease are uninsured. This disease ranges from asymptomatic to disabling.</p>	<p>Multnomah County CD Data base by spring of 2007.</p> <p>2. <u>Outreach to Providers:</u> Educate and encourage providers to report diseases appropriately.</p> <p>3. <u>Hepatitis C</u> a. Ongoing goal: determine the extent of the problem. b. Empower our population with information to increase awareness of how this disease is spread.</p>	<p>receive counseling to decrease transmission. Outbreaks will be minimized or averted. Use of the electronic CD database will streamline the reporting of diseases and the accessibility of statistics for our county.</p> <p>2. <u>Outreach to Providers:</u> Providers will be contacted about disease reporting at least twice annually via outreach to all providers; and prn as need arises to individual providers or all providers.</p> <p>3. <u>Hepatitis C</u> a. CD nurse will keep up with reporting requirements. b. Public will be offered brochures and education about the disease in our health department and in the places that public health interfaces with the public, like Cherry Festival. This disease can be discussed in our</p>	<p>dropoff in new cases of illness. CD RN and her back up will be trained to use the CD database. The excel spreadsheets will no longer be needed, saving valuable time.</p> <p>2. <u>Outreach to Providers:</u> There will be documentation of outreach to providers reaching or exceeding minimum of twice yearly.</p> <p>3. <u>Hepatitis C</u> a. Cases will be reported to the state in a timely manner. b. Education efforts will be documented.</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

	<p>c. Promote risk reduction.</p> <p>d. Promote increased screening for Hep C in the clients we serve.</p> <p>e. Provide education re. self management options to those affected.</p> <p>f. Optimize health of those affected.</p>	<p>radio programming.</p> <p>c. Clinic nurses will educate about Hep C during other risk reduction counseling sessions.</p> <p>d. Screening is offered by WSHD, and if possible, will be made available regardless of ability to pay.</p> <p>e. When interviewing Hep C positive individuals, the CD nurse will counsel about liver-healthy life choices. This will be done to the extent that time allows.</p> <p>f. Immunizations will be offered to Hep C positive individuals when interviewed by CD nurse or by their PCP's at office visits.</p>	<p>c. Risk Reduction Counselling will be given in our clinic to high risk individuals, when they present for family planning or STD visits. Brochures will be provided in public areas of health department.</p> <p>d. CD nurse will look into availability of free screening through Oregon DHS by Spring of 2009.</p> <p>e. Information on disease management will be given on an individual basis, and optimally, a support group may be started in our community. This is long term and contingent upon adequate nursing staffing.</p> <p>f. Providers in our region will be made aware of free vaccines</p>
--	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

			available to these clients via outreach by the CD nurse and/or immunization coordinator.
<p>STD</p> <p>1. <u>Reporting:</u> Rates of STD's have continued to rise steadily for the past several years, and are now over double the rates seen in the years 2000 and 2001.</p> <p>2. <u>Chlamydia:</u> This year, Wasco County had 60 cases of Chlamydia reported (and 8 cases of Gonorrhea.) This represented a large burden to follow up with partner testing and treatment.</p>	<p>STD</p> <p>1. <u>Reporting:</u></p> <p>a. Reports will be sent in to the State of Oregon in a timely manner.</p> <p>b. Efforts will be made to phone or reach 95% or greater of contacts if sufficient information is provided to call them, and recommend testing and treatment.</p> <p>2. <u>Chlamydia:</u></p> <p>a. Prevention: promotion of safe sex practices: abstinence, mutual monogamy, condom use during our clinic visits.</p> <p>b. Detection and treatment of</p>	<p>STD</p> <p>1. <u>Reporting:</u></p> <p>a. Accurate data will be available re. the extent of the disease burden for our region CD/STD nurse will look into availability of STD data base from Multnomah County.</p> <p>b. Others infected will be treated, original cases will not be reinfected, & transmission of disease will be limited.</p> <p>2. <u>Chlamydia:</u></p> <p>a. Clients in our clinic will receive prevention messages and be offered condoms during office visits. (Free condoms will also be readily available without office visit.)</p> <p>b. Following Title X</p>	<p>STD</p> <p>1. <u>Reporting:</u></p> <p>a. Optimal reporting rates of 95% or better will be maintained. If STD data base is available via Multnomah County, WSHD will obtain contract and training by spring of 2009.</p> <p>b. The state guideline of 75% of contacts receiving testing and treatment will be maintained or exceeded, evidenced in field reports.</p> <p>2. <u>Chlamydia:</u></p> <p>a. Client counseling to prevent STD transmission as evidenced by policy and</p>

	<p>cases & contacts (see above). Since this infection is often asymptomatic, case finding will be done by screening those at risk.</p> <p>c. Promote best practices to private providers.</p>	<p>guidelines by screening all sexually active women less than 25 years of age for Chlamydia during all pelvic exams and as otherwise indicated by Title X guidelines. Rigorous follow up of contacts to cases as well: see #1. above.</p> <p>c. Encouraging area providers to follow best practices in comprehensive screening for sexually active women under 25 years of age.</p>	<p>procedure, verifiable by chart review. Condoms offered at visits and available in restrooms.</p> <p>b. WSHD clients will continue to receive appropriate screening (verifiable by chart review.) 75% or greater contacts will be tested and treated as evidenced by review of reports to DHS.</p> <p>c. Area providers will be informed of best practices by providing CDC 2006 Guidelines on Treatment of Sexually Transmitted Diseases by June 2008, (and by our health officer by end of June 2009.)</p>
<p>HIV Case Management: 1. <u>Training:</u> Previous Case Manager left position</p>	<p>HIV Case Management: 1. <u>Training:</u> CD nurse will become trained in case management</p>	<p>HIV Case Management: 1. <u>Training:</u> Attend training February 2008; Time to do adequate case</p>	<p>HIV Case Management: 1. <u>Training:</u> Clients will be given adequate support evidenced at time of</p>

