



COLUMBIA HEALTH DISTRICT

Public Health Authority ♦ Columbia River Community Hospital

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June 10, 2009

Tom Engle, BSN, MS
Office of Community Health
DHS Public Health Division
800 N Oregon St.
Portland, Oregon 97232-2162

Dear Tom:

Please find attached the comprehensive triennial plan (CTP) for Columbia County. Thank you for extending our submission deadline. This spring we had many challenges to our small agency. We were overwhelmed with H1N1 activities as well as a city water system break that required the agency to operate in incident command structure. At the same time we are receiving fewer dollars to respond to such issues.

This CTP is for fiscal year 2009-10, but it includes activities that will cross the three year period. The agency offers services for women's health, nutrition education and vouchers for pregnant women and children 0-4 years of age, home visits for medically fragile infants and children, school-based health center acute and chronic care, immunizations, communicable disease exams and treatment, and environmental health inspections for the public's safety. The agency offers education programs like tobacco prevention, food service training, and public health preparedness.

This last year CHD public health has had an assessment committee reviewing tobacco, nutrition, built environments, and living well programs. The committee (Tobacco Related and Other Chronic Diseases) assessed the county. That is a difficult task in terms of built environments because the seven incorporated cities are fairly distant from each other and there are few projects in the unincorporated areas that link to city projects. For example bike paths are an element existing in each Columbia County city, yet connecting those paths would require all those people and agencies responsible for roads and highways to work for the same project. Cities offer a better avenue to assess the TROCD program elements. The committee will work on improving access to tobacco quit programs, establishing living well programs, promoting farmer's markets and community gardens, and other projects that the committee chooses.

Some of the clear deficits in services in Columbia County are infrastructure related. We have no hospital to serve a population of about 48,000. The entire county is considered a health professional shortage area (HPSA) by the federal government. Trying to recruit physicians without a local hospital is very difficult. The health district had focus groups throughout the county to assess health care needs. The primary issue was access to 24/7 health care. From those community groups came a group of citizens that were committed to creating a new tax base for the health district and building a small hospital. The ballot measure passed the first time which is a statement of some significance that the communities are invested in this infrastructure. The process is currently at the state certificate of need level. Once that process is finished, CHD will start building. The management group and the architecture firm are ready to build. CHD could be hiring contractors now with this project and help those who are unemployed.

CHD public health appreciates the public health division and the technical assistance that it provides throughout the division.

Sincerely,

A handwritten signature in black ink, appearing to read "Karen Fox Ladd".

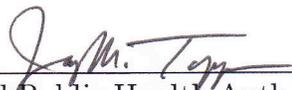
Karen Fox Ladd, BSN, MS
Administrator
Columbia Health District Public Health Authority

Columbia County Public Health Triennial Comprehensive Plan

Columbia Health District-Public Health Authority

Submitted June 2009

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

Columbia
County

6-12-09
Date

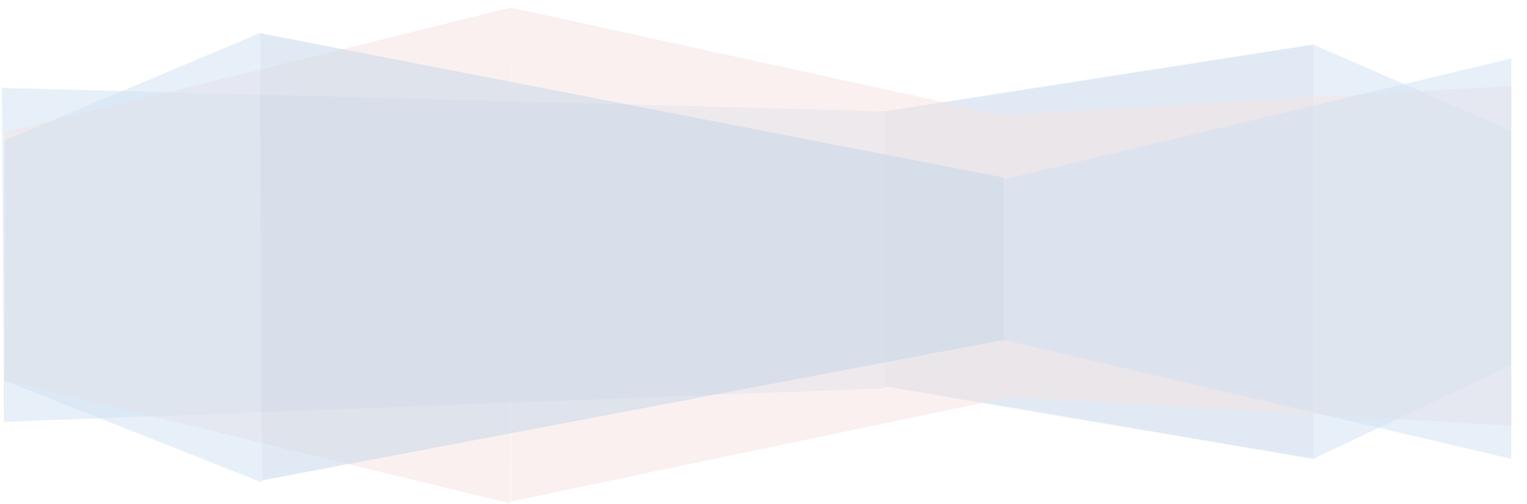


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SECTION 1: EXECUTIVE SUMMARY

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

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

Were there unlimited amounts of funding, one might expect that most public health needs would be met. The State of Oregon allots only 2.5% of its DHS budget to public health functions at the state and local levels combined. The funds that reach the local level are for specific programs. In Columbia County, these dollars supplement federal dollars to provide home visits to high risk infants and children, they supplement federal dollars that help fund emergency preparedness and they supplement communicable disease epidemiological response, and they supplement federal dollars that help provide prenatal care for women in need. The state also provides funding to school-based health centers (SBHC). The St. Helen’s school district in Columbia County receives funding that is passed through the local health department for health care to some elementary school students in the district. This last biennium we received school-based health center planning grants for three communities (Rainier, Vernonia, and St. Helen’s high school). Rainier school district completed both planning phases and recently opened their SBHC. Vernonia is planning for SBHC space in their plans to build a new school.

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

ORS 431.380 states that the distribution of funds to the local public health authority are to be used for public health services. The fiscal year 2009 – 2010 proposed health district budget is included in this document. The budget includes the hospital project as well as the public health programs. The proposed budget will not be accepted until late June. The state legislature has not finalized any state budgets and so all of the local level budget numbers are “our best estimate”. We do

know that there will be fewer dollars for programs given the state's economic forecast. The Conference of Local Health Officials and the state Public Health Division defined principles of how program cuts would be made. CLHO did not want to have reductions across all programs. Since funding amounts are minimal for many public health programs, it was decided that the division would cut entire programs rather than having each program suffer. For example, our TB program receives \$242 for the entire year. It wouldn't be worth calculating the cost of cutting the program by 20%. For this reason, we expect to lose the Babies First program due to the state program cuts. Family planning dollars will be decreased and an environmental health water program will lose half of its funding.

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

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

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

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

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

1. Prevents epidemics and the spread of disease
2. Protects against environmental hazards
3. Prevents injuries
4. Promotes and encourages health behaviors
5. Responds to disasters and communities in the recovery phase
6. Assures the quality and accessibility of health services

The second key concept is the ten essential public health services that are quite limited in Oregon rural counties. Lack of funds can be restrictive in meeting public

health needs. Sufficient resources to achieve these standards are necessary for compliance.

The action plans for this year will focus on current programs and their goals, objectives, actions, and evaluations. These plans are developed by county program staff and approved by state program staff. Each plan has a slightly different format and so the reader will have to realize that each program plan has its own framework and audience.

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COLUMBIA COUNTY STATISTICAL SNAPSHOT

Columbia County is 687 square miles of picturesque scenery. The Columbia River defines the northern and eastern borders of the county. The terrain is mountainous with winding two lane roads. Columbia County’s history is agriculture and timber oriented. Most of the agricultural land has been sold to developers and no longer produces fruits and vegetables. The timber industry is also decreasing. Housing development has replaced the farms. Family wage jobs are becoming increasingly scarce. Commuting to the Portland metro area is becoming the norm. Recently, the Columbia Rider transportation system has been established to transport commuters into the metro area. Additional routes are being mapped to provide services within Columbia County.

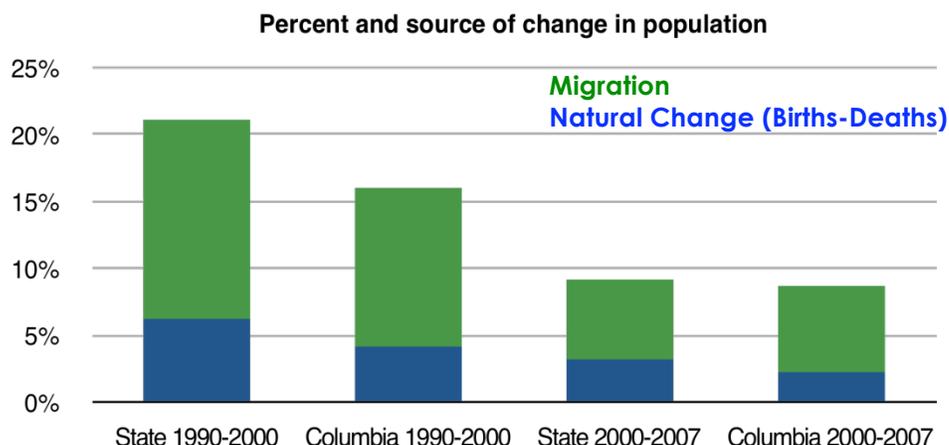
Geography: Northwest Oregon, 687 square miles.
Average Temperature: January 39°F July 68.4°F
Annual Precipitation: 44.6"

Population:

	Percent	2008
County	66%	31,858
Unincorporated	34%	23,742
TOTAL	100.00	48,095

Population Research Center, College of Urban and Public Affairs, Portland State University.

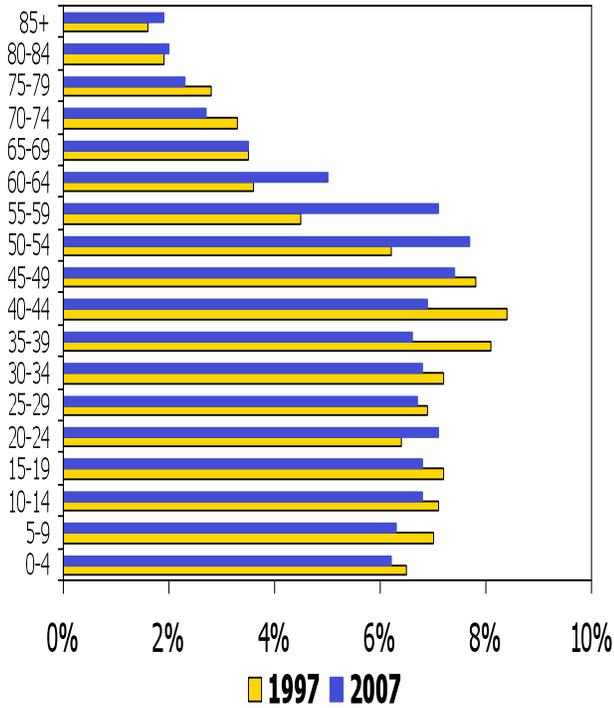
Of the deaths recorded for Columbia County residents in 2008, cancers and heart disease were the number one and two killers respectively. The cancer death rate was significantly higher than the state of Oregon rate with lung cancer being the most prevalent cancer.



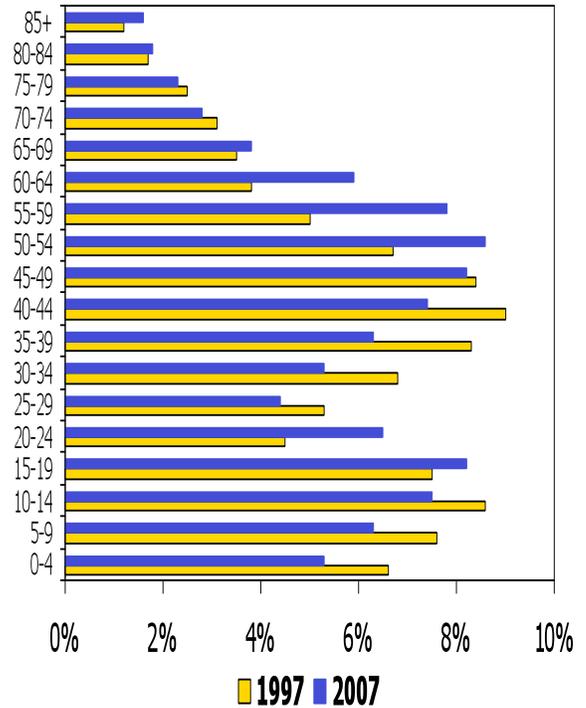
Percent of population by age, 1997 and 2007

Population Research Center, College of Urban and Public Affairs, Portland State University.

Oregon



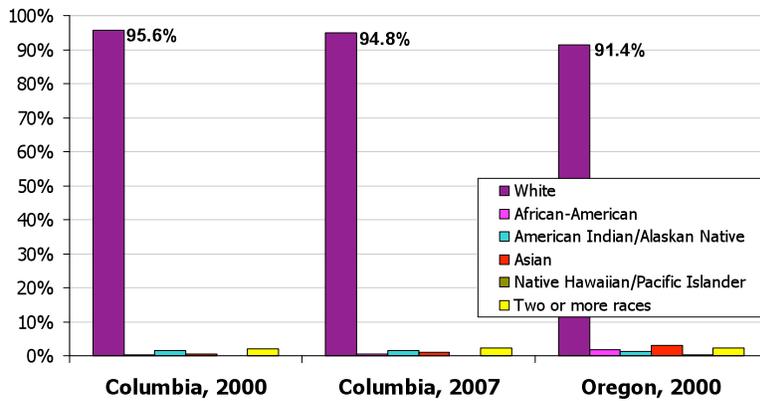
Columbia County



Population by race 2000 and 2007

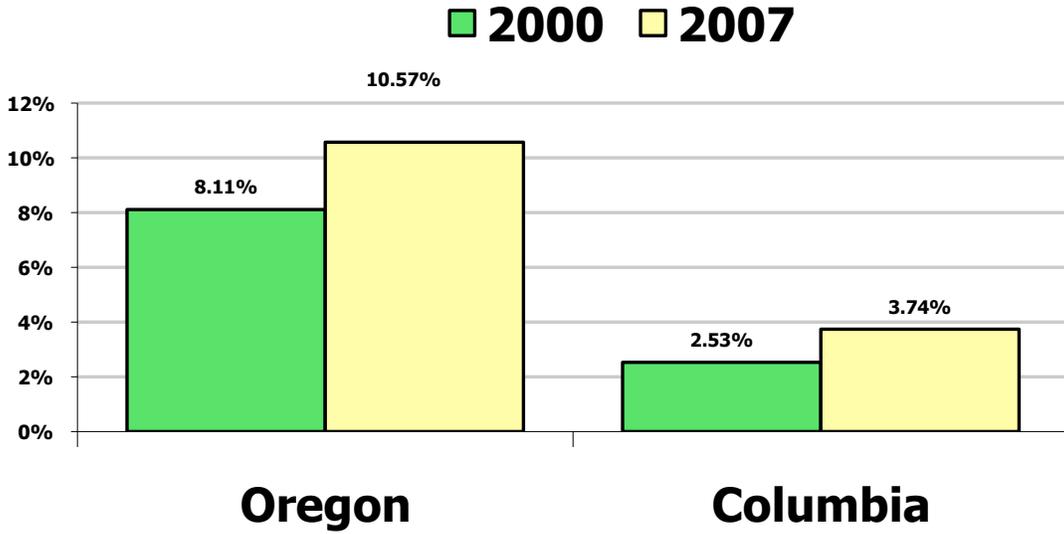
(Hispanics, an ethnic group, are represented in all racial categories)

Source: US Census Bureau County Population Estimates



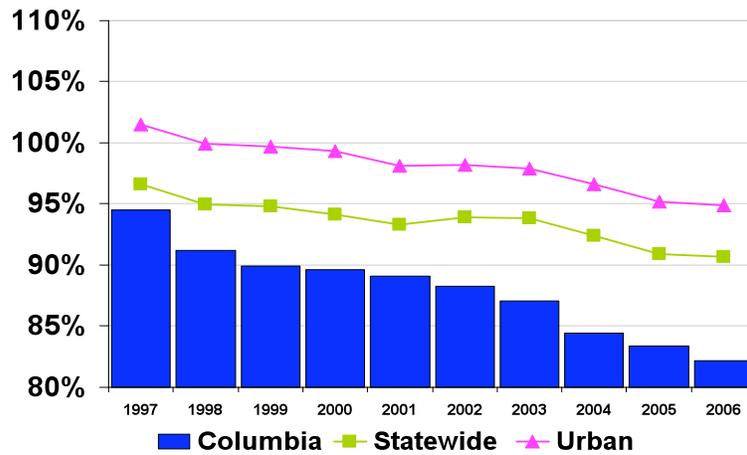
Percent that is Hispanic, 2000 and 2007

Source: US Census Bureau County Population Estimates
 Per capita personal income as percent of the U.S. per capita income



