

Deschutes County Health Services

Local Public Health Authority

ANNUAL PLAN 2009-2010

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I. EXECUTIVE SUMMARY

This 2009 Deschutes County Health Services Plan includes a summary of our local public health services and systems and a look at the condition of health in our local communities.

Noteworthy is Deschutes County's February, 2009, merger of the former County Health Department and the County Mental Health Department into a single integrated department. The goals associated with this action are to increase our efficiency, our cost effectiveness, our performance and our ability to better integrate our services for the benefit of our County and its residents. The new Department is titled Deschutes County Health Services (DCHS).

DCHS continues to provide a comprehensive array of public health services which meet the assurance standards described in OAR 333-014-055. Our services include:

- Communicable disease control and all hazards public health preparedness;
- Family health programs: maternal child health, family planning, WIC and immunizations;
- Vital records, health statistics and health trend monitoring;
- Chronic disease services: BCC program & tobacco prevention;
- Environmental health services through the Community Development Department; and
- Environmental toxicology investigation and intervention.

Key Findings and Recommendations—As in other Oregon communities, we face significant health issues and health disparities due to demographic, geographic, economic and lifestyle factors. Our most significant issues include:

- The oral health status of low income children;
- Access to basic primary care services for low income, uninsured County residents as well as those with a Medicaid or Medicare benefit, including children;
- Obesity rates in both children and adults;
- Our health system's capacity to serve bilingual (primarily Hispanic) families;
- Our public health capacity to address sexually transmitted infection;
- Our public health capacity to address communicable disease and food-borne illness events that require epidemiological investigation and follow-up;
- Our public health capacity to address chronic disease (prevention, education, and policy);
- The health, social and economic impact of substance abuse including methamphetamine;
- Low but improving immunization rates for our young children; and
- Drinking water quality preservation in southern Deschutes County.

Progress—The 2009-2010 Plan also recognizes notable progress in:

- Low teen pregnancy rates;
- Low school exclusion rates for school age immunization;
- Added capacity across the primary care safety net system;
- Exceptional breastfeeding rates among Deschutes County WIC mothers and
- Expansion of school based health centers capacity in La Pine, Redmond and Bend.

We also look forward to the fall 2009 completion of our 2009 Public Health Community Report. The 2007 report was well received and the new, expanded report will support our work in the community and strengthen our County's education and public health action agenda.

Deschutes County Health Services recommends continued focus on the long list of health issues challenging our communities and families. Though realistic about our State's financial resources during a down economy, we continue to endorse enhanced State financial support our public health capacity to control diseases and address chronic conditions in our population. The Department enjoys the support and active participation of our local Public Health Advisory Board, our Board of County Commissioners and a strong collegial relationship with our State public health partners as well as many local coalitions and agencies.

II. ASSESSMENT

A. Community Health Assessment

Community Health Profile: In March of 2007, the Department issued its third edition of a community health profile report. A PDF version of the report is attached as Appendix A. The report summarizes the major health issues and trends across Deschutes County. Please refer to the report for a comprehensive assessment of the health of the community. The Department will continue to support the collection of health data and reporting in this format on at least a biannual basis. In addition to the findings in the report, a few of the major health issues affecting our communities are noted below.

Access to Health Care/Safety Net Health Services: Access to basic primary, dental and behavioral health care and medical services remains one of the foremost needs across our communities. In reality, a crisis has arrived. It is estimated that approximately 25,000 Deschutes County residents lack any form of healthcare insurance and are disenfranchised from the health care system. Central Oregon, at 19.1%, has the highest uninsured rate in Oregon. Approximately 6,300 Deschutes County children remain uninsured. It is estimated that 13% of our children live below the poverty line. It is uneasy knowing these are many of the children facing the most significant health and dental issues.

As reported in 2008, it is estimated that 92% of all Central Oregon employers employ less than 20 personnel making the purchase of group insurance unaffordable for most. In addition, unemployment exceeds 14% in Deschutes County.

A significant percent of the uninsured are the working poor as well as Hispanic families who have migrated to the region in recent years. In safety net services, it is not uncommon to find the medically disenfranchised have gone many years without care and present with advanced health conditions that might have been easily treated or avoidable had the individual been able to access health services earlier. These problems present a considerable challenge in the safety net care setting.

Since 2003 we have also seen an increasing barrier to health care services for those insured individuals who have fee-for-service Medicare or Oregon Health Plan (OHP) coverage. This form of insurance is by no means a guarantee to health care services. An ever increasing number of physicians and practice groups are limiting and even refusing to treat clients with these forms of insurance, citing low reimbursement rates. Added together, we estimate approximately 33,000 residents—adults and children—face serious economic barriers and greatly limited access to primary care services. They are likely to struggle to find a medical home. One glimmer of good news is that a Rural Health Clinic in La Pine has remained committed to serving that community. By the summer of 2009, the clinic will begin operations as a Federally Qualified Health Clinic (FQHC), complementing the work of Mosaic Medical Center in the central and north parts of the County. Also significant is the recent incorporation of the La Pine community. This will only help in working with members of this community to address current and future health care needs.

In 2004, a new health care clinic, Volunteers in Medicine Clinic of the Cascades (VIM), opened its doors, providing an access point for low-income, uninsured residents of Deschutes County. The VIM clinic received over 7,500 patient visits in 2008.

Mosaic Medical expanded their FQHC network to Bend and Madras in 2005, bringing much needed access to Medicare and low-income clients. The Mosaic Medical system received more than 30,000 patient visits across Central Oregon in 2008.

The School Based Health Centers in La Pine, Redmond and Bend thrive as critical access points to health services for many of the school age youth in Deschutes County. The clinics are unique in Oregon in that they readily serve all school aged students, grades K-12.

Childhood Chronic Disease: Childhood asthma, diabetes and obesity are drawing increased attention at the local level. A coalition has been formed called Healthy Active Central Oregon (HACO) to identify and implement strategies aimed at addressing inactivity and obesity. The Oregon Healthy Teens Survey reveals that 19.5% of our 8th graders and 18.6% of our 11th graders are overweight. There has been a startling rise in obesity rates in children in the past two decades.

Communicable Disease: The Communicable Disease Program in Deschutes County continues to grow with increased numbers of disease cases, food-borne outbreaks, and requests for information from the community. The County population growth has increased from 115,367 in the year 2000 to 167,015 in 2008. Chlamydia continues to be the highest reported disease in Deschutes County, with an increase of more than 70% since 2001. The cases count for 2007 was 395 and 438 for 2008. Overall, communicable disease reports and investigations have increased more than 500% since 1998, creating an increased workload on staff for follow-up. The Department investigated 7 cases of syphilis and 6 cases of gonorrhea in 2008.

Deschutes County continues to have higher rates of giardiasis, the number of campylobacter continues to rise, and the number of food-borne illness outbreaks (Norwalk) have increased. Deschutes County is also averaging 20-25 cases of Hepatitis C a month (non-acute) which, since the disease became reportable in 2005, has created an unfunded workload for staff.

It has been a challenge to develop an effective reporting loop with local medical providers in the community. Due to high provider turnover and a large influx of new providers, the Communicable Disease team has found it difficult to educate and remind about reporting standards on a regular basis. In 2007 and 2008, presentations were done for the emergency room medical staff and local medical providers in hopes of improving the frequency of providers contacting the Department about reportable diseases.

The Communicable Disease team updated the West Nile Virus Plan, implemented surveillance in 2005, and is preparing for the spring of 2009. The team completed development of a SARS Plan and is in the process of updating the Pandemic Flu Plan, as well as participating in health system preparedness with Cascade Healthcare Community and numerous community partners.

Cultural Competency: Those of Hispanic origin are a fast growing group. Of 2,000 live births in Deschutes County in 2006, 234 (11.7%) were to Hispanic mothers. In 2007, we saw 2,083 live births with 287 (13.8%) to Hispanic mothers. Many of these families are non-English speaking and require translators to ensure they receive safe, effective care and services. Hispanic mothers have good access to prenatal care regardless of their insurance status through HealthyStart Prenatal Clinic. The service also offers childbirth and car seat safety classes in Spanish. Translation and cultural needs for Hispanic mothers are also well met in the Women, Infants & Children (WIC) program.

The reproductive health programs, including Family Planning and STD, have front office and clinical staff who are bilingual. An interpreter is available for clinicians who do not speak Spanish. All educational materials and forms are available in English and Spanish. The clinic uses a certified translator to translate or review all Spanish materials. The staff has had cultural competency training and works very hard to meet the needs of all cultures that access services at the Department. In February 2008, we started a "Males Only Clinic"

and have marketed services toward men who have sex with men. The staff who work this clinic are well trained in the needs of this community. Deschutes County is committed to providing equal access and eliminating barriers to care for all clients.

Demographic Population Changes: The County is challenged by a rapid population growth, making it difficult to keep pace with the increased demand for public health services. Deschutes County, again, ranks near the top in per-capita growth rate for 2008. The County Population at the end of 2008 is estimated to be over 167,000 citizens. The increased demand for prenatal services relative to the growth in the Hispanic population is noteworthy. Of 2,083 live births in 2007, 287 (13.8%) were to mothers of Hispanic ethnicity. In 2008 the HealthyStart Prenatal Program (our safety net prenatal program) assured for the delivery of 143 healthy babies; 95% were to Hispanic mothers.

Of note is the rate of growth in our over 65 senior population. Estimated to be 19,988 persons in 2006 (13.1% of the population), this figure is expected to grow to over 27,000 by 2010 and over 45,000 by 2025 a 143% increase from 2005-2025.

Emergency Preparedness: Program staff have developed a Pandemic Flu Plan, collaborated with community partners, and incorporated the plan into the County Emergency Response Plan. Deschutes County Health Services continues to work with the County Emergency Manager. The program hired a full-time coordinator in 2007 and since that time has made notable progress in staff training as well as community and health system readiness.

Environmental Health & Toxicology: In southern Deschutes County efforts to assure for the preservation of the quality of drinking water from groundwater sources have received acute attention. A recently completed U. S. Geological Survey indicates nitrates will continue to accumulate in the shallow water aquifer unless remediation efforts are undertaken. The County is still considering adopting new development codes that would address nitrate sources from septic system effluent. Citizens regularly contact the Department with concerns related to environmental toxicology. We anticipate more attention to health effects from West Nile Virus in 2008, given we had our first avian case in late 2006. We added a part-time position to the Department in 2008 to help address these growing areas of concern.

Family Violence: Family violence includes child abuse, domestic violence (intimate partner violence), sexual assault, and elder abuse.

Child Abuse: In 2001, the reported child abuse case rate in Deschutes County had increased from 10.8 to 11.6 and was considerably worse than the Oregon rate (344 substantiated victims). The rate decreased to 9.4 in 2002 (292 victims), fell further to 8.8 in 2003 (282 victims) and lowered to 8.2 in 2004 (276 victims); but remember the loss of public staffing dedicated to this area of concern. In 2003 there were approximately 1,800 calls to the local DHS Child Abuse Hot Line. The State of Oregon Benchmark for 2005 was 6.2 confirmed cases per 1,000 children. If we were to achieve this benchmark, then we would expect to avert 83 children from suffering as victims of reported and substantiated child abuse, based on a child population of 31,926 for 2004.

Unfortunately, the rate of confirmed child abuse in Deschutes County in 2005 was up 16% over 2004. The rate in 2005 is 9.6 per 1,000 children. In 2005 there were 32,821 children under the age of 18 in Deschutes County. This translates to 314 cases of confirmed child abuse in 2005. In 2006 there were 2,663 reported cases of child abuse in the tri-county Central Oregon area. Of these, approximately 2/3 were from Deschutes County. While the “substantiated” case rate for 2006 lowered slightly to 9.0 cases per 1,000 children—216 substantiated cases of abuse out of 758 investigated cases—it is worthy to note that Child

Protective Services is addressing only those cases where the child is believed to be at imminent risk of harm.

Social service workers state that the number of reports of abused children has not decreased much over time, even though the numbers might suggest this. The lower case rate numbers may well reflect a tightening of the definition of confirmed child abuse. DHS tightened the definition of a founded/confirmed child abuse case, specifically in the area of "threat of harm." The end result has been a lower number of founded cases as compared to previous years.

It is worthy to note there has been a significant increase in children ages 0-2 who are born to parents with known substance abuse problems, especially methamphetamine. A recently completed Healthy Teens Survey revealed that 20% of Deschutes County 11th grade females have been victims of sexual contact from an adult at some point during their life.

Domestic Violence: In 2001, an estimated 762 women and 489 men (1,251 total) were subjected to physical violence by an intimate partner. For 2002, the local women's shelter for battering and rape reports 302 women were sheltered for a total of 4,894 nights, and there were a total of 2,624 hot line calls. In 2003 the numbers increased to 386 women and children sheltered for a total of 4,086 nights and 3,311 hot line calls. In 2004 the numbers leveled off somewhat to 320 women and children sheltered for 4,072 nights and 2,704 hot line calls. Current community factors that impact the problem include increasing unemployment, lack of basic family resources for a growing number of people (putting greater stress on the family unit), a growing Hispanic population with cultural acceptance of intimate partner violence, and a growing problem of methamphetamine use.

The Department received a \$4,700 grant to improve the screening, reporting and referral process with our clientele. This will provide the resources to enhance the current level of service we are providing in this area. Staff were trained and policies revised in February, 2009.

Food-Borne Illness Reports: In 2007, we saw a number of reports of institution-wide Norovirus outbreaks, perhaps due to increased surveillance. There were 11 outbreaks reported in 2008 compared to 14 in 2007 and 12 in 2006. In 2008 we saw 11 Salmonella cases, compared to 18 in 2007 and 12 in 2006. The coordination between public health and environmental health is positive and has resulted in the formal assignment of environmental health service into the Department, which began July 1, 2007.

Health Officer: The Department fills the Health Officer role with the services of three Medical Directors. Dr. Richard Fawcett, an infectious disease physician, is the Deputy Health Officer and Medical Director of communicable disease services. Dr. Mary Norburg, an OB/GYN physician, is the Health Officer and Medical Director of our maternal child health services. Dr. Stephen Knapp, a family practice physician, is Deputy Health Officer and Medical Director of our pediatric and juvenile primary health care services. To date, this model has been sufficient to meet our needs.

Immunizations: Despite providing immunization to nearly 9,000 children in our Shots-For-Tots program, the rate for Deschutes County overall fell to last in the State with barely at 51% of our two-year olds fully covered with recommended vaccines in 2005. In 2008 the Department improved the immunization rate for its 0-2 years service population to 69%, up from 64% in 2007. 2009 will bring an acute focus to this issue and an affirmative plan to increase our rates. The program recently made significant progress by working with Central Oregon Pediatrics Associates to install the ALERT Immunization registry. We anticipate that this will help capture more accurate immunization status data and alert practitioners to the opportunity to vaccinate their young patients.

Injury Morbidity and Mortality: Injury remains the leading cause of death among Oregon's children aged 1-17 and young adults up to the age of 44. Injury is the fourth leading cause of death overall if all age groups are combined. Among all age groups, unintentional injuries resulted in 47 deaths in 1998, 45 in 2000, 43 in 2001, 56 in 2003 and 58 in 2004. Most injury related deaths occur as a result of motor vehicle accidents (38%), falls (29%), poisoning (10%), drowning (3%), firearm shootings, fires, suffocation and water transport incidents. Injuries are not "accidents" in that "injuries" can be predicted and prevented. The 2000 HRSA Community Health Status Report indicated that Deschutes County's rate of motor vehicle accidents (MVA) to be 26.1 compared to a national rate of 15.8 (1997 data). HRSA data reveals that 313 injuries were from falls, 135 from MVA, and 40 from other methods of transportation.

Lactation Services: The Department is deserving of recognition for programs that address breastfeeding including Maternal Child Health (MCH), Women, Infants & Children (WIC), Prenatal Care Clinic, and Oregon MothersCare. The agency seeks to improve coordination among these services for the purpose of consistency for clients as well as maximizing resources. A chief strategy is the revision of the WIC Breastfeeding Coordinator position to incorporate a leadership component to facilitate coordination and to provide shared training to all staff who provide breastfeeding services. The breastfeeding initiation rate among Deschutes County WIC clients is 94.4% based on 2007 data from CDC (Centers for Disease Control and Prevention). This data ranks Deschutes County as third highest among all Oregon WIC agencies.

Leading Causes of Death 2005—Deschutes County (1,062 deaths):

1. Cancer—23.7% (252)
2. Heart Disease—22.6% (240)
3. Cerebrovascular Disease—6.8% (72)
4. Unintentional Injuries—6.3% (67)
5. Chronic Lower Respiratory Disease—5.9% (63)
6. Diabetes—3.4% (37)
7. Alzheimer's Disease—3.4% (36)
8. Suicide—2.2% (23)
9. Alcohol Induced Deaths—1.7% (18)
10. Parkinson's Disease—1.2% (14)
11. Flu & Pneumonia—1.2% (13)

Note: Tobacco use contributed to an estimated 218 deaths in 2005.

Medical Examiner-Coroner: The Deschutes County Medical Examiner is housed within the office of the District Attorney for criminal investigative work. Other work is coordinated between the State Medical Examiner's office and the local Medical Examiner. The Medical Examiner is playing an increasingly important role in our Public Health system. A Medical Examiner, Dr. Chris Hatlestad, was hired in the fall of 2003 and has demonstrated a strong interest in working collaboratively with the Department on health trend analysis and deaths of public health significance. Thanks to Dr. Hatlestad's keen observations, we recently identified a death related to Hantavirus. Dr. Hatlestad is also an active participant in our health system effort to prepare for pandemic flu and participates regularly in local Child Fatality Review Board meetings.

Mental Health Services: The National Institute of Mental Health estimates that 26.2% of Americans 28 and older (1 in four adults) suffer from a diagnosable mental health disorder in a given year. When applied to the 2006 population estimate, this figure translates to over 30,000 Deschutes County residents. While resources for mental health assessment and treatment have diminished, Deschutes County is strong in provider partnerships which enhance the efficiency of existing services through coordination efforts.

Oral Health: Tooth decay remains the most common chronic disease in children age 5-17—five times more common than asthma. Children from low income families have nearly 12 times the number of restricted activity days due to the pain and suffering of tooth decay than do their counterparts from higher income families. In 2005-2006, 32.6% of Deschutes County 8th graders reported not having a visit to the dentist, higher than the statewide rate of 26.3%.

These same populations also have barriers to obtaining dental care including extremely limited safety net services, limited numbers of local dentists who accept OHP and limited capacity to cover the total plan enrollment for the region. A local safety net dental clinic reports they see an average of 50 uninsured school age children per month. Local emergency rooms report a significant number of visits for complications of untreated dental problems. Many OHP enrollees report being assigned to dentists who are out of the area, making it difficult for them to access care. Local dentists report low income and OHP populations are difficult to serve because of higher levels of dental problems and complications poorly covered by OHP.

Limited screening for children is provided in well child clinics as well as nurse home visiting programs. Eligible families may receive prescriptions for fluoride through well child clinics, and extensive prevention education is offered in all MCH programs. Pregnant women receive minimal screening and referral or case management to access a dentist.

The OHP population of pregnant women served in Maternity Case Management (MCM) has been identified as having high rates of dental problems and poor access to care. Participation in local oral health initiatives such as a new coalition and a prevention project in WIC has led to improved access to dental care as well as a better system of providing oral health prevention messages to pregnant women. The Oral Health Coalition continues to provide leadership in advocating for underserved populations in Deschutes County, and in 2005 developed teaching brochures to use with high-risk populations. The brochures continue to be distributed through our clinics, home visiting, WIC and the Ready Set Go program.

The Coalition is using volunteers to disseminate Cavity Free Kids training to community partners. The coalition has assisted Volunteers in Medicine (safety net clinic) and the community college in development of an adult dental clinic staffed by dental hygiene students and volunteer dentists. Give Kids A Smile Day was very successful in helping young children access free care. Currently, the coalition has developed a protocol to inform new dentists of the coalition. The Department received a grant from ODS to provide materials and fluoride for a dental screening program to be staffed by public health nurses to provide referral, education and fluoride varnish to children referred through WIC. Northwest Medical van is being scheduled through Volunteers in Medicine.

Despite 50 years of scientific and medical research on the health benefits of community water fluoridation, every city water supply in Deschutes County remains unfluoridated.

Prenatal Services: Deschutes County has developed a strong perinatal service system involving multiple community partnerships. A shared value among partners is prioritizing early access to prenatal care for all pregnant women regardless of income or insurance status. A highlight of this system is the partnership between Cascade Healthcare Community and the Department to provide a safety net prenatal care clinic for uninsured pregnant women known as the HealthyStart Prenatal Service. The elements of the system are interdependent and reliant on each other to make an optimal contribution to the continuum of need for pregnant women and their families.

Preliminary data show there were 1,948 live births in Deschutes County in 2008. Of them, 143 were births whose moms enrolled in the HealthyStart Prenatal Program. Of note is that 136 of the HealthyStart births were to Hispanic mothers. The HealthyStart Program processed and assisted 589 program participants with their application for the Oregon Health Plan. The HealthyStart Program was chosen to be one of two pilot projects for the Perinatal Expansion program which allows Citizen Alien Waived Emergency Medical (CAWEM) eligible pregnant women to be enrolled in CAWEM Plus. This program provides prenatal coverage through a County match via SCHIP funds. The pilot program will extend for a 15-month period, until September, 2009.

97.9% of pregnant women received adequate prenatal care in 2008. The rate for starting prenatal care in the first trimester has increased from 83% since the implementation of Oregon MothersCare in 1999 to 87.8% in 2008 (compared to a state rate of 78.5%). The low birth weight rate was 6.5% in 2008. Infant mortality was 0.6% in 2008, compared to 1% in 2001.

Substance Abuse: Methamphetamine use is on the rise and difficult to intervene. A local grass roots effort called the Meth Action Coalition has achieved tremendous community and business recognition of this devastating substance abuse.

Suicide: Suicide is the second leading cause of death among Oregon youth age 10-24. In Deschutes County there were 18 confirmed youth (10-17 years old) suicide attempts in 1999. That figure rose to 63 in 2003, prompting community-wide attention and discussion. There were 42 confirmed attempts in 2004 and 42 again in 2005. While 2/3 of youth suicide attempts are among females, 82% of youth suicide deaths are among males. For every suicide death among youth under the age of 18, there are an estimated 134 suicide attempts that are treated in hospital emergency rooms. Suicide for all ages accounted for 24 deaths in Deschutes County in 2002, 21 in 2003, 24 in 2004 and 23 in 2005.

In 2006 the Department attempted to launch the Connecting Youth pilot project to prevent second attempts of suicide in children under 18. Unfortunately this program failed to launch due to concerns raised at the local hospital over patients' privacy rights and was disbanded in the spring of 2007. The local Suicide Prevention Coalition remains active and is seeking grant funding to expand community outreach.

Unintended and Teen Pregnancy: Deschutes County Health Services continues to place high priority on teen pregnancy prevention. Although the teen pregnancy rate has decreased significantly in the past ten years, Deschutes County saw a slight rate increase in the past year. The teen pregnancy rate (per 1,000 female population 10-17) in Deschutes County was 8.6 in 2007 and 9.1 in 2008. The newest data is showing that the rate may be going back down this year.

Public health staff collaborate with community partners to assure access to reproductive health education and services. Each year the Reproductive Health Program, in collaboration with the schools, provides the STARS (Students Today Aren't Ready for Sex) program to almost 1,700 middle school students with over 160 high school volunteers as mentors. Within the past year our health educators have taught more than 215 classes on reproductive health to almost 6,000 students in middle schools, high schools, Central Oregon Community College and at several facilities with high-risk youth. They have incorporated important components like healthy relationships and communication into their presentations to make the curriculum more comprehensive. In the coming year we will be working closely with our State partners to implement the Oregon Youth Sexual Health Plan in our community.

B. Adequacy of Public Health Services ORS 431.416

Deschutes County Health Services provides quality service at an adequate level of capacity, given the resources provided through the County's general fund, Federal/State grants, and billable revenue. The Department continues to face increased demand for required services at a faster pace than resources can match. This is particularly challenging in our Communicable Disease cluster of programs where State funding remains weak and the expectations surrounding epidemiological investigation and follow-up are high. Our Maternal Child Health (MCH) services suffer much the same fate where, despite excellent talent and skills across the team, the demand for services outpaces capacity nearly 2:1. The Department provides exceptional services in its WIC, MCH, Communicable Disease, Family Planning and Environmental Health divisions. The Department will work to improve the efficiency and the cost profile of Family Planning services in 2008 and will address community-wide public health preparedness with renewed vigor.

The Department has added a new emphasis in health promotion and chronic disease prevention by clustering tobacco, asthma and obesity prevention efforts under one roof. The Department continues to be in need of capacity to address issues related to environmental toxicology and the link between environment and human health.

C. Provision of Basic Public Health Services

The Department provides the five basic services outlined in statute (ORS 431.416) and related rule, OAR Chapter 333, Division 14:

1. Epidemiology and Control of Preventable Diseases and Disorders

The minimum standards for communicable disease control are met and the system for enhanced communicable disease control has improved. With the increased population and preparedness requirements, the need for additional staff is great. The Communicable Disease Program responds 24/7 to information requests and currently sends a request to physicians who report Hepatitis C for permission to send educational information to the client. The program provides blood-borne pathogen training throughout the County and Hepatitis B vaccines for occupational purposes.

The Communicable Disease team pulls together to offer tuberculosis (TB) screening and testing to various local partners in the medical community and first responders. In 2007 the TB coordinator focused on screening our homeless shelters. Blood-borne pathogen outreach training is facilitated on request when staff is available.

In the fall of 2007, the Department began seasonal influenza surveillance. Data collected from provider testing through local clinics and hospital staff has given the Department a better picture of the effects of seasonal influenza in the community, as well as enhancing our ability to share local statistics with the public.

In 2008 there has been a greater focus on integrating planning among our Immunization, Communicable Disease and Preparedness programs to increase effectiveness and to decrease duplication of programming efforts.

The Communicable Disease team collaborates regularly with the media to prevent the spread of well-known and novel diseases in our area. The team works to ensure that education is available for the community when sought after and works with local media to be proactive with public education around topics such as tuberculosis, MRSA, influenza, etc.

Currently:

- The program has a Communicable Disease Program Manager, CD Coordinator, CD Health Educator, STD/CD backup RN, Immunization Coordinator, Public Health Preparedness Coordinator, HIV Case Manager, and support staff.
- There is a mechanism in place for 24/7 calls for communicable disease reporting and public health emergencies.
- Evaluations of facilities implicated in a food-borne outbreak are assessed by Environmental Health working in close collaboration with CD team staff. The Environmental Health Licenses Facilities Division transferred into the Public Health Department on July 1, 2007.
- Investigations are completed in a timely manner, control measures are taken, and reports are completed and sent to the State in the specific time frame.
- The program provides access to prevention, diagnosis, and treatment services to protect the public.
- Communicable disease trends are evaluated on a regular basis by the CD team, and objectives are developed.
- Immunizations are provided to the public.
- A needle exchange program was launched in early 2007.
- Rabies immunizations are provided in the jurisdiction.
- The program has generic press releases for outbreak information.

2. Parent and Child Health Services

Perinatal Services:

Prenatal Care Access—Reestablishment of the Oregon MothersCare system has resulted in significantly more OHP enrollments. Our Oregon MothersCare staff was reduced to 0.4 FTE in 2006 yet still served 577 women in 2007, with 90.4% receiving prenatal care in the first trimester and 66.0% of late contact clients starting prenatal care within two weeks of initial contact.

This team works in close collaboration with our own HealthyStart Prenatal Service—a safety net clinic where low income women who are ineligible for OHP receive high quality prenatal care and birth delivery services. The clinic is a collaborative program of the Department and Cascade Healthcare Community and has now reached capacity, having served over 300 women in 2006 and performed 182 birth deliveries. The program will be challenged in meeting the needs of Hispanic and non-English speaking pregnant women. A shortage of qualified translators makes it difficult for these women to get comprehensive services. A new opportunity exists with the CAWEM-OHP eligibility pilot project.

Dental Care—While OHP enrolled pregnant women have coverage for dental care; most area dentists refuse to provide care during the pregnancy. Home visiting nurses estimate that nearly 97% of women on their caseloads have serious dental problems yet are unable to access care. Our local Dental Plan (Northwest Dental) is in the process of carrying out a training agenda for participating dentists with the objective of increasing dental care provided during pregnancy. Significant improvements have occurred with access to care and prevention efforts (see Oral Health Section).