<p>September of 2007. Position is being filled by CD RN presently. WSHD currently has 4 clients in active Case Management.</p> <p>2. <u>Referrals:</u> Area providers do not seem to be aware of these services.</p>	<p>and continue to offer this service to present clients.</p> <p>2. <u>Referrals:</u></p> <p>a. Educate providers about HIV Case management</p> <p>b. Make brochures available to public.</p> <p>c. Consider outreach to high risk population via MSM community if possible.</p>	<p>management will hopefully be accomplished by streamlining other duties of CD and STD with electronic data bases.</p> <p>2. <u>Referrals:</u></p> <p>a. Once-yearly, visit area providers to inform.</p> <p>b. Provide brochures on case management to providers, and display at WSHD.</p> <p>c. Explore options to communicate with MSM community & IDU. See if this is feasible.</p>	<p>annual review of records and by triennial review.</p> <p>2. <u>Referrals:</u></p> <p>a. HIV/AIDs clients will be referred to WSHD on a periodic basis.</p> <p>b. Brochures will be displayed @ WSHD common areas; they will be made available to private medical clinics to be used in waiting areas or exam rooms.</p> <p>c. Communication with MSM and IDU community is long term goal. By Spring 2010 we will have identified ways to communicate with high risk communities.</p>
<p>HIV Prevention:</p> <p>1. <u>Staffing Change:</u> HIV Prevention position has undergone change of staffing and is currently being filled by CD RN.</p>	<p>HIV Prevention:</p> <p>1. <u>Staffing Change:</u></p> <p>a. Goal is to maintain continuity of program of prevention by training.</p>	<p>HIV Prevention:</p> <p><u>Staffing Change:</u></p> <p>a. Education/Training for CD RN, or person assigned to this program: Attend trainings as they are available (for rapid HIV testing, if</p>	<p>HIV Prevention:</p> <p>1. <u>Staffing Change:</u></p> <p>a. CD RN, or person assigned to this program will have appropriate training by Spring 2009.</p>

<p>2. <u>Incidence:</u> Wasco County had 4 new cases of HIV/AIDs diagnosed in 2007, (and 2 cases of Acute Hep C,) which may indicate elevated level of risky behaviors in community at large.</p>	<p>b. Increase program integrity and compliance: Bring program into compliance with State of Oregon guidelines.</p> <p>2. <u>Incidence:</u> a. WSHD HIV Prevention Program will minimize transmission of HIV in our community.</p>	<p>appropriate, and refresher training for HIV Counseling and Testing) to increase competency in this role.</p> <p>b. Policies and Procedures will be updated and signed by Health officer.</p> <p>2. <u>Incidence:</u> a. Increase awareness of HIV status of individuals at risk (and especially high risk individuals) via testing.</p> <p>b. Decrease risky behaviors via counseling & education to HIV</p>	<p>b. WSHD policies will be brought up to date to reflect DHS HIV Prevention Program requirements by end of 2008. This includes but is not limited to: creation of enhanced “Confidentiality Training” and documentation of ongoing yearly employee training, creation and maintenance of “Breach of Confidentiality Log”, as well as other policies and procedures as indicated at time of HIV prevention review.</p> <p>2. <u>Incidence:</u> a. HIV testing will be offered routinely to clients with clinic appointments.</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>3. <u>High rate of failure to return for HIV test results.</u> Currently, it appears 1/3-1/2 of all those tested for HIV do not return for results.</p> <p>4. <u>Individuals unaware of HIV status:</u> Knowledge of HIV status helps clients get appropriate medical treatment and can also help to decrease transmission by them.</p>	<p>3. <u>High rate of failure to return for HIV test results</u> Rapid HIV testing, if available will decrease the numbers of individuals who test but fail to obtain results of testing.</p> <p>4. <u>Individuals unaware of HIV status:</u> More Wasco Co. residents at risk for HIV will know their HIV status.</p>	<p>negative individuals and HIV positive individuals.</p> <p>c. Condoms will be available in the men's and women's bathrooms and stocked several times daily. Condoms are also offered at family planning clinic appointments and STD visits</p> <p>3. <u>High rate of failure to return for HIV test results</u> Explore availability and cost of rapid HIV testing.</p> <p>4. <u>Individuals unaware of HIV status:</u> Increase the rate of HIV testing.</p>	<p>b. Prevention messages are given @ clinic visits per Policy and Procedures to individuals regardless of HIV status. Prevention messages will also be reinforced to HIV positive individuals via case manager.</p> <p>c. Condoms will continue to be found in public restrooms free if charge @ WSHD and offered @ clinic appointments, verifiable by chart review.</p> <p>3. <u>High rate of failure to return for HIV test results:</u> We will know what our options are for HIV Rapid Testing by Spring 2009, and if appropriate, and affordable, will try to institute by Spring 2010.</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

