



KLAMATH COUNTY *department of* PUBLIC HEALTH  
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**Local Public Health Authority**  
**Annual Plan**  
**For FY 2009 – 2010**  
**Klamath County, Oregon**



*Healthy People in a Healthy Community*



**Public Health Services are for everyone and benefit the health of the whole community.**

**OUR MISSION:** *Working together to promote healthy choices that improve the quality of life and well-being of our communities.*

**I. EXECUTIVE SUMMARY AND FORWARD**

- A. The Klamath County Public Health Authority provides the five essential services** mandated by Oregon State statute primarily through federal grant dollars passed through by the Oregon Public Health Services Division, and client and licensee fees. In addition we receive approximately \$1.00 dollar per capita from the State of Oregon. Because our funding has remained flat or in slight decline for the past three years, our 2007-08 budget request “came in” with a shortfall of funding for 3.8 positions, but all positions were restored with the reinstatement of the Secure, Rural Schools federal legislation. In 2007-08 we received general fund dollars from Klamath County taxes, for the first time. In 2008-09, we received an increase from Klamath County’s share of General Alcohol and Tobacco taxes amounting to approximately \$2.95 per capita.
- B. Our communicable disease control and surveillance program** routinely handles on average 156 positive reports annually. Two thirds of these infections are sexually transmitted, and the overwhelming majority of these are Chlamydia cases. More troubling is the recent trend in Hepatitis C. Our numbers of acute Hepatitis C cases have doubled and we continue to receive a steady flow of chronic Hepatitis C reports. Vaccine preventable diseases average about thirteen per year, but even small outbreaks of meningococcal disease and Pertussis have overwhelmed our resources. Our recent active and latent cases of tuberculosis in immigrant populations and their visiting relatives have consumed the full time resources of a communicable disease nurse for a quarter of a fiscal year.
- C. Parent and Child Health Services** constitute the majority of our public health efforts. Klamath County continues to experience poor maternal child health indicators, with 28% of all children in Klamath County living in households with incomes under 100% of the Federal Poverty level.
1. Given the lack of adequate funding to support comprehensive public health interventions for families at risk, we have focused these past years on innovations to leverage more funding for critically needed services, especially through targeted case management. One of these initiatives has been to maintain the nationally recognized best practices we pioneered with our campaign to eliminate early childhood cavities. We will market our successful strategies to four other Oregon counties with elevated rates of children under 100% of the Federal Poverty guidelines, with funding from the Northwest/Alaska Center to Reduce Oral Health Disparities. Our WIC program continues to be the flagship program for our Health Department services, now providing services to 2700 clients annually. Program growth was made possible by the provision of additional WIC grants funds.
  2. In 2007-08, our **Family Planning Service** levels remained the same as in 2005-06 and 2006-07, in spite of the destabilizing changes in the family planning program which resulted from the new documented eligibility requirements of FPEP. The implementation of these new requirements has created the demand for almost one additional support staff person.

**3. Immunizations**

Klamath County's most recent childhood immunization rates are currently consistent with the state average and have continued to improve over the past four years. School exclusion rates in Klamath County also continue to decline.

**D. Environmental Health activities** are primarily focused on the Food Borne Illness Prevention program and Drinking Water System surveillance through contracts with the Oregon Public Health Services Division.

1. Approximately 365 facilities are licensed and inspected on an annual, semiannual or biannual basis.
2. The Environmental Health Division also inspects facilities that are licensed by other agencies. These include the school cafeterias, day care facilities, group homes, institutions and the summer lunch programs.
3. Over 170 Public Drinking water systems are monitored and surveyed. These systems range from small systems, serving 10 people, to systems serving over 500 people.
4. Our Environmental Health Services Division also has the critical responsibility of monitoring and controlling airborne particulate matter to ensure compliance with EPA air quality standards. We are in the process of implementing a new Air Quality Ordinance with much stricter regulations in order to meet the new federal airborne particulate matter standards.

**E. Health Statistics**

In 2006-07 the Department was required to initiate the new electronic Death Certificate program funded by Homeland Security. Although this technology will eventually streamline our issuance procedures, documentation and reporting, we experienced significant difficulties and increased time related to issuance because all the features of the new electronic reporting system are not operable currently. We are experiencing the need to enter data into our former data gathering system as well as the new electronic database. This double data entry results in a triple increase in the time needed to complete a death certificate transaction, a significant increase in workload to issue the 1200 death certificates we process annually.

**F. Health Information and Referral Services**

Our licensed and registered providers are recognized for the excellent health information and education we extend by phone, in classes and in person on the panoply of public health topics, as well as on our services. We enjoy a good rapport with the local media, and routinely utilize both radio and television media to get public health messages to the public. Additionally, the Klamath County Health Department has participated in a monthly radio show that allows audiences to call in with questions pertinent to public health.