Case Management and Social Services—Nurse Home Visiting—We are experiencing a decreasing ability to meet demand due to a decrease in capacity. The service will be in jeopardy if Medicaid reimbursements decrease. Population growth has caused demand for services to greatly exceed staff capacity. Currently staff cannot handle all high-risk referrals.

Intimate Partner Violence—Services are limited to the local family violence shelter and lack an outreach/education component.

Mental Health Services—County services have been reduced for indigent individuals, while OHP clients can receive assistance based on medical necessity.

Alcohol and Drug Treatment—With the exception of co-occurring disorders, most County services to eligible, priority populations are provided via contracting with private agencies in Deschutes County. Services are limited; OHP penetration rates are in need of improvement statewide.

Tobacco Cessation—Inadequate resources for tobacco cessation for pregnant women. The Smoke-Free Mother Baby project is limited and the only service available. It is noteworthy that nearly 40% of OHP mothers smoke during their pregnancy versus 11.2% of non OHP moms.

Breastfeeding Support—We are losing capacity for in-home nurse visiting service but remain strong in WIC and local hospital outreach programs. Support is improving with better coordination among perinatal services and the addition of the WIC Breastfeeding Peer Counselor Program.

Multicultural Service—The growing need for translators and Hispanic service results in an increasing gap between need and capacity as medical and human services experience shortfalls in resources.

Child Health Services: The Department provides education, screening, and follow-up for growth and development, hearing, vision, lead, and symptoms of illness for high-risk infants and children. These services are provided through School Based Health Centers in La Pine, Bend and Redmond, and nurse home visiting. Additionally, we provide assessment of parent/child interaction (NCAST) and Sudden Infant Death Syndrome (SIDS) follow-up. The demand for screening and follow-up of high-risk infants (Babies First) exceeds capacity. Approximately 40% of current referrals will not receive services. Coordination of community services has decreased leading to inconsistency of referrals from partners and making it difficult to track needs. The Department recently participated in submission of a LAUNCH grant application to the Substance Abuse and Mental Health Services Administration (SAMSHA) to address this concern.

La Pine School Based Health Center: Deschutes County is in its fifth year with a fully certified School Based Health Center (SBHC) serving grades K-12 in La Pine. This service adds capacity to the community's safety net care system and provides access to primary care for approximately 1,500 La Pine school students. In May of 2009, two new SBHCs were fully certified. The SBHC at Ensworth Elementary School in Bend serves the Bend-La Pine School District, and the SBHC at Lynch Elementary School in Redmond serves the Redmond School District.

Children with Special Health Care Needs: Children with physical, cognitive, and social disabilities are case managed by a MCH nurse specialist. The LHD contracts with Child Development and Rehab Center to provide the CACOON program.

Family Planning Services – ORS 435.025: Deschutes County Health Services maintains four reproductive health clinic sites to serve multiple areas of the County. We have two full-time clinics in Bend and Redmond, and within the past year we have expanded our services in La Pine from two Thursdays a month to every Thursday. For the past two years we have been serving youth and adolescents up to age 25 at the

Downtown Health Center two days a week and have expanded those services to three and a half days a week currently.

All clinics provide care under protocols and standing orders approved by the Medical Director, Mary Norburg MD. Reproductive health staff meet on a regular basis to discuss program updates, case studies, and information exchange. The program delivered service to 3,177 unduplicated clients in 2008 and averted 546 pregnancies.

Family Planning Expansion Project (FPEP) qualification and enrollment changes along with the increase in clients who are seen at no charge or partial fee threatens the ability of this program to maintain our current levels of service. Front office staff will work to get every client's citizenship verified at their first encounter at the clinic. If the client was born in Oregon, the client completes the Oregon Birth Match Form. If the client was born out of state and does not have access to his/her birth certificate, the client completes the Birth Certificate Request Form for the state where the client was born; the completed form is sent to the appropriate state. This minimizes the number of clients who qualify for FPEP but are not verified.

The registered nurses working in reproductive health are required to complete a very comprehensive training program and have nurse practitioner back-up available. The support staff are given training materials on the fundamentals of family planning that are based on up-to-date research and current guidelines. The training modules focus on birth control methods, anatomy and physiology, and STDs as well as communication skills, informed consent, and client education. We use a broad range of client education materials, many of which we have developed ourselves to meet the educational needs of the clients; these materials are reviewed by our Family Planning Advisory Committee. The materials are kept current and are available in Spanish and English. Materials are selected or developed for prevention as well as for education regarding specific conditions.

Our reproductive health community outreach and education has grown in the past several years. We have several health educators and AmeriCorps members who actively participate with community partners. They attend the Bend-La Pine School District's Health Advisory Board meetings and play an important role in helping that school district come into compliance with the sexuality education guidelines.

3. Collection and Reporting of Health Statistics

Vital records work related to births and deaths is well organized, highly accurate and extraordinarily efficient thanks to a small staff of highly trained and dedicated professionals. The local Medical Examiner is now compiling and sending information to the Department on deaths of public health significance and assisting in monitoring trend data related to injury and death related to illicit drug use. Vital statistics and communicable disease (CD) information is received and recorded in a timely manner.

The communicable disease information is forwarded to the State through the new CD database, and immunization data entry is completed daily. The numbers of births and deaths continue to increase related to a rapid increase in overall County population. In the past two years we have witnessed an explosive rise in birth numbers.

There were 2,083 live births in 2007, 2,000 in 2006, 1,783 in 2005 and 1,438 in 2000, revealing our upward trend. This represents a 25% increase in birth numbers over the most recent five-year period. There were 1,202 deaths recorded in 2005 compared to 916 in 2000. This represents a 32% increase over the five-year period. The Department issued an updated Community Health Profile report in March of 2007 (see Appendix A).

Deschutes County once again earns the distinction of being Oregon's fastest growing county per capita. According to Portland State University's Center for Population Studies, Deschutes County's population was estimated to be more than 167,000 in 2008 as compared 116,600 in 2000. This represents a 30% increase. Current population forecasts project the County population to increase steadily to 170,800 by 2010 and near 250,000 by 2025. 22.5% of our population, or 34,318 individuals, is under the age of 18.

Local partners have become increasingly reliant upon up-to-date and accurate population and birth forecast information for program and facility planning purposes. The Department has improved access to vital statistics through links in its own website. Reportable disease has increased consistently with increased population and improved communication with local physicians and laboratories.

Recently, the Department has worked to inform the community of the condition of health across the community. This has been done by producing bi-annual community health profile reports and by selectively profiling specific health issues such as obesity, access to primary care, and the oral health condition of children. The 2007 Health Report is attached as Appendix A. The 2009 Health Report will be released this fall.

4. Health Information and Referral

Health information and education is provided through Deschutes County Health Services in each program. On a typical day, 125 or more calls are received from the public wanting information on health related matters. Callers seek information ranging from primary care and mold control to animal bites and how to access the Oregon Health Plan. Clinicians and front office staff frequently serve as brokers of information to clients and make referrals for additional health and social services.

The Deschutes County Public Health Advisory Board has taken a keen interest in health promotion and education and is working closely with the Central Oregon Health Council on a health promotion initiative related to reducing the impact of obesity and diabetes.

We have added to our health promotion staff by creating a Community Wellness Coordinator at 1.0 FTE. This position works closely with community partners and the Public Health Advisory Board to develop and implement plans for expanded health promotion and community wellness activities based on community need.

5. Environmental Health

Deschutes County is fortunate to have a staff of highly trained and dedicated licensed sanitarians who do an outstanding job of assuring for the safety of public food establishments, pools, spas, daycare facilities, drinking water systems and septic systems.

Deschutes County Environmental Health (EH) currently operates through the Community Development Department of the County and provides licensed facility and food safety inspection, on-site sewage disposal permitting, and public water system inspection and assurance. The team is cross-trained in a number of aspects of environmental health services to take advantage of workflow often dependent upon the local winter climate. A close working relationship exists between the EH program staff and the communicable disease (CD) control team within the Department.

In recent years, there has been a number of environmental health issues addressed collaboratively between these two programs. The Health Director has an oversight role in all critical CD and EH case situations that have human health impacts. Currently, a joint governance model for environmental health services and supervision exists between the Health Director and the Director of Community Development. It is expected that coordination between the departments will be enhanced in the coming year. A member of the Environmental Health Team also participates in disaster and public health preparedness planning.

Licensed Facilities—Food Inspection Protection Program: Deschutes County, once again, holds the distinction of having the most licensed facilities to inspect per-capita in Oregon. In 2007 the EH staff inspected 1,850 food service establishments, temporary and mobile food units, commissaries, warehouses, and bed and breakfast establishments. In addition, the Licensed Facility team conducted a plan review on 85 new or remodeled restaurants and provided 1,325 food handler tests. The team also converted from the State DHS database system to Verizon/AccuTerm database which provides for “real time” data. The staff also taught five food handler classes across the communities we serve. Staff works in an “education” mode as much or more than an “overseer” mode when they conduct routine inspections, providing collegial relationships with the vendors.

Safe Drinking Water: The Environmental Health Division continues to provide professional technical and regulatory assistance to all 184 public water systems in Deschutes County. The team conducted 30 comprehensive sanitary surveys in 2007 and followed up on 10 deficient surveys. The team also investigated 31 water quality alerts associated with bacteriological and/or chemical contamination and responded to and resolved 3 significant non-compliers (systems not meeting EPA standards). The operators of the water systems follow the procedures for sampling and providing the population with safe drinking water. The County makes sure the sampling protocols are followed and follows up on samples which do not meet the Federal Safe Drinking Water Standards. The team is deserving of commendation for their continued efforts to reduce the number of systems on the EPA Significant Non-Compliant list from 60 in 2000 to just 3 in 2007. Security and emergency response plans are reviewed.

Currently, the County is engaged in an action plan to preserve the quality of the groundwater—drinking water source—in southern Deschutes County. The plan addresses nitrate reducing technology associated with homeowner septic systems. A U. S. Geological Study recently revealed the high probability of increased nitrate contamination if a remediation strategy is not adopted and implemented. Deschutes County Health Services worked with State staff to develop public messages on the health effects of nitrate consumption associated with drinking water.

In 2008 the Environmental Health program completed a project that mapped all County drinking water sources. This will ensure that if a source is contaminated residents can be immediately notified and directed to the appropriate alternative water source.

On-Site Wastewater Treatment: Environmental Health assessed 315 sites for feasibility for on-site wastewater treatment and dispersal systems and issued 1,772 permits and authorizations for new and existing systems. The program also performed 1,880 inspections to ensure proper siting, installation or abandonment of on-site systems, and permitted and inspected the replacement of 10 substandard trench systems, as well as helped facilitate the abandonment of 5 sewage drill holes.

Pool, Spa and Tourist Facilities: Environmental Health performed 350 pool and spa inspections in 2006 and an additional 50 inspections of tourist accommodations. In addition, the team reviewed 23 pool/spa plans for new facilities in 2006.

Schools and Child Care Facilities: Environmental Health conducted 102 National School Lunch Program Inspections in 2007, serving over 19,500 students per day. Related to inspection of day-care facilities, the EH team conducted 70 inspections of licensed child care facilities, giving the team a 100% inspection rate.

D. Adequacy of Other Key Services Critical to Public Health

Community Advocacy and Multicultural Health: The Department has provided support to local community coalitions addressing hunger, homelessness, methamphetamine abuse, child abuse, health care, childhood obesity and asthma. Note: Deschutes County Health Services hosts the Cascades East Learning Center interpreter students at our site to provide more clinical learning opportunities for the program.

Breast and Cervical Cancer—Safety Net Services: Sadly, the Oregon Breast and Cervical Cancer Program has not done a good job of its recent transitions at the State or local level, and access to care for this critical service has been progressively and greatly reduced in the past 20 months. After several years of providing the administrative and case management components of the program the Department was compelled to relinquish a regional based system with the promise of a new, more efficient statewide system in July of 2006. Expectation of a statewide system to manage eligibility, provider payment and client data management has not materialized. After eight months of attempting to patchwork the various components to the program, the Department realized the inability of sustaining this system.

We made a difficult administrative decision to phase out participation in this program and are no longer accepting patient referrals from our community. Prospective patients are now being referred back to the State hotline. Bend Memorial Clinic continues to accept patient referrals for screening and clinical follow-up. The Community Clinic of Bend has recently elected to curtail accepting patient referrals but will continue to screen and enroll eligible women from within their established patient clientele. The Department has prospective BCC clients scheduled for screening into June of 2007, but has ceased accepting more referrals.

Emergency Preparedness: Since the fall of 2005, the Department has taken a keen focus on health system readiness and capacity to respond to large-scale health events such as what might be expected during a pandemic influenza event. This endeavor concerns preparedness across the entire community health system, not just the local public health department. The Department has a part-time position focused in this area.

Emergency Preparedness in Deschutes County has improved with the Bioterrorism Grant and re-structuring of the Department focusing on a Communicable Disease Center. Program staff have developed smallpox plans, improved CD response times, developed a Pandemic Flu Plan, collaborated with community partners, and developed a new Bioterrorism Response Plan incorporated in the County Emergency Response Plan. The Department continues to work with the County emergency manager to plan County exercises. The Strategic National Stockpile Plan was completed in 2005 and is exercised each year.

The Department participated in a mass casualty drill in June of 2006. The team is currently working on the regional plan with the HRSA Coordinator and working with

Cascade Healthcare Community and the community on preparedness. The program will continue to develop materials on mass casualty and improve surveillance with providers.

The 24/7 system through an answering service improved the capability of staff to respond immediately to a public health issue. We also continue to meet with Jefferson and Crook County staff to improve coordination through the region. The staff will be leading the effort to improve the capability of all Department staff to respond to an emergency through ICS/NIMS training.

Laboratory Services: The Department provides laboratory services in compliance with CLIA standards. The lab manager oversees the laboratory procedures and provides technical services to clinicians. The Department has a contract with Central Oregon Pathology to provide those services not conducted at Oregon Public Health Labs or our local Cascade Healthcare Community laboratory. This arrangement provides for full-service laboratory services for family planning and sexually transmitted disease services. Arrangements are made with other local full-service medical labs to perform diagnostic lab work outside the scope of our internal labs. Local labs also report conditions reportable to the Communicable Disease team.

Nutrition: Screening, education, and assessment are provided extensively in MCH and WIC programs and are also offered to pregnant women in prenatal care clinic. Targeted screening and assessment are provided to adults in Family Planning and safety net primary care clinic. An acute focus on school nutrition has been developing over the past two years; and Bend, La Pine and Redmond schools are well ahead of State mandates when it comes to the nature of foods served and sold on their campuses.

Older Adult Health—Flu, Pneumonia, Norovirus, Falls: Prevention messages are provided to seniors through the Immunization and Communicable Disease Program. Media events promoting adult immunizations are provided yearly, and the Immunization staff is working with private medical providers to improve the adult immunization rates in offices. The Department maintains a senior resource directory; and information is given to clients regarding diabetes, chronic disease, breast and cervical cancer, and immunization clinics.

Primary Health Care Access for Low-Income Residents: It is estimated some 25,000 plus Deschutes County residents, or approximately 18% of the population, is without health insurance coverage. In addition, those with fee-for-service Medicare and Oregon Health Plan coverage suffer from a private market health care community which has greatly limited or closed their practice to these individuals, citing low reimbursement rates. We estimate 35,000-40,000 residents suffer from an economic barrier to basic health services. Many of these are children, working adults and new Hispanic families.

The Department has been at the forefront of addressing health care inequity for the past 10 years. The HealthyStart Prenatal Program, a partnership between Cascade Healthcare Community, East Cascades Women's Group and the County has provided full obstetrical and delivery care to all pregnant women with the inability to afford private market health care.

A new School Based Health Center (SBHC) opened in La Pine in late 2004, followed by a Federally Qualified Health Center (FQHC) in Bend—The Community Clinic of Bend, operated by the Ochoco Health System. The Department is working closely with and supports the efforts of Ochoco FQHC clinic in Prineville to establish this Expansion-site Clinic. In April of 2007 the County granted \$56,000 to the Ochoco Health System to add staffing capacity to help explore the feasibility of expanding services to the La Pine area. Recently a decision was made by the Ochoco Health System to forego expanding into La Pine at this time.

From 2002-2004 the Department operated a Community Care Clinic for medically indigent adults while working closely with other community partners to establish a Volunteers in Medicine (VIM) Clinic. In the spring of 2004 the Volunteers in Medicine Clinic officially opened and received nearly 7,500 patient visits in 2006. In September of 2003, a private clinic in La Pine was designated as a Rural Health Care Clinic.

Limited primary care is still an issue for both OHP and Medicare patients. Many local primary care physicians have severely limited their practice to these patient populations.

Indigent Care for Pregnant Women: Low income and uninsured women receive prenatal care and delivery services through the HealthyStart Prenatal Program. Those eligible for OHP are seen until enrollment and then transferred to private care. The program delivered 159 births in 2005, 182 in 2006, 187 in 2007, and saw a drop to 143 in 2008 with the declining Central Oregon economy. The program is a close collaboration between the Department and Cascade Healthcare Community, and contracts with a local OB practice for delivery services. The demographic profile of our clients has shifted towards Hispanic women, who do not have OHP coverage. We estimate there are, on average, 250+ pregnant women per year who fall between 100-185% of FPL. A loss of eligibility for OHP would simply overwhelm our local safety net program. The Perinatal Expansion Pilot has been key in program sustainability as community support lags in this economy.

Central Oregon Health Collaborative—Now Named Health Matters: This is one of Oregon's community based action groups attempting to address system reform aimed at improving health and access to care. Health Matters recently received its 501(c)(3) status and may soon attempt to model a suite of services similar to CHOICE Health out of Olympia, Washington. Other interests of the collaborative involve employee health and worksite wellness as well as community development initiatives that enhance the opportunity for residents to exercise, walk, bike and socialize. Most recently the collaborative has begun an initiative looking at medical home placement for children with special health care needs. Alisha Hopper is the Executive Director.

WIC—Women, Infants and Children: The WIC program offers nutrition counseling, referral services, breastfeeding education and food vouchers to women who are pregnant, post-partum and/or breastfeeding. The program also serves children from birth to five years old. The WIC Nutrition Education Plan for 2009-10 focuses on key nutrition messages related to the new food vouchers, incorporating participant centered services into counseling and classes, and increasing duration and exclusivity of breastfeeding.

III. ACTION PLAN

A. Epidemiology and Control of Preventable Disease & Disorder

1. COMMUNICABLE DISEASE

The Communicable Disease Program in Deschutes County continues to grow with increased numbers of disease cases, food-borne outbreaks, and requests for information from the community. The County population growth has increased from 115,367 in the year 2000 to over 167,000 in 2008. Chlamydia (CT) continues to be the highest reported disease in Deschutes County. CT cases increased to 438 in 2008 from 395 in 2007. The cases have nearly doubled in four years, which creates an increased workload on staff for follow-up. Gonorrhea case rates are below the State average but have increased over the past few years, primarily in middle-aged white men. The County has also had several syphilis cases over the past few years.

Deschutes County continues to have slightly higher than average rates of Giardiasis (compared with other counties in Oregon). The number of Campylobacter continues to be our main waterborne disease, and rates are on the high end compared to other Oregon counties. The number of food-borne illness outbreaks (Norwalk) has increased dramatically with the growth of the community and retirement homes in the area. Deschutes County averages 15-20 cases of Hepatitis C a month (non-acute), and since it became reportable in 2005 we are continuing to see numbers rise.

After several years of no reported active tuberculosis (TB) disease, in the past three years we have seen a substantial increase in the number of suspect TB cases in our area. In 2006 we had 44 individuals with LTBI (latent tuberculosis infection) and two active TB cases to manage. The Communicable Disease (CD) team updated the West Nile Plan, implemented surveillance in 2003 which has continued to date, and is preparing for the spring of 2009.

The program has completed the development of a Pandemic Flu Plan and is working with other employers and organizations to continue building an infrastructure that can address the threat of community-wide disease outbreaks. The program is participating in health system preparedness with Cascade Healthcare Community, has planned and practiced a number of table top exercises, and has participated in the Strategic National Exercises and state-wide Pandemic Influenza drills each year. Future trends include increased surveillance and awareness of potential communicable disease threats such as pandemic influenza, West Nile virus, bioterrorist agents, etc.

Current Condition Or Problem—General:

A constant in the realm of public health is that communicable diseases have long been known to be the primary cause of morbidity and mortality in man. Over the past hundred years, the incidence and prevalence of communicable disease has diminished. These declining rates were due to improved systems of sanitation and hygiene practices as well as the development of vaccines to help prevent the spread of disease. However, in recent years morbidity and mortality rates are climbing from newly identified diseases and resurgence of old diseases. According to Oregon Health Services, the five most prevalent infectious diseases in Deschutes County for 2008 were:

- Chlamydia (438)
- Hepatitis C (196)
- Campylobacter (44)
- Giardiasis (38)
- Salmonellosis (11)

Chlamydia continues to be the highest reported disease in Deschutes County. The cases have doubled in the past four years, which has increased workload for our staff a great deal. Gonorrhea and syphilis have also established a presence in the past five years and continue to increase with the population growth.

Deschutes County continues to have a high number of waterborne disease cases and increased numbers of Norwalk-like viruses in congregated living settings.

After several years of no reported active tuberculosis disease, the past two years included several new cases of both active TB, and inactive infections (LTBI). Also, due to the large geographical area, it has been difficult for nurses to travel daily to do directly observed therapy. The travel and time allotted has put a strain on other program priorities.

Goal:

To improve/maintain the health status of the citizens of Deschutes County by preventing/reducing the incidence of communicable disease through outreach education, epidemiological investigation and surveillance activities.

Activities:

Target Population	Who	What	Timeline
Deschutes County residents	CD Coordinator	Objective 1: <ul style="list-style-type: none"> • Mechanism in place to receive, evaluate, respond to urgent disease reports 24 hours a day, 7 days a week. • Provide epidemiological investigations on 100% of reportable diseases with 24 hours. 	Ongoing
Deschutes County residents	CD Team	Objective 2: <ul style="list-style-type: none"> • Case investigations are complete (>100%). • 100% of reported cases are reported to DHS by end of the calendar week of the completion of the investigation. • Information and recommendations on disease prevention are provided to 100% of exposed contacts locally. • All demographics are completed on the case reports. • CD investigations are to begin within one working day of report • Update CD database as needed. 	Ongoing
Medical providers	CD Coordinator Outreach Worker	Objective 3: Increase the number of medical providers reporting CD appropriately through outreach and education. <ul style="list-style-type: none"> • An emergency system for communication of CD alert information will be maintained. 	Ongoing
Medical providers	CD Coordinator	Objective 4: A more consistent feedback system regarding the outcome of the investigation will be provided to the health care provider.	Ongoing

Target Population	Who	What	Timeline
Veterinarians	CD Coordinator	Objective 5: Develop an improved zoonotic disease reporting system. Create an e-mail alert system for veterinarians.	12/1/09
Deschutes County residents	CD Team	Objective 6: Develop a Hepatitis C Plan that will address the increase in disease reports and community follow-up strategy within staffing constraints.	Completed
Deschutes County staff	CD Team	Objective 7: Provide blood-borne pathogen training to staff each year.	Completed
Deschutes County residents	CD Team	Objective 9: Update the Pandemic Influenza Plan and continue to prepare the community.	Ongoing

Evaluation:

- Objective 1: 24/7 system in place with positive test results.
- Objective 2: Completed reports sent to State—monthly evaluation.
- Objective 3: Improved reporting and communication with medical community.
- Objective 4: Development of a system for provider feedback and implementation.
- Objective 5: Development of a system for veterinarian reporting and implementation.
- Objective 6: Completion of the Hepatitis C Plan.
- Objective 7: Documented training.
- Objective 8: Updating of Pandemic Influenza Plan and develop Health System Preparedness Plan.

Current Condition Or Problem—HIV:

The number of HIV positive individuals continues to grow in Deschutes County with the increase in population. The incidence and prevalence of reported AIDS cases have been low, with no unusual aspect to the demographics. During the first year of the new HIV testing statistics, there were 16 reported cases of HIV in Deschutes County with 6 cases of AIDS. HIV individuals in Deschutes County still find difficulty living in a community with fears around HIV. There are currently 55 HIV positive clients enrolled in the HIV Case Management Program with the Department. It is anticipated that HIV caseloads will grow steadily over the next few years as more people move to the area.

Future considerations include concerns about the need for medical care and medication with the loss of the Oregon Health Plan programs. The program has seen an increase in positive women and new individuals moving to the area from out of state. Future trends and concerns also include the rising injection drug use (IDU) in the County and Hepatitis C cases which have a high co-morbidity rate with HIV. There is a new State law supporting the testing of pregnant women for HIV. We are focusing our outreach on high-risk groups which include those who use injection drugs and men who have sex with men (MSM).

Goal:

To improve/maintain the health status of the citizens of Deschutes County by preventing/reducing the incidence of communicable disease through outreach education, counseling, and testing for HIV.

Activities:

Target Population	Who	What	Timeline
HIV high-risk population HIV women HIV MSM	HIV Program staff	Objective 1: Organize and reassess the acuity levels of the client load in HIV Case Management.	Ongoing
HIV high-risk population	HIV Program staff	Objective 2: Increase the percentage of high-risk Deschutes County residents counseled and tested for HIV by 10% for the 2007-2008 fiscal year.	Completed
Women and children at risk for HIV	HIV Program staff	Objective 3: Improve the provider HIV testing of pregnant women through outreach and education. (New State law addressed this in 2005.)	Completed
Deschutes County residents	Program Manager HIV Staff	Objective 4: Update and improve prevention plan based on new CDC Guidelines.	Completed
High-risk population MSM, IDU	HIV Staff STD Clinician FP/STD Coordinator	Objective 5: Increase HIV testing numbers in the community using the new HIV Rapid Test. (Implemented.)	6/30/08

Evaluation:

- Objective 1: Organize and reassess participants in the HIV Case Management Program.
- Objective 2: Increased number of HIV tests performed for fiscal year 2007-08.
- Objective 3: Survey providers on HIV testing activity.
- Objective 4: Evaluate each HIV prevention activity and report quarterly to the HIV Program.
- Objective 5: Measure the number of new HIV tests completed.

Harm-Reduction (Hepatitis B and C, and HIV) Goals And Activities:

Objective	List Resources	Activities	Expected Effects/Outputs	Context
Reduce Hepatitis and HIV infection in people who use injection drugs and their networks.	Outreach staff member, Health Services buildings, and drop boxes around the County.	Facilitating needle exchange, providing boxes throughout the County for people to drop dirty needles. Promoting through word of mouth, pamphlets, cards, websites. Educational presentations given to local drug and alcohol treatment groups regarding HIV and Hepatitis transmission and prevention in an effort to increase awareness.	To prevent new HIV and Hepatitis infections, decrease client needle sharing, decrease reports of needles found in the community.	Conservative community that is just now starting to adopt harm reduction principles for the safety of the community at large. We are now seeing more people use the exchange and drop boxes than the previous year.
Increase testing among people who use injection drugs (IDU)	OHROCS program	Work with other community partners to build OHROCS program, promote testing with IDU clients, STD clinic clients, jail counseling and testing, jail risk reduction counseling, promote needle exchange services, and increase needle exchange sites.	Promote HIV and Hepatitis B & C testing among Dept. locations, develop and distribute informational and referral materials. <ul style="list-style-type: none"> • Outreach materials distributed to 15 IDU locations: jail, Parole and Probation, parks, laundromats, food banks, shelters, drug treatment centers, addiction recovery support groups, bars, hotels. *Target number of people who use injection drugs to be reached with HIV testing: 25.	Location of Department may be a barrier—not in a central location and transportation is a hindrance.

Objective	List Resources	Activities	Expected Effects/Outputs	Context
Reduce Hepatitis and HIV infection through education and peer support of practicing safer sex in the MSM population	Outreach staff member, advertising resources, word of mouth networking, internet resources, local PRIDE event, Drag Show, LGTBQ Fashion Show, Rainbow Alliance membership, State assistance	Promotional material, ads in local newspaper to increase interview opportunities on how best to reach the population and create buy-in from MSM population. Outreach through adult stores.	<ul style="list-style-type: none"> To have a larger network of contact in the MSM population who are passionate about partnering to reduce infection and spreading the word. To increase our knowledge about our local MSM population, how best to reach, network with, and interventions that will be the most successful. Outreach materials distributed to 5 MSM establishments: adult stores, parks, gyms. Outreach at 2 events organized by Human Dignity Coalition: PRIDE, Drag Show. 	Conservative community. Very difficult to break into the MSM network—underground. At this point we are focusing most of our efforts on networking to increase our understanding of the attitudes, beliefs, and behaviors of local MSM. Barriers include closeted, non-gay identifying, and down-low MSM. Building relationships with MSM is also an on-going project of the outreach worker. Peer supported interventions have not been received very well due to the community.
Increase HIV testing among MSM population	Outreach staff member, possible MSM peer volunteer	Staffing and different offsite locations to look at testing opportunities, promotional material, networks already created to spread word and encouragement of testing. Male Only Clinic will be held twice a month. This clinic began 2/28/08 in efforts to increase testing among men, especially MSM.	Increase testing among MSM. *Target number MSM to reach with HIV testing: 25.	Few MSM utilize the Department for HIV counseling and testing services.