			<p>4. <u>Individuals unaware of HIV status:</u></p> <ul style="list-style-type: none">a. If rapid testing is offered, there will be an increase percentage of people tested who are informed of their status.b. HIV testing is offered without cost to those who seek it.c. HIV testing is offered confidentially, without clients having to ask out loud at the front desk.d. There will be higher numbers of HIV tests being performed @ WSHD starting with 2008.
--	--	--	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>Tuberculosis Good News! Wasco County currently has a very low incidence of active Tuberculosis.</p> <p>1. <u>Detection of latent and active cases of M. tuberculosis:</u></p> <p>2. <u>Prevention of Active M. TB disease</u></p>	<p>Tuberculosis</p> <p>1. <u>Detection of latent and active cases of M. tuberculosis:</u></p> <p>a. Persons with TB infection or TB disease will be identified and offered services appropriately.</p> <p>2. <u>Prevention of Active M. TB disease</u></p> <p>a. WSHD will work to prevent Latent TB infections from progressing to active TB.</p>	<p>Tuberculosis</p> <p>1. <u>Detection of latent and active cases of M. tuberculosis:</u></p> <p>a. Surveillance will be done to detect latent cases of TB, and suspect cases as well (by PCP referral or otherwise).</p> <p>2. <u>Prevention of Active M. TB disease</u></p> <p>a. Treatment of Latent TB will be offered to 100% of medically eligible individuals, and strongly encouraged to those with risk factors favoring progression. Individuals are screened to</p>	<p>Tuberculosis</p> <p>1. <u>Detection of latent and active cases of M. tuberculosis:</u></p> <p>a. PPD screening is offered to those at risk for exposure (and anyone who seeks testing for compliance with job/school or other reasons) without appointment and with nominal charge (or free of charge if contacts to active case).</p> <p>2. <u>Prevention of Active M. TB disease</u></p> <p>a. Adherence to rigorous protocols, (comprehensive evaluation of PPD + individuals to target LTBI treatment to those at highest risk.) This will be verifiable by review of protocols and patient charts.</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>3. <u>Treatment of Active Cases of Tuberculosis</u></p>	<p>b. The number of new latent and active infections will be limited to the extent possible by minimizing exposures to infectious TB within our jurisdiction.</p> <p>3. <u>Treatment of Active Cases of Tuberculosis</u></p> <p>a. Active cases and suspect active cases will be responded to in Wasco Co. to eliminate active disease in our county and therefore maintain low incidence of TB disease.</p>	<p>determine appropriateness of a 9 month (or in certain cases, 6 mos.) treatment regimen.</p> <p>b. The public will be protected from exposure to active TB cases via appropriate detection, treatment, and if necessary, isolation of active cases and suspect active cases.</p> <p>3. <u>Treatment of Active Cases of Tuberculosis</u></p> <p>a. Persons identified as being suspicious for active TB will be evaluated by Sputum testing, radiology, and other tests as indicated; TB disease will be ruled out or confirmed and isolation will be used as needed to protect susceptible individuals. Cases, (and sometimes suspect cases) will be given</p>	<p>b. Protocols are in place to respond appropriately to TB Suspect cases. Appropriate use of protocols will be verifiable by chart review and adherence to State Guidelines will be verifiable by use of required reports to the state.</p> <p>3. <u>Treatment of Active Cases of Tuberculosis</u></p> <p>a. Treatment of cases and active cases will be done via WSHD protocols under the supervision of WSHD Health Officer. State Guidelines will be met for both Active TB treatment, and Contact Investigations. This will all be verifiable by chart review and by the completion of all required reports to the</p>
------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>4. <u>Adequate TB Control in Jail/Prison settings:</u></p> <p>a. State TB program has identified need for increased communication and coordination around TB in inmates.</p> <p>b. Continuity of care between</p>	<p>4. <u>Adequate TB Control in Jail/Prison settings:</u></p> <p>a. Enhanced communication will be established around Tuberculosis between WSHD and Norcor Jail.</p>	<p>medical treatment via Directly Observed Therapy and case management. TB Contact investigations will be completed for all cases of active disease, and appropriate screening and treatment done as indicated.</p> <p>4. <u>Adequate TB Control in Jail/Prison settings:</u></p> <p>a. WSHD TB case manager and WSHD health officer will be available for consultation to Norcor staff for medical management of TB suspects, cases and contacts as needed.</p>	<p>state.</p> <p>4. <u>Adequate TB Control in Jail/Prison settings:</u></p> <p>a. The Norcor facility and nurse practitioner have current protocols as well as a copy of “Tuberculosis Roles and Responsibilities : Correctional Facilities in Oregon” provided by the State of Oregon TB Program January of 2008. Examples of outreach to the jail can be evidenced on</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>facilities and between corrections and the community.</p>	<p>b. Inmates undergoing treatment will continue to receive care after they transfer out of jail to other facilities or the community.</p>	<p>b. WSHD will facilitate continuity of care for treatment of cases in the event of transfers to other facilities or to the community; transfer requests from the jail can be routed to the State TB program.</p>	<p>the CD yearly log of outreach to providers.</p> <p>b. Inter-jurisdictional transfers will be facilitated via the procedures/forms on the State of Oregon TB website. Employees or inmates in need of continuing treatment of suspect TB, active TB or contacts to TB @ time of discharge to the communities of Wasco, Sherman, or Gilliam counties will be able to continue treatment @ WSHD. This can be verified by audit of Norcor records of referrals to Wasco Sherman Health Department.</p>
--------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

7. Environmental Health Services:

Current Condition or Problem

1. The function of Wasco, Sherman and Gilliam Counties Environmental Health Program is to identify health risks in the environment and implement solutions that eliminate or reduce risk. This includes investigation and containing diseases and injuries to reduce the incidence of contagious diseases, and reduce the disabilities related to disease and injury.
2. Then Environmental Health (EH) program covers three counties: Wasco, Sherman and Gilliam.
3. The EH program currently contains 2 FTE Environmental Health Specialists (EHSs). This represents a reduction of the .5 FTE EHS added three years ago when Gilliam County was added to the EH program.
4. The Environmental Health services offered include, but are not limited to:
 - a. Sanitation inspections
 - b. Plan reviews
 - c. Licensing
 - d. Enforcement
 - e. Complaint investigation
 - f. Technical assistance and formal training of restaurants, public swimming pools and spas, motels, organizational camps and RV parks
 - g. State (DHS) Drinking Water Program
 - h. Department of Environmental Quality (DEQ) Onsite Wastewater Management Program

Additionally, Wasco County Environmental Health is the lead agency for the Tri County Hazardous Waste Management and Recycling Programs, serving Wasco, Sherman and Hood River Counties. These programs contain 1 FTE Hazardous Waste and Recycling Coordinator and .75 FTE Solid Waste Specialist.

Goals

1. To regain the .5 FTE EHS needed to maintain current services to Gilliam County.
2. To continue having a State Standardized Food Program Training Officer.
3. To conduct sanitation inspections of licensed facilities in a timely manner.
4. To continue coordinating food & water borne investigations and vector diseases within the Communicable Disease (CD) team.
5. To continue Food Handler training.

Activities

1. Conduct health inspections of all licensed facilities.
2. Conduct health inspections of unlicensed facilities as requested (prison, certified day care facilities, school food service programs, nursing homes, etc.).
3. Provide Environmental Health education to the public.
4. Collect data on licensed facilities, water systems and waste management.

Evaluation

1. Files will be maintained for each licensed facility and contain inspection reports.
2. Logs of citizen complaints will be kept regarding licensed facilities.
3. Logs of all animal bites are kept. Information will be provided to the state.
4. Food Handler testing records will be kept.