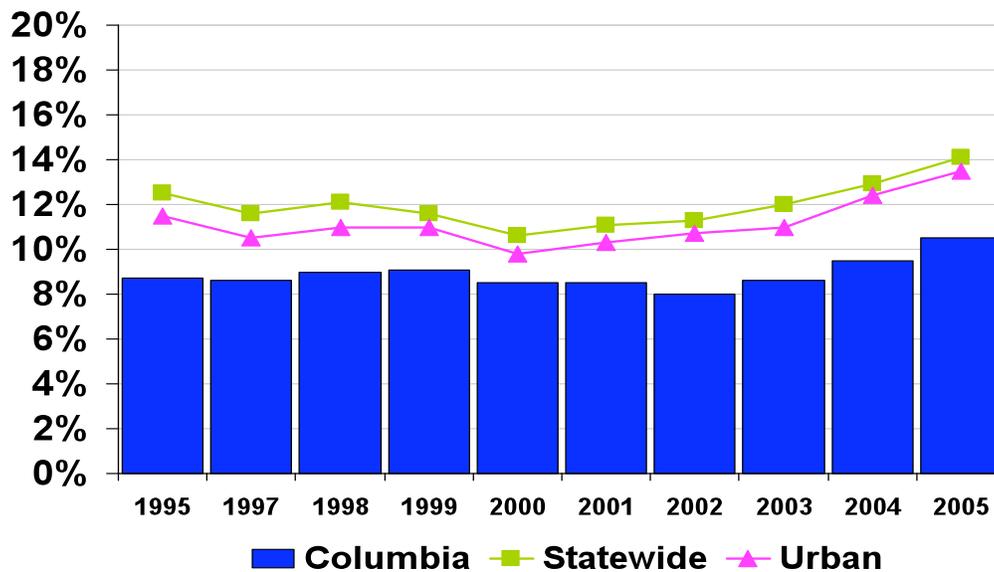
Per capita personal income as percent of the U.S. per capita income

Oregon Benchmark 11



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

Source: Current Population Survey (from US Bureau of Labor Statistics and US Census Bureau)
Oregon Benchmark 54



Number of Persons Eligible for Medicaid and Food Stamps Columbia County

State of Oregon, Division of Medical Assistance Programs | DMAP DSSURS data warehouse

Date	Number Eligible for Medicaid	Number Eligible for Food Stamps
Oct. 2002	3944	4366
Oct. 2003	3614	4839
Oct. 2004	4513	5188
Oct. 2006	4514	5404
Oct. 2007	4045	
Oct. 2008	4589	

Additional References

Child Welfare, Homelessness, Poverty, Self Sufficiency

Department of Human Services, Oregon Children, Adults and Families

http://www.oregon.gov/DHS/assistance/data/caf_charts/102008.pdf

www.dhs.state.or.us/abuse/publications/childabuserereports.htm

Community Action Team <http://www.cat-team.org/>

ADEQUACY AND EXTENT TO WHICH 5 BASIC SERVICES ARE PROVIDED

EPIDEMIOLOGY AND CONTROL OF PREVENTABLE DISEASES AND DISORDERS

CHD Public Health staff (public health nurses, environmental health specialists, and health officer) assess, monitor, and provide investigation of 42 diseases and nine other conditions that are considered uncommon and of potential public health significance. Laboratories licensed in the state of Oregon are required to report to counties on communicable disease results. Physicians are also required to report both lab confirmed and clinically suspect cases that are by law reportable. The public health staff investigates each report using the state's reporting guidelines, timelines, and technical assistance if needed. Disease reporting enables appropriate public health follow up for patients. Reporting helps public health identify outbreaks. Reporting helps provide a better understanding of morbidity patterns and may even save lives.

Public health works to identify those who have been exposed to communicable disease, provide health guidance and preventive measures and work to prevent the spread or recurrence of disease. Public health works with the community health providers to provide education to the general public on communicable diseases.

Funding is insufficient for staff to have an active surveillance system. Columbia County is a growing community and funding has been stagnant for several years. Yet new diseases are coming to our attention every year. Two public health staff spent two weeks tracking and responding to H1N1 virus information at the national, state, regional and local level. If any other communicable disease issue had occurred during that time, we wouldn't have been able to respond adequately. We have a five-member team that responds 24/7. One member always carries the phone. They test the others on a weekly basis. The on-call person checks the fax and messages on the weekends.

PARENT AND CHILD HEALTH SERVICES, INCLUDING FAMILY PLANNING CLINICS (ORS 435.205)

Public health offers prenatal care services in conjunction with Oregon Health Sciences University School of Nursing. The nurse midwife provides prenatal care until delivery. OHSU nurse midwives deliver the baby. Public health provides maternal case management to our clients. A public health nurse provides home visits to babies who are at risk of social or medical complications or care coordination for those infants who have known medical issues. Public health provides family planning services to women and men. Public health offers a range of contraceptive methods and pregnancy testing. Public health offers information and education on the options we provide.

Public health offers the Women, Infant, and Children (WIC) nutrition program and the farmer's market program when it is available. WIC travels to Clatskanie, Rainier, and Vernonia monthly to certify clients. The immunization nurse also travels with the WIC program to offer immunizations to the community.

CHD-PHA now has two school-based health centers in the county. St. Helens has an elementary student model and CHD passes through dollars to the St. Helens Student Foundation. Rainier has a K-12 student model and public health is the medical sponsor for this program currently. Rainier School District just opened their center in June 2009. Our goal is to have a school-based health center in each school district. Columbia County has five school districts.

COLLECTION AND REPORTING OF HEALTH STATISTICS

Columbia County registers all deaths that occur in Columbia County. Since we currently do not have a hospital, only at-home births are registered at the county level. The county forwards the information to the state as required by administrative rules. The county contracts with the state for medical examiner services. The state medical examiner's office determines whether a death in Columbia County requires an autopsy.

HEALTH INFORMATION AND REFERRALS

Columbia Health District public health strives to link people to needed personal health services and assures the provision of health care when otherwise unavailable. Columbia Health District has a new website that is updated by local public health program staff. This site is easy to use and has links to many of our partners. It is an excellent way for the local level to access the state website as well as the CDC website. Public Health also provides information and referral services during regular business hours. A local community action team agency produces a countywide resource booklet that all the local agencies use for referral.

Primary health care services are harder to provide referral for. There are no reduced fee or free clinics in Columbia County. OHSU Scappoose and Legacy St. Helens will provide services and bill clients after the service is provided. CHD public health refers to Outside In in Portland and The Family Health Clinic in Longview, Washington. Because of this lack of health care services, CHD public health has worked toward building a hospital and leading planning around the establishment of school-based health centers. CHD public health contracts with Oregon Health Sciences University School of Nursing for nurse practitioners to provide primary health care services and women's health care services.

CHD public health assists eligible people in applying for the Oregon Health Plan. CHD public health has most of their health education materials in alternative language formats. CHD public health has a translator service available. CHD public health provides access via a TTY number. CHD public health works in collaboration with Columbia County regarding vulnerable populations during emergencies and disasters.

CHD public health provides a competent public health and personal health care workforce. Life-long learning through continuing education, training, and mentoring is available to CHD employees. CHD public health has monthly staff meetings, an online training system, and offers continuing education activities throughout the year. Employees are encouraged to seek training opportunities connected with their positions. Most employees attend at least one outside training or conference each year. An educated and trained workforce helps public health attain its goals.

ENVIRONMENTAL HEALTH SERVICES

The environmental health program licenses and inspects restaurants, motels, RV parks, pools, spas and organizational camps. Our environmental health specialist

teaches and certifies food handlers. Food handlers can take the test for a permit in the public health office during regular business hours or take the test online. A link from the CHD public health website will take them to the Lane County food handler's online testing site. CHD public health also licenses and inspects temporary food events that are open to the public.

Public health investigates reported cases of food-borne and water-borne illnesses. Public health offers education and assistance to nursing homes, assisted living facilities and other institutional settings with outbreaks.

Environmental health monitors and surveys different water systems. There are community water systems; non-transient, non-community water systems; transient non-community water systems; and state regulated water systems. The water program is a program that has struggled for years. Last legislative session additional dollars were provided and CHD public health was able to hire a part-time environmental health specialist to monitor and follow up on significant non-compliers, to survey one-third of the water systems we need to survey and to work with systems to complete their emergency response plans. There is a possibility that these water dollars will be lost for the next biennium.

ADEQUACY OF OTHER SERVICES IMPORTANT TO THE COMMUNITY

HEALTH CARE ACCESS IN COLUMBIA COUNTY

Columbia County is a designated Health Professional Shortage Area in 2008 and 2009 surveys, and has been the most medically underserved county in Oregon, according to the State of Oregon's Area of Unmet Healthcare Needs evaluation. To attract more healthcare professionals and provide more healthcare options, in 2000 the Public Health Administrator researched the Federal Critical Access Hospital Program and secured a grant from the Northwest Oregon Economic Alliance. The grant funded a joint project with the Office of Rural Health to assess the county's needs, and propose solutions. Following the assessment, the District gave voters an opportunity to weigh in. In 2004, the voters approved with a 58% margin, a small tax rate to build a community hospital.

Since that time, CHD has hired an architectural and management firm, updated the original feasibility study twice, conducted a property search and purchase and applied for the state's Certificate of Need. We are looking for Federal and State grants for equipment and medical records infrastructure, and will begin a local giving program. Columbia River Community Hospital is slated to open in 2010.

The CHD Board has emphasized throughout the process that they want this 12-bed hospital with a 24/7 ER to be an active member of the community and a hub for

healthcare activities. The Board is emphasizing the need for state-of-the-art medical records to connect to larger hospitals and to monitor health status and identify quickly community health problems. Having a local hospital will also allow closer monitoring of local public health threats and setting community priorities. During disease outbreaks, Public Health staff can network with the established hospital framework to work together to best protect our population.

Not only is health care access limited in Columbia County, but also healthcare costs in Oregon and the U.S. have been growing at a rate higher than the rest of the market for the last decade. For clinical services provided, CHD-PHA is able to bill Oregon Health Plan to balance a portion of the rising costs. For those who are privately insured, there is a sliding scale based on household income. Uninsured patients are assisted in applying for enrollment in the Oregon Health Plan. The Office of Health Policy and Research presented a paper to the 74th legislative assembly titled “Trends in Oregon’s Healthcare Market and the Oregon Health Plan.” The paper is summarized below, to show the impact of Oregon Health Plan trends on individuals, families, and local public health authorities.

The main drivers of healthcare costs are: growing and shifting population, age distribution, racial and ethnic makeup, and economic factors. Oregon families do not have the financial capacity to contribute significantly toward healthcare costs until they are earning at least 250% of the federal poverty level (\$51,625 for a family of four in 2007). Increasingly expensive health insurance premiums and declining employer-sponsored coverage are both likely contributors to Oregon’s uninsured population, which remained statistically flat from 2004 at 17% uninsured to 15.6% uninsured in 2006. Unemployment in Columbia County is 14% as of April 2009, and with unemployment we see rising rates of uninsured.

Of Oregon Health Plan (OHP), Medicaid and SCHIP enrollees approximately 55% are children 18 years and under, 35% adults 19-64 years of age, and 9% adults 65 years and older.

A 2004 survey of children from low-income families in Oregon found that children without a usual source of care were three times more likely to be taken to an emergency room or an urgent care clinic for regular care. The School-Based Health Center planning efforts attempt to improve children’s access to primary care, thus reducing emergency room/urgent care visits.

Oregon’s health care safety net is a community’s response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services. Oregon’s healthcare safety net includes:

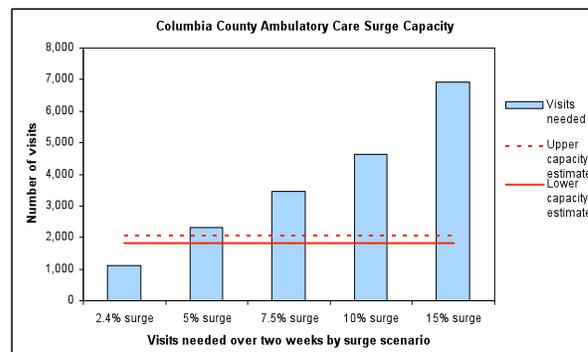
Type of Center	# in Columbia County
Federally Qualified Health Centers	0
Rural Health Centers	2
Tribal Health Centers	0
County Health Departments	1
Migrant Health Centers	0
School-Based Health Clinics (SBHC)	2
Veteran's Administration Clinics	0
Volunteer and Free Clinics	0
Hospital emergency departments	0
Some private healthcare providers	NA

Chronic disease in Oregon represents areas of opportunity for the state where improved quality and access to primary healthcare can improve health status and reduce costs associated with these conditions. Although heart disease has decreased over the last fifteen years, diabetes has increased. High-risk conditions such as high blood pressure, high cholesterol, and obesity are strongly related to many chronic conditions. Screening for these conditions can help to detect chronic disease early in its development. Decreasing prevalence of these conditions is important in reducing the chronic disease burden in the population. In 2008, CHD public health was awarded competitive funding to participate in an innovative initiative to reduce chronic disease through policy, systems, and environmental change. In 2009 additional implementation funding was awarded at the state level, as well as competitive grant funds from the Centers for Disease Control and Prevention and the National Association of City and County Health Officials.

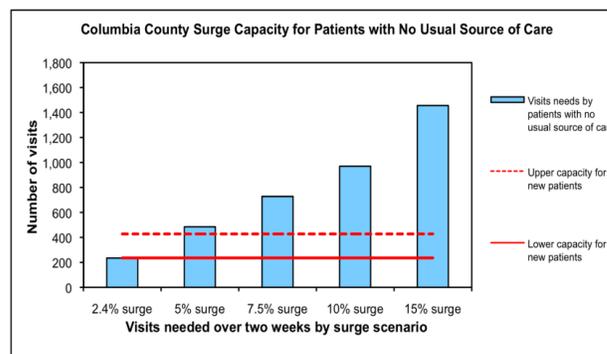
MEDICAL SURGE CAPABILITIES

Public Health Preparedness (PHP) is a public health program that networks and plans with the community medical system. The two entities support each other for the community's benefit. All medical clinics must have plans that address surge capacity as well as employer absenteeism during emergencies. Public Health has the system to access Strategic National Stockpile (SNS) supplies and the Medical Rescue Corp to assist in emergencies. The chart below shows that Columbia County would exceed a 5% capacity with less than 2000 extra visits.

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



The next chart shows that Columbia County's uninsured population would be overwhelmed at 2.4% surge (approximately 200 visits over two weeks). Columbia County clearly needs increased access to services. A hospital and more School-Based Health Centers would help with this need.

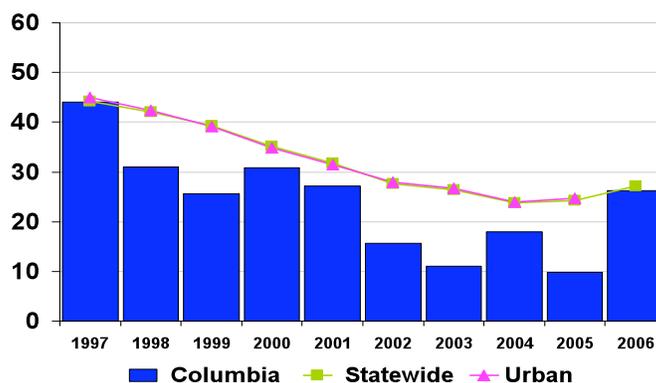


Columbia County needs improved health care access, particularly for the uninsured and low-income population.

PREGNANCY OUTCOMES AND RELATED ISSUES

Another significant health issue for Columbia County residents is women's health. CHD-PHA helps meet the health needs of women and children through multiple programs including the family planning program. In 2006, the family planning programs were required to implement new guidance from Centers for Medicare and Medicaid Services (CMS). In order to be eligible for a subsidized visit, a client has to provide proof of United States residency (picture ID plus birth certificate).

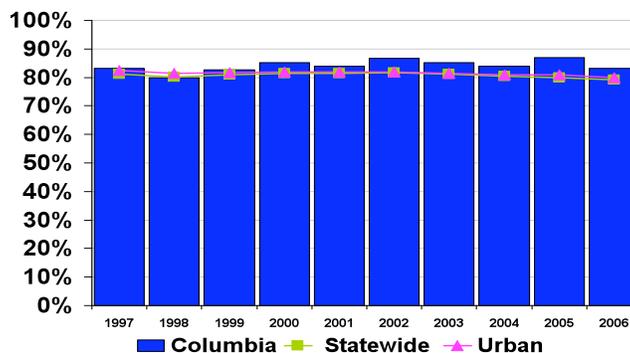
Pregnancy rate per 1,000 females ages 15-17



The number of clients receiving access to family planning services in out clinic declined.

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

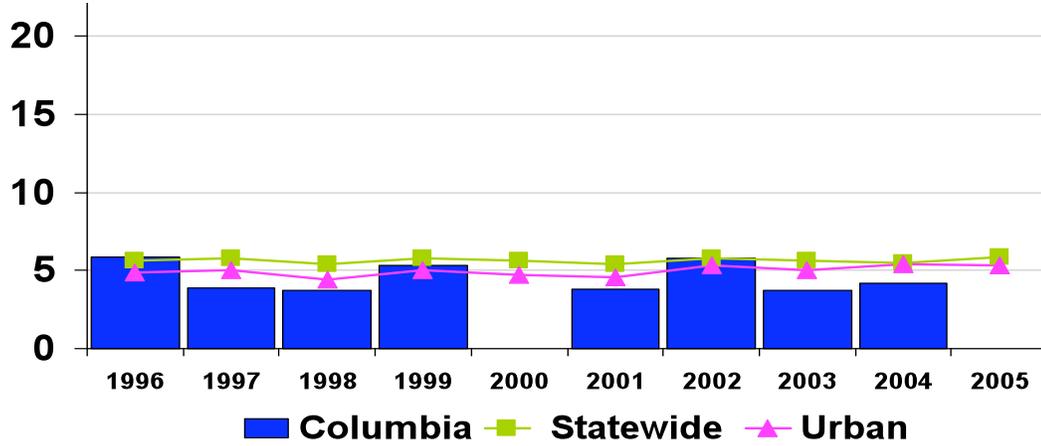
Oregon Department of Human Services, Center for Health Statistics, Oregon Vital Statistics
Annual Report Oregon Benchmark



CHD public health offers prenatal care. Although access has not changed much over time, Columbia County is still slightly better than the state average, overall.