Current Condition Or Problem—Tuberculosis:

Deschutes County has seen an increase in the amount of active TB cases, as well as LTBI cases. The result of new cases has increased the need for additional staff to assist in the Communicable Disease Program. In 2008 there were 36 clients receiving INH. In 2005 this number had jumped into the 60s and dropped into the 40s in 2006 (partly due to staff ability to do more outreach to treat). There has been a trend of Hispanic clients receiving LTBI in the past three years. The program hopes to work more with the homeless population and other high-risk groups to treat inactive infections before they become contagious.

Goal:

To provide comprehensive services to the community for the prevention and treatment of tuberculosis, while focusing on awareness and education throughout Deschutes County.

Activities:

Target Population	Who	What	Timeline
Deschutes County residents	CD Coordinator	Objective 1: Increase the number of PPD provided to high risk populations, and decrease to low-risk populations.	Ongoing
Deschutes County residents	CD Coordinator	Objective 2: HIV testing will be offered to all cases and suspected cases of tuberculosis.	Ongoing
Deschutes County residents receiving LBTI from Department.	CD Coordinator	Objective 3: Improve the number of clients completing LTBI from 60% to 75%.	6/30/08
Medical providers	CD Coordinator	Objective 4: Increase awareness to medical providers for active TB cases.	Ongoing
Shelter residents	CD Coordinator Program Manager	Objective 5: Explore the implementation of a screening program for shelter residents.	Completed
Deschutes County residents	CD Coordinator and Team	Objective 6: Update policies, forms, and protocols annually. (Completed.)	Ongoing
Deschutes County employees	CD Coordinator Program Manager	Objective 7: Update employee respiratory protection and screening program annually and provide fit testing for staff.	Ongoing

Evaluation:

- Objective 1: Target PPD tests provided through the Department.
- Objective 2: Documented HIV testing.
- Objective 3: Statistics from Oregon Health Services.
- Objective 4: Number of presentations and information packets to providers.
- Objective 5: Number of shelter residents receiving screening.
- Objective 6: Updated protocols and policies—documentation.
- Objective 7: Updated policy and documented fit testing.

Current Condition Or Problem—West Nile Virus:

The Deschutes River Basin is home to the Culex tarsalis, Culex pipiens, and Aedes vexans mosquitoes. These mosquitoes all have the potential to carry West Nile Virus (WNV), and this will pose a threat for animals and humans in Deschutes County. The current problem includes lack of information to the general public and lack of a County-wide vector control district.

Goal:

Decrease the morbidity and mortality of West Nile Virus through the development of an updated West Nile Virus response plan.

Activities:

Target Population	Who	What	Timeline
Deschutes County residents	Four Rivers Vector Control	Objective 1: Continue surveillance activities for the presence of specific mosquitoes throughout Deschutes County.	Completed
Deschutes County residents	Four Rivers Vector Control	Objective 2: Maintain vector control activities already in place.	Ongoing
Deschutes County residents	CD Coordinator Environment Health staff	Objective 3: Solicit dead bird submissions for testing from the public and appropriate local agencies.	Ongoing
Deschutes County residents	CD Team	Objective 4: Provide public information on personal protective measures. Send updated plan to officials. (Completed for 2006.)	Completed
Deschutes County residents	CD Coordinator	Objective 5: Continue public hotline for Deschutes County residents on the issues relating to West Nile Virus.	Completed

Evaluation:

- Objective 1: Surveillance activities ongoing through spring and summer.
- Objective 2: Continue current vector control activities through contract with Four Rivers Vector Control.
- Objective 3: Dead bird submission information to the public and system in place.
- Objective 4: Collection of materials and articles to the general public.
- Objective 5: Completion of community forums and ongoing update of West Nile Response Plan.

2. EMERGENCY PREPAREDNESS

Emergency Preparedness in Deschutes County has improved with Preparedness Grant dollars and re-structuring of the Department focusing more on how we will pull together as a team to address community disasters. Program staff have developed specific plans for a variety of potential threats to our County, as well as creating and participating in exercises to practice their functionality.

The Department is a key player and planner of the County Pandemic Influenza Plan. It includes a variety of partners from around the County and is exercised to identify response strengths and weakness within our Department and community.

All hazard response plans are incorporated in the County Emergency Response Plan. The Department continues to work with the County Emergency Manager to plan County exercises. The Strategic National Stockpile Plan was completed in 2005, exercised and

revised again in 2007. The team is currently working on the regional plan with the HRSA Coordinator, with Cascade Healthcare Community and the community on exercising plans, working together as a community to clarify roles, pool resources and staff. The program will continue to develop materials on mass casualty, participate in County and State exercises and improve surveillance with providers.

The 24/7 system works via an answering service, where a nurse can be reach at all times to receive disease and disaster reports of public health significance. On average we receive 3-5 after-hour calls per month from the public. We also continue to meet with staff from Jefferson and Crook counties to improve coordination throughout the region. The staff will be leading the effort to improve the capability of all Department staff to respond to an emergency through ICS/NIMS training.

Current Condition Or Problem:

Emergency Preparedness in Deschutes County has improved over the past five years with grant support and staff who are dedicated to helping the Department and community prepare for hazards that could overwhelm the County. Program staff have developed numerous plans, improved CD response times, collaborated with community partners, developed a basic disaster response plan, and continue to work with the County Emergency Manager to implement all the information into the County response plan. Needs include completion of materials on mass casualty, increased activity on the planning group and development of a health focused planning group.

Goal:

To improve the response to communicable disease and public health emergencies throughout Deschutes County.

Activities:

Target Population	Who	What	Timeline
Deschutes County residents	CD Program Manager Preparedness Coordinator	Objective 1: Participate with Cascade Healthcare Community and Emergency Management on an area preparedness planning group. <ul style="list-style-type: none"> To complete State requirements on drill development and practice, engaging community partners in the process. Pandemic planning ongoing. 	Ongoing
Deschutes County residents	CD Team	Objective 2: All Hazards Plans are integrated into the Local Emergency Operations Plan.	Ongoing
County partners	CD Team	Objective 3: Mutual aid agreements are in place for the tri-county region.	Completed
Deschutes County residents	CD Program Manager	Objective 4: 24/7 contact information as been provided to DHS, Health Services and other public safety agencies.	Ongoing
Mass immunization population	Immunization Coordinator CD Coordinator	Objective 5: Update and review NPS Plan (CD).	Ongoing

Target Population	Who	What	Timeline
Deschutes County residents	Preparedness Coordinator	Objective 6: Complete/update development of all plans: <ul style="list-style-type: none"> • Mass Prophylaxis • Smallpox Response • Pandemic Flu • Lab and provider reporting • Mass Casualty • Mechanisms for receiving and responding to CD reports • Identification and planning for meeting the needs of special populations 	Ongoing
Deschutes County residents	CD Team	Objective 7: Health risk information is communicated and disseminated through, but not limited to, the following measures: <ul style="list-style-type: none"> • Individual chosen to carry primary responsibility for coordinating aspects of public information communication has been designated. • The LHD Communication Officer actively participates in state-wide planning and coordination of public health messages. • The LHD Communication Officer is educated in the concept of ICS communication structure. • Local staff has participated in training for risk communication and how to use those techniques effectively. 	Ongoing
Veterinarians Animal population	CD Coordinator	Objective 8: Improve the Animal Surveillance System in Deschutes County through the Broadcast Fax System.	01/01/10
Department staff	Preparedness Coordinator	Objective 9: Training plan for all staff to be ICS and NIMS compliant.	Completed

Evaluation:

- Objective 1: Ongoing Disaster Planning Group.
- Objective 2: Integration of all plans.
- Objective 3: Mutual aid agreements in place.
- Objective 4: 24/7 communication intact.
- Objective 5: Completed NPS Plan.
- Objective 6: Plans completed.
- Objective 7: Risk Communication training documented and plan completed.
- Objective 8: Improved Animal Surveillance System.
- Objective 9: Staff trained in ICS and NIMS.

3. FOOD-BORNE ILLNESS REPORTS

Food-borne illness in Deschutes County remained similar to previous years, with four E-Coli 0157 reports and eleven Salmonella reports. At the end of 2005 there was a very large E-Coli 0157 outbreak, in which we had an opportunity to use the incident command system, as well as producing a food-borne outbreak manual for future events.

Public Health and Environmental Health continue to work together to address outbreaks, health education in the community, and sharing workload to address community concerns. There has been an increase in the number of Norwalk-like illnesses, with multiple nursing home and school outbreaks reported in both 2007 and 2008. Each year, as reports increase and staff numbers remain the same it becomes more and more difficult to thoroughly investigate each Norovirus outbreak.

4. IMMUNIZATIONS

The Immunization Program has worked hard to improve rates for two-year olds. In 1999, the County was ranked thirty-fifth in Oregon and steadily has moved up the scale. The extensive work with coalitions, community education, and providers has made a difference in outcomes.

The Shots for Tots Program will continue with the sponsorship of the High Desert Rotary Club. The club has chosen the Shots for Tots Program as their project with funding each year through the Rotary Duck Race and numerous fundraising projects. Issues in Deschutes County include prevention of Pertussis with an increased number of parents choosing not to immunize, Hepatitis B vaccinations implemented in the hospital, and the growing population of young children with no health care. The Immunization Coordinator will be continuing to work on a state-wide project to improve the status of the 4th DTap, as well as improve our birth to two-year old immunization rates for 2009. The past two years have been challenging for the program with staff turnover and inability to do much outreach in the community.

Current Condition Or Problem:

The Immunization Program needs to continue to grow with the increasing population in Deschutes County. The lack of providers who will see children with Oregon Health Plan is a concern, and the poverty level has increased with the increased unemployment. Shots for Tots continues to fill a gap, but the gap is growing. The Immunization Program has worked hard to improve rates for two-year olds, though there are still improvements to be made. The extensive work with coalitions, community education, and providers has made a difference in outcomes. Issues in Deschutes County also include prevention of Pertussis, with an increased number of parents choosing not to immunize; and the growing population of young children with no health care. We are seeing more physicians vaccinating infants at birth for Hepatitis B, which is an improvement from previous years.

Goal:

To improve the mortality and morbidity rates of Deschutes County citizens by reducing vaccine preventable diseases.

Local Health Department: Deschutes County
Plan A—Continuous Quality Improvement: Increase Up-to-Date Rates for Two-Year Olds
Fiscal Years 2007-2010

Year 1: July 2007-June 2008				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
Increase the up-to-date immunization rates of children under 24 months by 6% over the next three years within the Dept.	<p>Use 2006 AFIX data as the basis of comparison for projected change (62% total 2006).</p> <p>Fully screen each patient for immunizations at every visit. Assure every shot is entered in ALERT from clinic and off-site.</p> <p>Screen for immunizations at all WIC appts. and make sure clients with immunization needs are referred to PMD or HD immunization clinic ASAP. (Procedure on how this occurs should be in place and up to date.)</p> <p>Give all shots needed unless contraindicated.</p> <p>Check Hep B shot dates to insure spacing is correct (#3).</p> <p>Promote Varicella.</p>	<p>Increase the up-to-date rate by 2% the first year.</p> <p>Hold one training with WIC staff on how best to get clients up to date via screening and referrals.</p> <p>Have procedure completed on how WIC screens and refers.</p> <p>Consider recall and reminders for subsequent doses.</p>	<p>2007 AFIX data is 61% UTD for 4:3:1:3:3:1 series.</p> <p>Every shot within Dept. and offsite clinics, including Shots for Tots clinics, is entered into IRIS.</p>	<p>In 2007, there were staffing issues within the immunization program, and fewer immunization clinics were held.</p> <p>As of January, 2008, there is an Immunization Program Coordinator and Clinic Coordinator. The Department is offering more immunization clinics.</p>

Local Health Department: Deschutes County
Plan A—Continuous Quality Improvement: Increase Up-to-Date Rates for Two-Year Olds
Fiscal Years 2007-2010

Year 2: July 2008-June 2009				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>Continue strategies from 2007 and</p> <p>Increase the up-to-date immunization rates of children under 24 months by 6% over the next three years within the Dept.</p>	<p>Compare stats with 2006 AFIX report.</p> <p>Provide immunization information to expecting and new mothers.</p> <p>A. Prenatal classes B. Handouts at OB clinics. C. Handouts at birthing centers</p> <p>Promote co-operative working climate with local clinics.</p> <p>A. Hold annual information meetings/ trainings. B. Provide updates and education via e-mail to clinic liaisons.</p> <p>Conduct outreach and education through:</p> <p>A. Media B. Information tables at events C. Vaccine update trainings for clinicians.</p>	<p>Increase up-to-date rates by 2% over past year.</p> <p>Activities were implemented as planned.</p> <p>Missed shot rate decreased.</p> <p>At least one vaccine update meeting is held for Dept. staff.</p>	<p>2008 AFIX up-to-date rate is 69% for 4:3:1:3:3:1 series. This is an increase of 8% over the past year. This objective has been met.</p> <p>2008 missed shot rate decreased by 11%: 28% in 2007 to 17% in 2008.</p> <p>Quarterly immunization meetings were held for Dept. staff. Meetings have been scheduled for 2009.</p>	<p>Beginning in 2008, the immunization program was fully staffed. This enabled us to provide more immunization clinic hours and do more outreach and education to providers and the community.</p>

Local Health Department: Deschutes County
Plan A—Continuous Quality Improvement: Increase Up-to-Date Rates for Two-Year Olds
Fiscal Years 2007-2010

Year 3: July 2009-June 2010				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>Continue strategies from 2008 and</p> <p>Increase the up-to-date immunization rates of children under 24 months by 6% over the next three years within the Dept.</p>	<p>Compare stats with 2006 AFIX report.</p> <p>Provide immunization information to expecting and new mothers.</p> <p>A. Prenatal classes.</p> <p>B. Handouts at OB clinics.</p> <p>C. Handouts at birthing centers.</p> <p>D. Referrals from hospital.</p>	<p>Increase up-to-date rates by 2% over previous year.</p> <p>Activities were implemented as planned.</p>	<p>To be completed for the FY 2010 report.</p>	<p>To be completed for the FY 2010 report.</p>

Local Health Department: Deschutes County
Plan B—Chosen Focus Area: Increase Participation and Quality of Data to ALERT
Fiscal Years 2007-2010

Year 1: July 2007-June 2008				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>Increase the number of ALERT participants in Deschutes County.</p> <p>Increase amount of data submitted and improve quality of submissions</p>	<p>Use 2006 ALERT participation data as baseline.</p> <p>Review current participation and identify clinics needing improvement.</p> <p>Recruit any site not reporting (talk, encourage electronic reporting).</p> <p>Arrange for ALERT users class and invite players to attend. Use ALERT video, invite Health Educator to participate.</p>	<p>Number of participants in ALERT increased (contact is Marybeth Kurilo 971-673-0294).</p> <p>ALERT training classes held.</p> <p>Visits to sites needing in-house training.</p> <p>Information submitted to ALERT within 30 days of immunization.</p>	<p>Central Oregon Pediatric Associates (COPA), the largest pediatric clinic in Central Oregon, is now participating in ALERT.</p>	

Local Health Department: Deschutes County
Plan B—Chosen Focus Area: Increase Participation and Quality of Data to ALERT
Fiscal Years 2007-2010

Year 2: July 2008-June 2009				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>Continue with previous year objectives.</p> <p>Increase the number of ALERT participants in Deschutes County.</p> <p>Increase amount of data submitted and improve quality of submissions</p>	<p>Same plus: Review participation; determine number of sites submitting to ALERT.</p> <p>Review numbers submitted and have area Health Educator compare with vaccine ordering reports.</p> <p>Offer assistance to those sites needing help.</p>	<p>Number of participants in ALERT increased over past year</p> <p>Quality of data submitted improved</p> <p>Information submitted within 15 days of immunization.</p> <p>Visit two clinics to offer technical and/or educational assistance.</p>	<p>ALERT training and technical assistance were provided to COPA, Bend Memorial Clinic (BMC), Mosaic Medical and High Lakes clinics.</p> <p>COPA and BMC are submitting electronically. Other clinics are converting to e-transfer. Overall, the quality and quantity of ALERT data for Deschutes County has dramatically improved.</p>	<p>Much time and effort by the Immunization Coordinator was given to increasing provider participation in ALERT in 2008. As a result, providers and schools are now more confident in the data and are integrating the ALERT website into their practices.</p> <p>ALERT was also very beneficial to schools and the Dept. during primary review.</p>

Local Health Department: Deschutes County
Plan B—Chosen Focus Area: Increase Participation and Quality of Data to ALERT
Fiscal Years 2007-2010

Year 3: July 2009-June 2010				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>Continue with previous year objectives.</p> <p>Increase the number of ALERT participants in Deschutes County.</p> <p>Increase amount of data submitted and improve quality of submissions.</p>	<p>Same plus:</p> <p>Review ALERT participation reports and timeliness of reports (private practice clinics).</p> <p>Offer assistance classes or visit where needed.</p> <p>Sites delaying submission advised to report more often.</p> <p>Promote cooperative working climate with local clinics.</p> <p>A. Hold annual information meetings/ trainings.</p> <p>B. Recruit for local clinic representation on the Deschutes County Immunization Coalition (DCIC).</p>	<p>Same plus:</p> <p>ALERT participation reports have been reviewed.</p> <p>ALERT training classes and visits made.</p> <p>Immunization rates should increase.</p>	<p>To be completed for the FY 2010 report.</p>	<p>To be completed for the FY 2010 report.</p>

Local Health Department: Deschutes County
Plan B—Chosen Focus Area: Maintain and Enhance the Deschutes County Immunization
Coalition
Fiscal Years 2007-2010

Year 1: July 2007-June 2008				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>Continue with previous year objectives.</p> <p>Maintain and enhance the Deschutes County Immunization Coalition (DCIC).</p>	<p>Using 2006 make-up of DCIC, maintain the current membership</p> <p>A. Add community representation</p> <p>B. Involve child care providers</p> <p>C. Recruit school nurses</p> <p>D. Recruit special project reps (WIC, FAN)</p> <p>E. Do questionnaire on group's main goals.</p>	<p>Membership increased.</p> <p>Increased diversity of membership is evident.</p> <p>Strategic plans formulated and presented.</p>	<p>Both COPA and BMC Pediatrics are now participating in the DCIC.</p> <p>One child care provider and NeighborImpact (provides training for child care providers) are new members of the DCIC.</p> <p>A survey was conducted in March, 2008, assessing the barriers to immunization and the group's goals.</p>	<p>The DCIC met only once in 2007 due to staffing issues.</p> <p>The first 2008 meeting was held on March 18, and there were 13 participants. Dates have been set for the remainder of 2008.</p>

Local Health Department: Deschutes County
Plan B—Chosen Focus Area: Maintain and Enhance the Deschutes County Immunization
Coalition
Fiscal Years 2007-2010

Year 2: July 2008-June 2009				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>Continue with previous year objectives.</p> <p>Maintain and enhance the Deschutes County Immunization Coalition (DCIC).</p>	<p>Same plus:</p> <p>Review make up of coalition for possible recruitment.</p> <p>Explore development of questionnaire for community to help define needs and gaps.</p> <p>Provide recognition of members at annual public/private immunization meetings.</p>	<p>Membership maintained or enhanced with new members.</p> <p>Members recognized at County level.</p> <p>Strategic plan approved.</p>	<p>Three new clinics have become coalition members: Mosaic Medical, High Lakes Health, and Dr. Burket's clinic. There are currently 26 members.</p> <p>The coalition met bi-monthly in 2008-09.</p>	<p>The coalition's focus has changed in the past year, with greater emphasis on clinical immunization education, updates, and sharing best practices and issues.</p> <p>Participation from clinics has increased.</p> <p>Based on positive feedback from members, they feel the coalition is very useful for their work.</p>

Local Health Department: Deschutes County
Plan B—Chosen Focus Area: Maintain and Enhance the Deschutes County Immunization
Coalition
Fiscal Years 2007-2010

Year 3: July 2009-June 2010				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
Continue with previous year objectives. Maintain and enhance the Deschutes County Immunization Coalition (DCIC).	Same plus: Review strategic plan and update as necessary for 2011-2013.	Membership maintained or enhanced. Member recognition achieved. Review of strategic plan completed. Draft of strategic plan accomplished for years 2011-2013.	To be completed for the FY 2010 report.	To be completed for the FY 2010 report.

Local Health Department: Deschutes County
Plan B—Continuous Quality Improvement: Decrease the Late Start Rates in Deschutes
County
Fiscal Years 2007-2010

Year 1: July 2007-June 2008				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>Continue with previous year objective.</p> <p>Decrease number of late starts in Deschutes County by 3% over the next three years.</p>	<p>Use 2006 AFIX data as the basis of comparison for projected change (15% total 2006).</p> <p>Provide immunization information to expecting and new mothers</p> <p>A. Prenatal classes B. Handouts at birthing centers.</p> <p>Provide immunization information tapes to hospital, birthing centers.</p> <p>Present this as a topic for discussion meeting with local clinic staff.</p>	<p>Decrease the late start date rate by 1% the first year.</p>	<p>Late start rate remained at 15%.</p>	<p>In 2007, there were staffing issues within the immunization program. Fewer immunization clinics were held, and outreach was minimal.</p>

Local Health Department: Deschutes County
Plan B—Continuous Quality Improvement: Decrease the Late Start Rates in Deschutes
County
Fiscal Years 2007-2010

Year 2: July 2008-June 2009				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
Continue with previous year objectives. Decrease number of late starts in Deschutes County by 3% over the next three years.	Same plus: Discuss changes in rates at annual meetings with local clinics, solicit ideas from them.	Decrease the late start date rate by 1% compared to previous year's rate.	Late start rate decreased by 1% in 2008. Education materials were given to the hospital birthing center and distributed to birthing classes. Immunization Coordinator presented to two new mom's groups about immunizations.	

Local Health Department: Deschutes County
Plan B—Continuous Quality Improvement: Decrease the Late Start Rates in Deschutes
County
Fiscal Years 2007-2010

Year 3: July 2009-June 2010				
Objectives	Methods/Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
Continue with previous year objectives. Decrease number of late starts in Deschutes County by 3% over the next three years.	Same plus: Provide Quality Improvement training for local clinics.	Decrease the late start date rate by 1% compared to previous year's rate.	To be completed for the FY 2010 report	To be completed for the FY 2010 report

5. TOBACCO PREVENTION PROGRAM

Tobacco Use: Deschutes County is above state average rates for smokeless tobacco use in adults as well as our 8th and 11th graders. In 2006 we also saw a dramatic increase in cigarette smoking among our youth, which spiked up to 27.8% of our 11th graders reportedly smoking. Our Tobacco Prevention Coordinator and Tobacco Free Alliance are focusing on key areas that involve access to smoking cessation resources, reaching youth, promoting tobacco prevention resources in minority populations, and addressing second hand smoke exposure. Our County has had success in preventing pregnant women from using tobacco, which is reflected in the 11.1% use, lower than both the state average and the Healthy People 2010 objective.

ADDITIONAL REQUESTS: No revision to the Alert Plan.

B. Parent and Child Health Services, Including Family Planning Clinics as Described in ORS 435.205

1. WOMEN, INFANTS & CHILDREN (WIC)

**FY 2009 - 2010 WIC Nutrition Education Plan Form
THIS PLAN WAS SENT TO SARA SLOAN MAY 1, 2009.**

County/Agency: Deschutes County
Person Completing Form: Laura Spaulding
Date: April 28, 2009
Phone Number: 541-322-7450
Email Address: laura_spaulding@co.deschutes.or.us

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by May 1, 2009
Sara Sloan, 971-673-0043

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:

All Deschutes County WIC staff will complete the appropriate sections of the Food Package Assignment Module by December 31, 2009.

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:

All Deschutes County staff available will attend SWM sessions on Infant Feeding Cues on June 22-23, 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:

All NE lesson plans will be reviewed by the Coordinator and adjusted to be consistent with the Key Nutrition Messages 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. Complete and return Attachment A by May 1, 2009.

Implementation Plan and Timeline:

Please see attachment A for training supervisors, dates and topics.

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:

By October 31, 2009, we will use the state provided resources such as the Counseling Observation Guide to identify skills staff are using on a regular basis. We will also use the self-evaluation activities done during OWL onsite visits to identify skills staff want to improve on.

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:

By December 31, 2009, using information from Goal 2, Activity 1, we will incorporate time at staff meetings each month to review OWL-related case studies we have seen in clinic and wanted to handle better. We will also schedule time for peer-to-peer counseling to provide feedback on participant centered counseling skills.

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:

By October 31, 2009, WIC staff will provide inservices or written materials regarding Fresh Choices and Key Nutrition Messages to local public health nursing staff, the Breastfeeding Coalition of Oregon, Head Start and the Healthy Start Prenatal Program.

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:

We will collaborate with the state WIC Research Analysts for Fresh Choices evaluation by April 30, 2010. Prefer to administer questionnaires to participants.

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:

We will assess our breastfeeding promotion and support activities to identify strengths and weaknesses and identify possible strategies for improving breastfeeding support for exclusivity and duration by December 31, 2009.

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:

We will implement at least one strategy from Goal 4, Activity 1 in our agency by April 30, 2010.

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

Agency: Deschutes County WIC

Training Supervisors & Credentials: Laura Spaulding, RD, Coordinator/Supervisor;
Janet Harris, MS, RD
Sherri Tobin, MS, RD, IBCLC.

Staff Development Planned:

Based on planned new program initiatives (for example Oregon WIC Listens, new WIC food packages), your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2009 – June 30, 2010. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	Inservice Topic	Inservice Objective
1	September, 2009	Oregon WIC Listens Strength & Weakness Assmt.	To identify further training needs as related to Participant Centered Services.
2	December, 2009	Food Package Assignment Module, group	All staff will be able to assign correct food packages to clients.
3	March, 2010	Infant Feeding Cues Update	To review ways to incorporate infant feeding cues into counseling sessions and classes.
4	April, 2010	New strategies for supporting breastfeeding	All staff will be able to identify new ways DC WIC supports exclusivity and increased duration of breastfeeding.

EVALUATION OF WIC NUTRITION EDUCATION PLAN
FY 2008-2009

WIC Agency: Deschutes County

Person Completing Form: Janet Harris, Laura Spaulding

Date: April 29, 2009

Phone: 541-322-7450

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2009.

Please use the outcome evaluation criteria to assess the activities your agencies did for each Year Two Objectives. If your agency was unable to complete an activity please indicate why.

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

Year 2 Objective: During plan period, through informal discussions, staff in-services and or/targeted trainings, staff will be able to describe the general content of the new WIC food packages and begin to connect how these changes may influence current nutrition education messages.

Activity 1: By October 31, 2008, staff will review the WIC Program's Key Nutrition Messages and identify which ones they need additional training on.

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

- How were the WIC Program's Key Nutrition Messages shared with staff in your agency?
- Which messages did staff identify as needing additional training on?
- How did this training occur?

Response:

- A copy of the “Key Nutrition Messages for the Oregon WIC Program” was given to each certifier. We reviewed them as a group at the October 2nd Nutrition Education Meeting and targeted the ones that staff felt they would like more training on. The WIC RD (JH) presented an inservice on the new AAP Guideline for 2% milk in some children after 1 year. *Lipid Screening and Cardiovascular Health in Childhood – www.pediatrics.org/cgi/content/full/122/1/198
- The key nutrition messages that staff needed additional training on were:
 1. Dental Care and Pregnancy
 2. Training cups for Infants
- Inservices:
 1. Inservice on Oral Health During Pregnancy and Baby’s First Year (Oregon WIC Program) was presented by WIC RD’s (JH and ST) at the December 4th Nutrition Education Meeting.
 2. Facilitated discussion led by GK on Sippy, Tippy, and Training Cups at the January 8th Nutrition Education Meeting.