Drinking Water Program

Currently, no Wasco or Sherman county water systems are listed as being out of compliance by DHS Drinking Water (2-8-08). All systems are either up to date on Sanitary Surveys or have scheduled appointments for surveys in February 2008.

The current billing system is largely based on fees for services ensuring compliance with current standards and violation corrections. As water systems have receive more guidance and recommended improvements are made, it becomes difficult to reach full billing potential. Recently "State" water systems were added to county oversight by DHS. Most of these water systems have had no contact with county staff for years. The addition of the State Water Systems may make reaching the billing potential easier but it will also demand increased staff time.

Food Borne Illness & Fecal Oral Illness

Food borne disease investigation is conducted with a team approach, involving Environmental Health (EH) and the Communicable Disease (CD) team. Fecal-oral illness whether food, water or physical cross contamination is also investigated using a team approach. Either of the above events may activate a Crisis Action Center within the Health Department.

Prevention of contracting the illness or spreading it is key. Sanitation inspections are conducted in all DHS licensed facilities, along with schools, daycare centers and other facilities as requested. Food Handler classes are given and made available to all food service workers. Consultations on all sanitation issues are available.

Hazardous Waste and Recycling Services

Wasco Sherman Health Department is actively involved in hazardous waste and recycling activities. It is the lead agency in the Tri-County Hazardous Waste Management and Recycling Program, a coalition of Wasco, Sherman and Hood River Counties and the 6 incorporated cities within their boundaries. The Program has built two hazardous waste collection and storage buildings, one in Hood River and the other in The Dalles. It began holding hazardous waste collection events in July 2006.

89,294 pounds of hazardous waste were collected and 931 vehicles participated in the 17 events held by the Program from July 2006 until June 2007. That means that more than

44 and one half tons of hazardous material were prevented from entering the air, water and soils of the Tri-county region. In terms of weight, 89,294 pounds is about equivalent to 300 - 50 gallon drums filled with gasoline; or the combined weight of 27 Subaru Outback cars. Hazardous materials collected by the Program included DDT, PCBs, mercury and several banned agricultural chemicals.

The Program will hold 17 collection events in 2008, including 3 and one half events targeting the business and agricultural communities. The Program will team with the Students Recycling Used Technology Program to collect electronic waste (computers, printers, televisions, VCRs, etc.) at two of these events. The Program actively promotes safer alternatives to hazardous products via publications and presentations.

In 2007, Tri-County Program participants voted to expand the Program's focus beyond hazardous waste. New services will include planning and public education and outreach services to improve recycling and waste prevention practices in the region. A full-time Solid Waste and Recycling Coordinator and a part-time Solid Waste Specialist position were created to staff the Program.

Wasco County has yet to reach the 35% waste recovery rate mandated by the Oregon Department of Environmental Quality. (The 2006 Recovery Rate was 21.2%) As a result, the Solid Waste Coordinator conducted an assessment of recycling opportunities and services in Wasco County in 2007. She concluded that Wasco County residents did not have access to the same level of recycling services as most other residents of Oregon. Her research led to the adoption of the 2007-09 Wasco County Solid Waste Plan Update.

The Plan's goal is to reach Wasco County's 35% recovery rate by 2009. This will be achieved by improving both the infrastructure for recycling and the education and promotion activities that will help residents make use of the improved services. Major recycling system changes will occur in 2008.

In the northern part of the County, curbside (roadside) recycling services will be extended to every The Dalles Disposal residential customer and recycling services to commercial customers will be enhanced. Most The Dalles Disposal customers now receive weekly roadside recycling collection, but more than 13% do not. Those 550 additional residential customers will now receive alternate week recycling services. A structured outreach campaign will inform these customers of their new recycling opportunities.

Other residential service changes include the creation of a new mini-can garbage rate. The mini-can is about 1/3 smaller than a traditional garbage can, and the rate will be about 1/3 lower. Since more than half the waste in an average garbage can is recyclable, the mini-can will provide a financial reward to those who reduce their garbage by recycling. A structured outreach campaign will promote this program. Improvements to the commercial recycling system will include regular weekly recycling collection, the distribution of 1,000 60 gallon roll carts to hold recyclables, the provision of desk-top recycling boxes and enhanced educational services to businesses, schools and other organizations.

In the southern portion of the County, service improvements include expanded recycling depot hours and the adoption of a commingled materials sort at Mel's Sanitary Service in Tygh Valley. A recycling depot will be opened in Maupin, thanks in part to a grant from the DEQ. The Program will also provide recycling and waste prevention services to South County residents and businesses.

8. Emergency Preparedness Program:

Public Health Emergency Preparedness (PHEP) is core to the Health Department's capacity to plan for and respond to emergencies with significant health impacts. This program emphasizes our unique governmental public health responsibilities in Wasco, Sherman, and Gilliam Counties. Funds are provided under Program Element #12 for the Public Health Emergency Preparedness and Communicable Disease Response Programs and are used in accordance with set requirements to: operate Wasco Sherman Health Department's (WSHD) PHEP and Communicable Disease Response Program ("PHEP Program") in Wasco, Sherman, and Gilliam Counties.

The health department's PHEP program responsibilities are to respond to public health emergencies, to prevent, investigate, report and respond to outbreaks of communicable diseases, or the spread of communicable diseases, and to develop and maintain the capacity to operate such a PHEP Program". The PHEP program is a very extensive program which revolves around "**five key areas**" with the ultimate goal of responding effectively to all emergencies with significant health impacts by:

- 1) Developing a cadre of department staff capable of providing critical emergency public health services. This includes staffs that are competent in epidemiology and disease prevention, staffs who are certified with the nationally required National Incident Management System (NIMS).
- 2) Developing public health emergency plans, and exercises these plans to assure staff competency.
- 3) Coordinating the Department's preparedness activities with other County Departments and regional governmental partners.
- 4) Creating protocols to reduce disruptions of the Department's business and assure rapid recovery of services after an emergency.
- 5) Supporting household emergency preparedness on the part of local first responders as well as individual citizens.