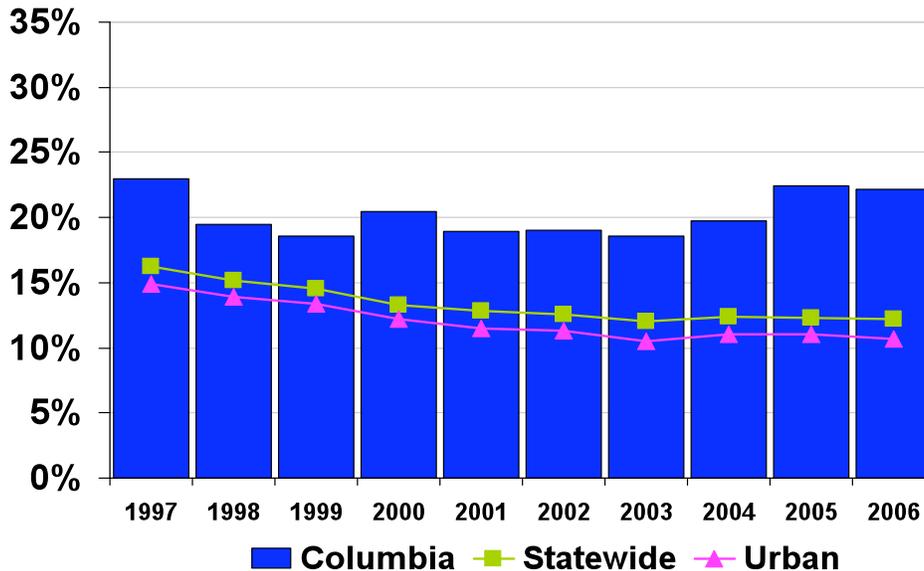
Infant mortality rate per 1000

Oregon Department of Human Services, Center for Health Statistics, Oregon Vital Statistics
Annual Report Oregon Benchmark 41



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

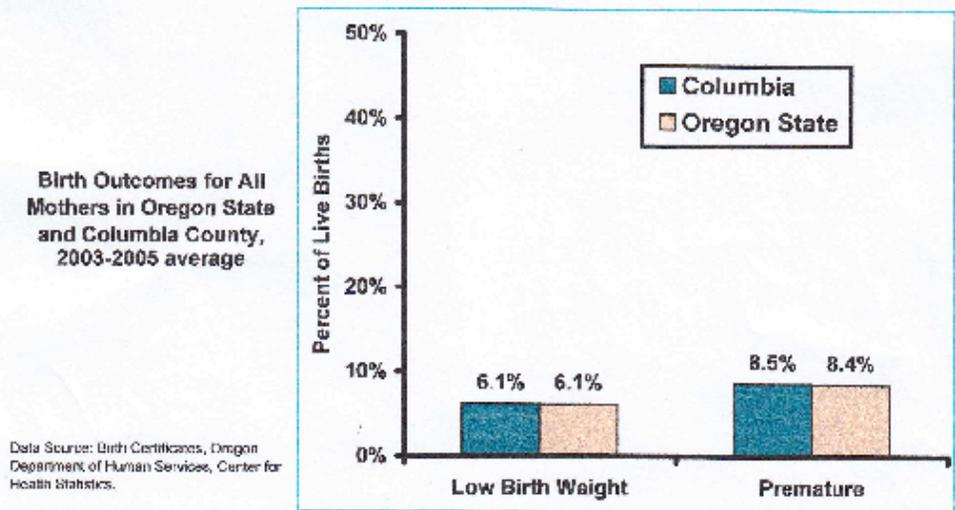
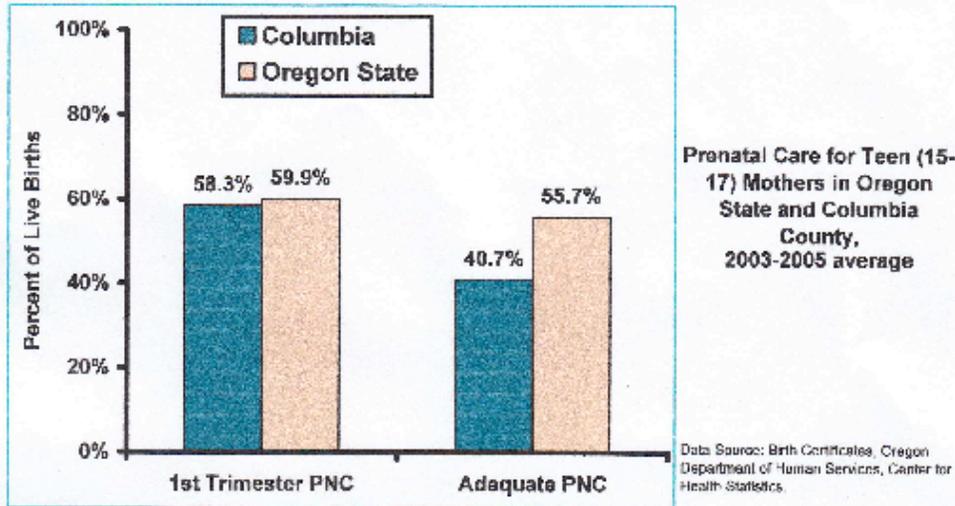
Oregon Department of Human Services, Center for Health Statistics, Oregon Vital Statistics
Annual Report Oregon Benchmark 53b



Infant mortality during 2001 was higher than the year prior, but better than Oregon's average, when comparing a five-year average rate. In 2004, there were two infant deaths. This is a difficult indicator to make statements about

because the numbers are too small for statistical comment. Columbia County has no obstetricians/gynecologists. Public Health offers a prenatal care program in conjunction with Oregon Health Sciences University. Legacy Health Systems offers prenatal care in St. Helens with two nurse midwives.

Teen Pregnancy and Birth in Columbia County, 2005



Prepared By: ORDHS, Office of Community Health and Health Planning (April 2007) using VistaPHw
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Pregnancy totals for all ages in Columbia County, Oregon, 2007 = 537. *Oregon Vital Statistics County Data 2007, DHS, Table 2-10.

Of this total, 4.3% received inadequate prenatal care (less than 5 prenatal visits or care began in 3rd trimester). This is significantly lower than the State average of 6.4%. Columbia County ranked in the top 10 for clients who received adequate prenatal care. **Oregon Vital Statistics County Data 2007, DHS, Table 2-20.*

In 2007, 84.1% of the 537 pregnant women in Columbia County, received prenatal care in the 1st trimester, this is significantly higher than the State average of 78.4%. **Oregon Vital Statistics County Data 2007, Table 2-20.*

Of the 537 total live births, 23 infants were born with low birth weight, or a low birth rate of 42.8 per 1000 births, compared to the State average low birth rate of 61.0 per 1000 births. **Oregon Vital Statistics County Data 2007, DHS, Table 2-32.*

Based on the Perinatal Data provided by DHS, Columbia County Public Health Authority provided prenatal care to 109 unduplicated women from July 2006 to June 2007:

- 89 were unplanned
- 89 had Nutritional Risk Factors
- 35 had Tobacco Use
- 13 had Substance Abuse Issues
- 4 noted Domestic Violence
- 18 had no High School Degree
- 0 were 17 years of age or under
- 4 were homeless
- 79 were unmarried

Maternal Risk Factors by County of Residence, Oregon 2007 shows Tobacco use in the 537 pregnant women in Columbia County was 16.1%, our County ranks 18th in the State of Oregon, above the State average of 11.7%. **Oregon Vital Statistics County Data 2007, DHS, Table 2-15.*

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

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

DISEASE PREVENTION AND HEALTH EDUCATION

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

Cause of Death	CHD-PHA Program to prevent
Tobacco use or second-hand smoke	Tobacco Prevention and Education Program (TPEP)
Poor diet	Healthy Communities Women, Infants, Children (WIC)
Alcohol consumption	
Microbial agents	Communicable Disease Environmental Health Immunizations Emergency Preparedness
Toxic agents	
Motor vehicle accidents	
Firearms	
Sexual behavior	Family Planning Students Today Aren't Ready for Sex (STARS)
Illicit drug use	

This year our county will receive a full grant for tobacco prevention dollars. Columbia County will educate and work with businesses and government around business policy. This program also works with schools and student groups. We also have a newly established school-based health center (2 total), and private grants to continue planning for two additional health centers.

Oregon has an Indoor Clean Air Act. The counties respond to complaints and provide the footwork for the state. The state health division also has limited funds available to provide some counties with a "Healthy Communities" grant to help prevent, diagnose and manage chronic diseases in local communities. Columbia County is a recipient of one of these grants. Additional steps are being taken to implement the three-year Healthy Communities plan, comprised of objectives established by the Columbia Community Health Advisory Council.

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

The second actual cause of death in the U.S. is poor diet. Counties provide diet education to several population groups. Through WIC, counties serve pregnant and breastfeeding women, infants and children through the age of four with nutritional risks. School-based health clinics and women's health clinics assess diet and educate if the client is interested. Columbia County has two school-based health centers: one in St. Helens that serves the K- 8 grade population, and one in Rainier

that serves K-12 grades. There are two other communities interested and planning for school-based health centers. The Columbia County Extension Service provides the community education programs available to the general public in our county.

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

The fourth largest actual cause of death in the U.S. is microbial agents. Public health has invested dollars that will help protect the entire population. CHD public health has for 20 years offered both influenza and pneumonia vaccinations to the entire population. Currently, the state is purchasing influenza vaccines. As part of our public health preparedness plan, we have developed a pandemic attachment to our overall county emergency plan. This funding gives us the opportunity to plan for the most likely major public health problem that might occur. Planning is essential and so is practice. The agency is practicing, using these vaccines and administering them to infrastructure resources in our communities as well the general population. The 2009 H1N1 influenza gave us the opportunity to exercise our communication, education and messaging skills. Staff turnover means that plans are not necessarily followed and chaos is created, so we continue to test our plans and exercise our employees on a yearly basis.

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

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

Illicit drug use is the ninth actual cause of death in the CDC list. Our community mental health agency does the only drug treatment with extensive education in our county. The unmet needs are many here. The dollars are finite and stretched thinner and thinner each year.

SECTION 3: ACTION PLAN

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EPIDEMIOLOGY AND CONTROL OF PREVENTABLE DISEASES

DESCRIPTIONS OF PROBLEMS, GOALS, ACTIVITIES

The role of public health and communicable diseases is defined in ORS 413.416 2(a) and the Oregon administrative rules 333-014-0050(2)(a). In this law it specifies the diseases of public health importance that must be reported by diagnostic laboratories and health care professionals. Local health departments are the first to investigate reports. Their role according to the 2007 Oregon Communicable Disease Summary is to collect demographic information about the case, characterize the illness, identify possible sources of the infection, and to take steps to prevent further transmission. Program elements # 01, #03 and #07 are the state contract components that allow funding of the activities and that define the requirements local counties are required to perform. Together funding, epidemiologic, and laboratory data constitute Oregon's surveillance system.

This table is a side-by-side comparison of some communicable diseases and their incidences in Columbia County in 2004 and 2007. The table shows minor changes in most of the reportable conditions listed:

Communicable disease	2004	2007
HIV/AIDS	2	25 (prevalence)
Campylobacteriosis	9	4
Chlamydiosis	72	96
Cryptosporidiosis	0	1
E.coli 0157	1	0
Giardiasis	2	5
Gonorrhoea	9	7
Haemophilus influenza	0	1
Hepatitis A	0	0
Hepatitis B (acute)	1	2
Hepatitis B (chronic)	1	1
Hepatitis C (acute)	0	0
Hepatitis C (chronic)	N/A	280(prevalence)
Hemolytic-uremic syndrome	0	0
Legionellosis	1	0
Leprosy	0	N/A
Listeriosis	0	0
Lyme Disease	0	0
Malaria	0	0
Meningococcal Disease	1	0
Pertussis	10	0
Q Fever	0	N/A

Communicable disease	2004	2007
Rabies, animal	0	0
Relapsing Fever	0	N/A
Salmonellosis	3	4
Shigellosis	4	1
Early Syphilis	0	0
Tuberculosis	0	0
Tularemia	0	N/A
Vibrio parahaemolyticus	0	N/A
West Nile	0	0
Yersiniosis	1	N/A

Chlamydiosis has continuously increased since 2004. It has also increased continuously statewide since 1998. Hopefully, this is a result of more people receiving health care and more practitioners testing for Chlamydia. Since chlamydia is bacterial it is easily treatable with follow through on the part of the cases and their partners.

Giardiasis has also been decreasing statewide since 1998 although not in Columbia County. This county provides lots of camping opportunities that include chances to drink untreated water out of rivers and streams that have been contaminated by animal excrement.

H. influenza now can be prevented by vaccination. However, there is currently a vaccine shortage and the current recommendation is to delay the last dose of the four dose vaccine series. There can also be cases of non-vaccine serotypes of H. influenza and this could be causing a new replacement disease in the 0-4 yr. old population and the more than 50 yr. old population.

Hepatitis A has constantly decreased since the vaccine was licensed in 1995. Columbia County hasn't had a case of Hepatitis A disease in several years. The school immunization law now includes hepatitis A vaccine as mandatory, so we expect even less disease. Statewide, there were only 33 cases of Hepatitis A disease in 2007.

The Hepatitis B vaccine has also caused the same impact on disease statistics. Hepatitis B disease has decreased continuously statewide since 1998. The behaviors that expose a person to Hepatitis B are still prominent – unclean needle use and/or unprotected sex with a person who carries the virus.

There are more cases of chronic Hepatitis C in our county than all the other combined reportable diseases total. While we recorded no cases of acute Hepatitis C disease, we are overwhelmed with case reports for chronic Hepatitis C disease.

There is no vaccine available for Hepatitis C. The specific test that isolates Hepatitis C from other hepatitis viri is fairly new.

Meningococcal diseases have decreased statewide and in Columbia County since 1998. A vaccine exists to prevent this disease.

Columbia County in 2004 had ten cases of Pertussis. Statewide and nationally the cases of Pertussis increased until a new vaccine was introduced. The Pertussis component of the DTP vaccine was only given in children 0-6 yrs. Many of the cases of Pertussis disease were in older children and adults. A new vaccine was approved for an older population. The state has given Columbia County Tdap “special projects” vaccine to help increase the number of people protected by the new vaccine. By being immunized, this group will prevent others from acquiring the disease. In 2007, Columbia County had zero cases of Pertussis disease.

The N/A listings in the above table is due to a revision of the reportable disease statute. These diseases no longer have a separate listing, but would still be reportable under the category of “uncommon illness of potential public health significance”.

In other communicable disease activities, public health is required to investigate outbreaks. In FY 2009, CHD public health investigated five potential outbreaks. One outbreak was linked to norovirus. Another investigation was an active tuberculosis case that exposed a worksite. We also had the yearly experience of having a large percentage of children home ill from school and trying to determine if it was anything specific or a combination of many illnesses. Specimens were collected with some results positive for influenza A and some results positive for influenza B. There were also positive streptococcal specimens.

The program elements of PE #01 and #03 include operating a communicable disease program in accordance with the requirements and standards set forth in ORS chapters 431, 432, and 437 and OAR chapter 333, divisions 12, 17, 18, 19 and 24. The local program must investigate individual cases of specific diseases that have the potential for becoming outbreaks and actual outbreaks of communicable diseases, institute appropriate control measures and submit reports to the Oregon Public Health Division.

Program element #07 allows Columbia County to provide HIV testing and counseling. The program requires a trained counselor who can assess risk, draw venous blood samples, and counsel clients according to their risk. The program also includes community outreach to populations that might be at risk. Columbia County uses the Partnership Project at OHSU for referrals. The Partnership Project provides an opportunity for persons living with HIV/AIDS to access medical and social services in the Portland metro area. All of the health systems as well as

government are represented by the Partnership Project. Program element #07 has its own planning format and is not presented within this document.

COMMUNICABLE DISEASE INVESTIGATION AND CONTROL

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

The following is an action plan for one of our communicable disease program goals:

Objectives	Activities	Outcome Measures	Evaluation
Columbia County will have a CD program that follows the standards and guidelines of Oregon during the CTP timeframe	Program staff (nurse, office manager, administrator and environmental health specialist) will: <ul style="list-style-type: none"> • Monitor lab reports daily • Access OHD CD website for investigative guidelines and forms to complete on each report • Contact physician for information • Contact client for information • Give educational information to client based on individual needs • Refer client to their MD for further information and care • Offer safety net services as available through CHD public health (including immunizations) • Enter data into state database • Field community questions • Access state on call person with any unusual circumstances • Consult with health officer if needed 	Reports will be filed in a timely manner Disease transmission will be limited through education and referral	
CD outbreaks will be investigated in a timely manner throughout the CTP timeframe	Program staff will: <ul style="list-style-type: none"> • Call state and acquire an outbreak number • Supply test kits based on symptoms • Educated and instructed facility staff on collection and collection process • Transport specimens to OPHL for testing • Provide education on breaking chain of transmission • Provide literature to facility staff • Provide updates to the facility as results become available • File report with the state CD section 	Limit transmission of communicable disease in group facilities Provide education to clients and facility staff Provide testing for some communicable diseases	

Objectives	Activities	Outcome Measures	Evaluation
Education and Training for program staff will be offered at least yearly	Program Staff will: <ul style="list-style-type: none"> • Attend OR-EPI • Complete CD 101 • Complete CD 303 • May attend other trainings as available and budget allows 	Program staff have completed training or are in process	
CD will have a 24/7 call system during the CTP timeframe	<ul style="list-style-type: none"> • A 5 member team exists to provide on call coverage for CD et.al • Each member has call once every 5 weeks • On-call member must test other members once each week with calls or e-mails • Response times will be less than an hour for this team 	<p>The on call team files a call out test roster response sheet each week</p> <p>If test is via HAN, HAN will use the member profiles</p>	

TUBERCULOSIS CASE MANAGEMENT

Program element #03 defines the local responsibility and minimum services required for a tuberculosis program. Columbia County received \$226 for this service in FY 2009. This hardly covers the cost of one investigation. Yet, the requirements include testing, reading the results (48-72 hrs. later), follow up referrals for more specific testing, working with the health care community to assure treatment of any person testing positive and tracking down others that might have been exposed. The standard of care for treatment is observing the client taking the medicine daily or however often the medication is given. TB is increasing in the world and the U.S. due to a standard that cannot be financed. In addition, TB is increasing and becoming resistant to many of the standard treatment drugs due to noncompliance.