Activity 2: By March 31, 2009, staff will review the proposed food package changes and:

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

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

- How did staff review the proposed food package changes?
- Which nutrition education messages were identified that need to be modified?
- How will these messages be shared with participants?

Response:

- We have been completing the State Provided Inservices per the State required training guidelines. The inservices use Power Point, facilitated discussion, etc.
 1. Lower Fat Milk Inservice for all WIC Staff on January 15th and January 20th, 2009 presented by the WIC RDs. Included a “milk challenge taste test.”
 2. Infant Feeding Inservice for all WIC Staff was presented by WIC RD (LS) and WIC IBCLC (JC) on March 12th and March 26th.
 3. Whole Grains Inservice will be presented to all WIC Staff by the WIC RDs in May.
- Our nutrition education messages will continue to be the same (increase whole grain and fiber consumption, increase fruit and vegetable consumption, to decrease saturated fat in the diet, and to continue to support breastfeeding). With Fresh Choices we will be able to provide a food package that is consistent with these messages!
- We have been using the State provided participant education materials to educate our participants during one-on-one appointments, Quick WIC workshops, and Bulletin Boards.

Activity 3: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2008-2009.

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

- Did your agency conduct the staff in-services you identified?
- Were the objectives for each in-service met?
- How do your staff in-services address the core areas of the CPA Competency Model?

Response:

- Yes, we have conducted the staff inservices identified and met our objectives for each one. Records of topics and attendance for Nutrition Education Meetings are kept on file. The inservices addressed the following Core Competencies:
 1. Review of Oregon WIC Key Nutrition Messages
 - Principles of Life-Cycle Nutrition
 - Nutrition Assessment Process
 - Multicultural Awareness
 - Nutrition Education
 2. Changing NE messages based on new food packages
 - Principles of Life-Cycle Nutrition
 - Nutrition Assessment Process
 - Communication
 - Multicultural awareness
 - Critical Thinking
 3. Mid-year evaluation of staff physical activity objective
 - Program Integrity
 4. State training on new food packages
 - Principles of Life-Cycle Nutrition
 - Communication
 - Multicultural Awareness
 - Critical Thinking
 - Technology Literacy

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

Year 2 Objective: During plan period, each agency will assess staff knowledge and skill level to identify areas of training needed to provide participant centered services.

Activity 1: By September 30, 2008 staff will review the assessment steps from the Dietary Risk Module and identify which ones they need additional training on.

Outcome evaluation: Please address the following questions in your response:

- Did staff review the assessment steps from the Dietary Risk Module?
- Which steps did staff identify as needing additional training on?
- How did this training occur?

Response:

- Yes, staff reviewed the assessment steps from the Dietary Risk Module and identified steps needing additional training using the WIC Nutrition Education Plan Goal 2, Activity 1 – Staff Assessment (see attached results--Attachment 1).
 1. The training occurred at the November 6th Nutrition Education Meeting by sharing the results of the assessment and reviewing appropriate sections of the Dietary Risk Module for manually assigned risks and documentation and probing questions.

Activity 2: By November 30, 2008, staff will evaluate how they have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules.

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

- How have staff modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules?

Response:

- Please see the results of the WIC Nutrition Education Plan Goal 2, Activity 2 – Staff Evaluation (see attached results--Attachment 2).

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

Year 2 Objective: During plan period, in order to help facilitate healthy behavior change for WIC staff and WIC clients, each local agency will select at least one objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Activity 1: Identify your objective and strategy to facilitate healthy behavior change for WIC staff.

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

- Which objective and strategy did your agency select?
- How did your agency decide on this objective and strategy?
- Did the strategy help meet the objective?
- What went well and what would you do differently?

Response:

- We selected Objective III – By 2012, increase by five percent the number of employees who are physically active for 30 minutes a day, at least five days per week.
- We selected Strategy C – Provide and promote flexible time policies to allow for opportunities for increased physical activity.
- We choose this objective and strategy because several staff members shared that they do not have time to exercise before or after work. We wanted to support staff in planning time throughout their workday to fit physical activity in and to support them as they overcome barriers to daily exercise.
- Both the option of adjusting templates to accommodate breaks for physical activity and having an “Exercise Tool Box” on site have enhanced a culture that values physical activity. Both have been utilized by a variety of staff and have contributed to a team attitude towards being active. We don't think we would do anything differently at this time.

Activity 2: Identify your objective and strategy to facilitate healthy behavior change for WIC clients.

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

- Which objective and strategy did your agency select?
- How did your agency decide on this objective and strategy?
- Did the strategy help meet your objective?
- What went well and what would you do differently?

Response:

- We choose Objective IV – By 2012, decrease television and other screen time for children. Specifically, reduce by two percent the number of children ages 2-18 who have more than two hours a day of screen time and work to ensure children two years and younger have no screen time.
- We choose the following strategy – We will promote Turn Off the TV Week in April 2009. In 2008, we will have at least one of our Quick WIC class themes by “Less Screen Time.”
- We decided on this strategy because we participated in the state “screen time” survey a couple of years ago and all of our staff were shocked to learn how much TV kids watch and how many very young children (< 2 years old) have TVs in their bedrooms. We hoped to decrease screen time and increase physical activity.
- We will administer the “Family TV Viewing Questionnaire” again in May 2009 to assess if we have met our objective.
- The “Reduce Screen Time” education handouts have been well received by Quick WIC participants.

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

Year 2 Objective: During plan period, in order to help improve breastfeeding outcomes for WIC participants, each local agency will select at least one objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Activity 1: Identify your objective and strategy to improve breastfeeding outcomes for WIC clients.

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

- Which objective and strategy did your agency select?
- How did your agency decide on this objective and strategy?
- Did the strategy help meet your objective?
- What went well and what would you do differently?

Response:

- We chose Activity 1 in the Home/Household setting. The objective: Objective I. By 2012, maintain the current level of breastfeeding initiation and increase by two percent a year the number of mothers who breastfeed exclusively for the first six months of a child’s life.
- We decided on this objective because although we have very high breastfeeding initiation rates in Deschutes County, we have lower 6-month exclusively breastfeeding mothers/babies. We have found that often times this is due to the mother returning to work and not having adequate time and facilities for pumping breast milk.
- One of our IBCLCs held four trainings on the Business Case for Breastfeeding. The first, in August 2008, was held with our own employer, Deschutes County. The second was a Toolkit training in September, 2008, on supporting working mothers and using the Toolkit for outreach; attendance included hospital and community nurses, Department nurses, WIC certifiers, OSU extension agents, Deschutes Co. benefits coordinator and La Leche League leader. The third was to representatives of the Old Mill shopping district in November, 2008. The fourth was for public information officers for many Central Oregon entities including Bend Chamber of Commerce, Bend-La Pine School District, Central Oregon Community College, Bend Parks and Recreation, and Cascade Healthcare Community. This meeting was to “inform the informers” about the program and let them know where to get answers.

- I believe education on the new law has helped Deschutes County, the employer, stay focused on the needs of breastfeeding staff (DC was already very supportive!) and also introduced the concept to other businesses. We are not sure if it has had a direct impact on exclusivity rates in our area.
- A different IBCLC conducted several breastfeeding related educational segments at our staff meetings in which medical office assistants were in attendance. These occurred on the following dates:
 - August 28, 2008
 - September 25, 2008
 - October 9, 2008
 - November 13, 2008
 - February 26, 2009
 Topics included post-partum scheduling/formula requests, pump requests, new food packages/formula requests, milk bank update, world breastfeeding month.
- I think the strategy that worked the best was having the medical office assistants receive education from our IBCLC. She not only did formal education at staff meetings but also does 1:1 education as the front office staff receive requests from clients, come to her office with questions, and bring up other breastfeeding longevity/exclusivity concerns. We will continue having our IBCLC present regular education topics for staff both formally and informally.

Attachment 1
WIC Nutrition Education Plan
Goal 2, Activity 1—Staff Assessment

What are some questions you are using to ask participants about their feeding behaviors?

- Tell me about how you are eating...
- What do you like about the way you eat?
- How do you feel about your diet?
- What are mealtimes like for your family?
- What does “your child” do to let you know she’s hungry/full?
- How do you feel about the way “your child” is eating?
- What word(s) describes the way your son eats?
- Tell me about your eating pattern...
- Tell me about feeding “your child”...
- What do you normally drink during the day?
- What have you heard about breastfeeding?
- What new foods is your baby/child eating?

What are some probing questions you are using to find out more information from participants?

- How do you feel about “your child” drinking from a bottle?
- Tell me more about “your child’s” picky eating...
- Tell me more about how you are eating...
- How are you managing the heartburn?
- Tell me more...
- What are the barriers to...?
- What ways is this a concern for you?
- What have you heard about...?
- What are your plans for introducing solids to your baby?
- How has being pregnant changed the way you eat?
- What does your doctor say about....?

Where in TWIST are you documenting manually assigned dietary risks?

- Progress notes/SOAP notes

What are some ways critical thinking skills can help with the diet assessment process?

- Helps you address possible dietary risks and what to do for their follow-up.
- Making sure the data collected matches the information from the client.
- Any more information needed in order to complete diet assessment
- It helps evaluate the entire “picture”...for example, ranges of formula intake per age can be used but not solely as a way to assess dietary needs are being met. We can also calculate weight gain and evaluate health status.

Which of the diet assessment steps are you comfortable with?

- 1st 4 steps...I don’t always have time to ask all mandatory questions.
- Introduction – “meet and greet”
- Asking about feeding behaviors

Which of the diet assessment steps would you like additional training/practice with?

- Manually assigned risks and documentation
- Probing

Attachment 2
WIC Nutrition Education Plan
Goal 2, Activity 2—Staff Evaluation

Use this tool to evaluate your approach to individual counseling.

Refer to: Section S-1 Introduction - Nutrition Risk Module
Section 1-1 Introduction to Dietary Risk – Dietary Risk Module

There are several steps involved in the WIC certification process. The first phase is the full assessment which consists of:

- Income screening/client demographics
- Anthropometric measurements
- Biochemical measurements
- Nutrition risk assessment
- Diet assessment

The second phase is counseling which consists of:

- Nutrition education
- Referrals
- Food package assignment
- Voucher issuance
- Second nutrition education contact plan

Think about some recent individual counseling sessions you had with WIC participants. Please answer the following questions.

How do you think your approach to individual counseling has changed, if at all, since you completed the Nutrition Risk and Dietary Risk Modules?

- It's not an exact science and I am able to use my "critical thinking" more often. Also, I'm trying to focus more on gathering information before rushing into education.
- I really try and "be open" to what the client is thinking? I guess more considerate.
- I try to honor what the client already knows and build from there
- More open-ended questions
- Asking client of their health issue is Dr diagnosed
- My counseling has changed more in relation to MI, not the modules. However, with infants, I don't default to diet as much as I used to. I tend to let them discuss the child more as a whole person rather than just being diet focused.
- The changes I am making in my counseling are so tied to MI, that it is difficult to think about it in terms of just the modules. I no longer focus so much on serving sizes but more on frequency, offerings, etc.
- I feel I am having "conversations" with clients, rather than "telling" them what to do.
- Not always but after telling them what we need to do, like weight, hemoglobin, etc., I now ask them permission to do so.

What are some specific things you are doing differently?

- I'm looking more closely at the risk codes and whether or not they will need further documentation.
- Not talking as much
- Asking more open-ended questions

- I am working on validating to positives I see, asking permission before sharing information, asking what concerns the client has, asking what they understand about the “concern, etc” rather than just spewing information at them.
- I’m “offering” handouts but not just “giving” them
- I’m working on recapping/summarizing what we’ve talked about or what they plan to do.
- Verifying risk codes – actually clicking on code to see if code is correct.
- Assessing the entire situation before educating
- Asking client
- Asking more probing and open-ended questions to find out what the client already knows.
- Less handouts and I ask what their concerns are, if any.
- Of course, MI is also affecting how I use the modules.
- I use the section in the Nutrition Risk Module – “More Information about Medical Conditions” – for assigning correct risk code
- I feel that I still need to narrow it all down to what the client is truly concerned about rather than covering too much. I want to work on finding ways to share the concerns and letting the client “mull it over” and decide what they want to focus on or work on.

2. Immunizations (See Epidemiology and Control of Preventable Diseases and Disorders section, page 25.)

3. Maternal Child Health

Basic Services:

The Department provided prenatal care to 316 clients in 2008 in the HealthyStart prenatal clinic, while Oregon MothersCare (OMC) provided OHP assistance and referral to 688 clients in 2008.

Our La Pine School Based Health Center (SBHC) is located in the parking lot of the La Pine High School and within walking distance of the middle school and elementary school. Once registered, students are able to walk in for sick visits without missing school or requiring parents to miss work to accompany them. Family planning services are not offered due to the School Board's refusal to support it in the School Based Center.

New School Based Health Centers opened in Bend and Redmond in 2009 and are fully certified. Our safety net well-child clinic has been rolled into the respective SBHCs to provide care to children birth to age 20.

Home visiting programs consist of Maternity Case Management in which 196 clients were served despite staffing shortages in 2008, and BabiesFirst! which saw 265 clients in 2008 of which some were also enrolled in CACOON. The Department contracts with Child Development and Rehabilitation Center to provide case management services through the CACOON program to children with a medical diagnosis.

Public health nursing staff are current on NCAST training and use these tools to assess attachment and provide parent training. Our CACOON Coordinator also participated in the Hawaii Telemedicine Grant in which local children with a medical issue were seen in Bend via teleconference and received case consultation from genetic specialists at OHSU. This grant ended in 2008.

Dental screening was provided by public health nurses for pregnant women and infants referred from WIC and our Latino Community Center. During the screening, clients received education on oral care, fluoride varnish if indicated, referral to OHP and dental care, and a dental kit (containing educational materials in English or Spanish, toothbrush, toothpaste, and Xylitol gum). The supplies were purchased with a small grant from the Oregon Dental Society.

In 2008, 42 dental screening clinics were held, with 275 clients seen; 258 fluoride varnish applications were applied. Our dental grant is over and staff are looking for additional funds. Currently, we are working on a collaboration with the Family Drug Court to host the Medical Teams International dental van at the Department.

Oregon MothersCare (OMC) continues to be offered and has assisted pregnant women with OHP assistance and referral to prenatal care. In 2006 our OMC program began faxing referrals to local dentists to assist women in access to dental care. The need for OMC is much greater than our current capacity (0.5 FTE), but our worker is also a WIC employee and has been able to help women with WIC certification during OMC appointments and with OHP assistance during WIC appointments which has greatly benefited coordination of care and access to services.

The Deschutes County WIC program served 2,918 families (of whom 73.6 % were working families), 2,148 women, 5,007 infants and children under 5 in 2008. 93.0% of our moms started out breastfeeding.

Perinatal

A. Problem:

Maternity case management is most effective if services begin early in pregnancy, but Deschutes County often receives second and third trimester referrals from community partners. Effective outcomes like smoking cessation, entrance to substance abuse treatment, adequate weight gain can be impacted most effectively with early entrance to public health home visiting services.

B. Goal:

The goal is to increase the number of women served before the third trimester of pregnancy and thereby improve pregnancy outcomes. The target is for 75% of referrals received to be first and second trimester and for the first contact to be made within three weeks of receiving the referral.

C. Activities:

1. Teach Family Planning staff and front office to refer all pregnant clients with risk factors at the time of pregnancy test to Maternity Case Management.
2. Visit OB/GYN providers, Planned Parenthood and other providers of pregnancy tests to explain services and simplify the referral process.
3. Create a tracking system for public health nurses to collect data on referral date and first contact date.
4. Inservice at WIC staff meeting on new target and brainstorm with them how to get earlier referrals (i.e., refer at time of call to schedule first pregnancy appointment).

All activities were completed in 2008.

D. Evaluation:

Perform data collection, data analysis to see if additional measures are needed. Program outcomes for MCM (Maternal Case Management) will be collected in Perinatal Data sheet and analyzed at State level. Effectiveness of the referral system will be measured by percentage of clients entering MCM in first or second trimester and number receiving full MCM package as appropriate to their risk factors.

4. Family Planning

**FAMILY PLANNING PROGRAM ANNUAL PLAN FOR
COUNTY PUBLIC HEALTH DEPARTMENT
FISCAL YEAR 2009-2010**

July 1, 2009 to June 30, 2010

THIS PLAN WAS SENT TO STATE FAMILY PLANNING PROGRAM MAY 1, 2009.

Agency: Deschutes County Health Services
Contact: Kathleen Christensen, 541-322-7407

As a condition of Title X, funding agencies are required to have a plan for their Family Planning Program, which includes objectives that meet SMART requirements (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime-Bound). In order to address state goals in the Title X grant application, each agency must identify how they will address each of the following two goals:

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

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

Please include the following four components in addressing these goals:

1. **Problem Statement**—For each goal, briefly describe the current situation in your county that will be addressed by that particular goal. The data provided may be helpful with this.
2. **Objective(s)**—Write one or more objectives for each goal. The objective(s) should be realistic for the resources you have available and measurable in some way. Please use the attached “Writing Objectives” for each goal in order to assure your agency objectives are SMART.
3. **Planned Activities**—Briefly describe one or more activities you plan to conduct in order to achieve your objective(s).
4. **Evaluation**—Briefly describe how you will evaluate the success of your activities and objectives, including data collection and sources. Keep this simple as in the example below.

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
FPEP qualification and enrollment changes along with the increase in clients who are seen at no charge or partial fee threatens the ability of this agency to maintain our current level of service.	1) Increase number of clients who could qualify for FPEP to a verified status.	<ul style="list-style-type: none"> ➤ Assign staff members to audit all FPEP charts for completeness and to follow-up with clients for proper documentation. ➤ Implement changes to get more information over the phone for Oregon Birth Match. 	➤ Ahlers data and audit reports.

Problem Statement	Objective(s)	Planned Activities	Evaluation
39.5% of our clients are supported by Title X compared to the state average of 25.4%. Title X funds are only 16% of our budget.	2) Increase community awareness of services through advertising and community outreach.	<ul style="list-style-type: none"> ➤ Continue to work with Anna Johnson, County Public Communications Coordinator, to establish an ongoing advertising and promotion plan. ➤ Continue to provide community outreach at the same level for the coming year. 	<ul style="list-style-type: none"> ➤ Data from Intake Form. "Where did client hear about our services?" ➤ Ahlers data and fiscal reports. ➤ Community Outreach Log
Deschutes County is a rural county with residents spread over 3,055 square miles. Transportation to services can be a barrier for many residents.	1) Provide geographically accessible services.	<ul style="list-style-type: none"> ➤ Continue to offer reproductive health services in Bend, Redmond and La Pine locations on a regular basis. ➤ Conduct a needs assessment for services in the Sisters area within the next year. 	<ul style="list-style-type: none"> ➤ Continue to monitor the number of clients seen at each clinic and appointment utilization. ➤ Continue to monitor length of time between request and appointment ➤ Needs assessment completed.

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
With an increase in birth control prices and more high-cost birth control methods being made available, it is hard to keep the medication costs within budget.	1) Continue to provide a broad range of birth control methods while being thoughtful of how medications are dispensed.	<ul style="list-style-type: none"> ➤ If the client chooses oral contraceptives as the method, client will be started on low-cost pills first. If high-cost pills are used, charting must support the reason for starting client on a higher cost pill. ➤ Counsel all clients wanting an IUD or Implanon about the potential side effects and costs to prevent premature removal of the method. ➤ Continue to use Arch Foundation for Mirena IUS's when possible. 	<ul style="list-style-type: none"> ➤ Monthly budget reports. ➤ Chart audits ➤ Track the number of these methods removed prematurely. ➤ Track income qualifications and the number of approvals.
83% of our clients are uninsured for primary care	1) All family planning clients will understand where they can receive primary care and access to preventative health services within the community.	<ul style="list-style-type: none"> ➤ Provide every family planning client information on primary care services and preventative health services as indicated. 	<ul style="list-style-type: none"> ➤ Chart audits

**FAMILY PLANNING PROGRAM ANNUAL PLAN FOR
COUNTY PUBLIC HEALTH DEPARTMENT
FISCAL YEAR 2008-2009**

July 1, 2008 to June 30, 2009

(Currently in Progress)

Goal/Objective	Progress on Activities
Goal 1, Objective 1 Implement a new income screening process with the front office staff.	<ul style="list-style-type: none"> ➤ New forms were developed that are easier for the client to understand and fill out. The client is asked to sign the income form stating that to the best of client's knowledge the information is accurate.
Goal 1, Objective 2 Increase knowledge and understanding of the FPEP program within our staff with the end goal of increasing FPEP enrollment.	<ul style="list-style-type: none"> ➤ The plan was to have all FP staff attend the FPEP Orientation and the Program Integrity Plan trainings by December 2008. We were able to have over 90% of our clinical, front office, medical records and billing staff attend both trainings. ➤ The plan was to provide incentives for clients to bring in paperwork. Although we tried hard to implement this objective we were not allowed to purchase incentives in the end.

Goal/Objective	Progress on Activities
<p>Goal 1, Objective 3 Explore bringing the BCC Program back to Deschutes County Health Services. Within the past year we estimate that 100-150 of our no-charge clients may have qualified for BCC.</p>	<p>➤ Inquiry was made with Rian Frachele at the State Family Planning Program. She said she would put Deschutes County Health Services on a list of clinics interested in being a provider for the program. We do not expect to hear anything until closer to July 1, 2009.</p>
<p>Goal 1, Objective 4 Work to create a more confidential reception area for both clinic offices in Bend and Redmond.</p>	<p>➤ We were able to remodel the front office and reception area at the Redmond Becky Johnson Center which has increased confidentiality for clients.</p> <p>➤ At the Bend office we met with Building Services and discussed structural modifications. An architectural plan was drawn up and dates were set for the remodel. At the same time we were planning to purchase new waiting room furniture and rearrange the seating to create a more confidential check-in area. Then, because of a number of concerns about economic crisis and funding issues, the projects were put on hold.</p>
<p>Goal 1, Objective 5 Increase community awareness through advertising and community outreach.</p>	<p>➤ We worked closely with Anna Johnson, County Public Information Officer, to establish an advertising plan which included:</p> <ul style="list-style-type: none"> • Outreach to businesses that do not provide insurance to their employees. • Advertising in several local publications. • The Chamber of Commerce wrote an article about access to family planning services that went to businesses in their newsletter. • Hanging flyers at local coffee shops, businesses and Central Oregon Community College. • Created a bookmark to give to clients to share with others who might need our services. <p>➤ Increase the number of reproductive health classroom presentations within the community. We far exceeded our goal of increasing the number of students receiving classroom presentations by 25%.</p> <ul style="list-style-type: none"> • School year 2006-2007 we presented to 777 students. • School year 2007-2008 we presented to 3,838 students. • School year 2008-2009 we project 5,800 students will receive classroom presentations.
<p>Goal 2, Objective 1 Unable to offer Implanon due to untrained staff.</p>	<p>➤ We did not meet our goal of having Implanon available by September 2008, but we did get a clinician trained and were able to start offering Implanon February 2009. We were able to get a second nurse practitioner trained in March and can now offer Implanon at multiple sites.</p>
<p>Goal 2, Objective 2 With an increase in birth control prices and more high-cost birth control methods being made available, it is hard to keep the medication budget at a manageable level.</p>	<p>➤ Clients have consistently been started on low-cost pills first. High-cost pills are used only if they are the best choice for the client and it is clearly documented. Staff are assessing how the client is managing the method and how well it is working for the client before giving large quantities.</p> <p>➤ We received and inserted 65 Mirenas from the Arch Foundation since July 1, 2009.</p> <p>➤ Medication costs have stayed within budget so far this fiscal year.</p>

UNPLANNED PREGNANCIES

Current Condition Or Problem:

In the process of assessing the issue of unintended pregnancies, it is clear that 5% of our continuing clients are still having positive pregnancy tests/ unplanned pregnancy.

Goal:

Improve the number of continuing clients with unplanned pregnancy to 2.5% in the coming year.

Activities:

Target Population	Who	What	Timeline
Unplanned pregnancy clients	Family Planning staff	Increase access to walk-in clinics. Improve triage so high-risk clients are not inadvertently turned away.	Ongoing
Unplanned pregnancy clients	Family Planning staff	Review and update birth control methods with staff; update protocols and best practices. Added Nuva Ring 3/04.	Ongoing
Unplanned pregnancy clients	Family Planning staff	Review and improve client information regarding using certain birth control methods. Added NuvaRing 3/04.	Ongoing
Unplanned pregnancy clients	Family Planning staff	Enhance ECP program/review literature and methodology.	Ongoing
Unplanned pregnancy clients	Family Planning staff	Review any new research on how to improve client compliance.	Ongoing
Family Planning staff	Family Planning staff	Staff discussions at staff meetings on success and failures for continued improvement.	Ongoing

Evaluation:

We did not meet our goal of improving the number of continuing clients with unplanned pregnancy to 2.5%. The number of unduplicated continuing clients with positive pregnancy tests/unplanned is 3%. Although close to goal, we will continue to evaluate our initiatives and act upon what we learn to reduce this rate. This rate is established by taking the number of continuing contraceptive clients divided into the number of positive pregnancy tests/unplanned, Region X Data System Report Table AL-5.

2005 Update: The Ahler's data system made a change to the reports available due to an Oregon State request. Therefore, an exact measurement cannot be applied to this problem. Using Ahler's data report #AL-2C, continuing clients plus unplanned pregnancies from AL 26, the rate is 4%. This is an increase of 1% from last year if the data is comparable. Efforts need to continue to improve the number of unplanned pregnancies occurring in continuing clients and particularly our teen clients. Plans are underway to open a teen specific clinic late spring or summer 2005. The intent is to provide education and support to teens in a location which might be more appropriate and during hours when teens are more available.

2006 Update: Although we cannot compare rates due to change in data, we know that according to Ahler's data report AL-5, reports indicate that of the clients using "no method" and are pregnant (unplanned), we note a reduction from 41.5 to 32.8. We

have increased our use of ECP, attempting to give our clients at risk ECP for future use. We are hopeful the addition of the Downtown Health Center for young adults will eliminate more barriers to education, information and contraception for our clients.

C. Environmental Health

The Environmental Health Division (EH) provides plan review, consultation and inspection of regulated public facilities (restaurants, pools, tourist facilities, schools and child care centers) and on-site wastewater and dispersal systems. The Division also regulates public water systems to provide safe drinking water and works with the Department on a variety of epidemiology programs and issues. In addition, EH is engaged in the proactive pursuit of protection of the groundwater in southern Deschutes County through grant funding. A staff of eight provides this range of services.

ADMINISTRATION

GOAL: Maintain a healthy work environment, which promotes an atmosphere of collaboration, education, and high morale among the Environmental Health staff.

Objectives:

63. Continue to cross train staff in all areas of Environmental Health to provide back-up and allow for a shifting workload during these uncertain times.
64. Continue to learn and fine tune the processes required for licensing and tracking all EH functions through our data bases.
65. Continue to update the web site to provide useful information to the public about EH programs.
66. Explore alternative work scheduling to better serve the customers and alleviate the stress of the seasonal workload.
67. Enter into contract with Lake County to do site evaluations in Lake County.

ON-SITE WASTEWATER TREATMENT

Goal: To provide homeowners who are served by on-site wastewater treatment systems with an operation and maintenance (O&M) oversight program that is practical and effective. Operation and maintenance tracking and reporting is mandatory as per OAR 340-071 for Alternative Treatment Technology (ATT), which the County is contracted to regulate.

Objectives:

68. Continue to refine database and office processes to efficiently track O&M activities.
69. Create a document detailing the processes of how the O&M activities are tracked.
70. Develop a plan for follow-up of time of sale transfers and non-compliant systems as required by OAR 340.071.
71. Hold a meeting with the O&M providers to find ways to more efficiently track annual inspections, fees, ownership changes, and contract extensions.

Goal: Maintain a service turn around average of 10 calendar days for issuance of approximately 1,200 annual permits; 30 calendar days for approximately 250 annual site evaluations; and 2 days for the 1,800 annual field inspections.

Objectives:

72. Become more efficient in our permit review and standardized inspection processes.
73. Develop checklists to help front counter technicians ensure a more efficient operation.

Goal: To communicate better with our customers

Objectives:

74. Attach the standardized inspection procedures flyer with permits.
75. Implement the use of the application questionnaire to better understand what the applicant is proposing.
76. Develop an electronic mail list for installers and distributors to improve information transfer.
77. Create an information sheet concerning recreational vehicle (RV) waste.
78. Research ways to provide treatment and disposal of low volumes of animal enclosure waste and water softener waste, which are not now regulated.