Assessment: "Five Key Areas"

1) Developing a cadre of Department staff capable of providing critical emergency public health services: The health department has had over the last several years a staff of approximately 22-25 employees. A major challenge for the PHEP program is the turnover rate of the health department's employees who need basic trainings pertaining to the PHEP. Despite a high staff turnover rate, the health department has had 90-100% of its employees certified with NIMS IS-100 & 700 courses. Every WSHD staff member must also complete an Employee Home Emergency Preparedness Plan. The health department also has staff who have had Public Information Officer (PIO) Training (4 staff members), Joint Information System and Center Training (1 staff member), Crisis & Emergency Risk Communication (CERC) (3 staff members), Communicable Disease (CD) 101, 303, and 810 Courses (several staff members), and the Health Alert Network (10 staff members).

2) Developing public health emergency plans, and exercises these plans to assure staff competency: Our PHEP Program has developed various response plans which include the following:

- Emergency Support Function 8
- PHEP Plan
- Radiological Emergency Plan
- Pandemic Flu Plan
- Chemical Response Plan
- Wild Land Fire Response Plan
- Strategic National Stockpile Plan
- Emergency Communications Plan
- Mass Fatalities Plan

After developing a plan, the main goal is to exercise each of the plans, making corrections to them, and integrating them into the Wasco, Sherman, and Gilliam Counties local Emergency Operations Plans. Every exercised plan has an After Action Report (AAR) which helps improve the health department’s response to a communicable disease outbreak and other public health emergencies throughout the three counties. Plans that have so far been exercised are: the Pandemic Influenza, Strategic National Stockpile, and Emergency Communications Plans.

In addition to developing and exercising a plan, the health department also assists small water system operators in Wasco and Sherman Counties in developing and implementing their own Emergency Response Plans (ERP).

3) Coordinating the Department’s preparedness activities with other County Departments and regional governmental partners: WSHD continues to work closely with the W/S/G Counties Emergency Managers, hospital and healthcare providers, and various other local/regional agencies to address issues related to public health emergency preparedness and response. PHEP meetings between the health department, W/S/G Counties Emergency Managers, and the hospital are conducted on a quarterly basis. In addition to regular PHEP meetings, the department is represented at the Hospital Preparedness Program (HPP) Region 6 board, communications, and exercise committees meetings.

The health department is also actively involved with The Wasco County Red Flag Task



Force, a partnership with a diverse group of local agencies, which actively promote home emergency preparedness to the county’s residents.

4) Creating protocols to reduce disruptions of the department’s business and assure rapid recovery of services after an emergency: Protocols and actions have been created to help reduce disruptions to the departments business during an emergency response, which include: Staff alerting and call down protocol, 24/7 testing and Health Alert Network (HAN) Alerting protocols, Crisis Action Center (CAC) activation and setup protocol, Initial action plan/bio-event flow chart, Incident Action Planning Process, Epidemiological Investigation/ Disease Surveillance, and State Lab Specimen Transport to Oregon State Public Health Lab (OSPHL).

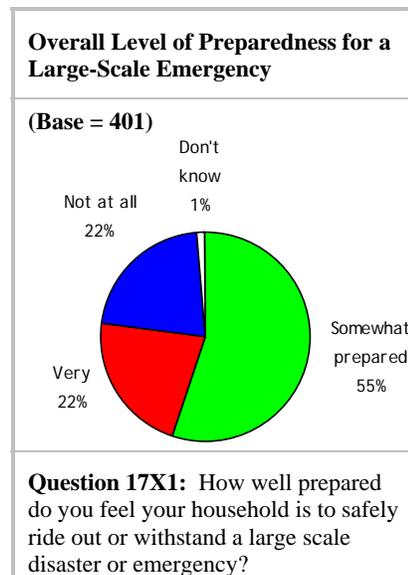
5) Supporting household emergency preparedness on the part of local first responders as well as individual citizens: In 2004, WSHD started promoting household emergency preparedness to both the public at large and 1st responders and their families. This effort has evolved into:

- a) The distribution of education flyers to the public at large
- b) Yearly radio interviews at local radio stations re: Home Emergency preparedness
- c) Presentations to Sherman and Gilliam County 1st responders, potential volunteers from the Kiwanis and Lions Clubs, and presentations to WSHD staff members
- d) Two home emergency preparedness fairs (through the red flag task force) at:
 - i) The Dalles Armory (2006),
 - ii) The Home Depot (2007)
- e) Surveys, which ask respondents how prepared they and their households are for an emergency where they would have to be self sufficient for up to 72 hours before help arrives.

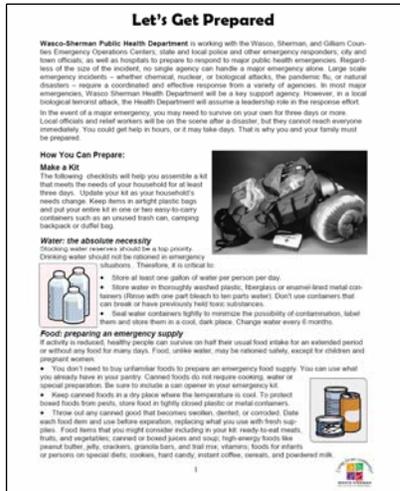
Emergency Preparedness

In November 2006 WSHD conducted a Community Assessment Survey that addressed attitudes and behaviors which affect the wellness of residents of Wasco, Sherman and Gilliam Counties (Survey conducted by the Gilmore Research Group). As part of the survey, respondents were asked several questions about their preparedness in the event of a large-scale disaster.

According to the Gilmore Group, “Data from this survey indicated that the overall level of preparedness of the population for a disaster was low. Most respondents do not seem to feel that they are especially well prepared to handle a major disaster: just over half (55%) said their households were only *somewhat prepared* to safely ride out a large-scale disaster or emergency, and 22% said they were *not prepared at all*”.



Furthermore the survey showed that “given an opportunity to answer either *yes* or *no* to questions asked about household emergency supplies of food, prescription medication, flashlights and radios, most respondents indicated that they were prepared. But less than half (49%) said they had a 3-day supply of water for each resident of the household. Younger respondents (between the ages of 18 and 35) were more likely to say they do not have a sufficient supply of water. A large majority of all respondents (83%) said they would comply with requests made by authorities to evacuate their communities in the event of a large-scale disaster or emergency”.