TOBACCO PREVENTION AND EDUCATION PROGRAM

Columbia County conducts Tobacco Prevention and Education Program (TPEP) activities. As described in Section I, part 3, TPEP attempts to tackle the number one cause of death, according to the CDC. Attachment 1 has the TPEP Action Plan for the 2009-2010 fiscal year, as presented to the state DHS office (contact below).

Tobacco Prevention Education Program:

Jacqueline Villnave, MPH
Community Programs Liaison
Diabetes Program Coordinator
Health Promotion and Chronic Disease Prevention Program
Oregon Public Health Services, DHS
800 NE Oregon St., Suite 730
Portland OR 97232-2162
phone 971-673-1039

PLANS FOR OBESITY, ASTHMA, AND DIABETES MANAGEMENT

Attachment 2 has the Healthy Communities (formerly called Tobacco Related and Other Chronic Diseases TROCD) program plan. The Healthy Communities program focuses on reducing asthma, obesity, arthritis, and other chronic diseases through policy, system, and environmental change.

Healthy Communities Program:

Jacqueline Villnave, MPH
Community Programs Liaison
Diabetes Program Coordinator
Health Promotion and Chronic Disease Prevention Program
Oregon Public Health Services, DHS
800 NE Oregon St., Suite 730
Portland OR 97232-2162
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PARENT AND CHILD HEALTH SERVICES, WITH FAMILY PLANNING CLINICS

PROBLEMS, GOALS, ACTIVITIES AND EVALUTIONS OAR 333-014-0050

Columbia County statistics showed an estimated 2,495 *Women In Need (WIN)* 2007, ages 13-44 according to the *Title X Family Planning Agency Data* information provided by DHS. Our family planning clinic served 692 unduplicated female clients, 10-44 years of age for FY 2008, or 27.7% of *Women In Need (WIN)* with the state average of 29.6%. From the *Title X Family Planning Agency Data* we also see that there were 531 *Women in need (WIN)* Teens 13-19 years of age for FY 2007. We also served 276 unduplicated female teen clients 10-19 years of age for the FY 2008, or 39.3% teen clients as a % of total clients, well above the State average of 28.8%.

Pregnancy Rates of Teens by County of Residence, Oregon 2007 shows teen pregnancy rate in ages 10-17 as 3.9 per 1000 women in Columbia County. This is significantly lower than the State average of 10.1%. (We are the 3rd lowest in the State!). **Oregon Vital Statistics Annual Report 2007, DHS, Table 10.1*. This is a reduction from the Oregon 2006 data, which showed the teen pregnancy rate ages 10–17 as 11.2 per 1000 women. Our Teen pregnancy rate for 10-17 year old women CY'04 = 6.6 – 5 year average = 7.4 (State rate CY'04=9.5). Our Rolling Rate from 10/04-0/05 = 4.0, well below the State Rolling Rate = 9.5. **Data supplied by Cheryl Connell at 11/06 Data Review*.

Our moving total, rolling rate and 2007 YTD Preliminary Rolling Rate (Jan. '07 to Dec. '07) = 3.6, the 3rd lowest in the State! And well below the State Rolling Rate=8.8 for 2007. **Teen Pregnancy Chart, DHS*. Many teens in Columbia County are unemployed, or working at minimum wage jobs. The U.S. Census 2000 Quick facts shows the percent of High School graduates in Columbia County aged 25+ as 85.6%,

and those with a Bachelor's degree or higher as 14.0%. The Median household income in Columbia County for 2007 = \$53,657. *U.S. Census Bureau State & County Quick Facts. Postponing parenthood will allow these young adults more time to improve their wages, continued education and employment possibilities. The Family Planning Program – FY 2008 Data Review provided from DHS reports that our agency averted 57 teen pregnancies (under 20 years of age) and 89 Adult pregnancies (20+ years old).

Columbia County is a rural community with an estimated population of 48,996 people in 2007. *U.S. Census Bureau State & County Quick Facts. Columbia County has over 500 births a year, but no hospital where women can deliver their babies. They must travel to Washington state or to Portland to a hospital or deliver their babies at home. Women have access to three nurse midwives and one family practice physician countywide for prenatal care. Most women travel to Portland for prenatal care. High-risk pregnant women are referred to Portland for their care. There are no local doctors who manage high-risk pregnancies. There is currently limited public transportation system, and our clients must travel by their own transportation, walk, use bicycles, or pay for a Taxi/Columbia River Rider bus service.

Our clinic hours of operation remain limited due to funding and space availability. As funds become available we hope to increase staffing, and clinic hours of operation. We continue to take great pride in providing quality confidential reproductive health care education and information to men, women and teens seeking services.

PROBLEMS, GOALS, ACTIVITIES AND EVALUATIONS FOR DHS CONTRACTS

Included in the services CHD-public health provides is STARS (Students Today Aren't Ready for Sex). STARS is a teen-mentoring abstinence only education program targeted towards middle school students and taught by high school teen leaders. The program provides important skill building tools to help students resist social peer pressure and focus on the message of that it's better to wait. STARS Teen Leaders teach middle school students refusal skills so they are empowered to effectively say "NO" to sexual activity. There are 5 lessons delivered over five consecutive weeks. DHS STARS specialists train the teen leaders. The teen leaders are accompanied by a classroom facilitator in the 6th grade classrooms while delivering the material.

STARS is conducted in St. Helens, Scappoose, and Vernonia School Districts in Columbia County. Each of the school districts delivers the program to the 6th grade. Below is a table with the number of teen leaders and 6th grade participants from each of the school districts. St Helens has been providing the program for about 12

years consistently and its Vernonia and Scappoose’s second year offering the program.

School District	Scappoose	St. Helens	Vernonia
6 th Grade Students	170	270	60
Teen Leaders	10	22	4

Currently there are two Teen Advisory Board (TAB) members from the St. Helens High School. Columbia County is allotted only two TAB members who represent the county at the regional level. TAB members collaborate with other high school students on ways to reduce teen pregnancy rates in their community. Our TAB members have been very instrumental in keeping STARS going in Columbia County.

WOMEN, INFANTS, AND CHILDREN PLAN

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

Year 3 Objective: During planning period, staff will be able to work with participants to select the food package that is the most appropriate for their individual needs.

Activity 1: Staff will complete the appropriate sections of the new Food Package Assignment Module by December 31, 2009.

Resources: Food Package Assignment Module to be released summer 2009.

Implementation Plan and Timeline: Staff will complete the appropriate sections of the new Food Package Assignment module by December 31, 2009 as part of the staff training plan, staff in-services, and monthly staff meetings.

Activity 2: Staff will receive training in the basics of interpreting infant feeding cues in order to better support participants with infant feeding, breastfeeding education and to provide anticipatory guidance when implementing the new WIC food packages by December 31, 2009.

Resources: Sessions on Infant Feeding Cues at the WIC Statewide Meeting June 22-23, 2009.

Implementation Plan and Timeline: Staff will be assigned to attend the Infant Feeding Cues sessions at the statewide meeting. Staff unable to attend the sessions will be trained via one-to-one in-services by attending staff. Anticipatory guidance training has begun, will be evaluated at the July 2009 staff-training meeting and will conclude by December 31, 2009.

Activity 3: Each local agency will review and revise as necessary their nutrition education lesson plans and written education materials to assure consistency with the Key Nutrition Messages and changes with the new WIC food packages by August 1, 2009. **Example:** Pregnant women will no longer be able to routinely purchase whole milk with their WIC FIs. If the nutrition education materials your agency uses indicates all pregnant women should drink whole milk, those materials would need to be revised.

Implementation Plan and Timeline: Classes and educational materials will be reviewed and revised during monthly staff meetings to be sure the information is current and reflective of the key nutrition messages and consistent with the new food packages. Changes and revisions will be completed by August 1, 2009.

Activity 4: Identify your agency training supervisor(s) and projected staff in-service training dates and topics for FY 2009-2010.

Implementation Plan and Timeline: Please see table below

**FY 2009-2010 WIC Nutrition Education Plan
WIC Staff Training Plan – 7/1/2009 through 6/30/2010**

Quarter	Month	In-Service Topic	In-Service Objective
1	July, 2009	Fresh Choices Anticipatory Guidance	To more fully prepare staff to properly educate WIC families regarding food package changes
2	October, 2009	Food Package Assignment Module	To insure the completion of appropriate sections of the new food package assignment module
3	January, 2010	Fresh Choices and Oregon WIC Listens	To review and evaluate the implementation of new food packages and participant-centered counseling
4	April, 2010	Breastfeeding	To review the educational materials and classes offered and how to improve exclusivity/duration rates

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

Year 3 Objective: During planning, each agency will develop a plan for incorporating participant centered services in their daily clinic activities.

Activity 1: Each agency will identify the core components of participant centered services that are being consistently utilized by staff and which components need further developing by October 31, 2009. **Examples:** Use state provided resources such as the Counseling Observation Guide to identify participant centered skills staff are using on a regular basis. Use state provided resources such as self-evaluation activities done during Oregon WIC Listens onsite visits to identify skills staff are working on and want to improve on.

Implementation Plan and Timeline: Staff will continue to use participant-centered counseling, peer observations and other state-provided tools to improve their Oregon WIC Listens skills. Monthly staff meetings will include a short O.W.L. in-service with an opportunity for staff to share their experiences, concerns, and/or successes.

Activity 2: Each agency will implement at least two strategies to promote growth of staff's ability to continue to provide participant centered services by December 31, 2009. **Examples:** Using the information from Goal 2, Activity 1, schedule quarterly staff meeting time to review Oregon WIC Listens Continuing Education activities related to participant centered skills staff identified they want to improve on.

Schedule time for peer-to-peer observations to focus on enhancing participant centered services.

Implementation Plan and Timeline: The quarterly staff training scheduled for January 2010 will focus specifically on Oregon WIC Listens continuing education and staff will complete their peer-to-peer observations by December 31, 2009.

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

Year 3 Objective: During planning period, each agency will develop a plan to consistently promote the Key Nutrition Messages related to Fresh Choices thereby supporting the foundation for health and nutrition of all WIC families.

- *Breastfeeding is a gift of love.*
- *Focus on fruit.*
- *Vary your veggies.*
- *Make half your grains whole.*
- *Serve low-fat milk to adults and children over the age of 2.*

Activity 1: Each agency will implement strategies for promoting the positive changes with Fresh Choices with community partners by October 31, 2009.

Example: Determine which partners in your community are the highest priority to contact such as medical providers, food pantries, breastfeeding coalitions, and/or Head Start programs. Provide a staff in-service, written materials or presentation to those partners regarding Fresh Choices.

Implementation Plan and Timeline: Fresh Choices materials will be distributed to all local preschools, HeadStart programs, food pantries, and medical providers by October 31, 2009.

Activity 2: Each agency will collaborate with the state WIC Research Analysts for Fresh Choices evaluation by April 30, 2010. **Example:** Your agency is a cooperative partner in a state led evaluation of Fresh Choices such as hosting focus groups or administering questionnaires with participants.

Implementation Plan and Timeline: The local WIC staff will fully cooperate with state research analysts in all of the required Fresh Choices evaluation activities.

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

Year 3 Objective: During planning period, each agency will develop a plan to promote breastfeeding exclusivity and duration thereby supporting the foundation

for health and nutrition of all WIC families.

Activity 1: Using state provided resources, each agency will assess their breastfeeding promotion and support activities to identify strengths and weaknesses and identify possible strategies for improving their support for breastfeeding exclusivity and duration by December 31, 2009.

Resources: State provided Oregon WIC Breastfeeding Study data, the breastfeeding promotion assessment tool and technical assistance for using the tool. Technical assistance will be provided as needed from the agency's assigned nutrition consultant and/or the state breastfeeding coordinator.

Implementation Plan and Timeline: By December 31, 2009, the local WIC staff and the local WIC breastfeeding coordinator will evaluate the breastfeeding materials and classes currently offered to insure they are appropriate and relevant. Any necessary changes will be made by January 31, 2010.

Activity 2: Each agency will implement at least one identified strategy from Goal 4, Activity 1 in their agency by April 30, 2010.

Implementation Plan and Timeline: The use of local one-to-one peer support or peer support groups will be explored as a strategy to promote breastfeeding exclusivity and duration.

IMMUNIZATION PLAN

This is the first year of a new triennial comprehensive plan for Columbia County. The first year of the plan will be for a six-month period of time due to changes defined by the state health division. The last two years of the plan will be twelve-month periods of time. This will change our reporting period to a calendar year rather than a fiscal year (July through June), which better matches how CDC captures data.

Immunizations are one of the best preventive health measures available. The schedule of childhood vaccines developed by the American Academy of Pediatrics and the Centers for Disease Control now help to protect against fourteen diseases. If you review a disease baseline from the 20th century and compare it to prevalence of specific diseases in 2004, the decrease in cases of those specific diseases clearly shows how amazing vaccines are (Red Book: 2006 Report of the Committee of Infectious Diseases, 27th edition). Smallpox, diphtheria, polio, and congenital rubella syndrome have all been decreased by 100% with the advent of vaccines. Other childhood illnesses that can have tragic consequences, such as tetanus, measles, mumps, rubella, and H. influenza type B have also been decreased by percentages that range from 82% to 99% due to vaccines.

For 2007, Columbia County had one case of H. influenza and two cases of hepatitis B. Oregon lists Columbia County in the middle of the range of Oregon counties for both H. influenza cases and hepatitis B occurring from 1998 to 2007. (www.oregon.gov/DHS/ph/imm/Research/index.shtml#county).

The two-year-old up-to-date immunization rate for Columbia County in 2008 was 71%. The SDA region one rate was 73% and the Oregon local health department average was 72%. The immunizations that are included in this rate are: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hepatitis B, and one Varicella. In order to be up-to-date, a two year old has to have received all of the vaccinations listed above. This information comes from the 2008 Annual Assessment of Immunization Rates and Practices provided by the OSPH division immunization program. The goal would be to have 100% of two year olds up to date.

Vaccines have even become a method for preventing specific cancers caused by some types of the human papilloma virus. The HPV vaccine became available in Columbia County in 2007. It has the potential to decrease cancers as well as decrease pap smear abnormalities caused by this virus and therefore decrease costs of health care. Another new vaccine is herpes zoster vaccine. This vaccine helps prevent shingles in older adults. Columbia County is not yet able to offer this vaccine except by special arrangement due to its high cost.

Most of our vaccines are provided through a CDC grant and we order and receive vaccines on a monthly basis. We are obligated to pay the cost of any vaccine that is destroyed or lost by other means. We also receive a grant from the state of Oregon. For fiscal year 2009, Columbia County received \$15,321. Program element #43 of the state contract clarifies all the requirements that the health department must meet in order to receive this grant. This grant supports one day each week for immunization activities. This day includes immunizing children, ordering vaccine, completing the monthly vaccine report to the state, completing review process forms, transferring vaccine administration data via electronic transfer, completing the immunization status report, and completing the annual progress reports, and completing the outreach and education activities. The goals and objectives selected for this program follow in the chart listed “Immunization Comprehensive Triennial Plan”.