Goal: Communicate better with each other.

Objectives:

79. Provide two sets of southern Deschutes County water table maps for staff reference.
80. Create a complete book of all Alternative Treatment Technology information.
81. Create a collection of approved product and application information for easy staff reference.

Goal: Develop an on-site storm water review process to coordinate with on-site wastewater permit review and planning site plan review.

Objective:

82. Ensure that all water dispersal needs are met, particularly conflicts between storm water and on-site wastewater dispersal.

GROUNDWATER PROTECTION PROGRAM FOR SOUTHERN DESCHUTES COUNTY

Goal: Apply the tools, experience, and information gained from the La Pine National Demonstration Project and the County Regional Problem Solving Project to identify and implement solutions to protect and improve the quality of the sole source of drinking water in southern Deschutes County.

Objectives:

83. Assist the Department of Environmental Quality (DEQ) in achieving a sustainable solution to the public health hazard in southern Deschutes County.
84. Provide homeowners and installers with updated information about denitrifying technologies.
85. Evaluate newly approved technologies for nitrogen reduction capabilities.
86. Assist planning with “High Groundwater Lot Work Plan” as provided in their work plan.
87. Implement the financial assistance program in coordination with the Planning Division.

FOOD SERVICE FACILITIES

Goal: To provide operators of food service facilities with the education and tools to protect the public from food-borne illness.

Objectives:

88. Create and implement on-line Temporary Restaurant License application and issuance.

89. Allow for one Environmental Health Specialist per year to train and be certified as a Standardized Inspection Officer by the Department of Human Services (DHS) to ensure greater consistency in licensed facility inspections.
90. Update all existing handouts, brochures and information on the Web site.
91. Add the mobile food unit inspection reports to our on-line database.
92. Perform either self-assessment or baseline survey for the Food and Drug Administration's (FDA) Voluntary National Food Regulatory Standards Program.
93. Send a newsletter to licensed restaurant and mobile food unit owners annually and explore other methods of informing food service operators of current events.
94. Perform 100% of required inspections on all licensed food service establishments.
95. Implement the complete Temporary Restaurant changeover by correcting language and fees in fee schedule.

POOLS AND SPAS

Goal: Provide oversight and education to all public pool and spa operators and to protect the public from water-borne disease.

Objectives:

96. Provide clear and detailed handouts to help educate pool and spa operators on relevant issues regarding pool and spa maintenance, best management practices and local, state and federal rule changes.
 - a. Provide educational material to pool operators about changes to the wading pool rules.
 - b. Provide educational material to pool operators about changes required to submerged main drain grates and the Federal Virginia Graeme Baker Pool and Spa safety act
97. Create an educational approach to routine inspections.
98. Provide EH staff with opportunities to:
 - Gain pool and spa inspection experience,
 - Add to the diversity of understanding of pool management and chemical handling through continuing education, and
 - Learn effective communication methods targeting pool and spa operators.
99. Investigate the need for a specific County ordinance to regulate continuing non-compliers and other rule abuses not addressed by State pool and spa codes.
100. Ensure Deschutes County representation to any State committee is well informed and up-to-date on industry and code changes.
101. Work with the Information Technology section to modify the exiting license facility data base to link facilities with multiple interdisciplinary licenses (i.e., hotel with food service and pool/spa).

DRINKING WATER

Goal: Assure citizens of Deschutes County safe drinking water by implementing and enforcing drinking water standards through professional technical and regulatory assistance to all public water systems.

Objectives:

102. Maintain current level of customer service for public health and drinking water inquiries.
103. Continue to keep the number of Significant Non-Complier (SNC) systems to a minimum.
104. Continue working on the additional 42 small public systems recently added to inventory.

- 105. Maintain sanitary survey rate of 41 per year to meet increased inspection frequency and the addition of new water systems.
- 106. Earn 80% or more of the Drinking Water State Revolving Fund allocation.
- 107. Complete the Drinking Water Mapping Project working with GIS staff.
- 108. Maintain immediate response time for water quality alerts.
- 109. Continue to train additional staff in this growing program.
- 110. Identify and inventory public water systems not currently regulated.

HEALTH SERVICES

Goal: To aid Deschutes County Health Services (DCHS) in their mission to provide public health services to the community.

Objectives:

- 111. Maintain the high level of communication with DCHS by continuing to attend meetings with them to discuss public health needs and how we can work together to meet those needs.
- 112. Assist DCHS in food-borne illness investigations.
- 113. Assist DCHS and County disaster preparedness teams by becoming a part of the emergency response plans.

D. Health Statistics

Current Condition Or Problem:

The process and activity of conducting community health needs assessment and planning continues to evolve as an area of focus for the Department. We are proud to have delivered our third bi-annual Community Health Report in March of 2007. Service planning and resource allocation decisions are increasingly dependent upon current, relevant and accurate baseline data specific to the local community. The essential purpose of these reports is to assist in community needs assessments and service planning. More recently the Department and community partners have recognized the value of monitoring health indicators as a means to measure the success or impact of various human service programs.

Dynamic change in the social and economic environment has created an increased need for health and social support services at a time when public revenues are limited and the health system budget is strained. This climate necessitates highly targeted service provision to maximize the effect of programming. The Department is a proud partner in this effort and has served as a leader to stimulate dialog, planning and resources dedicated to meeting the public health needs of our community.

The Department has not yet developed a true center of emphasis on health statistic monitoring and reporting but has increasingly relied upon the abilities of a few key staff to produce regular updates in the form of Health Profiles. Frequent requests for specific information are assigned to the program or staff who seem most closely associated with the nature of the data being requested. This frequently results in staff having to fit the work into their other routine duties.

The Department has intranet and web technology at its disposal in addition to several staff who demonstrate strong technical skills in this area. A challenge is to restructure work assignments to better accommodate for this growing area of need.

In part to respond to the community's interest in health statistics, the Department published its third Community Health Report in March of 2007. Our 2009 report will be published in the fall of 2009. The 2007 report, included as Appendix A, covers a wide variety of subject matter ranging from population statistics, infectious disease, chronic disease, child and adolescent health and preventable disease.

Goal: Bi-Annual Health Status Report: Continue with the excellent work done in 2002 and 2004 by producing a periodic health status report which monitors the priority health issues affecting the community.

Activities:

Target Population	Who	What	Timeline
Deschutes County residents	Management	We will survey our staffing capacity and talent then assign a lead role to a member of our team who can best assure managing the logistics of producing an annual report.	Ongoing
Deschutes County residents	Management	We will collect data from similar sources used in the 2002, 2004 and 2007 reports and continue with trend reporting for 2008-09.	Ongoing
Deschutes County residents	Management	We will closely align the focus of the report to complement the community priorities as identified in the comprehensive planning efforts associated with SB 555.	Ongoing
Deschutes County residents	Management	We will plan to produce the next report in 2009.	Spring 2009

Evaluation:

We will conduct a written survey to determine the opinion of key community partners related to the value, need for, content and quality of the report. This will include:

- Our own Public Health Advisory Board
- Commission on Children and Families
- Educational Service District Team (ESD)
- Central Oregon Health Council
- State Human Service Agency Partners

Goal: Center of Emphasis in Health Statistics and Community Health: Develop resources (staff and time) dedicated to monitoring health trends and producing reports. The Director's vision includes integrating community health promotion and prevention work with health statistics and monitoring.

Activities:

Target Population	Who	What	Timeline
Deschutes County residents	Management	Survey the Department to determine scope of demand for providing health statistical information to the public, other community partners and for internal operations and projects	Ongoing
Deschutes County residents	Management	Based on this assessment, gauge the level of staff support necessary to meet this demand.	Ongoing
Deschutes County residents	Management	Structure this service to fit within a community health and prevention area of focused programming as resources allow.	Ongoing

Target Population	Who	What	Timeline
Deschutes County residents	Management	Propose a placeholder in our budget for the resources necessary to create a center of emphasis in community health, prevention and health statistical reporting.	2008-09 Budget Cycle
Deschutes County residents	Management	Develop a location on our Department web site which serves as a place to post and update critical health statistical information specific to Deschutes County.	By spring 2007
Deschutes County residents	Management	Coordinate with the Central Oregon Health Council and the Commission on Children and Families to identify a plan of action for maintaining a wide variety of social and health performance measures.	Ongoing

Evaluation:

We will assess the value of creating this type of new service from a cost verses utility perspective. This will involve an internal assessment of the value/efficiency of work redesign as well as assessing the value of proving data on our web site, determined by the number of “hits” to the system.

E. Information And Referral

Current Condition Or Problem:

A significant volume of health information and referral is made across all programs and services on a daily basis. A Hepatitis scare in 2003 resulted in over 300 phone calls from the public in just four hours. The flu vaccine shortage of 2004 resulted in a similar demand for public information. We fear these examples may pale in comparison to the daily demand for information should West Nile Virus materialize. The information disseminated within formal clinical program activity with specific clients is very accurate, complete, and targeted. However, there is a randomness to public requests, by phone or in person, that is difficult to measure. The Department does not track the frequency of requests or their nature but has become quite adept at referring callers to resources outside the public health domain. A very handy brochure from our local Family Resource Center contains a wealth of service referral information and is frequently used by reception staff.

Goals:

1. The Department will survey for the frequency and nature of calls on a periodic basis.
2. Employee Orientation will include training on providing information and referral advice.
3. Employees will be given an opportunity to provide input on methods to enhance the quality of this service.

Activities:

Target Population	Who	What	Timeline
Deschutes County residents	Management Front Office Team	We will survey the Department to determine the scope and frequency of demand for providing health information and referral to the general public.	Ongoing
Health Services support staff	Management	We will continue to develop basic employee orientation materials and training related to providing health information and referral.	Ongoing

Target Population	Who	What	Timeline
Health Services clinical and front office staff	All staff	We will implement round-table discussion within and between work teams to elicit ideas related to enhancing the quality of this service. We will document ideas and assign specific tasks as part of an overall quality improvement process.	Ongoing

Evaluation:

1. We will report to staff and our Public Health Advisory Board the results of our survey related to measuring the frequency and nature of information and referral calls from the general public.
2. We will implement a tool to measure the satisfaction and quality of orientation materials and training from the perspective of our staff.
3. We will implement a tool to measure the satisfaction and quality of service from the perspective of our clients/public.
4. We developed a new employee orientation checklist to assure we are preparing employees to provide information and referral as appropriate.
5. We will incorporate staff recommendations for enhancing the quality of this service into a formal quality improvement initiative for the Department. The Support Services Manager will be charged with oversight on this activity.

F. Public Health Emergency Preparedness (See Epidemiology and Control of Preventable Diseases and Disorders section, page 25.)

G. Other Issues

None, other than noted in previous sections.

IV. ADDITIONAL REQUIREMENTS

1. An organizational chart is attached; see Appendix B.
2. Senate Bill 555: The local Commission on Children and Families stands as a separate Department within the Deschutes County organization structure.
 - Deschutes County Health Services continues a close partnership with the Commission on Children and Families (CCF) in the development of many components of the local Comprehensive Community Plan.
 - The Plan itself contains sections relevant to public health and consistent with the Oregon Benchmark Project. Assurance for childhood immunizations, teen pregnancy prevention, hunger prevention, oral health care, primary health, smoking cessation, and cultural competency are just a few examples.
 - The Department Director regularly participates in CCF planning work, is involved in the local Professional Advisory Committee to the CCF, and attends CCF executive team meetings.

V. UNMET COMMUNITY NEEDS

A. Primary Care

Current Condition Or Problem:

There are approximately 25,000 uninsured individuals currently living in Deschutes County. This compares to approximately 14,000 just in 2002. Changes in Oregon Health Plan (OHP) eligibility made between 2002 and now have significantly worsened this problem. To compound this situation, many local medical care providers have simply closed their practices to the few remaining adult OHP-Categorical clients and fee-for-service Medicare clients. Nearly 30% of our total population has severely limited or no access to basic physical health care services, mental health care, or oral health care.

La Pine, Oregon, is geographically isolated from most health care services in the County and has a population of approximately 14,000, with a median family income of about \$24,000 and an estimated 24% unemployment rate. The area has a high percentage of older adults (over the age of 65) at 22%. Recent years have seen the demise of private practice medical practices in this community. Even a Rural Health Clinic (RHC), established in 2003, has struggled financially in this market.

Goals And Accomplishments:

1. Rural Health Clinic: In September of 2003 a Rural Health Clinic in La Pine, Oregon, was formally designated by HRSA. This practice, owned by Dr. Lisa Steffey, is estimated to have the capacity to serve approx. 6,000 to 8,000 clients, many of whom are Medicare/Medicaid. The clinic continues to experience cash flow challenges as well as difficulty with provider/practitioner recruitment.
2. La Pine: A financial feasibility study related to establishing a Federally Qualified Health Center (FQHC) in La Pine was conducted by the Ochoco FQHC clinic in Prineville. This study determined that an FQHC would be fiscally challenged with a new Rural Health Clinic just established.
3. Community Clinic of Bend FQHC: The Department supported planning and a grant request to HRSA by the Ochoco FQHC clinic to establish an FQHC “expansion” site in Bend. The Department made an official request to HRSA to designate an area of southeast Bend a *Medically Underserved Area*. The designation was granted, and soon our friends at the Ochoco Clinic were drafting an FQHC grant request for the Bend community. In October of 2004, HRSA provided notice of a grant award to establish a fully operational FQHC in Bend. The clinic has opened at 409 Greenwood Avenue (April, 2005) and received over 10,000 patient visits in 2006.
4. The Volunteers In Medicine (VIM): The VIM clinic in Bend opened for clients in early April, 2004, with a mission of serving low income uninsured residents of the County. The VIM clinic will have received over 3,000 clinic visits in its first year of operation. The clinic has been an invaluable resource to our communities. The Department’s own Community Care Clinic closed up shop in the late summer of 2004 as the VIM clinic became fully operational.
5. HealthyStart Prenatal Clinic: The Department continues to operate the HealthyStart Prenatal Clinic, which serves to offer universal access to prenatal and obstetrical care for all women regardless of ability to pay. The demise of the OHP plan may result in a significant increase in demand for this safety net health service. The program served more than 340 women in 2004 and provided some 120 deliveries—nearly 8% of all deliveries performed in the County.

6. A School Based Health Center (SBHC): An SBHC has been operating in the La Pine community since the spring of 2005. The clinic is operated as an extension of the Department. The Maternal Child Health Team, under the leadership of Elaine Severson, worked tirelessly with local school officials, school nurses and community partners to bring this clinic into fruition. Continued operation of the clinic is largely dependent upon legislative support from the Governor's budget which proposes to expand the number of clinics in Oregon. Two new fully certified SBHCs opened in 2008, one in Bend and one in Redmond.

7. Northwest (NW) Medical Teams Dental Van: The local VIM clinic, Central Oregon Oral Health Coalition and La Pine Community Action Team have been instrumental in bringing the NW Medical Teams mobile dental service to Central Oregon for repeated visits. This service targets low income uninsured residents of Central Oregon and is staffed by volunteer dentists and hygienists.

8. Kemple Dental Clinic: For more than 10 years Dr. H. M. Kemple has operated a free dental clinic for the disadvantaged children of Deschutes County, serving several thousand children to date. The clinic is currently housed at the Juvenile Corrections facility in Bend.

Activities:

Target Population	Who	What	Timeline
Deschutes County residents	Health Services	Continue participation in community-based coalitions, councils, steering committees and boards which are dedicated to addressing access to health care for low income and medically uninsured individuals.	Ongoing
Deschutes County residents	Health Services	Work closely with community health care leaders from the hospital and medical clinic systems to establish a system of care for Medicaid clients.	Ongoing
Deschutes County residents	Health Services	Assess the capacity of the mid-level providers to open their practices to these clients.	Ongoing
Deschutes County residents	Health Services	Establish an urban setting Federally supported Community Health Center or FQHC model in Bend.	Completed
Deschutes County residents	Health Services	Perform a financial evaluation of operating a primary care clinic through the Department. Completed in the fall of 2004 – determined to be financially challenging.	Completed
Deschutes County residents	Health Services	Confirmation of the level of financial, medical, specialty support, and lab/radiology support across the medical community to assist with delivery of comprehensive health care to these individuals.	Ongoing

Target Population	Who	What	Timeline
Deschutes County residents	Health Services	Develop a broad coalition of support from the County, private medical market and not-for-profit hospital system. Establish a Central Oregon Health Care SafetyNet Coalition. This activity has recently matured into a 501(c)(3) known as the Central Oregon Health Collaborative.	Ongoing

Evaluation:

The time line for preliminary evaluation of the components related to creating a system of care for the uninsured and Medicaid-OHP clients is ongoing as the situational needs and opportunities evolve. The ultimate test of success will be measured by the number of individuals who can be served by this system, and its ability to address the "access to care" issue for an estimated 25,000-35,000 individuals.

B. Methamphetamine Abuse

Current Condition Or Problem:

The current status of methamphetamine abuse is frequently referred to as “epidemic,” and yet we have precious little hard data upon which to draw that conclusion. Yet, with the hard data we do have and given the real life testimonials of corrections officers, court officials, mental health therapists and community members it does indeed appear we have an “epidemic” of sorts on our hands.

At best, the methamphetamine abuse issue has a huge negative impact on our courts, our corrections system, our schools and our communities. Worse, methamphetamine abuse has a tragic impact on our families, our children, our health, our economy and may be the single most “urgent” issue impacting our communities. Methamphetamine abuse impacts us as parents, spouses, educators, employers, public officials and community members, and appears to have a pervasive presence in many if not most of the serious social issues facing us citizens.

In 2004, methamphetamine abuse accounted for 43% of all substance abuse treatment services delivered by Deschutes County Mental Health. This eclipsed—for the first time ever—alcohol as the #1 substance for which clients sought services. Local law enforcement estimates well over 80% of all property crimes are related to methamphetamine abuse. From October of 2003 to February of 2005 the amount of methamphetamine seized by local law enforcement officials increased a whopping 649%. Our colleagues with State Child Protective Services indicate methamphetamine is involved in far too many child abuse and neglect cases and in nearly all cases where parental rights are terminated.

Community Call to Action:

Since early 2004 a group of dedicated volunteers has fostered community discussion, increased awareness and promoted a call to action to address the methamphetamine abuse issue. The Meth Action Coalition was formed on the heels of a community summit held in the spring of 2004 to increase knowledge and interest in the community about methamphetamine abuse. Since that time, community leaders and public officials have taken a much keener interest in addressing this issue. Recently, Deschutes County Mental Health submitted a sizable HRSA grant intended to add capacity in addressing this substance abuse issue. Planning is currently underway to try to establish a formal community-wide prevention and education effort to curb this epidemic.

C. Hunger and Nutritional Health

This is a very significant problem for many of our families and children. While Deschutes County's population increased 24% from 2000-2005, the number of people accessing food bank programs each month increased by 45% during this same period. School district data suggest some primary schools have more than 60% of their students on public assistance meal programs. Unemployment and poverty in some areas of our county approach 25% of the individuals living there. Hunger is a very real problem.

D. Tobacco Use

The elimination of the Measure 44 funded Tobacco Prevention Program presented an immediate and significant public health issue. The success of the program was well documented, and we are now faced with regaining lost ground as the incidence of tobacco use by youth has risen in the face of the program's demise. Fortunately, Deschutes County is one of several that have received partial re-funding of the Tobacco Prevention Program. Much more could be done to prevent the health effects of exposure to tobacco products.

E. Mental Health Services for Uninsured

The elimination of many behavioral health supports for our citizens needing these services presents very real public health issues. Untreated behavioral health illness will have a cascading effect on public safety, employment, stable home environment and personal self-adjustment.

F. Family Violence

The rapid rise in family violence incidents speaks loudly to the unmet need in this area. Deschutes County's rate of family violence well exceeds recent State averages. It is a system crying out for resources, at a time when social service supports in this area are being de-funded.

G. Children With Special Health Care Needs

Services for these very special children once again make the list as one of the most tragically under funded needs in our communities. Public and school health nurses continually struggle to find resources, in terms of medical care access, respite care, treatment and durable medical equipment to help meet the needs of these children.

H. Health and Social Support Assets for Ex-Incarcerated Populations

Studies indicate a lack of basic supports stands as a significant barrier to successful re-entry for ex-incarcerated populations. A coalition of community agencies has begun to look at crafting a program specifically for adult women to aid in this endeavor.

I. Children's Oral Health

As of September of 2004, Deschutes County ranked as one of the ten worst counties statewide for untreated dental disease in children. In schools where more than 30% of students are on free/reduced lunches, decay rates are generally 400% higher than in the more affluent student populations. This situation applies to many of our area schools, most especially in La Pine. This fact speaks miles to the relationship between poverty and oral health care in our children. In Deschutes County, 55% of 6-8 year olds have a history of dental decay and a full 29% of these children have untreated dental decay. Dental disease accounts for 5.7 missed days of school for every 100 of our Deschutes County school children. Efforts to raise community awareness, to reach high-risk populations, and to discuss the merits of community water fluoridation are currently underway.

J. Childhood Obesity

The increasing prevalence of overweight children and adults across the United States and in Deschutes County is a major public health concern. Approximately 70% of Oregon deaths are due to chronic disease in which obesity is a primary risk factor. Since 1970 there has been a 200% increase in the prevalence of obesity among all children and a whopping 300% increase among teens. In a 2004 report, 28% of Oregon 8th graders were identified as overweight. Per capita soft drink consumption has more than doubled in the past 30 years, and one fourth of all vegetables eaten in the United States are French fries. If we are unable to get our arms around this large problem, we face dire health consequences in the years ahead. The burden of this morbidity will impact not only the health of the nation but also will likely bankrupt an already overtaxed health care financial system.

VI. BUDGET

Budget location information: Sherri Pinner, Business/Operations Manager
 Deschutes County Health Services
 2577 NE Courtney Drive
 Bend, OR 97701
 (541) 322-7509

FINANCIAL ASSISTANCE AWARD

State of Oregon Department of Human Services Public Health Services			Page 1 of 3
1) Grantee Name: Deschutes County Health Dept. Street: 2577 N. E. Courtney City: Bend State: OR Zip Code: 97701	2) Issue Date April 10, 2009	This Action ORIGINAL FY2010	
		3) Award Period From July 1, 2009 Through June 30, 2010	
4) DHS Public Health Funds Approved			
Program	Previous Award	Increase/ (Decrease)	Grant Award
PE 01 State Support for Public Health			189,488
PE 03 TB Case Management			1,208
PE 07 HIV Prevention Services HIV Prevention Block Grant Services Ryan White Title II HIV / AIDS Services			28,832
PE 08 Ryan White--Case Management			84,318
PE 08 Ryan White--Support Services			21,082
PE 12 Pub. Health Emergency Preparedness/(July-Aug. 9)			15,649 (a)
PE 12 Pub. Health Emergency Preparedness/(Aug 10-June30)			121,666
PE 13 Tobacco Prevention & Education			113,150
PE 15 Healthy Communities			65,000
PE 39 Maternity Case Management FAMILY HEALTH SERVICES			1,000 (e)
PE 40 Women, Infants and Children FAMILY HEALTH SERVICES			621,608 (b,c)
5) FOOTNOTES:			
a) July-August 9th awards must be spent by 8/9/2009 and a report submitted for that period. b) July-Sept. grant is \$155,402 and includes \$5,936 of minimum Nutrition Education and \$7,420 for Breastfeeding Promotion c) Oct.-June grant is \$486,206 and includes \$93,241 of minimum Nutrition Education and \$22,259 for Breastfeeding Promotion d) July - September grant is \$5,740 ; October - June grant is \$17,220 e) \$1,000 must be spent by December 31, 2009. f) The Funding Formula includes 5 counties (Curry, Deschutes, Josephine, Klamath & Washington) with increased awards that are contingent on successful completion of May 2009 initial SBHC certification visit. g) MCH Funds will not be shifted between categories or fund types. The same program may be funded by more than one fund type, however, federal funds may not be used as match for other federal funds (such as Medicaid).			
6) Capital Outlay Requested in This Action:			
Prior approval is required for Capital Outlay. Capital Outlay is defined as an expenditure for equipment with a purchase price in excess of \$5,000 and a life expectancy greater than one year.			
PROGRAM	ITEM DESCRIPTION	COST	PROG. APPROV

**State of Oregon
Department of Human Services
Public Health Services**

Page 2 of 3

1) Grantee Name: Deschutes County Health Dept.		2) Issue Date April 10, 2009	This Action ORIGINAL FY2010
Street: 2577 N. E. Courtney City: Bend State: OR Zip Code: 97701		3) Award Period From July 1, 2009 Through June 30, 2010	
4) DHS Public Health Funds Approved			
Program	Previous Award	Increase/ (Decrease)	Grant Award
PE 40 WIC -- PEER Counseling FAMILY HEALTH SERVICES			22,960 (d)
PE 41 Family Planning Agency Grant FAMILY HEALTH SERVICES			142,109
PE 42 MCH-TitleV -- Flexible Funds FAMILY HEALTH SERVICES			41,171 (g)
PE 42 MCH-TitleV -- Child & Adolescent Health FAMILY HEALTH SERVICES			17,644 (g)
PE 42 MCH/Perinatal Health -- General Fund FAMILY HEALTH SERVICES			6,042 (g)
PE 42 MCH/Child & Adolescent Health -- General Fund FAMILY HEALTH SERVICES			11,337 (g)
PE 42 Babies First FAMILY HEALTH SERVICES			19,131 (g)
			20,018
FAMILY HEALTH SERVICES			
PE 43 Immunization Special Payments FAMILY HEALTH SERVICES			44,751
PE 44 School Based Health Centers FAMILY HEALTH SERVICES			120,000 (f)
5) FOOTNOTES:			
6) Capital Outlay Requested in This Action:			
Prior approval is required for Capital Outlay. Capital Outlay is defined as an expenditure for equipment with a purchase price in excess of \$5,000 and a life expectancy greater than one year.			
PROGRAM	ITEM DESCRIPTION	COST	PROG. APPROV

VII. MINIMUM STANDARDS

To the best of our knowledge we are in compliance with these program indicators according to the Minimum Standards for Local Health Departments:

A. 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.

B. 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. **(For some yes, others no.)**
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.

C. 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.

D. 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. **The County has recently adopted a 30 foot smoke free entrance policy for all County buildings.**

E. 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 Juvenile Corrections Health
- 75. Yes No Clients identified at nutritional risk are provided with or referred for appropriate interventions. **(Limited)**
- 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.

F. 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. **(These exist within the private and/or non-profit community but not all of these are available within the local health department.)**

G. Parent and Child Health

- 82. Yes No Perinatal care is provided directly or by referral.
- 83. Yes No Immunizations are provided for infants, children, adolescents and adults either directly or by referral.
- 84. Yes No Comprehensive family planning services are provided directly or by referral.
- 85. Yes No Services for the early detection and follow-up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.
- 86. Yes No Child abuse prevention and treatment services are provided directly or by referral.

- 87. Yes No There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.
- 88. Yes No There is a system in place for identifying and following up on high risk infants.
- 89. Yes No There is a system in place to follow-up on all reported SIDS deaths.
- 90. Yes No Preventive oral health services are provided directly or by referral.
- 91. Yes No Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets. **(Limited to MCH programs & WIC via dental varnish.)**
- 92. Yes No Injury prevention services are provided within the community.

H. Primary Health Care

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

I. 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.

J. Health Department Personnel Qualifications

Administrator Name: Scott Johnson

- 103. Yes No The local health department Health Administrator meets minimum qualifications:
A Master's degree from an accredited college or university in public health, health administration, public administration, behavioral, social or health science, or related field, plus far more than two years of related experience.

104. Yes X No ___ The local health department Supervising Public Health Nurse(s) meets minimum qualifications:
Licensure as a registered nurse in the State of Oregon, progressively responsible experience in a public health agency;

AND

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

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

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

OR

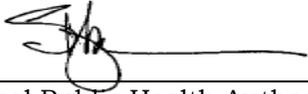
A Master's degree in an environmental science, public health, public administration or related field with two years progressively responsible experience in a public health agency.

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

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

The Department has recently matured to a Medical Director model of oversight with two physicians designated with equal responsibility/authority over specific programmatic areas. Dr. Richard Fawcett is our lead Health Officer, Dr. Mary Norburg is Deputy Health Officer.

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



Local Public Health Authority

DESCHUTES
County

June 1, 2009
Date

S:\Mental_Health\Scott\Reports & Plans\2009\DCHS Local Public Health Authority Annual Plan 2009-2010.doc

DESCHUTES COUNTY HEALTH REPORT 2007



The Deschutes County Health Department
presents this report to the residents of Deschutes County so they may be
better informed about the health issues and behaviors that affect their lives.