**G. Emergency Preparedness**

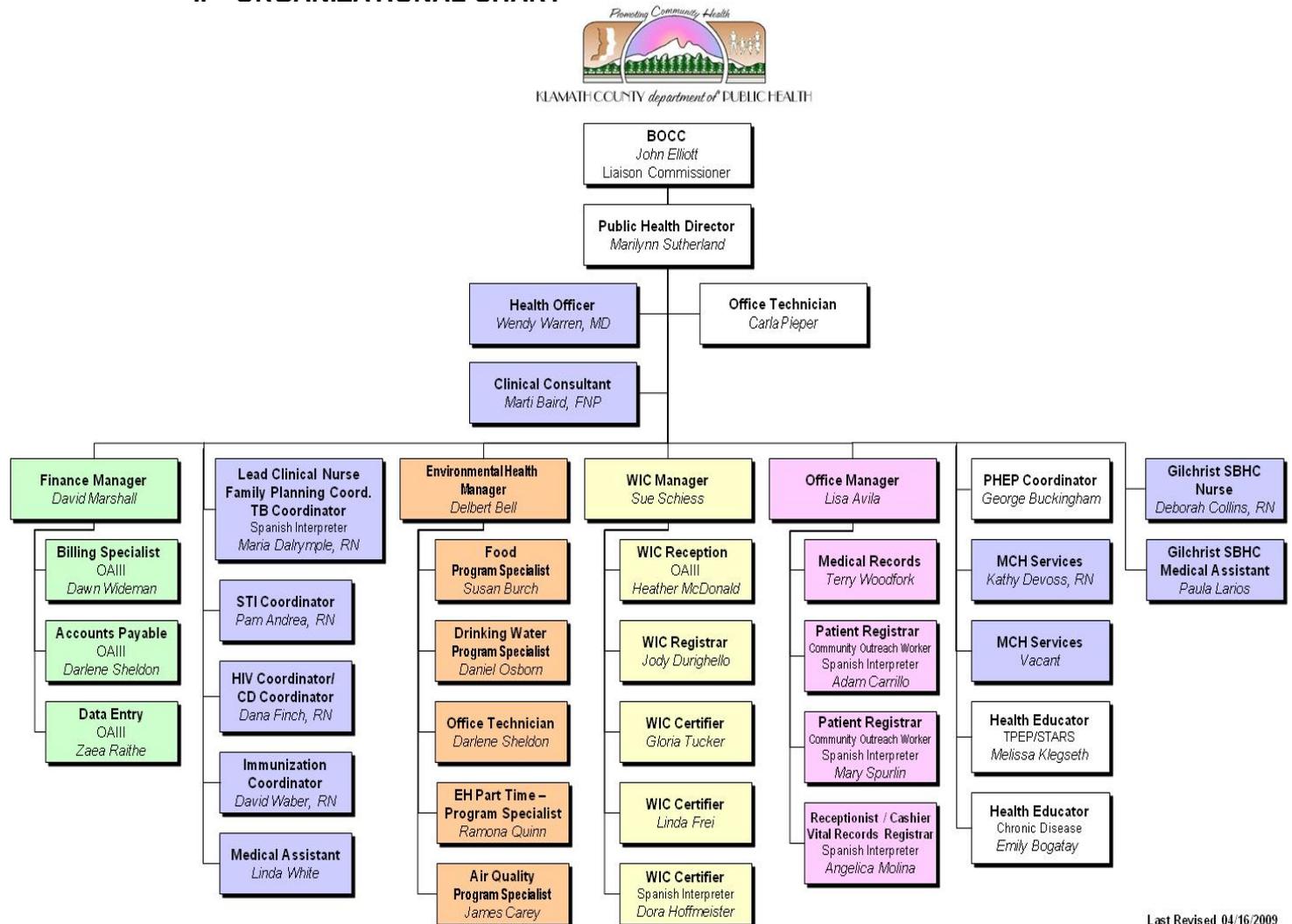
Increased electronic reporting and communication capacity continue to improve our public health preparedness. From 2006 through 2008, we completed all of our required emergency response plans in either draft or final form. We continued dialogue and the staging of exercises with our local military base and have increased surveillance efforts with our newly named medical center, Sky Lakes Medical Center. In support of Klamath County's Emergency Services Department, the Health

Department has also been a key player in the development of a County wide interagency emergency management team. We have added a back-up bilingual PHN to improve our capacity to better meet the need of special populations in an emergency. Our public health preparedness team continues recommended ICS training.

**H. Other**

Broad community or true population based interventions have been limited by funding opportunities to the STARS and TPEP positive youth behavior programs, (the latter having been re-instituted in fiscal 05-06) and the Public Health Preparedness program. However, the Department has been requested to receive and be the lead agency for a Healthy Active Klamath grant from a local health care foundation. This funding will allow the Dept. enhanced collaboration with the community to improve the physical activity and nutritional status of school aged youth.