OTHER AREAS

MATERNAL CHILD HEALTH SERVICES

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

Goal:

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

Activity:

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

Evaluation:

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

FAMILY PLANNING ANNUAL REPORT AND PLAN

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

Year of Activity	Problem Statement	Objective(s)	Planned Activities	Evaluation	Progress (those currently in process) as of 2009
2008-2009	Only 2.3% of total clients are male.	Increase the percentage of male clients served by 1%.	<ul style="list-style-type: none"> Attend community events, i.e. fairs and festivals, and provide FPEP flyers and information. Continue community outreach. Attend Vernonia and Rainier School Health Committee Council Meeting. Make clinic Male-friendly environment 	Increase number of males seen by 1% in December 2008 data.	<ul style="list-style-type: none"> From the Title X Family Planning Agency Data FY 2008, only 1.8% of total clients served were male, with the State average of 4.3%. Continuous community outreach, i.e. attending fairs and festivals, providing FPEP flyers, and information. Continue to make/sustain clinic as a male-friendly environment.
2009-2010	Changes in FPEP Enrollment has led to increased staff time without additional reimbursement, threatening the ability of the agency to maintain current level of service.	Increase revenue from donations by 1% for the period ending June 30, 2010	<ul style="list-style-type: none"> Acquire a sample donation Policy and Procedure from Oregon DHS consistent with Title X guidelines to adapt for use at CHDPHA. Ongoing training of staff on donation policy and procedure. Evaluate Policy for consistency, fairness and effectiveness. Utilize Ahlers scheduling/billing program for donation requests. 	Quarterly and fiscal year end revenue reports. Customer feedback.	Not yet started

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

Year of Activity	Problem Statement	Objective(s)	Planned Activities	Evaluation	Progress (those currently in process)
2008-2009	There were 443 Women in need teens 13-19 years of age for FY 2006. Our clinic served 301 unduplicated female teens 10-19 for FY 2007, or 41.3% (State average is 27.4%).	Increase the percentage of teen clients seen by 1%.	<ul style="list-style-type: none"> Attend community events, i.e. fairs and festivals, and provide FPEP flyers and information. Continue community outreach. Attend school based health center countywide planning meeting March 6th. Attend Vernonia and Rainier School Health Committee Council Meeting. 	Increase number of teens seen by 1% in the December 2008 data.	<ul style="list-style-type: none"> From the Title X Family Planning Agency Data FY 2007/2008: there were 531 Women in need teens 13-19 years of age for FY 2007. Our clinic served 276 unduplicated female teens 10-19 for FY 2008, or 39.3%, with the State average of 28.8%. Continuous community outreach, i.e. attending fairs and festivals, providing FPEP flyers and information.
2009-2010	Implanons – none inserted to date	<ul style="list-style-type: none"> CNM will offer Implanon as BC Method Insertion of Implanon device 	<ul style="list-style-type: none"> Identify clients that are suitable for the Implanon CNM will complete training/become certified in Implanon insertion Procedure Policy developed with surgical/patient consents developed. 	# of Implanon inserted.	Not yet started

PLANS FOR OTHER MCH ACTIVITIES

CHD-Public Health also coordinates the planning and implementation of new School-Based Health Centers in the county. In 2000, St. Helens School District opened Sacagawea Health Center, serving students up to 8th grade. In 2009, Rainier School District opened the Rainier Health Center serving kids in grades kindergarten through high school. The coordinator is currently working with St. Helens to plan for a high school SBHC in 2010, and Vernonia School District to plan for a SBHC in 2011. School-Based Health Centers improve health care access on 46 campuses in Oregon. In Columbia County, where health care access is particularly limited, SBHCs have impacted many families. For additional SBHC information, please contact Rosalyn Liu.

School-Based Health Centers:

Rosalyn Liu, Systems Development Specialist
School-Based Health Center Program
Adolescent Health Section
Office of Family Health
Oregon State Public Health Division, DHS
800 NE Oregon St, Ste 825
Portland, OR 97232
Phone: 971.673.0248
Fax: 971.673.0240
Email: rosalyn.liu@state.or.us

DESCRIPTION OF SERVICES

The responsibilities of the state Office of Environmental Health, DHS Public Health and the counties of Oregon are to:

- Assure statewide control of environmental hazards through drinking water protection, radiation protection, environmental toxicology, epidemiology programs
- Regulate food, recreational facilities (including pools and lodging) and the “honest pint”

The local level provides services according to Oregon Revised Statutes 624.010 – 624.121 including such rules concerning construction and operation of restaurants, bed and breakfast facilities, and temporary restaurants as are reasonably necessary to protect the health of those using these facilities. The rules include:

1. Water supply adequate in quantity and safe for human consumption
2. Disposal of sewage, refuse and other wastes
3. Cleanliness and accessibility of toilets and hand washing facilities
4. Cleanliness of the premises
5. Refrigeration of perishable foods
6. Storage of food for protection against dust, dirt and contamination
7. Equipment of proper construction and cleanliness of equipment
8. Control of insects and rodents
9. Cleanliness and grooming of food workers
10. Exclusion of unauthorized persons from food preparation and storage areas
11. Review of proposed plans for construction and re-modeling of facilities subject to licensing

DESCRIPTION OF HOW PROGRAM REQUIREMENTS WILL BE MET

Columbia County has 123 restaurants. Each restaurant is inspected twice/year routinely. If issues arise, follow up inspections occur. Columbia County had 240 temporary restaurants last year with 150 temporary restaurants at summer events. Columbia County has a county fair, city festivals, 13 Nights on the River (a weekly event all summer long) in St. Helens. All events require licensing to protect the public's health by inspecting to assure standards are in place.

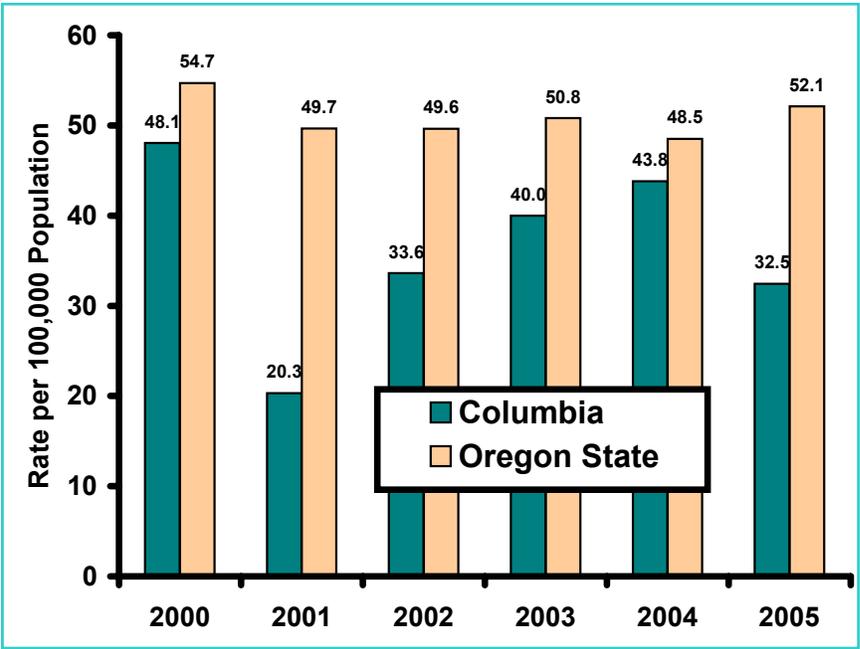
ORS 624 also requires that “any person involved in the preparation or service of food in a restaurant or food service facility licensed under ORS 624.020 or 624.320 must complete a food training program and earn a certificate of completion within thirty days after hire”. CHD public health offers food handler’s books and testing during regular business hours. The website also provides a link in order to take the food handler’s test online. The online testing and permitting is offered in conjunction with Lane County.

ORS 448.005 – 448.090 regulate traveler’s accommodations, recreational parks, colleges, schools, organizational camps (446.310), clubs, pools, wading pools connected to private and public businesses. Columbia County has 190 traveler’s accommodations and pools. These accommodations are inspected routinely.

Water systems are regulated under ORS 448.115 – 448.285. The purpose of this statute is to ensure that all Oregonians have safe drinking water and provide a simple and effective regulatory program for the drinking water systems. The combined state/ local system is a means to improve inadequate drinking water systems. The federal safe drinking water act strives to provide good water quality with technical, financial, and educational assistance. The state/local program provides useful water quality information for the public and partners. Water quality standards provide protection to the public and preservation of the water of the state. Along with monitoring and best practices the state strives to maintain quality water standards.

The two charts below compare Columbia County and the state of Oregon on

- Food and waterborne disease rates from 2000 – 2005 and
- Rates of selected food and waterborne disease from 2000 – 2005 averages

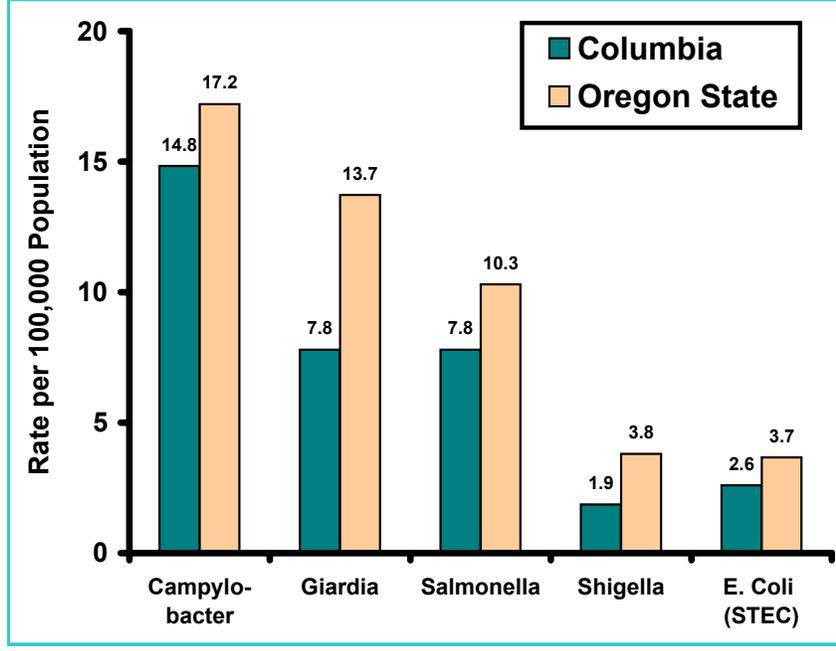


Food & Waterborne Disease Rates in Oregon State and Columbia County, 2000-2005

Includes Campylobacter, Cryptosporidium, Cyclospora, E. coli (STEC), Giardia, Listeria, Salmonella, Shigella, Vibrio, Yersinia

Data Source: Oregon Department of Human Services, Acute and Communicable Disease Prevention.

Rates of Selected Food & Waterborne Disease in Oregon State and Columbia County, 2000-2005 average



Data Source: Oregon Department of Human Services, Acute and Communicable Disease Prevention.

Columbia County had lower disease rates and rates of selected food and waterborne diseases than the state for this period of time. The data source for this information is the Oregon Department of Human Services, Acute and Communicable Disease Prevention. Although Columbia County has lower rates than the state of Oregon overall, the county still struggles with those diseases. Columbia County also struggles with having staff to respond to outbreaks and disease investigations. Columbia County will work on two goals for the next fiscal year.

1. Timely response to institutional outbreak settings

- a. Epidemiological response will commence within 24 hours of notification
 - Environmental health specialist or nurse will establish an outbreak investigation with the state
 - EHS or nurse will obtain forms from state and disease guidelines
- b. Epidemiological process will be prompt and complete
 - EHS or nurse will open investigation with the facility
 - EHS or nurse will obtain sample test kits
 - EHS or nurse will transport the kits and forms to the PHL
 - EHS or nurse will review test results as they return
 - EHS and nurse will establish a plan of action for the facility
 - EHS and nurse will provide educational materials to the facility
 - Nurse will work with the facility infection control person
 - EHS will inspect and work with the kitchen supervisor (if appropriate to the disease)
 - EHS will fill out state epidemiological report
 - EHS or nurse will check back in with facility for two weeks after chain of infection has been broken
- c. Evaluation will be completed by the nurse and the EHS after each outbreak
 - All staff involved will meet and evaluate process
 - All suggestions for change will be given to the administrator
2. Timely response of significant noncompliers (SNCs) in small water systems to improve water quality for system users
 - a. EHS will respond to SNCs within two weeks of receiving the report
 - EHS will respond to individual SNCs within time frame
 - If unable to meet the time frame, the EHS will notify the administrator
 - Administrator will decide whether to add extra EHS time
 - b. EHS will use process established by the state
 - EHS will work with water system owner for correction or
 - EHS will direct an additional EHS to follow up
 - EHS will work with water system until issue is resolved
 - c. EHS will evaluate process and complete report for the state
 - EHS will submit report to the state
 - EHS will attend continuing education trainings on water quality
 - EHS will evaluate and assist the water system owner if additional resources are needed

HEALTH STATISTICS

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

The recent funding of the Healthy Communities program required the collection and compilation of local-level health statistics. Community resources pertaining to access to health care, fresh produce, physical activity and support groups were inventoried. Additionally, epidemiological statistics were collected from sources such as the Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System, Oregon Healthy Teens, and many others. This inventory will be improved with the completion of a new CDC tool, called the Community Health Assessment Resource Tool (CHART).

Columbia Health District Public Health Authority strives to link people to needed personal health services and assures the provision of health care when otherwise unavailable. Columbia Health District has a new website that is updated by local public health program staff. This site is easy to use and has links to many of our partners. It is an excellent way for the local level to access the state website as well as the CDC website. Public Health also provides information and referral services during regular business hours. A local community action team agency produces a countywide resource booklet that all the local agencies use for referral.

Primary health care services are harder to provide referral for. There are no reduced fee or free clinics in Columbia County. OHSU Scappoose and Legacy St. Helens will provide services and bill clients after the service is provided. CHD public health refers to Outside In in Portland and The Family Health Clinic in Longview, Washington. Because of this lack of health care services, CHD public health has worked toward building a hospital and leading planning around the establishment of school-based health centers. CHD public health contracts with Oregon Health Sciences University School of Nursing for nurse practitioners to provide primary health care services and women's health care services.

CHD-PHA assists eligible people in applying for the Oregon Health Plan. CHD public health has most of their health education materials in alternative language formats. CHD public health has a translator service available. CHD public health provides access via a TTY number. CHD public health works in collaboration with Columbia County regarding vulnerable populations during emergencies and disasters.

CHD-PHA provides a competent public health and personal health care workforce. Life-long learning through continuing education, training, and mentoring is available to CHD employees. CHD public health has monthly staff meetings, an online training system, and offers continuing education activities throughout the year. Employees are encouraged to seek training opportunities connected with their positions. Most employees attend at least one outside training or conference each year. An educated and trained workforce helps public health attain its goals.

PUBLIC HEALTH EMERGENCY PREPAREDNESS

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

Disaster hit in December 2007. During the December “Flood 2007”, Vernonia, Mist, surrounding areas of Clatskanie, and portions of St. Helens were severely affected. The flood was declared a national disaster. The medical needs were many and diverse. Most of the resources came from outside the county because a good infrastructure does not exist. Severe winter storms continued to adversely affect Columbia County during December 2008 and into January 2009 with heavy snowfall and flooding which caused a variety of challenges for all residents in the county including power outages and difficulty accessing critical medical services (i.e. dialysis, chemo therapy treatments). Resources from outside the county were required to address transportation needs of those citizens who required critical medical treatments. Columbia Health District Public Health Authority worked in conjunction with the county Emergency Management (EM) team to provide current information in January 2009 regarding ground water quality via a new web-based communication tool, WebEOC, implemented by EM.

An epidemic of “swine flu” (aka, H1N1 influenza) was declared the end of April 2009, which evolved into a pandemic in early May 2009. During this influenza outbreak, Columbia Health District Public Health Authority stood up their Department Operations Center (DOC) implementing their pre-operational Incident Command Structure following the guidelines of FEMA’s Incident Command Structure. While activated, the DOC conducted disease surveillance, community mitigation to reduce disease transmission and illness severity, and provided information to the health care communities in the county as well as community partners, stakeholders, and the general public.

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

(Washington state), and Columbia counties are working on a regional memorandum of understanding to be used in exercises and emergencies and in standing up the medical reserve corps for emergencies.

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

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

SECTION 4: ADDITIONAL REQUIREMENTS

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PUBLIC HEALTH BOARD

Public health services and enforcement authority are provided by the Columbia Health District in an intergovernmental agreement between Columbia County and the Columbia Health District. The District, a public non-profit with a publicly elected board, provides the public health services required in ORS 431.375 - 431.385 and ORS 431.416 and rule (Chapter 333, Division 14). The health district board acts as the board of health. The CHD board meets each month at a regularly scheduled time. The Columbia Health District is a political subdivision and municipal corporation of the state of Oregon. It formed and is governed under the provisions of ORS 440.305-440.310. The mission of CHD is to respond to the health needs of the citizens of the district and surrounding communities.

COORDINATION WITH LOCAL AGENCIES

Columbia Health District-Public Health Authority provides many health services to the community, as well as partnering with several local agencies. Those partnerships are described below.

Mental health services: contracted out from the county to a private, non-profit agency; the county retains the authority. Columbia Community Mental Health agency subcontracts services to other private, non-profit entities.

Columbia County Commission on Children and Families: a department within county government.

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

State DHS services: are provided by state staff through yet another agency (i.e. self sufficiency, food stamps, and senior and disabled services).

School Districts: memorandums of understanding with Rainier School District and the St. Helens Student Foundation to provide school-based health center services.