INTRODUCTION

The Deschutes County Health Department is pleased to present the *Deschutes County Health Report*, a compilation of key health indicators for our county. The goal of this report is to provide health data that can be used by local government and community agencies, health care providers, and other interested community members and groups to help identify and better address the health needs of Deschutes County.

The health indicators examined in this report are used to represent trends by tracking measurable changes over time. As much as possible we use established national and statewide goals, such as the U.S. Surgeon General's Healthy People 2010 objectives and the Oregon Progress Board's 2005 benchmarks, to gauge our progress. Our concept of health is broad, as indicated by the inclusion of data regarding issues such as poverty, homelessness, and violent injury.

The *Deschutes County Health Report* identifies several important areas where the County meets national health objectives or has improved over the last several years. Some examples are:

- First trimester prenatal care – Deschutes County has

consistently ranked among the highest in Oregon.

- Teen pregnancy rates – dropping to an all time low in Deschutes County.
- Breastfeeding initiation – Oregon's Women, Infants, and Children (WIC) program ranks first in the nation for breastfeeding initiation. The Deschutes County WIC initiation rate is even higher.

The report also points to areas where significant work still needs to be done. Examples are:

- Rising obesity rates, especially in children
- Immunization rates far below the state average
- Alcohol, tobacco, and other drug use among adolescents
- High percentage of residents without health care coverage
- Lack of fluoridated water supplies to prevent tooth decay and improve oral health

It is our hope that the information provided by this report will motivate local government, community agencies, and citizens to collaboratively address the growing health needs across our county. By improving the health of our residents, we strengthen the community as a whole.

NOTE ON DATA AND BENCHMARKS

(Healthy People 2010 Objectives and Oregon 2005 Benchmarks)

This report relies exclusively on secondary data, i.e. data collected by other organizations, and utilizes the most current data available from these sources. Healthy People 2010 objectives and Oregon 2005 Benchmarks are given in relation to Deschutes County data when available and appropriate. Healthy People 2010 is a federal initiative which sets national disease prevention and health promotion objectives to be achieved by the end of this decade. Oregon Benchmarks are set by the Oregon Progress Board as statewide objectives.

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DEMOGRAPHICS

Deschutes County Population by Age, 2006

	0-17 years	18-64 years	65+ years
	34,381	98,246	19,988
total %	(22.5%)	(64.4%)	(13.1%)

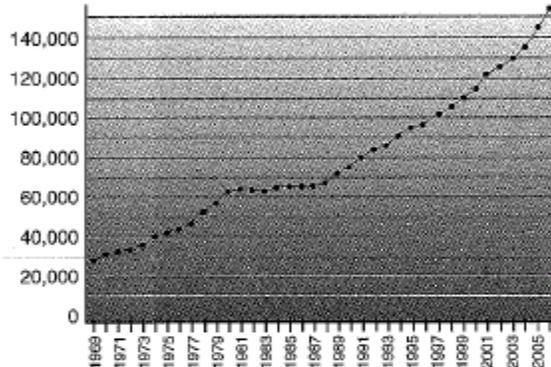
Source: Portland State University-Population Research Center, 2006 Age Estimates

Oregon Population by Age, 2006

	0-17 years	18-64 years	65+ years
	872,280	2,356,686	461,539
total %	(23.6%)	(63.9%)	(12.5%)

Source: Portland State University-Population Research Center, 2006 Age Estimates

Deschutes County Population 1969-2006



Population of Deschutes County, 2006: 152,615. Deschutes County continues to be the fastest growing county in Oregon, with a 32.3% increase in population from April 2000 - July 2006.

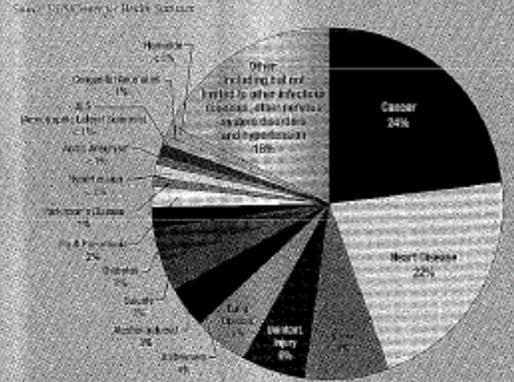
Source: Portland State University-Population Research Center, 2006 Oregon Population Report and 2006 Preliminary Population Estimates.

Education Level - 2005*

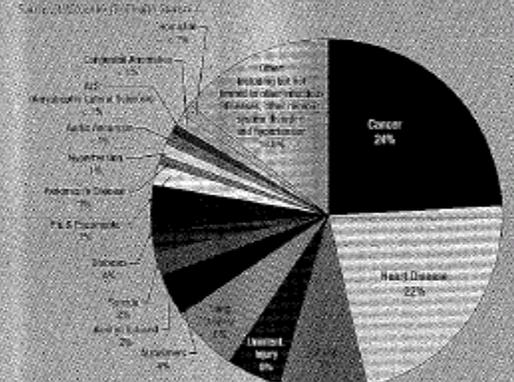
	Deschutes County	Oregon	United States
Less than HS degree	12%	13%	16%
HS Graduate	22%	26%	30%
Some College, no Degree	28%	26%	20%
Associate Degree	9%	7%	7%
Bachelor Degree	21%	18%	18%
Graduate or Professional Degree	8%	10%	10%

* Numbers may not add up to 100% due to rounding.
Source: U.S. Census, 2005 American Community Survey

Leading Causes of Death Deschutes County, 2004

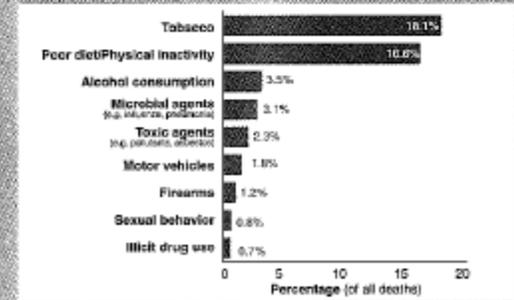


Leading Causes of Death Oregon, 2004



Actual Causes Associated with Death United States, 2000*

Behavioral and lifestyle choices such as smoking, poor nutrition, and physical inactivity are major contributors to the leading killers, which include heart disease, cancer and people. It is anticipated that the consequences of physical inactivity and poor nutrition will soon overtake obesity as the leading cause of death in the United States.



* Source: Behavioral Risk Factor Surveillance System, CDC, 2000. CDC, 2000. Behavioral Risk Factor Surveillance System, CDC, 2000. CDC, 2000.

3 DESCHUTES COUNTY HEALTH REPORT 2007

Births & Deaths, Deschutes County, 2000-2005

	2000	2001	2002	2003	2004	2005
Births	1,438	1,480	1,487	1,575	1,663	1,783
Birth Rate	12.3	12.1	11.8	12.1	12.3	12.4
Deaths	916	957	973	997	961	N/A*
Death Rate	7.9	7.8	7.7	7.6	7.1	N/A*

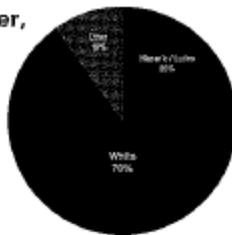
*N/A - Not Available
Source: DHS / Center for Health Statistics

Emerging Access Needs

While only 5.2% of the Deschutes County population in 2005 was made up of Hispanics, 12% of births in 2005 were to Hispanic mothers. As the Hispanic and other minority populations continue to grow in Deschutes County, we must work to reduce cultural and linguistic barriers that prevent equal access to public information and community services.

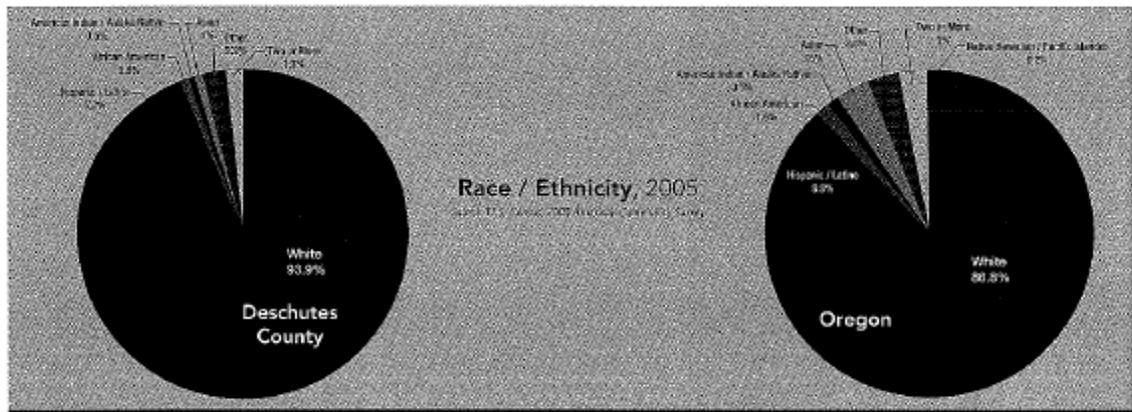
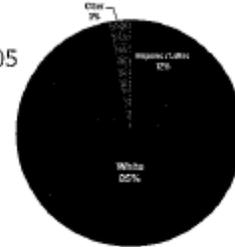
Race / Ethnicity of Mother, Oregon Births, 2005

Source: DHS / Center for Health Statistics



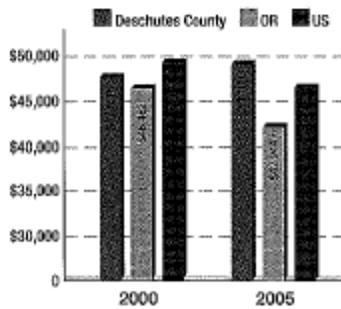
Race / Ethnicity of Mother, Deschutes County Births, 2005

Source: DHS / Center for Health Statistics



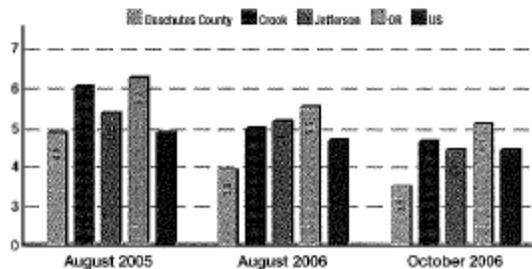
ECONOMY

Median Household Income



Source: U.S. Census, 2005 American Community Survey

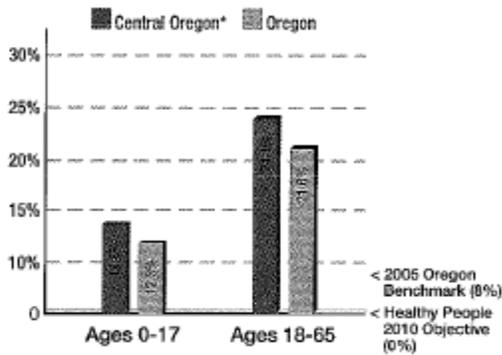
Unemployment Rates



Source: U.S. Census, 2005 American Community Survey, Oregon Employment Department

ACCESS TO HEALTH CARE

Uninsured:
Individuals with No Health Insurance, 2004

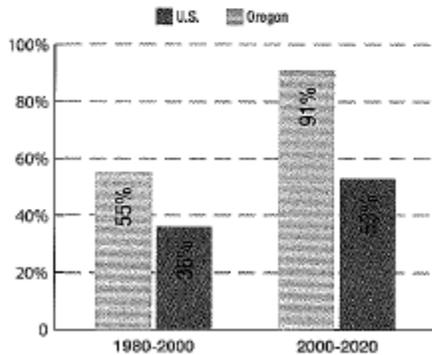


*Combined regional estimates for Crook, Deschutes and Jefferson counties.
Source: Oregon Population Survey, 2004

The percentage of uninsured Central Oregonians shown above equals approximately 32,450 people. Of those, 6,120 are children under the age of 18 years.

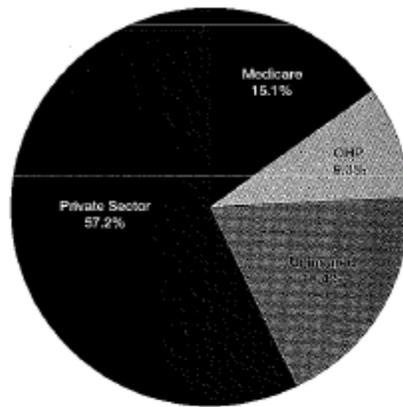
The consequences of high uninsured rates can be devastating. The Kaiser Commission on Medicaid and the Uninsured conducted a thorough review of the past 25 years of health services research on the effects of health insurance coverage. The results demonstrated that the uninsured receive less preventive care, are diagnosed at more advanced stages, and once diagnosed, tend to receive less therapeutic care such as drugs and surgical interventions.

MEDICARE
Projected Change in Oregon & U.S. Population
65+ Years of Age



If population projections hold true, the increase in residents 65+ years of age in Deschutes County will be significant. There is serious reason to be concerned about where these people will receive care.
Source: Health Resources and Services Administration

Central Oregon Population
by Source of Coverage*



*Note: OHP data is from 6/06. The most current Medicare, private sector and uninsured data is from 2003 and 2004.
Source: Oregon Population Survey, 2004

Consequences of High Uninsured and Medicaid Rates:

The "cost shifting" cycle. This refers to the shifting of people and costs between segments of the health care market. When Medicare and Medicaid reimbursements fail to cover the full cost of providing care, there is a "cost shift" to private payers to make up the difference. The increasing costs are passed along to employers and consumers in the form of higher premiums, which changes the market and makes health coverage less affordable.

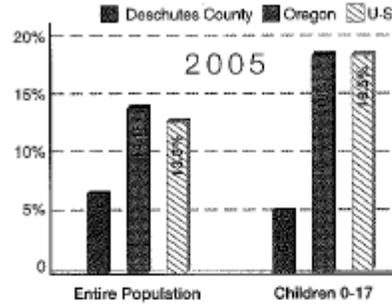
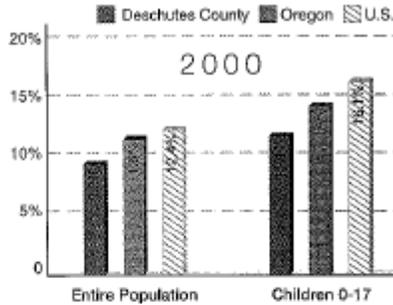
MEDICAID

Oregon Health Plan Enrollees, December 2006

As of December, 2006 there were 11,490 Oregon Health Plan enrollees in Deschutes County. Of those, 438 people were enrolled in the OHP Standard plan, which makes them "open card" patients. While they are permitted to seek care from any provider, there is no requirement that providers accept them as patients. The result has been an inability for many with OHP Standard coverage to access care and establish a medical home.

POVERTY, HUNGER & HOMELESSNESS

Poverty: Individuals Living in Poverty, 2000 vs 2005



In Deschutes County, a total of 9,072 individuals, including 1,522 children, were living in poverty in 2005.
 Source: U.S. Census Bureau, American Community Survey, 2005

HOMELESSNESS

Tri-County Homeless Count, 7/26/06

- 1,144 individuals
- 727 adults (64%)
- 417 were children under the age of 18 (36%)
- 154 were under the age of 6 years

On January 26, 2006, the Homeless Leadership Council, with the help of 264 volunteers, conducted a count of homeless residents in Oregon, Deschutes, Jefferson and Crook counties. The primary self-reported reason for homelessness was economic hardship as 44% reported that they were homeless because they could not afford rent. Only 365 people (27%) had access to some form of shelter by a local housing provider. The remaining 979 (73%) were living with family or friends, living outdoors or in cars, or staying in their rooms. Currently there are only 195 emergency shelter beds and 145 transitional housing beds available in the region.

Homeless Students, 2005/06 School Year

A total of 334 homeless students were identified in Deschutes County during the 2005/06 school year, statewide 13,159 homeless students were identified. These numbers are thought to be significant undercount as many students, especially at the high school level, do not want it known that they are homeless.

- Unexpected events, such as paying for an emergency visit to the hospital or a car repair, can quickly force families into poverty.

- In 2005, there was a monthly average of 13,712 participants in Deschutes County's Food Stamp Program.

- During the 2005-06 school year, 33.7% of students in Deschutes County public schools were approved for Free and Reduced Lunch Programs.

Source: Oregon Department of Education

HUNGER

Oregon's national hunger ranking has dropped from #1 in 2002 to #17 in 2004, according to the United States Department of Agriculture. The change is thought to be the result of improved food stamp outreach and increased funding for and use of emergency food. While access to food has improved, it is important to note that the poverty still exists, and many families are often forced to choose between food and other expenses.

Food Bank Programs, 2005

While the Deschutes County population increased by 24% from 2000-2005, the number of people accessing food bank programs each month increased by 45%. This increase may be a reflection of the rising cost of living coupled with local wages that have not kept pace with housing and energy costs.

- Monthly average of individuals receiving food through emergency food bank programs in Deschutes County: 4998

Source: NeighborImpact

ADULT CHRONIC DISEASE

Many factors contribute to developing chronic disease. Many of these factors are lifestyle behaviors that can be modified. By altering behaviors, we can reduce the risk of developing heart disease, stroke, cancer, diabetes, lung disease and arthritis. For people diagnosed with chronic conditions, good disease management, including changes in nutrition and physical activity, dramatically reduces the risk of complications.

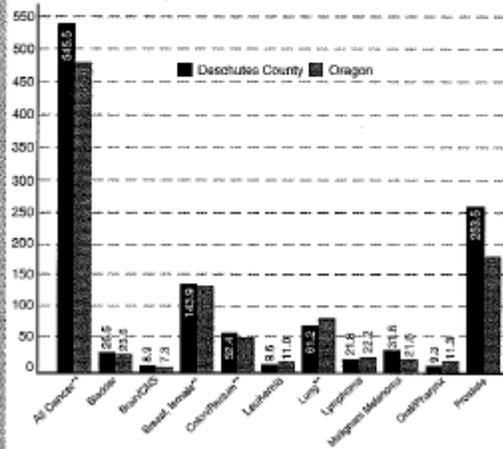
Communities, schools, worksites and health care sites can support and promote healthy behaviors through policies and environments like smoke-free worksites, healthy cafeteria meals, sidewalks and bike paths, incentives for bicycle and pedestrian commuters, worksite health promotion programs, and insurance coverage for preventive services such as mammography and tobacco cessation.

Cancer Cases and Deaths Deschutes County, 1999-2003

Type of Cancer	Number of Malignant Cases	Number of Deaths	Mortality to Incidence Ratio*
All Cancers	707	232	30
Bladder	38	5	13
Brain/CNS	13	3	23
Breast, female	58	17	29
Colon/Rectum	67	21	31
Leukemia	12	3	25
Lung	80	64	80
Lymphoma	39	10	26
Malignant Mesothelioma	44	6	14
Oral Pharynx	12	5	42
Prostate	139	11	8

*Mortality to incidence ratio (MIR) provides a measure of disease severity. The lower the ratio, the less severe the disease. For example, a ratio of 100 indicates that for every 100 cases, 100 people die. A ratio of 10 indicates that for every 100 cases, only 10 people die. Source: DHS-Oregon Cancer Registry (OSCaR), 2004

Rates* of Cancer Cases, 1996-2003



* Age-Adjusted Rate per 100,000 ** Data range is 1999-2003
Source: DHS-Oregon Cancer Registry (OSCaR), 2004

Cardiovascular Disease

	Deschutes County	Oregon	Healthy People 2010 Objective
Coronary Heart Disease	3.3%*	3.6%*	
Heart attack	3.9%*	3.6%*	
Stroke	2.3%*	2.6%**	
Heart disease death rate	161.42***	179.23**	166
Stroke death rate	40.15***	51.94**	48

* Behavioral Risk Factor Surveillance System, 2002-2005 combined dataset
** Behavioral Risk Factor Surveillance System, 2005
*** Age-Adjusted death rate per 100,000 population - Oregon Death Certificates, 2004

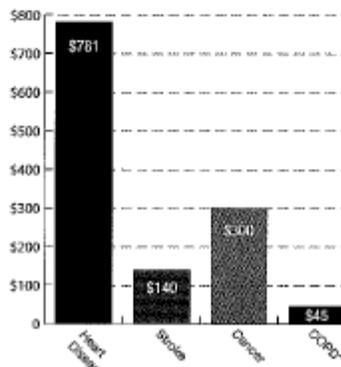
Cardiovascular disease (CVD) includes coronary heart disease, atherosclerosis, stroke and high blood pressure. It is the number one cause of death and disability in the United States and in Oregon.

Source: DHS-Oregon Heart Disease and Stroke Prevention Program

The Economic Impact of Cardiovascular Disease

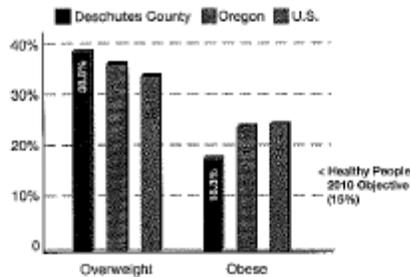
There were over 40,000 hospitalizations of Oregonians for cardiovascular disease in 2004 (State Hospital Discharge Index), resulting in more than \$1.1 billion in hospital costs for heart disease, stroke, and related diseases. Cardiovascular disease-related hospitalizations greatly exceeded the costs of other chronic disease-related causes of hospitalization (see graph below). It is important to recognize that hospitalization costs reflect only a portion of the full financial burden of cardiovascular disease. Other expenditures include medications, rehabilitation, outpatient care, long-term care, and loss of productivity.

Hospitalization Costs by Principal Diagnosis, 2004



*Chronic obstructive pulmonary disease
Source: DHS/Oregon Heart Disease and Stroke Prevention Program, Oregon Heart Disease and Stroke Rates, 2006; Oregon Hospital Discharge Index

Overweight and Obesity* among Adults, 2005

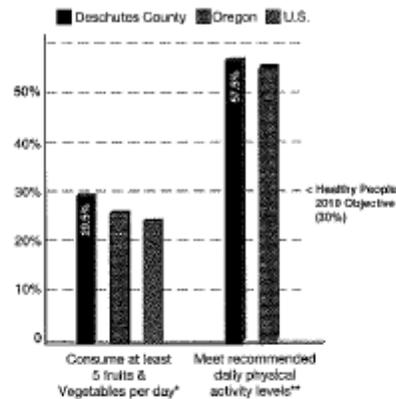


*In adults, obesity is defined as a Body Mass Index (BMI) of 30 kg/m² or more; overweight is a BMI of 25 kg/m² or more. BMI is calculated as weight in kilograms (kg) divided by the square of height in meters (m²).

Overweight and obesity are major contributors to many preventable causes of death. Being overweight or obese substantially raises the risk of illness from high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and problems breathing, and certain types of cancers.

Source: Centers for Disease Control and Prevention, State-Specific Prevalence of Obesity among Adults - United States, 2003, MMWR September 13, 2005, 30 (No. 38), Behavior Risk Factor Surveillance System

Nutrition and Physical Activity in Adults, 2002-2005



* U.S. percentage is from 2005 only

** moderate-intensity physical activity for 30+ minutes per day

Source: Behavior Risk Factor Surveillance System; DHSH Health Promotion and Chronic Disease Prevention Program

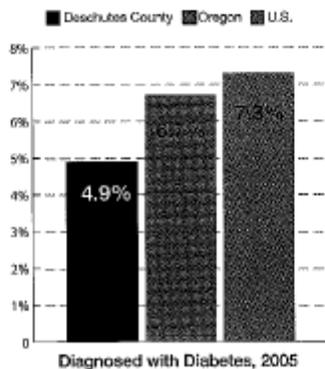
Chronic diseases are heavily impacted by poor nutrition and lack of physical activity. Deschutes County falls far short of the Healthy People 2010 objective for improved nutrition which calls for 75% of the population to consume the minimum servings of fruits (two daily servings) and 50% to consume the minimum servings of vegetables (three daily servings with at least 1/3 being dark green/deep-yellow). However, the County exceeds Healthy People 2010 objective for daily physical activity levels.

Source: Behavior Risk Factor Surveillance System; DHSH Health Promotion and Chronic Disease Prevention Program.

Diabetes

Diabetes can lead to serious complications and premature death. People with diabetes can take steps to control the disease and lower the risk of complications. Type 2 diabetes accounts for about 90 percent to 95 percent of all diagnosed cases of diabetes. Many people with type 2 diabetes can control their blood glucose levels by following a healthy meal plan and exercise program, losing excess weight, and taking oral medication. Risk for the development of type 2 diabetes include older age, obesity, a family history of diabetes, a history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity. Recent studies suggest that type 2 diabetes in children and adolescents, although still rare, is being diagnosed more frequently. This trend is thought to be tied to rising obesity rates in children and adolescents.

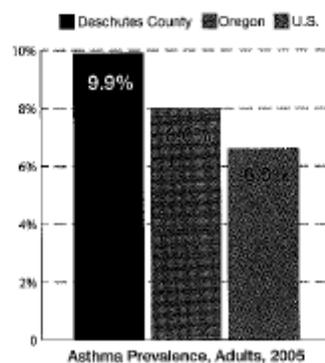
Source: American Diabetes Association, 2005. Diabetes and Its Complications, 4th Edition, 141-149, 2005.



Asthma

Asthma is a lung disease that can be chronic and life threatening. Triggers include viruses, allergies, tobacco smoke, and gases and particles in the air. Smoking exposure to asthma or allergy triggers can often control asthma.

Source: American Lung Association, 2005. Asthma, 10th Edition, 10-11, 2005.

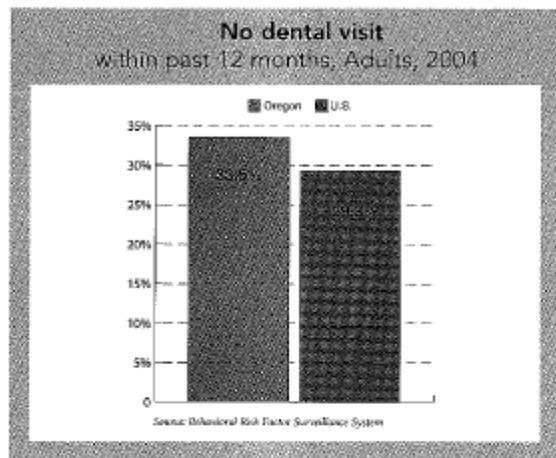
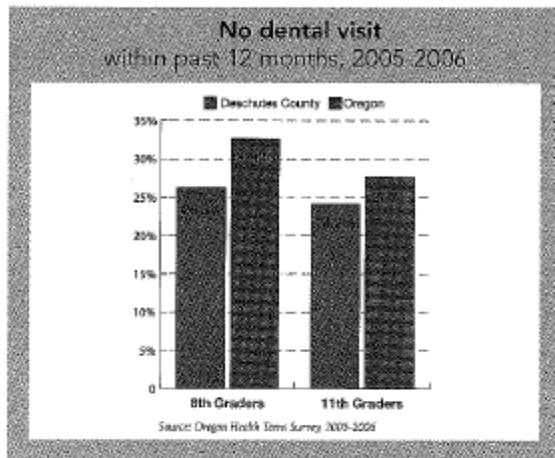


ORAL HEALTH

Although tooth decay is largely preventable, it remains the most common chronic disease of children age 5 to 17 years—5 times more common than asthma. Untreated decay can lead to infection, pain, and the loss of teeth. Poor children have nearly 12 times more restricted-activity days because of dental-related illness than children from higher-income families. Pain and suffering due to untreated tooth decay can

lead to problems in eating, speaking, and learning. Many adults also have untreated tooth decay: In the U.S., 27% of those 35 to 44 years old and 30% of those 65 years and older. Emerging evidence points to a strong link between oral diseases and many medical conditions and poor health outcomes.

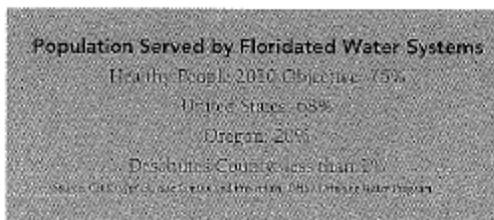
Source: Centers for Disease Control and Prevention, Preventing Dental Caries



Fluoridated Water

Fluoridation of community water is the single most effective public health measure to prevent tooth decay and improve oral health over a lifetime. More than 50 years of scientific research has found that people living in communities with fluoridated water have healthier teeth and fewer cavities than those living where the water is not fluoridated. While many communities have naturally occurring fluoride at levels sufficient to prevent tooth decay, there are thousands of communities where naturally occurring fluoride levels are deficient. It is in these places that small amounts of fluoride have been added to drinking water supplies, resulting in decreasing rates of tooth decay. Water fluoridation is extremely cost effective. Every dollar spent on community water fluoridation saves from \$7 to \$42 in treatment costs, depending on the size of the community.