Action Plan

As a result of the survey, WSHD put together a *Lets Get Prepared* flyer in both English and Spanish. The handout flyer gives ideas and examples on how to make a home emergency plan and how to put together a home emergency kit. The overall goal of these flyers was to encourage people to better prepare themselves and their families for a large scale emergency and how to be self sufficient for up to 72 hours before help arrives. The handouts are posted on both our English and Spanish websites: www.wshd.org. In addition to the flyers, one can also find other information about emergency preparedness on our websites. It is the policy of the health department to hand out as many of these *Lets Get*

Prepared flyers as possible to the general population, including the staff of our local community partners and first responders' agencies.

Current Condition or Problem

Emergency Preparedness in Wasco, Sherman, and Gilliam Counties is better now than it has been in the past years. This is evident by the numerous emergency response plans that the program has, the improved CD response times, redundant communications capabilities, and continued collaborating with community partners and county Emergency Managers. The improvement of the PHEP program is not only due the department's PHEP staff, but also due to the dedicated men and women from a diverse group of agencies that the health department works with. Despite of the progress made in Public Health Emergency Preparedness, the health department preparedness program feels that it is essential that it continues to build new partnerships and strengthening existing ones.

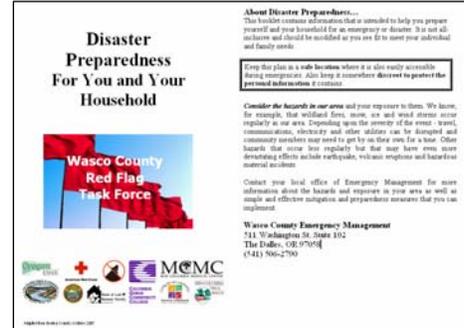
As a by-product from the original November 2006 Community Assessment Survey, WSHD, in collaboration with the Sherman and Gilliam County Emergency Management Offices put together a small survey different from the Gilmore Group one, for the two county's first responders. The purpose of this survey was to determine whether or not our first responders and their household were themselves prepared for a major emergency (where help would not arrive until approximately 72 hours after the emergency).

By having 1st responders and their families be prepared at home before a public health disaster strikes, makes it easier to leave their families behind while they are responding to one. Results in both counties show that the majority of first responders are not prepared at home for a large scale emergency. Despite the fact that this survey was not done in Wasco County, one can assume that the same results apply.

Efforts are currently underway through the Wasco County Red Flag Task force to supply every 1st responder within Wasco County with a disaster preparedness handbook to enable our first responders (including WSHD staff) to put together their own home emergency plans before a disaster strikes. This handbook will also become available to first responders in Sherman and Gilliam Counties through their respective emergency

managers.

In addition to promoting home emergency preparedness, there is certainly many more work to be completed by the PHEP program such as PE-12 required mutual aid agreements with regional health departments, written Point of Dispensing agreements, SNS Plan update, and Hazard Vulnerability Assessment, the needs of vulnerable population in a disaster, Emergency communications, etc. All above stated work will still need to be completed despite the recent program budget cut of 20%.



Goal

The ultimate goal of the PHEP program is to enable the Wasco Sherman Health Department and its dedicated staff to respond effectively and as efficiently as possible to all public health emergencies, whether alone or jointly with other community partners. This goal can be accomplished by:

- 1) Continuing to improve on the **“five key areas”** presented earlier in this report, which includes empowering the first responders from Wasco, Sherman, and Gilliam Counties to put together a home emergency plan. By having a home emergency plan ready 1st responders may be more inclined to report for duty when there is a large public health emergency (i.e. pandemic influenza).
- 2) Completing as much of PE-12 as possible, despite the fact that we sustained a 20% budget cut in FY 2007-2008.

Activities

- PE-12 requirements will be completed as per the health department FY 2007-2008 work plan.
- Home emergency handbook will be revised again at a RFTF meeting (February 2008) and subsequently presented to 1st responders of Wasco County.
- Wasco County Emergency Manager will look into the definition of “First Responders” to see who or which agency staff would qualify as a first responder.
- The RFTF is focused on promoting this handbook initially to 1st responders of Wasco County. Copies of the handbook would then be made available to the Emergency Managers of Sherman and Gilliam Counties for their respective County’s 1st responders.
- Funding sources will be sought from local businesses to cover the cost of about 500 or 600 handouts.
- Handbook will be presented to 1st responders in Wasco County and thereafter made available to the public.

Evaluation

As per PE-12, the WSHD PHEP program is evaluated yearly by the State of Oregon Department of Human Services', Public Health Division's PHEP Program. Efforts to promote home emergency preparedness to 1st responders is shown in the table below and evaluated accordingly.

Target Population	Who	What	Timeline
Wasco County 1 st responders	Red Flag Task Force, WSHD PHEP Program, Emergency Management Office.	(Objective # 1) Promote home emergency preparedness to first responders in Wasco, Sherman, and Gilliam Counties.	ongoing
Wasco, Sherman, Gilliam County Residents	RFTF in partnership with The Home Depot and other local businesses.	(Objective # 2) Promote home emergency preparedness to residents in Wasco, Sherman, and Gilliam Counties.	ongoing

Year in Review: In this fiscal year, 90% of staff members had their National Incident Management System (NIMS)-100 & 700 certificates. Ten Health Alert Network (HAN) recipients (100%) had a current alerting profile. We continue to meet with our local community partners through:

- Monthly State-wide PHEP conference calls,
- Bi-monthly Hospital Preparedness Program (HPP) Region 6 board, communications, and exercises committee meetings
- Quarterly Wasco County Red Flag Task Force meetings
- The Pan Flu community engagement meeting
- Three PHEP Meetings with emergency managers from Wasco, Sherman, and Gilliam Counties.