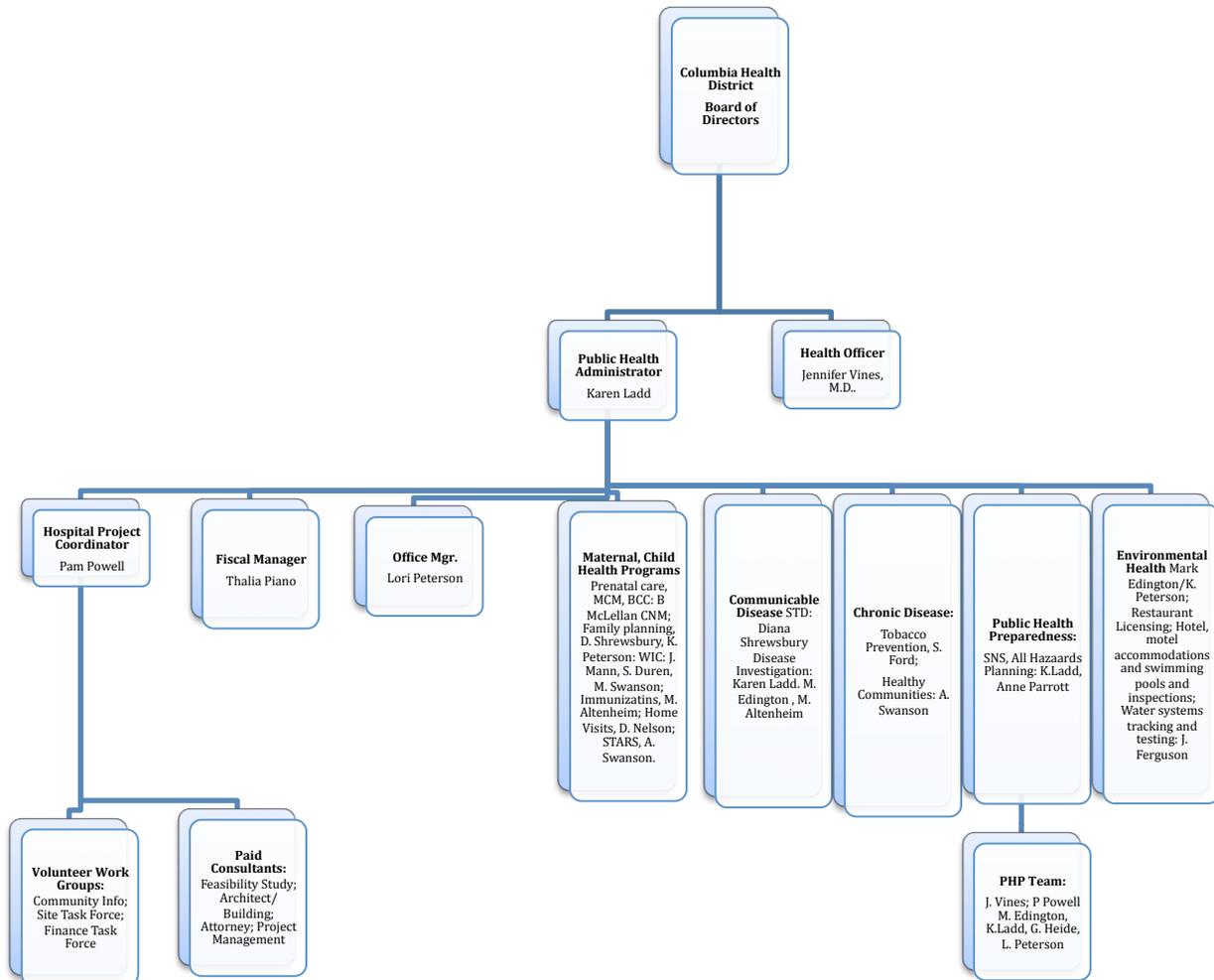
Oregon Health Sciences University: contract for provision of medical care through OHSU Nurse Practitioners.

Involvement of CHD-PHA staff in the local communities takes many forms. The public health staff participates in committees linked with their role inside the agency. The following are committees with which the CHD staff participates, locally.

- Columbia County local alcohol and drug prevention committee/Columbia County Mental Health advisory committee
- Head Start advisory committee
- Healthy Start advisory committee
- Early intervention advisory committee
- District attorney's MDT committee
- SBHC advisory committees (Rainier, Vernonia)
- St. Helens school-based health center advisory board (Sacagawea Health center)
- Local Commission on Children and Families
- Columbia County emergency planning association
- Medical reserve corps
- Homeland security emergency planning committee
- Public health foundation of Columbia County
- Teen Health Advocacy Teams (Rainier, Vernonia, St. Helens)

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

ORGANIZATIONAL CHART OF CHD-PHA



SECTION 5: UNMET NEEDS

UNMET NEEDS

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

We lack physicians. The county needs about 19 primary care and 40 specialists. There is no hospital and no emergency room in the county and the closest ER is approximately 30 miles away. There is one urgent care clinic in the county and it does not provide services 24 hours a day. We have major unmet prevention and mental health needs, and all services in outlying rural areas are minimal. Children are particularly under served--we have a projected need for four pediatricians, yet only one currently practices in the county. In both Clatskanie and Vernonia, there is a higher death rate among young people than the rate for Oregon. We aim to expand the School-Based Health Center program thus, improving access to health care in an environment that feels safe and familiar for children.

Our population base is growing rapidly. We have a limited transportation service. Additionally many residents have low-income levels, and receive fewer services because of the lack of local health services and the challenges of transportation to outside services.

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

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

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

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

Further, it provides local infrastructure to a community:

- c. Collection and reporting of health statistics.
- d. Health information and referral services.
- e. Environmental health services.

In addition to being a medically underserved county, Columbia is also lacking many resources for patients with chronic conditions. Below is a description of a few of the identified needs.

Columbia County has an enormous need for nutrition education for not only the diabetes population, but for our low socioeconomic population, children, organizations, and agencies. Residents do not have access to the Meals Made Easy program designed to educate and empower diabetes patients to plan meals specific to their dietary needs. In addition to Meals Made Easy there were classes offered on food safety, food purchasing, and meal planning. The classes were affiliated through the OSU Extension office. While these programs are not typically provided through public health, CHD-PHA is currently working with the OSU Extension Service to strategize possibilities for expanding the outreach of these programs in Columbia County to meet the needs of this vulnerable population.

Additionally, Columbia County does not offer any Living Well programs for those impacted by HIV/AIDS. Living Well is designed to support, empower, and educate those impacted by chronic conditions via peer group mentorship. CHD -PHA does provide HIV/AIDS testing and counseling. If a client is found positive CHD-PHA refers the client to Partnership Project at OHSU for case management. However, this creates many transportation barriers for patients.

Another best-practice program that Columbia County is missing is the Arthritis Foundation Exercise Program. Although this program has not been offered in the past, we aim to address this need in the near future.

SECTION 6: BUDGET

2370 Gable Road
Saint Helens, Oregon 97051

Columbia Health District Proposed Budget Fiscal Year 2010

Preserve ♦Promote ♦Protect

Public Health is a division of the Columbia Health District. The District's mission is to increase health care resources in Columbia County and to provide public health services to citizens in the county.

The Columbia Health District Board of Directors serves as the governmental policy board for Public Health. The board usually holds two meetings monthly that are open to the public. A meeting schedule is available by calling 503.397.4651.

Columbia Health District Board of Directors

***Chair Mr. Jay Tappan
Director Mr. Gary Heide
Director Ms. Laura Tomanka
Director Ms. Alice Dunlap
Director Mr. David Schmor***

The Columbia Health District does not discriminate on the basis of physical ability, race, color, national origin or handicap. If special accommodations are required, please contact the Columbia Health District staff, 503.397.4651, extension 211, one day prior to the meeting.

May 14, 2009
Budget Message

It is my privilege to present to you the proposed budget for fiscal year 2009-2010 for your review and approval. As required by law, the proposed budget is balanced and it provides for the basic needs and requirements of the District. The budget has been prepared with the expertise of the Public Health Administrator Karen Fox Ladd, Hospital Consultant Tary Carlson, Administrative Services Manager and the auditor's recommendations.

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

Were there unlimited amounts of funding, one might expect that most public health needs would be met. The State of Oregon allots only 2.5% of its DHS budget to public health functions at the state and local levels combined. The funds that reach the local level are for specific programs. In Columbia County, those dollars supplement federal dollars to provide emergency preparedness, communicable disease, epidemiological response, disease prevention and supplement federal dollars that help provide prenatal care for women in need. The state also provides funding to school-based health centers. Over the past two years Columbia County has received phase I and phase II planning dollars to develop new health centers in three different school districts. We will have two school based health centers for the fiscal year 2009-2010, those being Sacagawea Health Center and Rainier K-12 Health Center.

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

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

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

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

Administer and enforce the rules of the local public health authority, and the

Public health rules and law of DHS assure activities necessary for the preservation of health or prevention of disease in the area under its jurisdiction as provided in the annual plan of the authority or district are performed. These activities shall include:

- Epidemiology and control of preventable diseases and disorders
- Parent and child health services, including family planning clinics (ORS 435.205)
- Collection and reporting of health statistics
- Health information and referral environmental health services

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

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

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages health behaviors
- Responds to disasters and communities in the recovery phase
- Assures the quality and accessibility of health services

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

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

In the proposed budget, two funds remain active: the General Fund and Public Health Fund.

State funding estimates for Public Health programs are as accurate to date as possible. **Revenue estimates are based on historical information and are the best information that we currently have.**

Our Intergovernmental Agreement with Columbia County specifies a contractual amount of a minimum of \$100,000 in county general funds to help provide mandated public health services.

Columbia County will continue to receive “Healthy Communities” grant money, formerly know as Tobacco Related and Other Chronic Disease. In addition, Columbia County is the recipient of an Achieve Grant in the amount of \$25,0000.00 to continue planning for infrastructure for healthy communities.

The State has proposed a new funding formula for the School Based Health Centers. If implemented, this new formula we will continue to support Sacagawea Clinic as well as the new Rainier School Clinic. Public Health has also received a Regence Grant for \$20,000.00 to help plan for sustainability.

The Columbia River Community Hospital Project is still in pre-construction phase, but some site work will begin this fall. The project continues to collect tax revenue and deposit it in the State Government Pool, where it is drawing interest. Tary Carlson of Ethos Development, project manager for the hospital, prepared the pre-construction budget.

The approval and adoption of this budget will allow the District and its Public Health Authority to continue to provide services to the citizens of Columbia County.

Respectfully submitted,

Thalia D. Piano, Budget Officer

Historical Data								
Actual 06/07	Actual 07/08	Budget 08/09		Description	Proposed	Approved	Adopted	
Resources								
621,468	1,265,193	1,398,579	1	Available Cash on Hand	1,150,000	1,150,000	1	
21,650	66,000	70,200	2	Interest	50,000	50,000	2	
50	-	0	3	Misc. Income	0	0	3	
18,500,000	18,500,000	18,500,000	4	Hospital Project Construction Loan	18,500,000	18,500,000	4	
2,500,000	2,500,000	0	5	Property Loan	0	0	5	
21,643,168	22,331,193	19,968,779	6	Total Resources, Except Taxes	19,700,000	19,700,000	6	
858,254	850,160	900,378	7	Taxes Base	929,712	929,712	7	
			8	Taxes collected			8	
22,501,422	23,181,353	20,869,157	9	TOTAL RESOURCES	20,629,712	20,629,712	9	
Expenditure Summary								
116,000	116,000	116,000	10	Wages	116,000	116,000	10	
44,700	44,700	44,700	11	Benefits	44,700	44,700	11	
160,700	160,700	160,700	12	Total Personal Services	160,700	160,700	12	
1,000	800	0	13	Advertising & Publicity	-	-	13	
1,900	6,000	5,428	14	Audit	-	-	14	
-	-	6,000	15	Elections	-	-	15	
-	-	-	16	Board Compensation	8,000	8,000	16	
200	200	200	17	Filing Fees (audit)	200	200	17	
1,500	1,500	9,175	18	Insurance	-	-	18	
10,000	7,500	7,500	19	Legal & Consulting	7,500	7,500	19	
950	2,100	2,100	20	Membership Dues	2,100	2,100	20	
500	500	1,500	21	Miscellaneous	1,500	1,500	21	
2,500	2,500	2,500	22	Travel & Professional Develop.	2,500	2,500	22	
			23	Columbia River Hospital Project			23	
565,379	50,000	50,000	24	Accumulated interest	50,000	50,000	24	
-	-	-	25	Advertising	2,500	2,500	25	
	800,000	800,000	26	Architect/Engineering Fees	800,000	800,000	26	
25,000	25,000	25,000	27	Certificate of Need	25,000	25,000	27	
	10,000	10,000	28	Loan Fees	10,000	10,000	28	
10,000	125,000	125,000	29	Project Consulting	250,000	250,000	29	
	160,000	160,000	30	Project Management Fees	160,000	160,000	30	
	400,000	400,000	31	Project Permits & Fees	400,000	400,000	31	
	20,000	20,000	32	Special Inspections	20,000	20,000	32	
200,000	-	162,977	33	Hospital Project Development	158,279	158,279	33	
100,000	-	0	34	Repay line of credit loan	0	0	34	
918,929	1,611,100	1,787,380	35	Total Materials & Services	1,897,579	1,897,579	35	
5,000,000	4,500,000	4,500,000	36	Building Construction	4,500,000	4,500,000	36	
-	100,000	100,000	37	Building Equipment Purchases	100,000	100,000	37	
500,000	2,500,000	700,000	38	Land Acquisition	0	0	38	
5,500,000	7,100,000	5,300,000	39	Total Capital Outlay	4,600,000	4,600,000	39	
	2,500,000	0	40	Pay off Property Loan	0	0	40	
	700,000	700,000	41	Debt Service	700,000	700,000	41	
	3,200,000	700,000	42	Total Debt Service	700,000	700,000	42	
45,000	69,525	0	43	Transfer to Public Health	0	0	43	
500,000	500,000	500,000	44	Contingency	500,000	500,000	44	
7,124,629	12,641,325	8,448,080	45	Total Expenditures	7,858,279	7,858,279	45	
15,376,793	10,540,028	12,421,077	46	Unappropriated	12,771,433	12,771,433	46	
22,501,422	23,181,353	20,869,157	47	TOTAL	20,629,712	20,629,712	47	

**Public Health Authority
Resource**

Columbia Health District
Fiscal Year 09/10

Historical Data			Resource		Fiscal Year 09/10		
Actual 06/07	Actual 07/08	Budget 08/09		Description	Proposed	Approved	Adopted
102,500	76,000	76,000	1	Cash On Hand	72,000	72,000	1
1,850	1,850	1,000	2	Interest	1,000	1,000	2
	473,395	556,581	3	State Grants:	609,284	609,284	3
27,409	27,221	54,742	4	State Support	54,623	54,623	4
196	219	219	5	TB Case Management	226	226	5
49,160	-	-	6	BCC Education & Screening	-	-	6
7,988	-	-	7	Komen Program	-	-	7
5,069	-	7,845	8	HIV Prevention	7,269	7,269	8
5,196	4,619	5,757	9	STARS	5,737	5,737	9
111,789	105,539	91,882	10	Bioterrorism Grant	90,872	90,872	10
-	-	12,550	11	CRI	10,824	10,824	11
8,385	29,564	-	12	Pan Flu	-	-	12
5,517	-	-	13	Health Alert Network	-	-	13
25,000	25,000	60,800	14	Tobacco Prevention	63,310	63,310	14
-	-	21,216	15	TROCD	48,750	48,750	15
161,513	150,208	157,616	16	WIC	173,916	173,916	16
19,164	21,569	23,134	17	Family Planning	22,994	22,994	17
25,241	24,497	34,093	18	Child & Adolescent Health	32,552	32,552	18
11,000	11,000	2,768	19	Perinatal	2,890	2,890	19
8,450	8,685	8,685	20	Babies First	-	-	20
50,000	50,000	60,000	21	School Based Clinics	80,000	80,000	21
23,415	15,274	15,274	22	Immunization Programs	15,321	15,321	22
			23	OTHER GRANTS:			23
11,552	11,552	11,552	24	Cacoon Grant	11,552	11,552	24
43,000	-	-	25	CCCF CASA Grant	-	-	25
-	-	-	26	Achieve Grant	25,000	25,000	26
-	-	-	27	Regence Grant	20,000	20,000	27
8,700	8,700	22,132	28	Water Systems	22,132	22,132	28
100,000	100,000	100,000	29	Columbia County	100,000	100,000	29
67,500	69,525	162,914	30	Hospital Project Staff Support	158,278	158,278	30
20,000	11,500	11,580	31	Client Fees	10,175	10,175	31
70,300	75,670	80,550	32	Environmental Fees	72,800	72,800	32
158,000	158,000	180,000	33	Fam. Planning Expansion Fees	180,000	180,000	33
50,000	41,150	34,200	34	OHP & Other Insurance	40,910	40,910	34
13,000	12,000	12,000	35	Water Surveys (SRF Billings)	22,260	22,260	35
-	-	-	36	Rainier Health Center Fees	10,000	10,000	36
500	500	500	37	Misc. & Reimb.	100	100	37
1,000	100	100	38	Donations	100	100	38
1,192,394	1,039,942	1,249,109	39	Subtotal	1,355,591	1,355,591	39
35,000	35,000	35,000	40	State Supplied Vaccine(non-cash)	35,000	35,000	40
1,227,394	1,074,942	1,284,109	41	Total Resources	1,390,591	1,390,591	41

Employee	% FTE	Payroll/Gross Pay
PERSONNEL:	\$ 136,342	
Karen Ladd	0.25	\$ 20,353
Thalia Piano	0.20	\$ 10,929
Pam Powell	100	\$ 32,979
Ashley Swanson	0.15	\$ 9,988
Jennifer Vines	100	\$ 24,000
		\$ 96,622
Benefits & Taxes:		\$ 39,720

Public Health Administrator attends all hospital related functions.
Fiscal responsibility
Hospital Project Coordinator
Hospital Project support staff, Public Health Foundation support
Health Officer for the District, liason for the project.