Source: Surgeon General Statement on Community Water Fluoridation, December 3, 2007, BHS/Oral Health Program



Dental Care During Pregnancy

Fewer than half the women in Oregon seek needed dental care during pregnancy, and only one-third receive education on how to care for their infant's teeth.

Source: DHS / Oral Health Program

MENTAL HEALTH

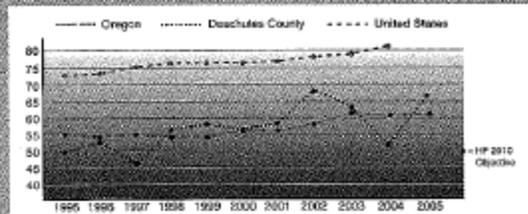
The National Institute of Mental Health estimates that 26.2% of Americans ages 28 and older (about one in four adults) suffer from a diagnosable mental disorder in a given year. When applied to the 2006 population estimates for Deschutes County, this figure translates to 29,546 Deschutes County residents. Although mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion: About 6% or 1 in 17, who suffer from a serious mental illness. Applied to Deschutes County, that would equal 6,938 individuals.

The annual prevalence of mental disorders among older adults (ages 55 years and older) is not as well documented as that for younger adults. The experience of loss with aging (loss of physical capacities, loss of social status and self-esteem, and the death of friends and loved ones) can lead to bereavement-associated depression. Among adults, suicide rates increase with age and are very high among those 65 years and older.

Source: CDC, U.S. Department of Health and Human Services, 2007

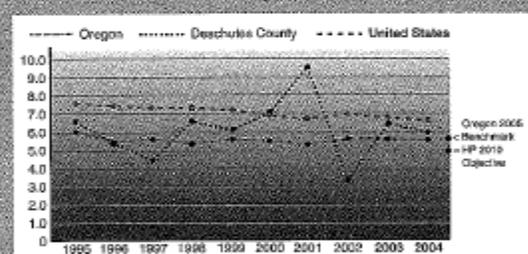
MATERNAL, CHILD & ADOLESCENT HEALTH

Low Birthweight Rate of Low Birthweight* Infants per 1,000



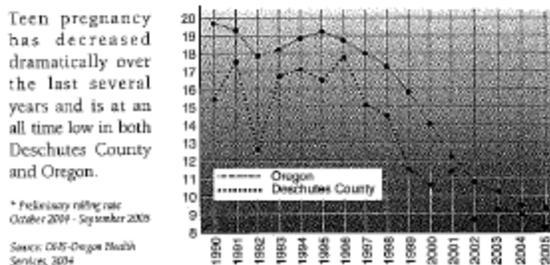
*Low birthweight is defined as under 2,500 grams
 Source: DHS/Oregon Center for Health Statistics; CDC National Center for Health Statistics
 Deschutes County is still far from meeting the Healthy People 2010 objective of 50 low birthweight infants per 1,000 births. Low birthweight infants who survive are at increased risk for health problems ranging from neurodevelopmental disabilities to respiratory disorders.

Infant Mortality Rate of Infant Mortality* per 1,000 Live Births



*Infant mortality is defined as the death of a child prior to its first birthday.
 Source: DHS-Oregon Health Services, 2007
 While the Deschutes County infant mortality rate has been consistently lower than the national rate, it is still significantly higher than the Healthy People 2010 objective of 4.5 per 1,000 live births. Factors that effect infant mortality include smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness. Early and continuous prenatal care helps identify conditions and behavior that can lead to infant deaths.

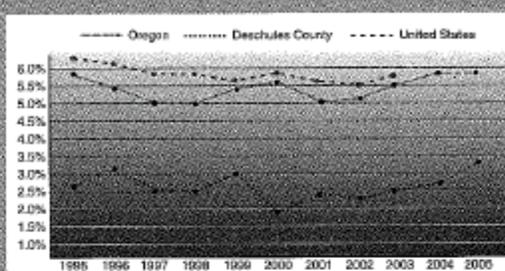
Teen Pregnancy Rate of Teen Pregnancy per 1,000 Females Ages 10-17



Teen pregnancy has decreased dramatically over the last several years and is at an all time low in both Deschutes County and Oregon.

*Fettersing rifing rate
 October 2009 - September 2005
 Source: DHS-Oregon Health Services, 2004

Prenatal Care Percent of Pregnant Women getting Inadequate Prenatal Care*



*Inadequate prenatal care is defined as care that began in the third trimester or consisted of less than five prenatal visits.
 Source: DHS/Oregon Center for Health Statistics

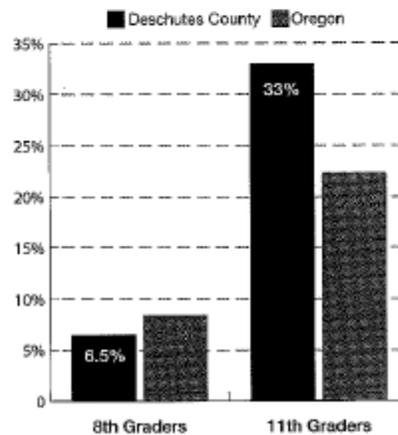
Percent of Women Receiving First Trimester Care

	1999	2000	2001	2002	2003	2004	2005
Deschutes County	81.3%	80.7%	80.7%	81.5%	80.0%	80.0%	80.2%
Oregon	80.9%	81.1%	81.5%	81.6%	81.1%	80.4%	81.0%
United States	81.3%	81.1%	81.3%	81.0%	81.1%	80.9%	80.8%
OR 2005 Benchmark	>>85%						
Healthy People 2010	>>85%						

Deschutes County has consistently ranked among the top Oregon counties with the highest rates of first trimester prenatal care. Early and continuous prenatal care is an important way to improve the long-term health of mothers and to prevent adverse birth outcomes.

* N/A = Not Available
 Source: DHS/Center for Health Statistics; CDC National Center for Health Statistics

Sexual Intercourse with Two or More Partners, 2005-2006



Source: Oregon Health Survey, 2003-2006

Breastfeeding

The American Academy of Pediatrics (AAP) recommends that breastfeeding continue for at least one year. Breastfed babies are sick less than babies who are fed infant formula, and they have fewer ear aches, allergies, colic, and illnesses. These babies are also less likely to develop chronic conditions, including obesity and diabetes later in life. Oregon's Women, Infants, and Children (WIC) program ranks first in the nation for breastfeeding initiation at 64%. This Deschutes County initiation rate is even higher. Of infants born between January 1, 2008 and September 25, 2008, who were enrolled in Deschutes County WIC and had their first certification for breastfeeding on file at age 9, 73% initiated breastfeeding. Both the County and State rate far surpass the Healthy People 2010 objective of 75% breastfeeding initiation.

Source: Deschutes WIC Office, Oregon Health Division

Immunization

Vaccination-based immunization rates are calculated to reflect the percentage of children considered "up to date" on their immunizations by two years of age. The rates are affected by multiple factors, including parental choice to delay vaccination and clinical decisions to provide vaccines at intervals different from the Recommended Schedule*. The vaccines included prevention diseases: diphtheria, tetanus, pertussis, whooping cough, measles, mumps, rubella, Haemophilus influenzae type B, hepatitis B, and chicken pox.

Percentage of Two-year-olds Fully Covered with Recommended* Vaccines, 2005

Deschutes County: 51.0% Oregon: 71.8%

*The recommended schedule for the delivery of immunization is provided by the American Academy of Pediatrics, which recommends that the routine childhood immunization schedule and schedule of immunizations for children ages 0-6 years be followed. ACOG's recommendations to the federal government, which makes such recommendations.

Source: CDC, Immunization Schedule

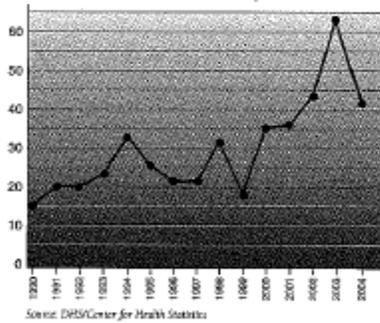
ADOLESCENT SUICIDE

In 2004, suicide claimed the lives of 67 Oregon youth aged 10-24 years. Suicide was the second leading cause of death among Oregonians aged 10-24 years. Oregon's youth suicide rate has been higher than the national rate for decades. For every suicide death among youth under 18 years, there are an estimated 134 suicide attempts that are treated in hospital emergency rooms. In Oregon in 2004, 81% of suicide

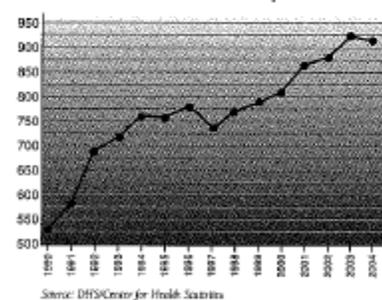
deaths in youth 24 years and under were among males, while 19% were among females. Firearms were used in 54% of Oregon youth suicide deaths. Factors associated with youth suicide include: prior suicide attempt, history of depression, substance abuse, family history of suicide, incarceration, firearm access and feelings of hopelessness.

Source: DHS/Center for Health Statistics, Youth Suicide Facts, 2006; Oregon Vital Statistics Annual Report, 2006, Volume 2, Morbidity

Deschutes Co. Adolescent Suicide Attempts*



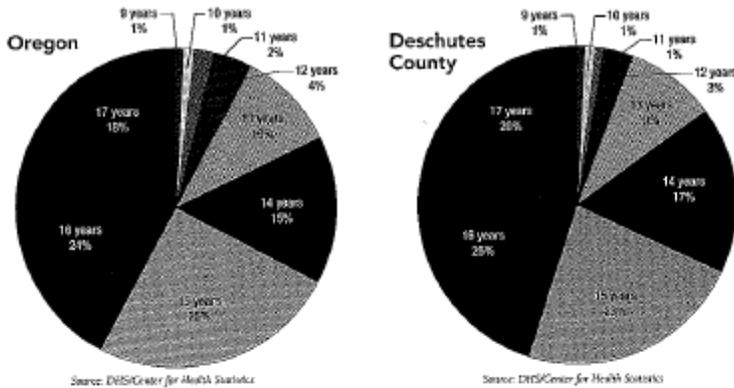
Oregon Adolescent Suicide Attempts*



*These numbers reflect suicide attempts resulting in hospitalizations or deaths of children ages 10-17.

When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied.
Hippocrates, Greek physician (437 BC - 356 BC)

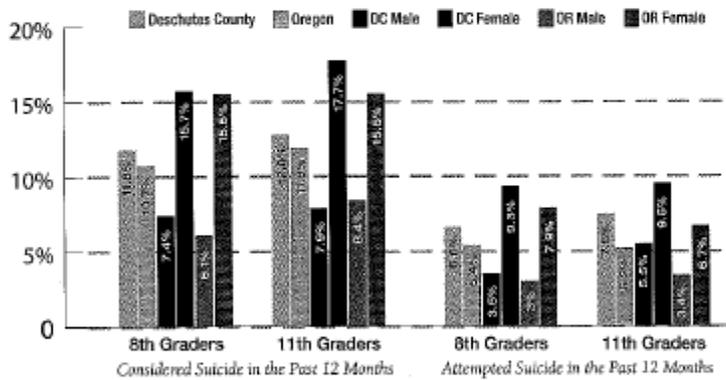
Percentage of Adolescent Suicide Attempts by Age, 2000-2004



Reasons given for Suicide Attempts, Oregon Minors, 2004

Reasons	Total
Total	652
Family Discord	487
School Related Problems	246
Arguments w/ Boy/Girlfriend	100
Substance Abuse	118
Peer Pressure/Conflict	82
Rape or Sexual Abuse	63
Death of Family Member/Friend	49
Move or New School	47
Physical Abuse	42
Problems with the Law	34
Suicide by Friend/Relative	22
Pregnancy	7
Other Reasons	143

Adolescent Mental Health
8th and 11th Graders, 2005-2006



Protective Factors

- that shield people from the risks associated with suicide
- Family and community support
 - Skills in problem solving, conflict resolution, and nonviolent handling of disputes
 - Cultural and religious beliefs that discourage suicide and support self-preservation instincts
 - Effective clinical care for mental, physical, and substance use disorders
 - Easy access to a variety of clinical interventions and support

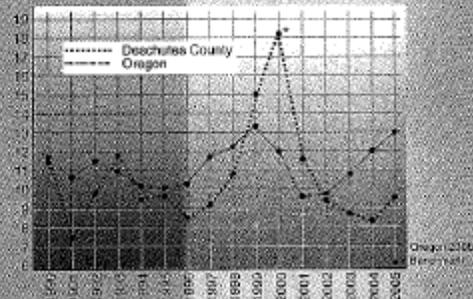
Child Abuse and Neglect

Foster Care - 10.1% of children in foster care in Deschutes County did not have stable placements in 2003, meaning that they were moved three or more times in the previous 12 months. Nationwide, the percentage is 14.4%.

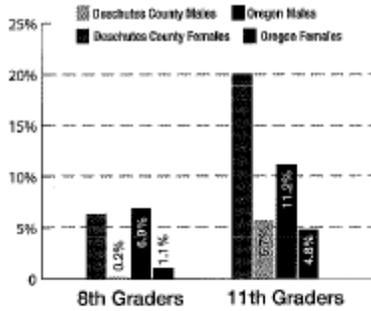
Recurrence of Maltreatment - In 2003, 10.2% of child abuse/neglect victims in Deschutes County were re-abused within six months of prior victimization. Statewide, the percentage is 12.2%.

Rate of Children (under 18 years) who were Abused or Neglected**

**The rate is calculated as the number of children under 18 years of age who were abused or neglected in a given year divided by the total number of children under 18 years of age in that year.

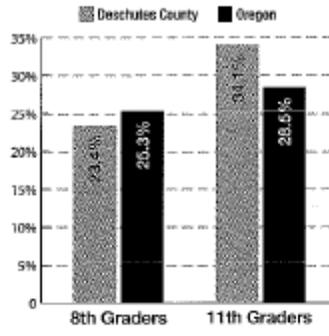


Sexual Contact from an Adult at Any Time During Life



Source: Oregon Health Trends Survey, 2005-2006

Intentional Physical Harm by an Adult



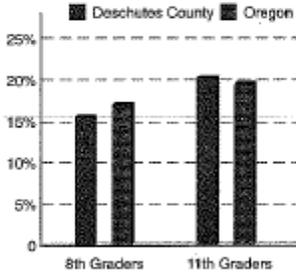
Source: Oregon Health Trends Survey, 2005-2006

KIDS Center

The KIDS Center serves approximately 450 children annually who need evaluation and treatment for sexual abuse, physical and emotional abuse, and neglect. The Center is also spearheading a revolutionary sexual abuse prevention training and outreach program in Central Oregon. This national research-based program, called Darkness to Light, educates adults to prevent, recognize, and react responsibly to child sexual abuse. It's estimated that for every adult trained in this program, 10 children are better protected. To find out more, call the KIDS Center Prevention Program at 541-312-5092.

CHILDHOOD CHRONIC DISEASE

Asthma in Children
Diagnosis of Asthma, 2005-2006



Childhood asthma is a disorder with genetic predispositions and a strong allergic component. Approximately 75 to 80 percent of children with asthma have significant allergies. Asthma is controllable through the proper use of medications and the reduction of exposure to asthma triggers.

Source: Oregon Health Trends Survey, 2005-2006; American Lung Association

Diabetes in Children

The national prevalence of diagnosed diabetes among people under 20 years of age is 0.22%. Applying this percentage to the local level, approximately 90 Deschutes County residents under 20 years of age are likely to have diabetes. Recent studies suggest that type 2 diabetes in children and adolescents (previously thought of as adult-onset diabetes), although still rare, is being diagnosed more frequently. This trend is thought to be due to rising obesity rates in children and adolescents.

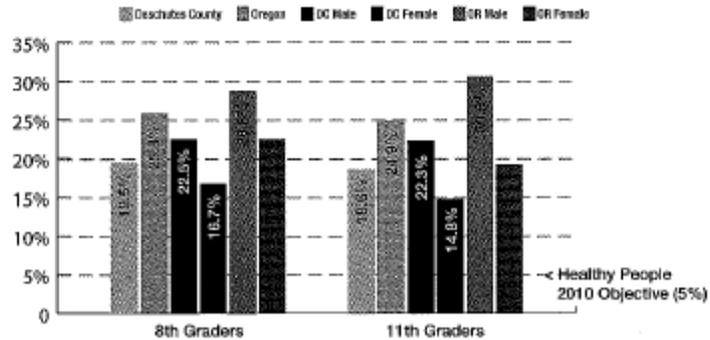
Source: American Diabetes Association, 2006

Overweight & Obesity* in Children
Overweight or At Risk for Overweight, 2005-2006

There has been a startling rise in obesity rates in children over the past two decades. The trend is occurring throughout the United States, in all age groups, across all socioeconomic strata, and among all ethnic groups. Although Deschutes County is doing better, compared to Oregon as a whole, the percentage of overweight and obese children in this County still far exceeds the Healthy People 2010 objective, which calls for only 5% of children and adolescents as overweight or obese.

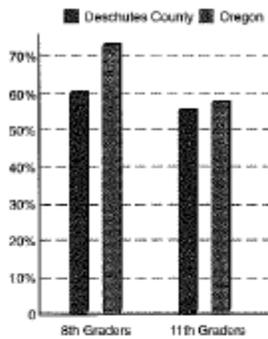
*Obesity (BMI of 30 or more) and overweight (BMI of 25 or more) are defined as 20% above the ideal and 10% above the ideal, respectively. BMI based on CDC growth charts.

Source: Oregon Health Trends Survey, 2005-2006; Healthy People 2010



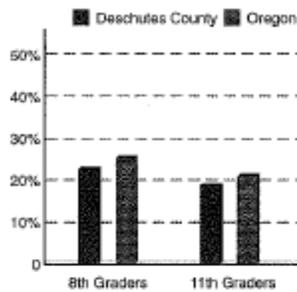
Nutrition and Physical Activity in Children

Physically Active Four or More Days During the Past Week*, 2005-2006



*For a total of at least 60 minutes per day
Source: Oregon Health Tests Survey, 2005-2006

Consumption of 5 Fruits and Vegetables Daily, 2005-2006



Source: Oregon Health Tests Survey, 2005-2006

Public Health Defined

"Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy."

Institute of Medicine

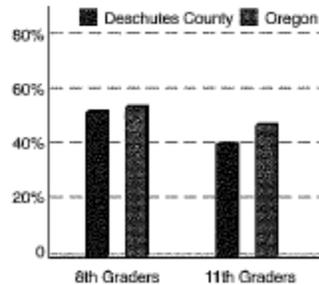
Regular physical activity and the consumption of a sufficient serving of fruits and vegetables are two key factors thought to have a protective effect against certain chronic, or "lifestyle," diseases such as diabetes and high blood pressure, and is an effective way to reduce obesity. Deschutes County eighth and eleventh graders fall short of state averages for both physical activity and daily consumption of fruits and vegetables.



Screen Time

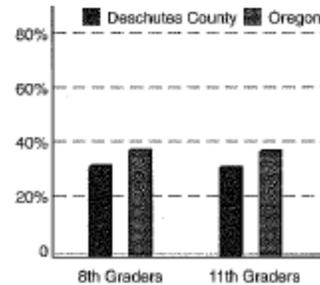
The amount of time spent watching a computer monitor, video games, and text messaging has become known as "screen time." Significant attention to all of these various types of media is expected to be a contributing factor to rising obesity trends throughout the country. According to a 2005 Kaiser Family Foundation report, children ages 8 to 18 spend more time (49.5 hours per week) in front of a computer, television, and game console than any other activity in their lives except sleeping.

Spend 2+ Hours Watching TV Daily* 2005-2006



*on an average school day
Source: Oregon Health Tests Survey, 2005-2006

Spend 2+ Hours on Internet or Video Games Daily* 2005-2006



*on an average school day
Source: Oregon Health Tests Survey, 2005-2006

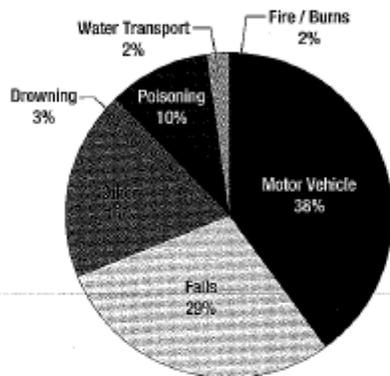
UNINTENTIONAL INJURY

Injuries, both violent and unintentional, are a significant public health issue. According to the Centers for Disease Control and Prevention, injuries claim more potential years of life lost prematurely before age 65 than any other cause of death. While injury is the fourth leading cause of death in the United States, it is the **leading cause of death for children and young adults** between 1 and 44 years of age. Extensive research has shown that injuries are similar to diseases in that injuries are not accidents, do not occur at random, and have identified risk and protective factors making them preventable.

For children in particular, risk occurs primarily because of environments where heavy neighborhood traffic makes outdoor play areas unsafe or where safety devices, such as bicycle helmets, car seats, or smoke detectors, are unaffordable or may seem less important than other necessities. By implementing proven interventions, such as child car seats, environmental measures to lessen traffic speed and volume in neighborhoods, bicycle helmets, and smoke detectors, injury deaths among children can be reduced significantly.

Sources: Centers for Disease Control and Prevention, Society for Public Health Education

**Unintentional Injury Deaths
Deschutes County, 2004**



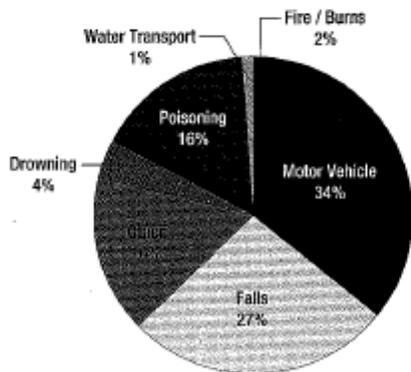
Source: DHS/Center for Health Statistics

	1999	2000	2001	2002	2003	2004	Total
Oregon	1,144	1,211	1,257	1,392	1,368	1,423	7,895
Deschutes County	30	45	42	39	56	53	279

Of the 279 unintentional injury deaths in Deschutes County, 133 were due to motor vehicle accidents (47.7%). Fifty-six were due to falls (20.1%).

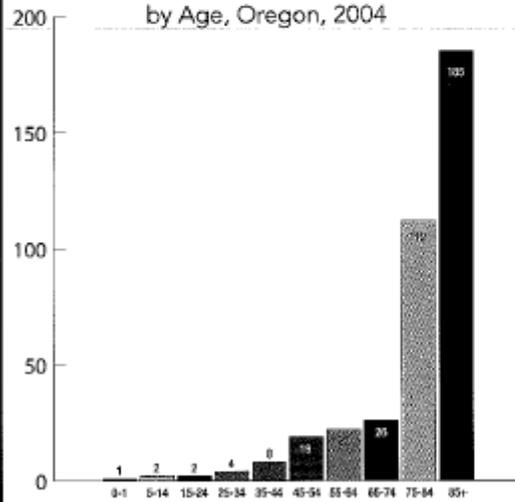
Source: DHS/Center for Health Statistics

**Unintentional Injury Deaths
Oregon, 2004**



Source: DHS/Center for Health Statistics

**Unintentional Fatal Falls
by Age, Oregon, 2004**



The risk of fatal falls increases significantly with age. While the all-age death rate for Oregon is 10.63 per 100,000, the death rate for those 75 years and older is 129.58. Many falls can be prevented through modifications to the living environment, regular vision checks, and exercise.

Source: DHS/Center for Health Statistics, Centers for Disease Control and Prevention

Domestic Violence

Intimate partner violence (IPV) is a public health problem that impacts individuals, families, and communities throughout Oregon. A survey conducted in 2001-2002 found that one in ten Oregon women age 18-55 experienced IPV (defined as physical and/or sexual assault by an intimate partner) in the five years preceding the survey, equating more than 85,000 women applied to the local level, that would equal approximately 11,000 women in Deschutes County.

- The Central Oregon Rape and Rape Alliance (CORRA) answered 1,930 hotline calls from Deschutes County residents in 2005.

- CORRA provided shelter to 125 adults and 148 children in Deschutes County in 2005.

Source: CDC, National Violence Against Women Survey and Rape, Abuse, and Incest National Center (RAINN), 2005

All-Terrain Vehicle (ATV) Deaths and Injuries

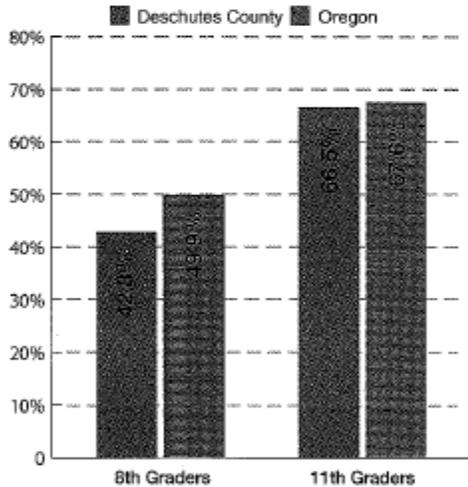
- In the United States, between 1982-2005, there were 5,799 ATV-related deaths. Thirty-two percent of those deaths occurred among children under age 16.

- In Oregon, between 1999-2004, 16 children under age 18 died as a result of ATV-related injuries. The average age of death was 11.7 years. Only two of these children were wearing a helmet at the time of the incident.

- Since 1999, the number of hospital admissions among children in Oregon for major trauma due to ATV-related injuries has increased by 146.

Source: CDC, National Center for Injury Prevention and Control, 2006

Rarely or Never Wore a Bike Helmet During Past 12 months*, 2005 - 2006



*Among those who rode a bicycle during that time
Source: DHS/Office of Disease Prevention and Epidemiology, CD Summary, May 18, 2006

Concussion in Teen Sports

Mild Traumatic Brain Injury (MTBI), commonly known as concussion, arises from blunt trauma or acceleration or deceleration forces to the head. While many youth - and even coaches or parents - may not consider the injury serious, the reality is that up to 15% of MTBI patients experience persistent disabling conditions. In addition, youth who have sustained and MTBI and return to play before healing has occurred are three times more likely to sustain another MTBI, which can cause longer-lasting damage, such as brain swelling, permanent brain damage, and (rarely) even death.

Oregon data: Using injury rates from a recent study conducted by the Centers of Disease Control and Prevention, the Oregon Injury Prevention Program estimated that at least 8,500 injuries, including 678 MTBIs, were experienced by Oregon student athletes in the 2004-2005 school year.

Source: CD Summary, December 21, 2006, Vol. 35, No. 23; DHS/Injury Events in Progress; Centers for Disease Control and Prevention

Sport	MTBI as % of injuries	Estimated concussions	Rate / 1000 exposures
Girls soccer	15%	96	0.35
Girls basketball	12%	86	0.24
Boys basketball	3%	28	0.07
Football	10%	348	0.44
Boys soccer	10%	72	0.23
Wrestling	5%	34	0.12

Violent Injury Firearm Deaths, 1997 - 2004

	1997	1998	1999	2000	2001	2002	2003	2004
Oregon	428	441	391	378	360	376	303	383
Deschutes County	15	13	13	N/A*	16	21	12	17

*County level data not available for 2000

Source: DHS/Center for Health Statistics

Of the 107 firearm deaths in Deschutes County, 1997-2004 (excluding 1999), 91 were due to suicide (85%). In Oregon, of the 3,150 firearm deaths, 2,493 were due to suicide (79%).

SUBSTANCE ABUSE

Tobacco Adults

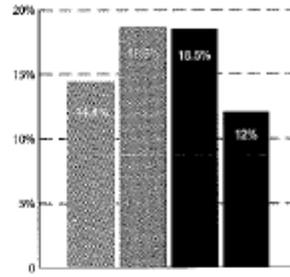
Tobacco use remains the leading preventable cause of death in the United States, causing nearly 440,000 deaths each year, and resulting in an annual cost of more than \$73 billion in direct medical costs. More than 8.6 million people in the United States have at least one serious illness caused by smoking. Tobacco use is steadily declining in Deschutes County but still remains higher than both state and national objectives. Rates are especially high among County youth.