We've conducted numerous exercises such as:

- Simulated Transport of Pan Flu Specimen
- SNS Ordering Drill
- PandOra Full Scale Exercise in three counties
- Chemical Spill Drill in Wasco County
- Vital Records Preparedness Exercise
- Boardman Evacuation Full Scale Exercise
- Internal tests of 24/7 phone system and the State's quarterly after hours testing
- Internal Health Alert Network (HAN) tests including statewide bi-monthly alerts
- exercise on how long it takes HAN recipients assembled at the workplace

We've responded to 3 significant local emergencies and used the Incident Command System (ICS) during those responses.

All of our emergency plans and procedures are NIMS compliant. Three Plans were updated in FY 06-07: 1) ESF 8/Health and Medical Annex, 2) Public Health Emergency Preparedness Plan, 3) Emergency Communication Plan. New Plans for FY 06-07: 1) Chemical Event Response Plan, 2) Natural Disaster Response Plan: Wild Land Fire, 3) Radiation Event Response Plan.

IV. Collection and Reporting of Health Statistics

Mandate: (ORS 431.416 Local public health authority or health district; duties) 431.520
Disposal of health records

Description: Vital Records program assures accurate, timely and confidential registration of birth and death events. Birth and Death Certificates are issued in accordance with federal and state statutes to maintain the integrity and accuracy of birth and death information. Rapid issuance of accurate certificates minimizes the opportunity for identity theft and assures accurate recording of cause of death and identification of birth parents.

Activities: The County Registrar and three Deputy Registrars issue birth and death certificates within the first six months of the event in a timely manner. One of the Deputy Registrars is bilingual and is also a Notary to be able to serve clients needing corrections to records or paternity affidavits.

Vital Records: Birth Certificates

Wasco Sherman Health Department (WSHD) registers vital records for both Wasco and Sherman Counties. However, the vast majority of births occur in Wasco County, as the area's local hospital is located in The Dalles.

Until January 1, 2008, birth records were entered by a clerk at Mid Columbia Medical Center (MCMC) and original birth certificates were sent to WSHD for registration, and then sent to the state. Forms from home births were likewise registered at WSHD.

As of January 1, 2008, all birth records are entered in to the Electronic Birth Registration System (EBRS). EBRS is a component of Oregon Vital Events Registration System (OVERS), which is a web-based registration system. OVERS eliminated the need for County registrars to register birth certificates; forms are now completed by a hospital birth clerk and registered electronically by the state. Home birth forms are sent directly to the state.

Clients may continue to purchase birth certificates at WSHD, for up to 6 months after a birth has occurred. Birth certificates are printed directly from EBRS and the client receives their copy or copies immediately. The price has remained the same- \$20 for the first copy and \$15 for each additional copy.

Vital Records: Death Certificates

Registrar and Deputy Registrars review death certificates received on site for accuracy and completeness. Requests for certified copies are filled in a timely manner. Certified copies for all electronic records are printed from EDRS, hybrid and all paper records are made on the copier. All transactions are entered into EDRS, all records and intaglio paper are kept secure.

V. Health Information & Referral

Hard Copy Resources:

- 1) **WSPH website:** <http://www.wshd.org/wshd/>
- 2) **WSPH brochure:** available onsite
- 3) **Local Phone Book:** government listing
- 4) **Commission on Children's & Family Resource Directory**

Websites:

- 1) **Wasco County website:** name and phone number listing with external link to our site <http://co.wasco.or.us/>
- 2) **State of Oregon website:** multiple links from this site; one being a page linking to all county health departments in Oregon
<http://oregon.gov/DHS/ph/lhd/lhd.shtml>
- 3) **Services Resource Directory:** a printed directory of services updated every 2 years for Hood River, Sherman, Wasco, Klickitat, and Skamania counties
- 4) **A to Z Gorge Info website:**
<http://www.a2zgorge.info/services/WascoSherman.htm>
- 5) **Sherman County website:** http://www.sherman-county.com/govt_public_health.asp
- 6) **Eastern Oregon Developmental Disability Resources website:**
http://www.eoddr.com/county/county_wasco_type.html
- 7) **Western Tobacco Prevention Project website:**
http://westerntobaccoprevention.org/documents/Oregon_County_Directory.pdf
- 8) **Oregon Department of Environmental Quality website:**
<http://www.deq.state.or.us/lq/sw/hhw/collection.htm>
- 9) **Local Health Department Immunization Contact List for Schools and Children's Facilities:** found on the Oregon State Bureau of Labor and Industries website <http://www.boli.state.or.us/DHS/ph/imm/docs/SchCoordlist07.pdf>
- 10) **The Arc of the Mid-Columbia website:**
<http://community.gorge.net/arcofmidcolumbia/Local%20Resources.htm>
- 11) **Columbia Gorge Family Resources webpage:** <http://columbia-gorge-family-resources.com/eng-health.pdf>
- 12) **HIV-AIDS Education & Prevention Services by county:** listing on Oregon Department of Education webpage:
<http://www.ode.state.or.us/search/page/?id=1120>
- 13) **Listing of Oregon STD clinics:** http://www.herpes-coldsores.com/support/std_clinic_us_oregon.htm
- 14) **Oregon Aids Hotline website:** <http://www.oregonaidshotline.com/alpha.php>
- 15) **Oregon Vital Records Offices listing:** <http://www.vitalrec.com/orcounties.html>
- 16) **Health Guide USA:**
http://healthguideusa.org/oregon_county_health_departments.htm
- 17) **Columbia Gorge AIDS Project:**
<http://www.columbiagorgeaidsproject.org/resources.cfm>

VI. Additional Requirements

Wasco Sherman Health Dept Organizational Chart: separate attachment.

VII. Budget

The Wasco County Budget Committee meets April 22-24, 2008. The final budget will be approved by the county court at their regular meeting either June 11 or 25. The budget numbers below represents the current fiscal period.

Projected Revenue 2007-2008

From DHS:	\$547,673
From Grants & Fees:	\$1,315,065
General Fund:	<u>\$348,353</u>
Total	\$2,211,091

To obtain a copy of the Wasco Sherman Health Department's public health budget:

Kathi Hall
Business Manager
Wasco Sherman Health Dept
419 E. 7th
The Dalles, OR 97058
541-506-2628
kathih@co.wasco.or.us

VIII. Minimum Program Standards

1. Yes No A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes No The Local Health Authority meets at least annually to address public health concerns.
3. Yes No A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.
4. Yes No Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes No Ongoing community assessment is performed to analyze and evaluate community data.