MATERIALS & SERVICES:	Budget Amount	CHD
Facility	\$ 48,895	\$ 7,334
Insurance	\$ 18,350	\$ 9,175
Audit	\$ 10,855	\$ 5,428
	\$ 78,100	#####

Public Health Building Lease
Property and Professional Liability
Fee for audit service

**Public Health Authority
Expenditures**

Columbia Health District
Fiscal Year 09/10

Historical Data										
Actual 06/07	Actual 07/08	Budget 08/09		Description	No.	Range	Proposed	Approved	Adopted	
554,184	698,331	888,824	1	Total Salaries			695,973	695,973		1
			2	Administrator	1	9	82,215	82,215		2
			3	Fiscal Services	1	7	45,608	45,608		3
			4	RNs/Medical Support	3	6-9	130,671	130,671		4
			5	Sanitarian	1	9	71,933	71,933		5
			6	Program Coordinator	4	2-4	170,823	170,823		6
			7	WIC Certifiers	2	9	65,550	65,550		7
			8	Health Ed & Outreach	1	9	34,202	34,202		8
			9	Support Staff	4	2-9	90,171	90,171		9
			10	On Call - Bioterrorism		N/A	4,800	4,800		10
			11	Taxes & Benefits			293,303	293,303		11
554,184	698,331	888,824	12	Total Personal Services			989,276	989,276		12
			13	Materials & Services:						13
50,547	48,552	42,017	14	Facility/Utilities/Maintenance			42,683	42,683		14
11,210	10,700	11,300	15	Phone & Communications			13,435	13,435		15
75,000	70,116	51,000	16	Professional Services			79,000	79,000		16
15,200	11,000	10,000	17	Lab Services			8,000	8,000		17
14,200	13,143	20,000	18	Office Supplies & Equipment			22,000	22,000		18
6,000	6,000	6,000	19	Postage			6,970	6,970		19
64,880	58,200	70,000	20	Med. Sups/Pharm./Contra.			64,200	64,200		20
4,000	2,500	4,500	21	Program Supplies			4,500	4,500		21
5,000	4,800	5,500	22	Community Projects & Events			5,500	5,500		22
16,970	17,000	15,020	23	Travel & Mileage			22,312	22,312		23
7,750	6,850	5,000	24	Continuing Education			9,110	9,110		24
18,350	18,350	9,175	25	Insurance & Fees			18,350	18,350		25
-	5,000	0	26	Health Reimbursement Account			0	0		26
4,000	4,000	5,428	27	Audit			10,855	10,855		27
950	200	200	28	Bank Fees			200	200		28
200	200	200	29	Misc.			200	200		29
45,000	45,000	54,000	30	School Clinic			34,000	34,000		30
294,257	276,611	309,340	31	Total Materials & Services			341,315	341,315		31
25,000	20,000	25,000	32	Contingency			25,000	25,000		32
873,441	994,942	1,223,164	33	Total Cash Expenditures			1,355,591	1,355,591		33
35,000	35,000	35,000	34	State Supplied Vaccine(non-cash)			35,000	35,000		34
908,441	1,029,942	1,258,164	35	Total Expenditures			1,390,591	1,390,591		35
86	-	25,945	36	Unappropriated			-	-		36
908,527	1,029,942	1,284,109	37	Total			1,390,591	1,390,591		37

PHA Salary

Matrix

Beginning July 1, 2009 - June 30, 2010

Current, 7/1/08-6/30/2009									
Position	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
Administrator	61818	63981	66206	68536	70928	73424	75941	78645	81474
hourly rate	29.72	30.76	31.83	32.95	34.10	35.30	36.51	37.81	39.17
Program Manager	52749	54558	56451	58469	61110	62629	64813	67080	69430
hourly rate	25.36	26.23	27.14	28.11	29.38	30.11	31.16	32.25	33.38
Admin Services Mgr	16.92	17.47	18.09	18.72	19.38	20.06	20.77	21.50	22.26
Office Mgr/WIC Lead	12.94	13.35	13.84	14.31	14.84	15.36	15.89	16.47	17.34
Coord 1	18.76	19.43	20.11	20.81	21.55	22.31	23.09	23.88	24.71
Coord 2	20.97	21.70	22.46	23.24	24.09	24.92	25.78	26.69	27.61
RN 1	18.76	19.43	20.11	20.81	21.55	22.31	23.09	23.88	24.71
RN 2	20.97	21.70	22.46	23.24	24.09	24.92	25.78	26.69	27.61
Sec/Clerk	11.54	11.94	12.36	12.81	13.26	13.73	14.19	14.67	15.20
WIC Certifier	12.10	12.50	12.94	13.38	13.84	14.31	14.84	15.36	15.89

With 1% increase									
Position	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
Administrator	62442	64626	66872	69222	71635	74152	76710	79435	82285
hourly rate	30.02	31.07	32.15	33.28	34.44	35.65	36.88	38.19	39.56
Program Manager	53269	55099	57013	59051	61714	63253	65458	67746	70117
hourly rate	25.61	26.49	27.41	28.39	29.67	30.41	31.47	32.57	33.71
Admin Services Mgr	17.09	17.64	18.27	18.91	19.57	20.26	20.98	21.72	22.48
Office Mgr/WIC Lead	13.07	13.48	13.98	14.45	14.99	15.51	16.05	16.63	17.51
Coord 1	18.95	19.62	20.31	21.02	21.77	22.53	23.32	24.12	24.96
Coord 2	21.18	21.92	22.68	23.47	24.33	25.17	26.04	26.96	27.89
RN 1	18.95	19.62	20.31	21.02	21.77	22.53	23.32	24.12	24.96
RN 2	21.18	21.92	22.68	23.47	24.33	25.17	26.04	26.96	27.89
Sec/Clerk	11.66	12.06	12.48	12.94	13.39	13.87	14.33	14.82	15.35
WIC Certifier	12.22	12.63	13.07	13.51	13.98	14.45	14.99	15.51	16.05

With 3% increase									
Position	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
Administrator	63673	65900	68192	70592	73056	75627	78219	81004	83918
hourly rate	30.61	30.76	32.78	33.94	35.12	36.36	37.61	38.94	40.31
Program Manager	54331	56195	58145	60223	62943	64508	66757	69092	71513
hourly rate	26.12	27.02	27.95	28.95	30.26	31.01	32.09	33.22	34.38
Admin Services Mgr	17.43	17.99	18.63	19.28	19.96	20.66	21.39	22.15	22.93
Office Mgr/WIC Lead	13.33	13.75	14.26	14.74	15.29	15.82	16.37	16.96	17.86
Coord 1	19.32	20.01	20.71	21.43	22.20	22.98	23.78	24.60	25.45
Coord 2	21.60	22.35	23.13	23.94	24.81	25.67	26.55	27.49	28.44
RN 1	19.32	20.01	20.71	21.43	22.20	22.98	23.78	24.60	25.45
RN 2	21.60	22.35	23.13	23.94	24.81	25.67	26.55	27.49	28.44
Sec/Clerk	11.89	12.30	12.73	13.19	13.66	14.14	14.62	15.11	15.66
WIC Certifier	12.46	12.88	13.33	13.78	14.26	14.74	15.29	15.82	16.37

With 3.3% increase									
Position	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
Administrator	63856	66102	68390	70803	73278	75837	78437	81245	84157
hourly rate	30.70	31.78	32.88	34.04	35.23	36.46	37.71	39.06	40.46
Program Manager	54496	56368	58323	60403	63128	64688	66955	69285	71718
hourly rate	26.20	27.10	28.04	29.04	30.35	31.10	32.19	33.31	34.48
Admin Services Mgr	17.48	18.05	18.69	19.34	20.02	20.72	21.46	22.21	22.99
Office Mgr/WIC Lead	13.37	13.79	14.30	14.78	15.33	15.87	16.41	17.01	17.91
Coord 1	19.38	20.07	20.77	21.50	22.26	23.05	23.85	24.67	25.53
Coord 2	21.66	22.42	23.20	24.01	24.88	25.74	26.63	27.57	28.52
RN 1	19.38	20.07	20.77	21.50	22.26	23.05	23.85	24.67	25.53
RN 2	21.66	22.42	23.20	24.01	24.88	25.74	26.63	27.57	28.52
Sec/Clerk	11.92	12.33	12.77	13.23	13.70	14.18	14.66	15.15	15.70
WIC Certifier	12.50	12.91	13.37	13.82	14.30	14.78	15.33	15.87	16.41

Salary Matrix

SECTION 7: MINIMUM STANDARDS

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

Organization

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

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

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

Control of Communicable Diseases

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

38. Yes No Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
39. Yes No Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.
40. Yes No Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.
41. Yes No There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
42. Yes No There is a mechanism for reporting and following up on zoonotic diseases to the local health department.
43. Yes No A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
44. Yes No Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
45. Yes No Immunizations for human target populations are available within the local health department jurisdiction.
46. Yes No Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

47. Yes No Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes No Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.

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

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

Health Education and Health Promotion

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

Nutrition

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

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

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

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

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

Older Adult Health

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

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

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

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

Parent and Child Health

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

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

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

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

Primary Health Care

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

98. Yes 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

Local health department Health Administrator minimum qualifications:

The Administrator must have a Bachelor degree plus graduate courses (or equivalents) that align with those recommended by the Council on Education for Public Health. These are: Biostatistics, Epidemiology, Environmental health sciences, Health services administration, and Social and behavioral sciences relevant to public health problems. The Administrator must demonstrate at least 3 years of increasing responsibility and experience in public health or a related field.

Answer the following questions:

Administrator name: Karen Fox Ladd

Does the Administrator have a Bachelor degree? Yes X No ___

Does the Administrator have at least 3 years experience in public health or a related field? Yes X No ___

Has the Administrator taken a graduate level course in biostatistics? Yes X No ___

Has the Administrator taken a graduate level course in epidemiology? Yes X No ___

Has the Administrator taken a graduate level course in environmental health? Yes X No ___

Has the Administrator taken a graduate level course in health services administration? Yes X No ___

Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems? Yes X No ___

a. Yes X No ___ The local health department Health Administrator meets minimum qualifications:

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

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

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

AND

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

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

c. 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.

d. 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.

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

ATTACHMENTS

ATTACHMENT 1:

Tobacco Prevention Education Program (TPEP) Annual Plan

ATTACHMENT 2:

Healthy Communities Annual Plan

ATTACHMENT 1

Tobacco Prevention Education Program (TPEP) Annual Plan

Plans are created and submitted to the state DHS Office, annually.

Columbia Community Health Advisory Council

While Columbia County had an active Tobacco Coalition until 1995, the change in state funding caused for a shift in community involvement in tobacco prevention. As of June 2008, with the aid of the Tobacco-Related and Other Chronic Disease (TROCD) program, the Columbia Community Health Advisory Council (CCHAC) was created. The CCHAC is comprised of driven community leaders, strategizing system changes to prevent tobacco initiation, use and consumption in Columbia County. In partnership with the TROCD program, the TPEP coordinator co-facilitates CCHAC activities, improving local health department efficiency.

Process for gathering input and support:

The CCHAC has been productive in work sessions for each of the four TROCD-targeted settings co-facilitated by the TROCD/TPEP coordinators. The CCHAC reconvenes as a whole, every other month to discuss the work groups progress and barriers. The first breakout session was spent reviewing a summary page of their setting from the assessment. The group members provided corrections and other valuable information to keep the assessment up to date. The work groups provided an efficient way of extracting the needs from the CCHAC members for each of the goals. The TROCD and TPEP Coordinators created objectives based on the information provided by the CCHAC members. At the next meeting the CCHAC members were asked: (1) Does the objective adequately summarized what the workgroup discussed, (2) Areas for improvement (3) Identify local champions, and (4) Who is the specific population the objective should be targeting? This process has become a vital part of receiving CCHAC involvement and creating outcomes for the 3 year plan.

Members of the CCHAC include:

- Anne McConnell Retired Nurse / Member of the Public Health Foundation of Columbia County
- Betty Mayfield Retired news reporter from the Clatskanie Chief & member of the Rainier SBHC planning committee
- Bill Blank Market Manager for the Scappoose farmers market.
- Catherine Webber RN Parent and SBHC volunteer
- Ed Serra Superintendent for Clatskanie school district
- Gary Heide Columbia Health District Board member – Vice Chair & Minister
- Hyla Ridenour Columbia River Fire & Rescue
- Janet Kenna Columbia County Commission on Children and Families Director
- Local Tobacco Control Advisory Form
- Jenny Rudolph Columbia County OSU Extension office
- Joan Owens Columbia Community Mental Health / Sacagawea

Oversight Committee member

- Kathye Beck United Way of Columbia County
- Leanne Grasset Columbia Community Mental Health
- Patty Marmann Health Moving Forward group
- Paul Estrella Zingti Massage
- Rita Bernhard Columbia County Commissioner
- Robin Fouche Clatskanie Together Coalition
- Skip Baker St. Helens
- Tracie Smith Direct for the Columbia Pacific Food Bank
- Jennifer Vines Health Officer for Columbia Health District
- Karen Ladd Columbia County Public Health Administrator
- Jacqueline Villnave State TROCD Liaison
- Jill Dale Previously an active CCHAC member – Employment relocation, but still provides input
- Columbia Health District Board Members Policy governing board for Columbia Health District – Public Health Authority

Meeting dates:

Since June 2008, the CCHAC has met monthly to assess community needs, study best practice strategies, and create SMART objectives for reducing tobacco use and improving community health. CCHAC efforts are geared toward creating a three-year plan to accomplish the state-established goals and community-created objectives.

2009 Meeting Dates:

July 16th
August 13th
September 17th
October 15th
November 19th
December: No Meeting

2010 Meeting Dates:

January 21st
February 18th
March 18th
April 15th
May 20th
June 17th

Development of Local Champions

The following is an outline of the process by which CHD-PHA will assist in the development of local champions. We will aim to improve local tobacco prevention efforts, and build capacity for TROCD, utilizing the following strategies.

Community Leader	Educational Means	Schedule/Frequency	Intended Outcomes
Ed Serra Superintendent Clatskanie SD	In-person meeting	August 2009	Increase active participation in CCHAC
Woody Davis OSU Extension Office Columbia County Fair and Rodeo	In-person meeting	September & November 2009	Begin partnership to create a tobacco-free county fair
Chip Buble Director, Columbia County Extension	Presentation to Fair and Rodeo committee	January 2010	
Columbia County Commission on Children and Families	Presentation	October 2009	Awareness of tobacco exposure at summer community events
	One-to-one meetings with event coordinators	Bimonthly, October 2009-June 2010	Partnership for reducing exposure Summer 2010 (policy creation, support)
Nate Underwood Principal Vernonia High School	One-to-one Partnering with Vernonia Student Health Advisory Committee	Monthly	Improve student involvement of tobacco initiation prevention in Vernonia Junior and Senior high schools.
Ken Cox Superintendent Vernonia School District			
Jay Tappan Fire Chief Columbia River Fire and Rescue	One-to-one meetings	<i>August 2009:</i> Initial informational meeting & brainstorming. Begin networking with elected officials <i>October 2009:</i> Follow-up report on networked contacts.	Improve networking and relationships with local elected officials, so educational tools will be accepted more openly by elected officials
Bill Blank Manager Scappoose Farmer's Market and Active Community Member	One-to-one meetings Presentation support	Monthly communication at CCHAC meetings. Bimonthly one-to-one meetings City Council and School District presentations, possibly quarterly	Empowerment, provide LHD support to present to his networks: Scappoose City Councils, school districts to provide healthy, local produce

IMPLEMENT SMOKEFREE WORKPLACE LAW

By June 2010, Columbia County will have responded to all complaints of violation of the Smokefree Workplace Law according to the protocol specified in the Delegation Agreement.

Goal Areas:

- ✓ Eliminate or reduce exposure to secondhand smoke
- ✓ Countering pro-tobacco influences
- ✓ Promote quitting

Critical Questions:

Considering any disparities identified through community assessment, what sectors of the community have been prioritized or targeted for this objective? Provide rationale. *All workplaces are expected to be in full compliance of the ICAA. Those who have had multiple complaints will receive additional resources during their site visit.*

What types of technical and/or data assistance do you anticipate needing from staff and partners? *Continued support with WEMS is appreciated, and additional training may be needed for one more CHD staff member.*

Activities

	Date		Tasks	Subcategory	1st Quarter		2nd Quarter			3rd Quarter			4th Quarter		
	Start	End			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
<input type="checkbox"/>	July 2009	June 2010	TPEP staff will respond to complaints of violation, conduct site visits, and manage WEMS and hard copy files.	Coordination and Collaboration											
<input type="checkbox"/>	July 2009	June 2010	TPEP staff will participate in DHS/TPEP evaluation activities as assigned, to study compliance with the law.	Assessment											
<input type="checkbox"/>	July 2009	June 2010	"Celebrate Clean Air" cards (figure 1) will be distributed at all community presentations and meeting.	Community Education and Outreach											
<input type="checkbox"/>	July 2009		Weblink for complaints on CHDPHA website.	Community Education and Outreach											
<input type="checkbox"/>	July 2009	June 2010	Reporting information and quit resources are distributed at every site visit.	Community Education and Outreach											
<input type="checkbox"/>	July 2009	June 2010	Coordinate with DHS TPEP liaison to collect reporting/violation statistics around Oregon.	Coordination/ Collaboration											
<input type="checkbox"/>	Dec 2009	Dec 2009	Create a press release with interviews from "model businesses" and newly smoke-free bars, as well as comparison statistics.	Earned Media/Media Advocacy											
<input type="checkbox"/>	Jan 2010	Jan 2010	Submit to all local papers	Earned Media/Media Advocacy											
<input type="checkbox"/>	Aug 2009	Sep 2009	Create a handbook for implementation and enforcement which includes annual workplan status, and directions for WEMS and conducting site visits. To be used as a guide for any person responsible for TPEP tasks in case of TPEP staff absence or turnover	Policy Development, Implementation, and Enforcement											
<input type="checkbox"/>	Aug 2009	Sep 2009	Refer to existing "Guide to TPEP Site Visits" created January 15, 2009	Policy Development, Implementation, and Enforcement											

SMOKEFREE MULTI-UNIT HOUSING

By June 2010, two additional multi-unit housing facilities in St. Helens (the county seat of Columbia County) will have adopted no-smoking rules for their properties.