In 2006, 22.6% of all deaths in Deschutes County were tobacco-related. Tobacco-related deaths are mainly due to three causes: cardiovascular disease, cancer, and respiratory disease.

Source: CDC WONDER, 2006

Tobacco Use (Smoking), Adults, 2005

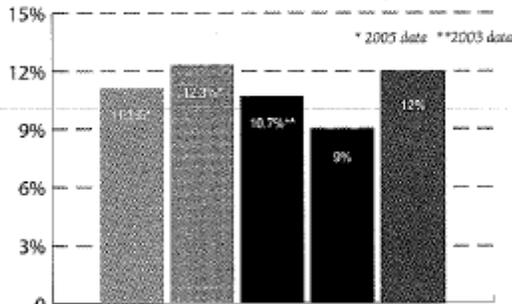
Deschutes County Oregon United States Healthy People 2010 Objective



Source: Oregon Tobacco Prevention and Education Program, Behavioral Risk Factor Surveillance System, 2005; Centers for Disease Control and Prevention

Pregnant Women Who Use Tobacco (Smoking)

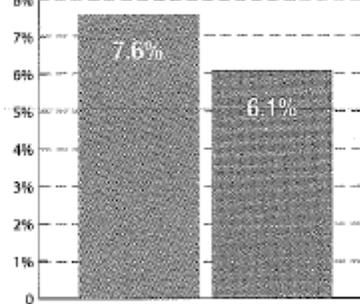
Deschutes County Oregon United States 2005 Oregon Benchmark Healthy People 2010 Objective



Source: Oregon Tobacco Prevention and Education Program, Behavioral Risk Factor Surveillance System, 2005; Centers for Disease Control and Prevention

Smokeless Tobacco*, Adults, 2005

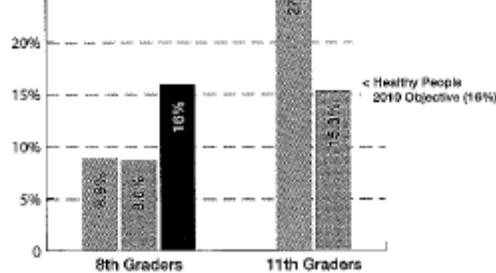
Deschutes County Oregon



Source: Oregon Tobacco Prevention and Education Program

8th and 11th Graders who Smoked Cigarettes in the Past 30 Days, 2005-2006

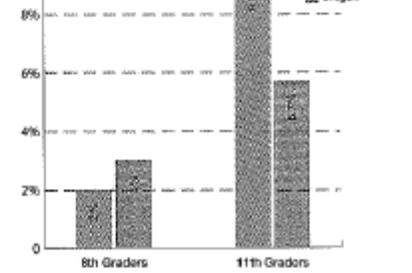
Deschutes County Oregon Oregon Benchmark



Source: Oregon Healthy Teens Survey, 2005-2006; Centers for Disease Control and Prevention

8th and 11th Graders Who Used Smokeless Tobacco in the Past 30 Days, 2005-2006

Deschutes County Oregon



Source: Oregon Healthy Teens Survey, 2005-2006

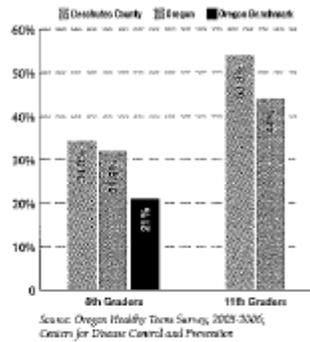
ALCOHOL AND ILLICIT DRUG USE

Alcohol is the most commonly used and abused drug among youth in the United States. Age at first use of alcohol is an important indicator of future consumption. Youth who use alcohol before the age of 15 are five times more likely to develop alcohol dependence as an adult.

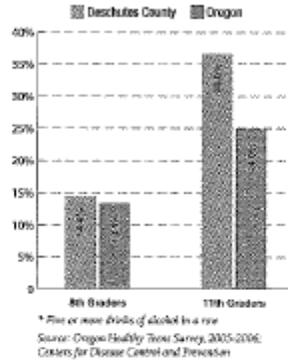
These youth are also more likely to develop other drug dependency problems. Prevention and intervention can help to reduce risk factors and boost protective factors that guard against initiation of alcohol and drug use.

Source: Centers for Disease Control and Prevention

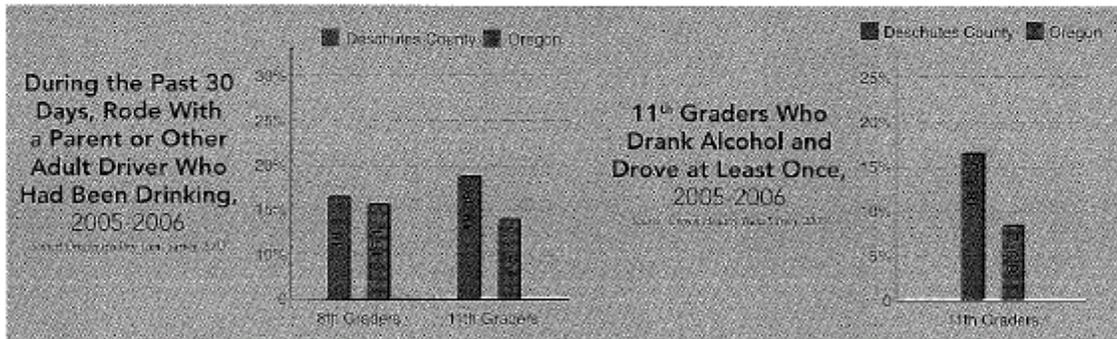
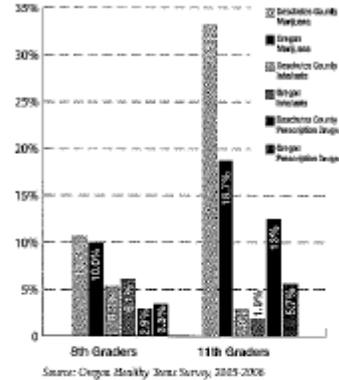
**8th and 11th Graders:
Use of Alcohol at Least Once
in the Past 30 Days, 2005-2006**



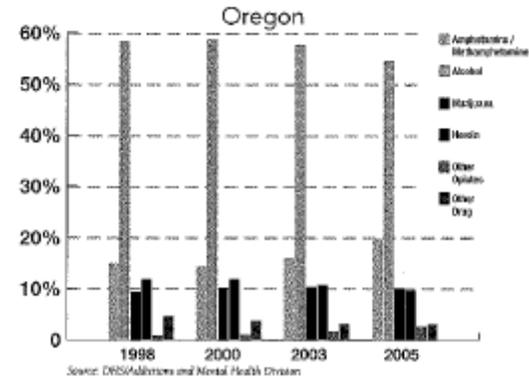
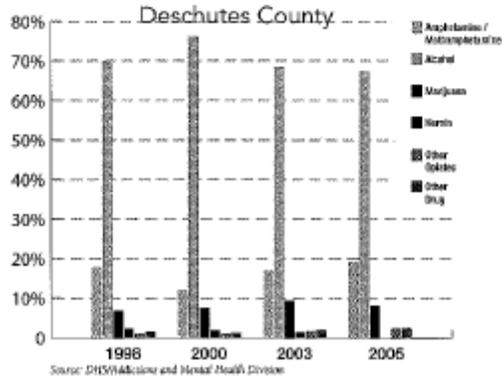
**8th and 11th Graders:
Binge Drinking*
in the Past 30 Days, 2005-2006**



**8th and 11th Graders:
Use of Illicit Drugs with
the Past 30 Days, 2005-2006**



Treatment by Primary Substance Abused



METHAMPHETAMINE

Methamphetamine (or "meth") is a highly addictive, synthetic stimulant drug that affects the central nervous system. The ingredients used to manufacture meth are highly toxic and include benzene, para-chloroamine, Dime, butane, acid,ephedrine, white gas, water, lard, and more. Chronic meth use can lead to psychotic behavior and debilitating side effects, such as extreme weight loss, the development of open sores on the face and arms, cardiovascular complications, and a severe decline in oral health. The manufacture of meth exposes humans, animals, and the environment to toxic and explosive chemicals.

Disease Transmission

Disease transmission among meth users is a very real possibility. In a July 2005 survey of Deschutes County jail inmates, 98% of admitted meth users acknowledged injection as the primary route of drug use. Other injection drug users have reported that within the past six months they had used needles or other injection equipment that had been previously used by someone else. Because of this, injection drug users are vulnerable to a diverse range of infectious and communicable diseases, including HIV and hepatitis C, which can result in considerable morbidity and mortality. It can also result in the spread of these diseases to others in the community, including those who do not use drugs. Unfortunately, intensive treatment geared for meth addicts is limited in Central

Oregon. Users often face a wait of up to two weeks for treatment, during which time many of them relapse.

- In 1999, Deschutes County was designated a High-Intensity Drug Trafficking Area (HIDTA), a federal label for areas within the United States that exhibit serious drug-trafficking problems.

- In 2005, the Deschutes County Sheriff's Office had 378 arrests due to meth possession - 14% of the total arrests for the year.

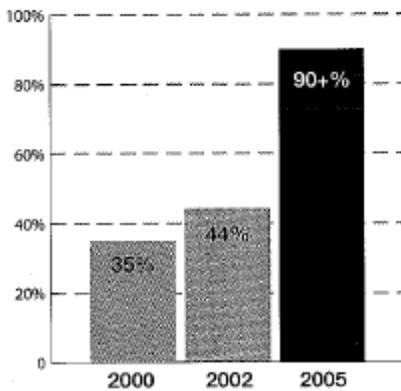
Meth Seizures

- From 11/04 to 3/06, the CODE Team* seized 12.8 pounds of meth.
- From 7/05 to 9/06, the CODE team seized 2.4 pounds of meth.
- During just the first quarter of 2007, the CODE team seized over 9.5 pounds of meth.

The Central Oregon Drug Enforcement Unit and other law enforcement agencies patrol the area in search of activities from the Bend Police Department, Coquille County Sheriff's Department, Rainier Police Department, Elsie Sheriff's Department, Lake County Sheriff's Department, Local County Sheriff's Department, Jefferson County Sheriff's Department, Deschutes County Sheriff's Office, and the Deschutes County Drug Enforcement Administration, and the Oregon National Guard.

*The CODE team consists of the Bend Police Department, Coquille County Sheriff's Department, Lake County Sheriff's Department, and the Oregon National Guard.

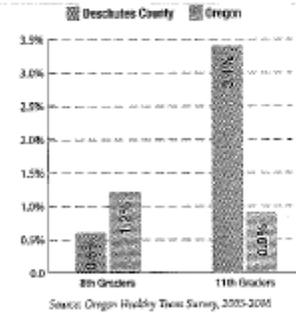
Purity* of Meth seized in Central Oregon



*The purity of meth directly relates to its addictiveness. The higher the purity, the more addictive the drug. Only super labs found in Mexico and California are able to produce meth of such high purity, which means that most meth in Central Oregon is now transported here, not manufactured here.

Source: Central Oregon Drug Enforcement (CODE) Unit

8th & 11th Graders: Use of Methamphetamines within the Past 30 Days, 2005 - 2006



Source: Oregon Healthy Youth Survey, 2005-2006

Deschutes County Clients of the KIDS Center

In 2005, 25% of the caregivers that brought children to the KIDS Center for a child abuse evaluation self-reported that there was meth in the home environment. In 2006, 27% disclosed meth in the home. These numbers are thought to be an under-representation due to the reluctance in self-reporting meth use around children.

A December, 2006 methamphetamine survey of KIDS Center therapists found that 61% of therapy clients have meth in their home environments. This figure is more likely an accurate representation of the problem given that therapists could trust with kids and their families over an extended period of time.

Source: KIDS Center

ENVIRONMENTAL HEALTH

Drinking Water

• All properly tested water from community water systems in Deschutes County currently meets federal drinking water standards.

• There were no waterborne disease outbreaks in Deschutes County throughout 2004-2005, however there were four E. coli/boil water alerts. All were taken care of and there were no reported human cases as a result.

Source: Deschutes County Environmental Health Division

Food Safety

• Deschutes County has approximately 650 food service establishments. Each of these is inspected twice a year, matching the most per capita anywhere in the state. In addition, the summer season brings over 300 temporary restaurants that require inspection.

• Deschutes County Public and Environmental Health investigated over 100 food borne illness complaints in 2005.

Source: Deschutes County Environmental Health Division, Deschutes County Health Department

Hazardous Waste

• Currently there are 109 environmental cleanup sites throughout Deschutes County as listed by the Oregon Department of Environmental Quality. To be included on the list, the sites have known or suspected hazardous substance contamination.

• There are currently no federal Superfund sites in Deschutes County.

Source: Oregon Department of Environmental Quality, Environmental Cleanup Site Information Database, 12/04/2006, United States Environmental Protection Agency

Outdoor Air Quality

• The 1990 Clean Air Act reduced emissions from industry to less than 15% of pollutants. Motor vehicles are now the primary source of air pollution in Oregon. Emissions from cars contribute to ground level ozone pollution (smog), especially on hot summer days. Other major causes of pollution are from wood stoves, gas-powered lawn mowers, motor boats, paints, solvents, aerosols, and outdoor burning. In 2005, Deschutes County had 346 days ranked at the highest level of the Air Quality Index ("good") and 19 ranked as "moderate."

• Deschutes County is in compliance with all federal air quality standards.

Source: Oregon Department of Environmental Quality, 2005 Oregon Air Quality Data Report

Solid Waste

• Deschutes County is among the highest producing counties in Oregon for pounds of municipal solid waste landfilled or incinerated per capita. The two main contributors are construction waste resulting from rapid population growth and waste from the tourism-based economy.

• Deschutes County ranked 16th of Oregon counties in

the amount of solid waste "recovered" per capita in 2005. Recovery refers to solid waste that is recycled, composted, or used in energy recovery.

• Of the 62,523 tons of recovered waste in Deschutes County in 2005, 72% was recycled, 23% was composted, and 5% was burned for energy.

Pounds of Municipal Solid Waste Disposed Per Capita, 1992 - 2005

	1992	1994	1996	1998	2000	2002	2004	2005
Oregon	1,513	1,483	1,339	1,609	1,617	1,554	1,630	1,667
Deschutes County	1,720	2,155	2,070	1,884	1,904	2,049	2,237	2,240
Oregon Benchmark								1,575

Source: DHEQ Environmental Inventory Program, Deschutes County Health Department

Recreational Water and Blue-Green Algae

Most algae are harmless, but there are several species of blue-green algae that may produce harmful toxins. During warm weather periods, blue-green algae blooms may concentrate to hazardous levels. Advisories are issued when cell counts exceed certain limits or when potentially harmful toxin levels are found. Toxins in water may be absorbed by humans when swallowed and when inhaled as droplets or spray in the air, potentially causing harmful short-term and long-term health effects. Pets and other animals are also at risk. Since June 2004, health advisories have been issued at four bodies of water in Deschutes County because of significant blooms of blue-green algae: Lava Lake, Crane Prairie Reservoir, Paulina Lake, and Wickiup Reservoir.

Source: DHEQ Environmental Inventory Program, Deschutes County Health Department

Vector Borne Diseases: West Nile Virus

West Nile Virus (WNV) is transmitted to humans and animals through the bite of infected mosquitoes. The vast majority of those infected with the virus have no symptoms or have a mild fever and flu-like illness. In rare cases, the virus can cause encephalitis, an inflammation of the brain, or death. WNV was first detected in Oregon in August 2004 with the first human, horse, and bird cases diagnosed. Since then, cases have increased significantly in Oregon, resulting in one human death in 2006. There have been no human cases acquired in Deschutes County. The Deschutes County Health Department continues to conduct surveillance of WNV through the testing of mosquitoes and dead birds.

West Nile Virus, Human Cases, Oregon, 2005

2004 - 1
2005 - 0
2006 - 70*

*The data includes that were reported out of state.
Source: DHEQ Office of Disease Prevention and Epidemiology, Communicable Disease Surveillance Report, 2005

WHY RECYCLE?

There are significant energy savings and greenhouse gas reductions made as a result of recovered waste. For example, making aluminum from old beverage containers uses 93% less energy than making aluminum from bauxite. Newsprint made from old newspapers requires 43% less energy to make than newsprint made from wood. Additionally, net greenhouse gas reduction associated with materials recycled, composted, and burned for energy in 2005 are estimated at 3.3 million metric tons of carbon dioxide equivalent. The Oregon Department of Environmental Quality estimates that number to be comparable to removing 710,000 average passenger cars from Oregon roads.

Source: State of Oregon Department of Environmental Quality

COMMUNICABLE DISEASE

Sexually Transmitted Infections (STIs)

The number of STIs reported and requiring clinical follow-up in Deschutes County has increased by 314% since 1998.

CHLAMYDIA

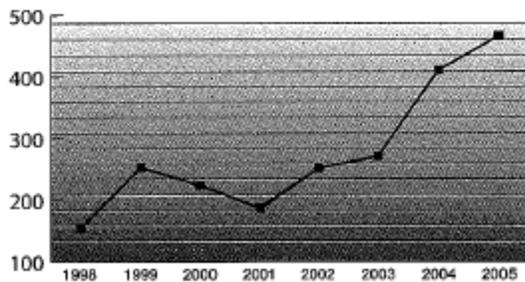
In 2006, Chlamydia accounted for over 97% of the STD diagnosis in Deschutes County. Chlamydia, a bacterial infection, is transmitted through oral, vaginal and anal sex. Although curable, it can have severe consequences including infertility and problems in newborns of infected mothers. Symptoms of Chlamydia are often mild or absent, which can delay diagnosis long enough to cause serious complications.

Deschutes County STI Cases, 1998-2006

	Chlamydia	Gonorrhea	Early Syphilis
1998	73	0	0
1999	145	7	0
2000	170	5	0
2001	207	11	1
2002	197	6	0
2003	177	3	1
2004	280	6	1
2005	314	8	1
2006	372	7	3

Communicable Disease Cases

Requiring Epidemiological Investigation, Excluding STIs



The number of communicable disease cases requiring in-depth epidemiological investigation in Deschutes County has increased by nearly 200% since 1998.

Source: Deschutes County Health Department

HIV/AIDS

Oregon instituted HIV reporting in October 2001, as part of a national effort to better track infection rates and to present a more accurate epidemiological picture of the problem in our state. Prior to HIV reporting, only diagnosed AIDS cases were reported to the State. Since HIV reporting began, Deschutes County has reported a total of 32 confirmed, HIV positive tests. While the numbers may seem small, it is important that they be understood in the appropriate context. They cannot be considered a true picture of HIV in this community for several reasons: HIV reporting began just five years ago, many people get tested for HIV outside of Deschutes County and then move here at a later date, and only about half of all persons in the United States report ever having been tested for HIV, meaning that there is a significant number of persons living with HIV who do not yet know it.

There are currently 55 HIV positive clients enrolled in the Ryan White Case Management Program with the Deschutes County Health Department. Case managers help determine eligibility for prescription drugs, health insurance, housing, disability, medical and dental care, and mental health counseling. It is anticipated that HIV caseloads will grow steadily over the next few years as more people move into the area and local opportunities for testing become increasingly available. Additionally, the implementation of named reporting of HIV infection will assist in accurately determining the severity of the epidemic and effectively slow its spread through enhanced partner notification. The Centers for Disease Control and Prevention recommends that everyone seriously consider being tested for HIV at least once, as there are estimated to be over 250,000 U.S. citizens with HIV who are not even aware they have the virus.

HIV/AIDS, Deschutes County and Oregon, 2000-2005

	Deschutes AIDS Cases	Deschutes HIV+ Cases	Oregon AIDS	Oregon HIV+
2000	4	N/A*	201	N/A*
2001	3	N/A*	253	N/A*
2002	5	16	262	716
2003	5	1	174	321
2004	3	7	208	288
2005	2	8	140	284

*HIV+ reporting began in October 2001

Source: OREGON Office of Disease Prevention and Epidemiology, Communicable Disease Surveillance Report, 2005

GIARDIASIS

Giardiasis is a diarrheal illness caused by the parasite, Giardia Lamblia. Giardia is one of the most common causes of waterborne disease (drinking and recreational) in humans in the United States. Symptoms generally begin 1-2 weeks after becoming infected and last 2-6 weeks.

Giardiasis Cases, 1998-2005

	Deschutes County	Oregon
1998	89	839
1999	102	896
2000	53	789
2001	34	514
2002	29	435
2003	21	402
2004	28	439
2005	11	419

Source: DHS/Office of Disease Prevention and Epidemiology, Deschutes County Communicable Disease Program

CAMPYLOBACTERIOSIS

Campylobacter is the most common bacterial cause of diarrhea in the United States. Most cases occur as single cases in the summer months and not as part of a large outbreak. Campylobacteriosis is a bacterial infection that affects the intestines and, on rare occasions, the bloodstream. Campylobacter is usually spread by eating or drinking contaminated food or water. It is sometimes spread through contact with infected people or animals. Symptoms generally appear 2-5 days after the contact is made. Most people will recover without any formal treatment.

Campylobacter, 1998-2005

	Deschutes County	Oregon
1998	89	839
1999	102	896
2000	53	789
2001	34	514
2002	29	435
2003	21	402
2004	28	439
2005	11	419

Source: DHS/Office of Disease Prevention and Epidemiology, Deschutes County Communicable Disease Program

OTHER COMMUNICABLE DISEASES

- Norwalk-like viruses are very contagious and can spread easily from person to person. Symptoms include nausea, vomiting, diarrhea, and some stomach cramping. In most people the illness is self-limiting with symptoms lasting for about 1 or 2 days, with no long-term health effects related to their illness. While not reportable in Oregon by law,

the Deschutes County Health Department investigates numerous outbreaks throughout the year.

- Pertussis, or whooping cough, is a highly contagious respiratory disease caused by a bacterium found in the mouth, nose and throat of an infected person. Pertussis poses significant risk for hospitalization and death of infants (less than 6 months). In 2004, Oregon experienced an upswing in the number of pertussis cases, reaching the highest level since 1959. More than 80% of all cases were located in Benton, Lane, Douglas, and Clackamas counties. Deschutes County had two confirmed cases.

- Hepatitis C is a liver disease caused by a virus spread through needle-sharing, occupational needles, and in childbirth by infected mothers. While 80% of infected people have no symptoms, the infection can lead to serious liver disease. A new reporting process, begun in 2005, is anticipated to provide a more accurate picture of the burden in Deschutes County. There were 290 positive lab reports of Hepatitis C in 2005.

- Influenza. On average, 5%-20% of the American population gets the flu each year, resulting in 36,000 deaths nationwide. Deschutes County had 15 deaths due to influenza/pneumonia in 2004.

Source: DHS/Office of Disease Prevention and Epidemiology, Deschutes County Communicable Disease Program

PANDEMIC PLANNING

In cooperation with local and statewide partners, the Deschutes County Health Department conducted a pandemic exercise on November 1-2, 2006. The Health Department is continuously improving plans for preparedness by working with the Deschutes County Emergency Manager to coordinate response to events. Partners in that process include schools, health systems, and local business establishments.



DID YOU KNOW?
 There is a new rapid HIV test that gives accurate results in just 20 minutes. Testing is available at several locations throughout Deschutes County.

DATA SOURCES

Oregon Healthy Teens Survey

Since 2000, the Youth Risk Behavior Survey and the Oregon Public School Drug Use Survey have been combined into a single annual survey, Oregon Healthy Teens. The OHT is Oregon's effort to monitor the health and well-being of adolescents through a comprehensive, school-based, anonymous and voluntary survey. OHT is conducted among 8th and 11th graders statewide. <http://www.dhs.state.or.us/dhs/ph/chs/youthsurvey>

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing random-digit dialed telephone survey of adults concerning health-related behaviors. The BRFSS was developed by the Centers for Disease Control and Prevention and is conducted in all states in the United States. Each year, 3,000-15,000 adult Oregonians are interviewed on questions related to health behavior risk factors such as seat belt use, diet, weight control, tobacco and alcohol use, physical exercise, preventive health screenings, and use of preventive and other health care services. The data are weighted to represent all adults aged 18 years and older. Each state may add questions to the CD survey. <http://www.cdc.gov/brfss>

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) is one component of the federal Department of Health and Human Services (HHS). This serves as the principal agency in the United States government for protecting the health and safety of all Americans. The CDC's mission is to promote the health and quality of life by preventing and controlling disease, injury, and disability. <http://www.cdc.gov>

DHS/Center for Health Statistics

The Center for Health Statistics (CHS) is responsible for registering, certifying, amending, and issuing Oregon vital records. <http://www.dhs.state.or.us/dhs/ph/chs>

DHS/Office of Disease Prevention and Epidemiology

The Office of Disease Prevention and Epidemiology identifies, monitors and seeks to control the factors that threaten the health of Oregonians. The Office is comprised of the following programs: Injury Prevention and Epidemiology, HIV/STD/TB Program, Health Promotion and Chronic Disease Prevention, and Acute and Communicable Disease Program. <http://www.oregon.gov/DHS/ph/odpe>

National Center for Health Statistics

The National Center for Health Statistics (NCHS) is the Nation's principal health statistics agency. NCHS collects data from birth and death records, medical records, interview surveys, and through direct physical exams and laboratory testing to guide actions and policies with the aim of improving the health of residents of the United States. NCHS is a key element of the national public health infrastructure, providing important surveillance information that helps identify and address critical health problems. <http://www.cdc.gov/nchs/nhus.htm>

Portland State University, Population Research Center

The Population Research Center began in 1956, initiated by the State of Oregon with the purpose to prepare annual population estimates for cities and counties in order to distribute state tax revenues. The original program was transferred in 1965 to Portland State University, where it has taken on additional duties including the Oregon State Data Center, the lead agency in the state for relationships with the U.S. Census Bureau. <http://www.pdx.edu/prc>



DESCHUTES COUNTY HEALTH REPORT



Services and Information



Clinic Services

Family planning
Sexually transmitted disease
Prenatal pregnancy prevention

Communicable Disease

Investigation, communicable disease
epidemiology, HIV testing, counseling,
case management, Emergency preparedness

Women, Infants and Children Program (WIC)

Nutrition counseling
Breastfeeding promotion and education
Maternity case management
Prenatal care, home visiting nurses

Maternal and Child Health Services

Maternity case management
Visiting nurses
Well child clinics
Prenatal care

Prevention and Education Programs

Tobacco prevention and education
Breast and cervical cancer program
HIV prevention and testing
Chronic Disease Prevention
Community Wellness

To download a copy of this report,
visit: www.deschutes.org/healthreport

HEALTH DEPARTMENT CONTACT INFORMATION

Bend

Health and Human Services Building
2577 N.E. Courtney Drive
Bend, Oregon 97701
541-322-7400

Downtown Health Center

(Serving young adults through age 25)
1128 NW Harriman
Bend, Oregon 97701
541-322-7457

Redmond

Becky Johnson Center
412 S.W. 8th Street
Redmond, Oregon 97756
541-617-4775

La Pine (Thursdays only)

La Pine Community Campus
51605 Coach Rd.
La Pine, Oregon 97739
541-322-7400

Health Department Website
www.deschutes.org/health

Communicable Disease Reporting
541-322-7418

MISSION STATEMENT

The mission of Deschutes County Health Department is to promote and protect community health and safety through assessment, collaboration, policy development, education, prevention, and the delivery of compassionate care.

Public Health Director

Daniel Pedersen, Ph.D., MPH, MPA/HA

Medical Directors

Mary Salsbery, M.D.
Stephen Kilgus, M.D.
Richard Fawcett, M.D.

Public Health

Advisory Board Members

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Vice-Chair: James Karamihales, M.D.
Secretary: Nancy Knoble, R.S.
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Harold Kempke, DDS
Pete Melinger, Ph.D.
Mary Joanne Kuhar, M.D.
Austen Wright, E.A.
Brynard Miller, M.D.
Craig Bennett, M.D.
Nancy Rice

Top Ten Public Health Achievements - U.S.

- Vaccination
- Motor vehicle safety
- Safer workplaces
- Control of infectious diseases
- Decline in deaths from coronary heart disease and stroke
- Safe and healthful foods
- Healthier mothers and babies
- Access to family planning
- Fluoridation of drinking water
- Recognition of tobacco use as a health hazard

Source: National Center for Health Statistics, *Healthy People 2010*, 2000-2010

Appendix B

DESCHUTES COUNTY HEALTH SERVICES ORGANIZATIONAL STRUCTURE