6. Yes No Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes No Local health officials develop and manage an annual operating budget.
8. Yes No Generally accepted public accounting practices are used for managing funds.
9. Yes No All revenues generated from public health services are allocated to public health programs.
10. Yes No Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes No Personnel policies and procedures are available for all employees.
12. Yes No All positions have written job descriptions, including minimum qualifications.
13. Yes No Written performance evaluations are done annually.
14. Yes No Evidence of staff development activities exists.
15. Yes No Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes No Records include minimum information required by each program.
17. Yes No A records manual of all forms used is reviewed annually.
18. Yes No There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes No Filing and retrieval of health records follow written procedures.
20. Yes No Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes No Local health department telephone numbers and facilities' addresses are publicized.
22. Yes No Health information and referral services are available during regular business hours.

23. Yes No Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.
24. Yes No 100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.
25. Yes No To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes No Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes No Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.
28. Yes No A system to obtain reports of deaths of public health significance is in place.
29. Yes No Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.
30. Yes No Health department administration and county medical examiner review collaborative efforts at least annually.
31. Yes No Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes No Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes No Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes No Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes No Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.

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

Control of Communicable Diseases

37. Yes No There is a mechanism for reporting communicable disease cases to the health department.
38. Yes No Investigations of reportable conditions and communicable 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. (Added per G.S. request, not in program indicators)

Health Education and Health Promotion

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

Nutrition

73. Yes No Local health department reviews population data to promote appropriate nutritional services.
74. The following health department programs include an assessment of nutritional status:
- a. Yes No WIC
 - b. Yes No Family Planning
 - c. Yes No Parent and Child Health
 - d. Yes No Older Adult Health
 - e. Yes No Corrections Health
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 (Vacancy) 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.

Agencies are **required** to include with the submitted Annual Plan:

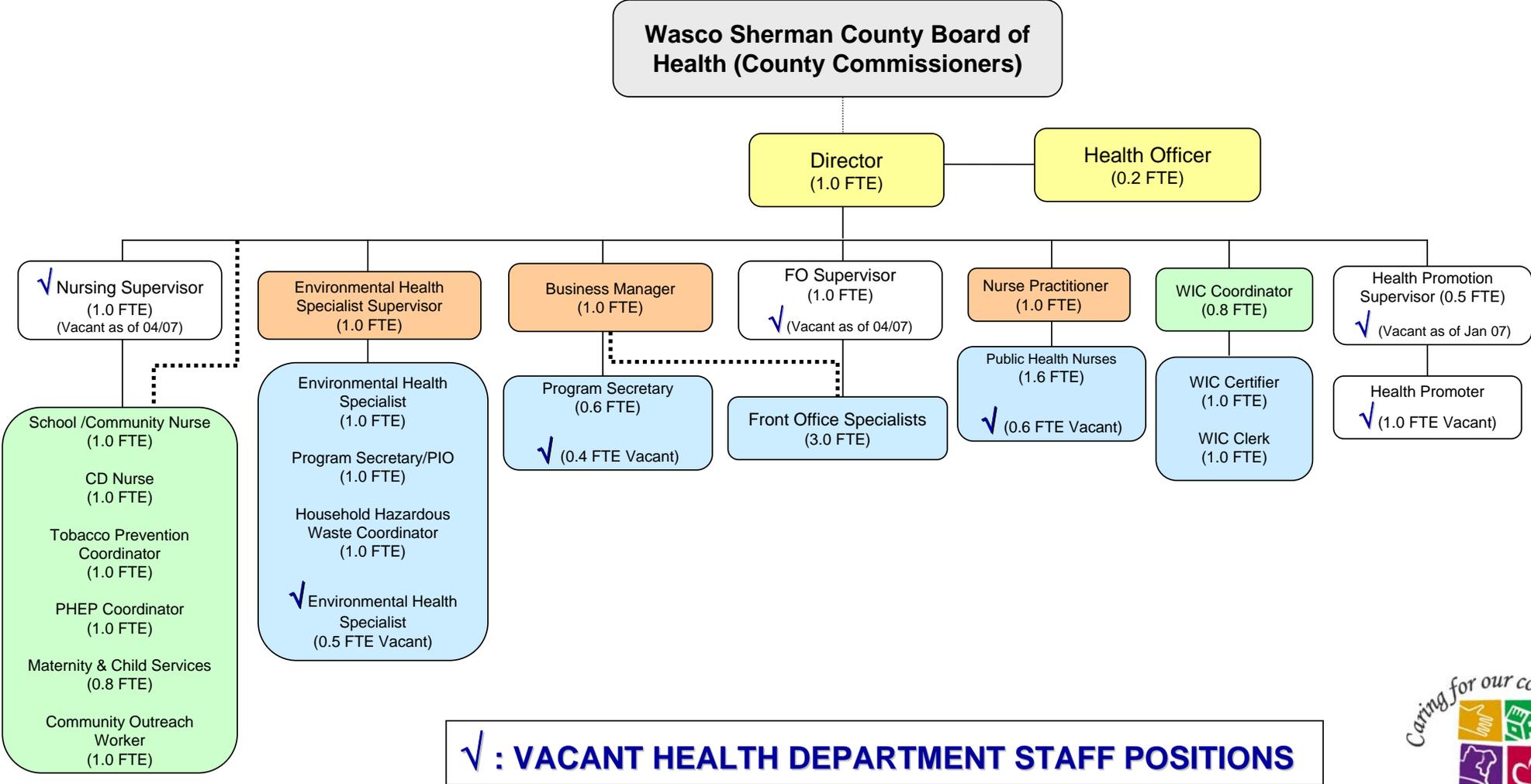
The local public health authority is submitting the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431.375–431.385 and ORS 431.416, are performed.

Local Public Health Authority

County

Date

Wasco Sherman Health Department Organizational Chart



Wasco Sherman Health Department Organizational Chart