Goal Areas:

- ✓ Eliminate or reduce exposure to secondhand smoke
- ✓ Countering pro-tobacco influences
- ✓ Promote quitting

Critical Questions:

Considering any disparities identified through community assessment, what sectors of the community have been prioritized or targeted for this objective? Provide rationale. *Rental populations in St. Helens. Because St. Helens is the county seat and contains the largest quantity of MUH sites, it will be the major focus, to set precedence for the smaller towns in the county. Renters are typically a lower-income population; pre-existing low-cost cessation classes will be promoted to apartment residents to support and encourage their efforts to quit.*

What types of technical and/or data assistance do you anticipate needing from staff and partners? *Continued support from Diane Laughter and Health in Sight LLC documents for assessment and model policies.*

Activities

Date		Tasks	Subcategory	1st Quarter		2nd Quarter			3rd Quarter			4th Quarter		
Start	End			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
<input type="checkbox"/>	July 2009	July 2009	Contact Jay Tappan, Columbia River Fire and Rescue Chief for housing contacts and advisory.	Coordination and Collaboration	▣									
<input type="checkbox"/>	July 2009	July 2009	Use list of apartments in Columbia County, sort by city of management, and then add to that list those that are located in St. Helens but managed by an out-of-town agency.	Community Education	▣									
<input type="checkbox"/>	Aug 2009	Sept 2009	Make initial contact by phone, and provide "A Landlord's Guide to No-Smoking policies" and Quit line resources	Community Education	▣	▣								
<input type="checkbox"/>	Oct 2009	Mar 2010	In-person meeting with 50% of MUH managers in St. Helens	Community Education Policy Development/ Implementation			▣	▣	▣	▣	▣	▣	▣	▣
<input type="checkbox"/>	Aug 2009	Dec 2009	Engage interested property managers as partners and/or advisory.	Coordination and Collaboration	▣	▣	▣	▣	▣					
<input type="checkbox"/>	Aug 2009	Dec 2009	Track properties that have Adopted No-Smoking Rules with document of same name, by Health in Sight LLC	Assessment	▣	▣	▣	▣	▣					
<input type="checkbox"/>	Sept 2009	June 2010	Use "A landlord's Guide to No-Smoking Policies" to assist property owners/managers in the adoption of no-smoking policies.	Policy Development/ Implementation		▣	▣	▣	▣	▣	▣	▣	▣	▣
<input type="checkbox"/>	Sept 2009	June 2010	10% create new policies	Community Education		▣	▣	▣	▣	▣	▣	▣	▣	▣
<input type="checkbox"/>	July 2009	June 2010	Provide positive press for those business who have adopted a tobacco-free policy.	Earned Media/Media Advocacy	▣	▣	▣	▣	▣	▣	▣	▣	▣	▣
<input type="checkbox"/>	July 2009	June 2010	Continued partnership with Diane Laughter for development of press releases and op	Earned Media/Media Advocacy	▣	▣	▣	▣	▣	▣	▣	▣	▣	▣

TOBACCO-FREE HEAD START/CHILD CARE PROGRAMS

By June 2010, at least 3 of 5 Head Start Programs in Columbia County will be completely tobacco-free. Those without TF policies completed will have the tools necessary to develop and implement tobacco-free campus policies.

Goal Areas:

- ✓ Eliminate or reduce exposure to secondhand smoke
- ✓ Counter pro-tobacco influences
- ✓ Promote quitting

Critical Questions:

Considering any disparities identified through community assessment, what sectors of the community have been prioritized or targeted for this objective? Provide rationale. *Low income families will be the primary beneficiaries of Head Start TF campus policies.*

What types of technical and/or data assistance do you anticipate needing from staff and partners? *As identified in the Activities list (below), extensive collaboration with ALAO will be critical to achieving this objective.*

Activities

	Date		Tasks	Subcategory	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter				
	Start	End			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
<input type="checkbox"/>	July 2009	July 2009	Contact Andrew Epstein at ALAO for guidance in developing feasible action plans.	Coordination/ Collaboration	▬▬▬	▬▬▬									
<input type="checkbox"/>	July 2009	Aug 2009	Contact Health Specialist at each Head Start to inquire about current policies.	Coordination/ Collaboration Assessment	▬▬▬	▬▬▬									
<input type="checkbox"/>	July 2009	Aug 2009	Determine scope of operation for each Head Start	Coordination/ Collaboration Assessment	▬▬▬	▬▬▬									
<input type="checkbox"/>	July 2009	July 2009	Contact TPEP Coordinators in Clatsop and Tillamook counties to discuss current strategies for shared Head Start program: Community Action Team.	Coordination/ Collaboration	▬▬▬										
<input type="checkbox"/>	July 2009	Aug 2009	Become familiar with Environmental Protection Agency resources, to refer to for Head Start Health Specialists.	Community Education and Outreach	▬▬▬	▬▬▬									
<input type="checkbox"/>	Aug 2009	Sept 2009	Distribute "Care for their Air" to all Head Start contacts	Community Education and Outreach	▬▬▬	▬▬▬									
<input type="checkbox"/>	Sept 2009	Oct 2009	Present short Fact Sheet for Head Start programs to post on websites and send home to parents about the risks associated with SHS, and what Head Start programs are doing to reduce exposure to SHS.	Community Education and Outreach		▬▬▬	▬▬▬								
<input type="checkbox"/>	Sept 2009	Oct 2009	Highlight Head Start TF campus policies, remind other families of the impact of SHS on health, provide resources for other child care facilities in a press release.	Media Advocacy		▬▬▬	▬▬▬								
<input type="checkbox"/>	Oct 2009	Feb 2010	If necessary, provide TROCD/TPEP presentation to Head Start personnel, with "Fresh Air for Little Noses" materials.	Community Education and Outreach			▬▬▬	▬▬▬	▬▬▬	▬▬▬	▬▬▬				
<input type="checkbox"/>	Feb 2010	April 2010	Coordinate with ALAO to determine most effective policy for the individual sites.	Policy Development, Implementation, and Enforcement						▬▬▬	▬▬▬	▬▬▬			
<input type="checkbox"/>	April 2010	June 2010	Acquire sample policies from ALAO, and meet with Health Specialists to review and amend policy.	Policy Development, Implementation, and Enforcement								▬▬▬	▬▬▬	▬▬▬	
<input type="checkbox"/>	June 2010	June 2010	Provide assistance and support to Health Specialists for staff presentations, outreach, and placement of signage for implementation.	Policy Development, Implementation, and Enforcement											▬▬▬

TOBACCO-FREE HOSPITALS

By opening (Spring 2010) Columbia River Community Hospital will have adopted a comprehensive tobacco-free campus policy.

Goal Areas:

- ✓ Eliminate or reduce exposure to secondhand smoke
- ✓ Promote quitting
- ✓ Reduce the burden of tobacco-related chronic diseases

Critical Questions:

Considering any disparities identified through community assessment, what sectors of the community have been prioritized or targeted for this objective? Provide rationale. *Those who will receive care through the hospital: low income seeking emergency services, and those with otherwise limited access to health care in Columbia County.*

What types of technical and/or data assistance do you anticipate needing from staff and partners?

- *Example policies from Providence (CHD Board would like to review Providence policies, to start).*
- *Models of hospital tobacco-free campus policies*

Activities

Date		Tasks	Subcategory	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter					
Start	End			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
<input type="checkbox"/>	Jul 2009	Sep 2009	Research Model Policies http://www.oregon.gov/DHS/ph/tobacco/tpep/tpolicyresources.shtml	Assessment	▣▣▣▣	▣▣▣▣	▣▣▣▣								
<input type="checkbox"/>	Jul 2009	Sep 2009	In-person meeting between TPEP/TROCD Coordinators and CHD Board member to gain understanding of policy implementation process. Emphasize importance of policy	Coordination/ Collaboration Community Education	▣▣▣▣	▣▣▣▣	▣▣▣▣								
<input type="checkbox"/>	Sep 2009	Oct 2009	Hold a special work session with CCHAC Health System workgroup to draft a CRCH TF campus policy	Coordination/ Collaboration			▣▣▣▣	▣▣▣▣							
<input type="checkbox"/>	Jan 2010	Jan 2010	Present proposed policy to CHD Board for approval	Policy Implementation						▣▣▣▣					
<input type="checkbox"/>	Feb 2010	Mar 2010	Attend CHD Board meetings for policy implementation strategies with hospital CEO	Policy Implementation							▣▣▣▣	▣▣▣▣			
<input type="checkbox"/>	Jan 2010	Mar 2010	Work with hospital maintenance staff for placement of TF campus signage	Policy Implementation						▣▣▣▣	▣▣▣▣	▣▣▣▣			
<input type="checkbox"/>	Mar 2010	Mar 2010	Press Release announcing latest health-related policy! Emphasize cessation resources such as Quitline and brochures in the community resources section of hospital	Community Education/ Outreach Media Advocacy								▣▣▣▣			

TOBACCO-FREE SCHOOLS

By June 2010, Vernonia School District will have approved an A+ rated tobacco-free campus policy modeled by best practices.

Goal Areas:

- ✓ Eliminate or reduce exposure to secondhand smoke
- ✓ Counter pro-tobacco influences
- ✓ Promote quitting
- ✓ Reduce youth access to tobacco

Critical Questions:

Considering any disparities identified through community assessment, what sectors of the community have been prioritized or targeted for this objective? Provide rationale. *The Vernonia School District has expressed the greatest interest in improving tobacco policies.*

What types of technical and/or data assistance do you anticipate needing from staff and partners? *Information on tobacco policies/initiatives state-wide*

TF Schools Activities

Date		Tasks	Subcategory	1st Quarter 2nd Quarter 3rd Quarter 4th Quarter											
				Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Vernonia School District															
<input type="checkbox"/>	July 2009 - Aug 2009	Review the school district tobacco policies gathered during the Community Assessment TROCD capacity building phase.	Assessment												
<input type="checkbox"/>	July 2009 - Oct 2009	TPEP coordinator work with VSHAC and THAT to create model tobacco policy	Coordination & Collaboration												
<input type="checkbox"/>	Jul 2009 - Aug 2009	Present policy to Superintendent for review and opportunity for questions/answers/concerns	Community Outreach & Education												
<input type="checkbox"/>	Sep 2009 - Sep 2009	Present proposed policy to Vernonia School Board for review and approval.	Policy Implementation												
<input type="checkbox"/>	Nov 2009 - Dec 2009	Present finalized policy to Vernonia school district staff.	Policy Implementation/ Enforcement												
<input type="checkbox"/>	Jan 2010 - Mar 2010	Support School District staff and students in the proper placement of signs and messages about the TF campus policy	Policy Implementation/ Enforcement												
<input type="checkbox"/>	Oct 2009 - Oct 2009	Press release to Vernonia Voice and Independent on the new Tobacco policy implementation	Media Advocacy												

TOBACCO-FREE WORKSITES: COLUMBIA HEALTH DISTRICT (CHD)

By February 2010, Columbia Health District will have passed a tobacco-free campus policy.

Goal Areas:

- ✓ Eliminate or reduce exposure to secondhand smoke
- ✓ Promote quitting

Critical Questions:

1. Considering any disparities identified through community assessment, what sectors of the community have been prioritized or targeted for this objective? Provide rationale.
 - a. Low-income populations most often frequent CHD offices and clinics, and are most likely to use tobacco.
 - b. Importance of providing adequate signage, and disposal receptacles
2. What types of technical and/or data assistance do you anticipate needing from staff and partners?
 - a. Work with business manager to review existing policy and structure.
 - b. Work with liaison to see sample policies

Activities

	Date		Tasks	Subcategory	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter					
	Start	End			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
<input type="checkbox"/>	Sep 2009	Oct 2009	Review Healthy Worksite Assessment that was completed during TROCD capacity building phase.	Assessment			▣▣▣▣	▣▣▣▣								
<input type="checkbox"/>	Sep 2009	Oct 2009	Access state TPEP resources as provided in Best Practice Objective handbook	Policy Development			▣▣▣▣	▣▣▣▣								
<input type="checkbox"/>	Sep 2009	Oct 2009	Meet face-to-face with CHD Administrator and Business Manager to draft a TF campus policy. Finalize in face-to-face meeting with CHD Admin. and Bus. Mgr.	Coordination/ Collaboration			▣▣▣▣	▣▣▣▣								
<input type="checkbox"/>	Oct 2009	Oct 2009	Email draft policy to CHD Staff for review and review face-to-face at staff meeting. Opportunity for questions/answers/concerns following a short presentation about current TPEP work and Col. Co. statistics.	Community Education/ Outreach				▣▣▣▣								
<input type="checkbox"/>	Nov 2009	Nov 2009	Present proposed policy to CHD Board for review and approval.	Policy Implementation					▣▣▣▣							
<input type="checkbox"/>	Jan 2010	Jan 2010	Present finalized policy to CHD staff at Staff Meeting	Policy Implementation /Enforcement						▣▣▣▣						
<input type="checkbox"/>	Jan 2010	Feb 2010	Post appropriate signage on CHD campus	Policy Implementation /Enforcement							▣▣▣▣	▣▣▣▣				
<input type="checkbox"/>	Mar 2010	Mar 2010	Report policy improvement to Columbia Emergency Planning Association, offer support for other businesses to create TF campus policies as well.	Media Advocacy												▣▣▣▣

ATTACHMENT 2

Healthy Communities Program Annual Plan
(Formerly Tobacco-Related and Other Chronic Diseases/TROCD)

Plans are created and submitted to the state DHS Office, annually.

Best Practice Objective 2: Healthy Worksites

Date		Tasks	Subcategory	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
Start	End			Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10
Sep 2009	Oct 2009	Review Healthy Worksite Assessment that was completed during TROCD capacity building phase.	Assessment												
Sep 2009	Oct 2009	Access state TROCD resources as provided in Best Practice Objective handbook	Policy Development												
Sep 2009	Oct 2009	Work with CHD Administrator and Business Manager to create a healthy meeting policy	Coordination/ Collaboration												
Oct 2009	Oct 2009	Email draft policy to CHD Staff for review and opportunity for questions/answers/concerns	Community Education/Outreach												
Nov 2009	Nov 2009	Present proposed policy to CHD Board for review and approval.	Policy Implementation												
Jan 2010	Jan 2010	Present finalized policy to CHD staff at Staff Meeting	Policy Implementation/ Enforcement												
Jan 2010	Feb 2010	Provide materials to CHD employees for compliance.	Policy Implementation/ Enforcement												
Mar 2010	Mar 2010	Report policy improvement to Columbia Emergency Planning Association, offer support for other businesses to create healthy meeting policies as well.	Media Advocacy												

Date		Tasks	Subcategory	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
Start	End			Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10
May 2009	Jul 2009	Collaborate with CCHAC worksite work group to create two different surveys.	Coordination/ Collaboration												
Aug 2009	Sep 2009	Contact all chamber of commerce for buy in and approval.	Community Education/Outreach												
Aug 2009	Sep 2009	Create an incentive for business to fill out survey through the chamber.	Community Education/Outreach												
Oct 2009	Dec 2009	Send out survey to the businesses through the Chambers. Ascertain whether wellness policies exist and to what level.	Coordination/ Collaboration												
Jan 2010	Feb 2010	Recognition in the paper for businesses who are promoting health and wellness at their worksite.	Media Advocacy												
Mar 2010	Jun 2010	Work with worksite group to create plan for the businesses who do not have health policies in place	Coordination/ Collaboration												

Best Practice Objective 3: Healthy Hospitals/Health Systems

Date		Tasks	Subcategory	Notes	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
Start	End				Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10
Jul 2009	Sep 2009	Research model policies	Assessment	http://www.oregon.gov/DHS/ph/tobacco/tpep/tpolicyresources.shtml												
Jul 2009	Sep 2009	In-person meeting between TPEP/TROCD Coordinators and CHD Board member to gain understanding of policy implementation process.	Coordination/ Collaboration Community Education	Emphasize importance of policy												
Sep 2009	Oct 2009	Hold a special work session with CCHAC Health System workgroup to draft a CRCH TF campus policy	Coordination/ Collaboration													
Jan 2010	Jan 2010	Present proposed policy to CHD Board	Policy Implementation													
Mar 2010	Mar 2010	Press Release announcing latest health-related policy!	Community Edu./ Outreach Media Advocacy	Emphasize cessation resources such as QuitLine												

Best Practice Objective 7: Healthy k-12 Schools

Date		Tasks	Subcategory	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
Start	End			Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10
Mar 2009	Mar 2009	Review the policies gathered during the Community Assessment TROCD capacity building phase.	Assessment												
Mar 2009	Mar 2009	TPEP/SBHC Coordinator introduce TROCD Coordinator to the Vernonia School Health Advisory Council (VSHAC), and the Teen Health Advocacy Team (THAT.)	Coordination & Collaboration												
Apr 2009	Oct 2009	TPEP and TROCD Coordinators work with VSHAC and THAT to create model wellness policy	Coordination & Collaboration												
Jul 2009	Aug 2009	Present policy to Superintendent for review and opportunity for questions/answers/concerns	Community Outreach & Education												
Sep 2009	Sep 2009	Present proposed policy to Vernonia School Board for review and approval.	Policy Implementation												
Nov 2009	Dec 2009	Present finalized policy to Vernonia school district staff.	Policy Implementation/ Enforcement												
Oct 2009	Oct 2009	Press release to Vernonia Voice and Independent on the new Wellness policy implementation	Media Advocacy												

Date		Tasks	Subcategory	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
Start	End			Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10
Mar 2009	Mar 2009	Review the policies gathered during the Community Assessment TROCD capacity building phase.	Assessment												
May 2009	May 2009	Coordinate with the TPEP/SBHC Coordinator, TROCD Coordinator, Debby Webster (Food Manager), Teen Health Advocacy Team (THAT), and the Rainier School District Nurse to create a committee to draft policy.	Coordination & Collaboration												
June 2009	Oct 2009	Committee meets to draft policy	Coordination & Collaboration												
Nov 2009	Dec 2009	Present policy to Superintendent for review and opportunity for questions/answers/concerns	Community Outreach & Education												
Jan 2010	Jan 2010	Present proposed policy to Rainier School Board for review and approval.	Policy Implementation												
Mar 2010	Apr 2010	Present finalized policy to Rainier School staff.	Policy Implementation/ Enforcement												
Mar 2010	Mar 2010	Press release in school newsletter and post on school district websites.	Media Advocacy												