**I. ORGANIZATIONAL CHART**



Last Revised 04/16/2009

**J. INTRODUCTION TO KLAMATH COUNTY**

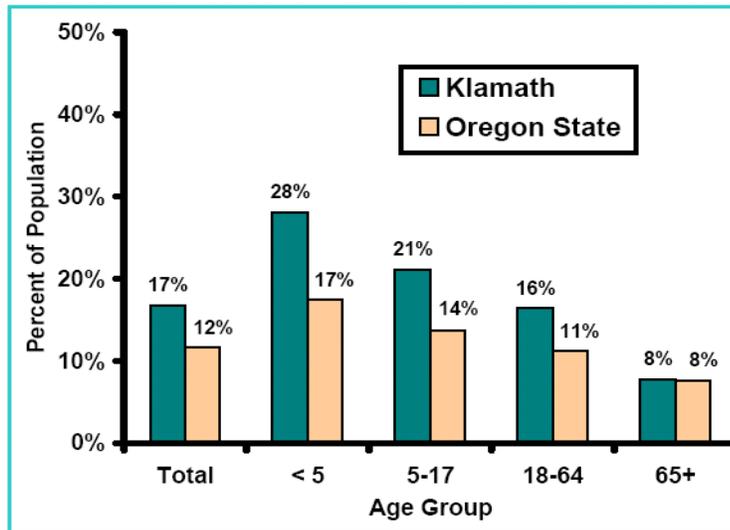
1. Klamath County sits at 4200 feet in a basin in south-central Oregon, bordered by the Cascade Mountains on the west. Klamath County is ranked the fourth largest Oregon County at 6135 square miles.
2. According to (1) OREGON HEALTH INFORMATION Klamath County had a population of approximately 65,815 residents in 2007, with a growth rate of 2.6% since 2000.

2005 Demographic Data			
AGE		ETHNICITY	
18-34	23.9%	White	84.0%
35-64	59.3%	Black	00.8%
65 or older	16.9%	Hispanic	08.7%
SEX		Asian	01.1 %
Male	50.2%	American Indian	04.1%
Female	49.8%	Other	01.3%

3. Economic Indicators:

- a) The 2007 OREGON BENCHMARKS reported an improving trend in Klamath County’s economic well-being, from a rank of the 27th poorest in 2005 to a rank of 22nd among Oregon’s 36 counties in 2007. But, for those over 65, every other age group in Klamath County has significantly higher poverty rates than the state average for each of those groups. More than 50% of all births are funded by Medicaid and 52% of all children attending school in Klamath County participate in the school lunch program.

Population By Age Under 100% of Federal Poverty Level in Oregon State and Klamath County, 1999



Data Source: 2000 U.S. Census.

- b) More Klamath County youth graduate from high school than the state average, but a significant number of Klamath County’s young people,(age 18-14) leave the County for educational and employment opportunities. Klamath County’s current college completion rate of 16.1% is higher than the average for rural counties in Oregon, but significantly lower than the statewide three year average of 26.8 %.

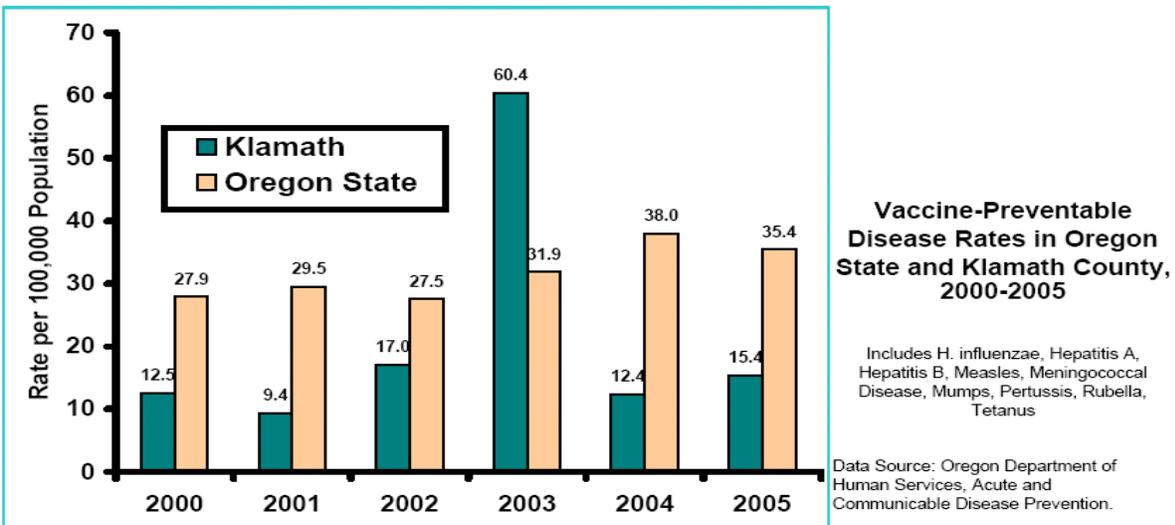
## II. ASSESSMENT – ANNUAL

Although this three year plan is more comprehensive in scope than the customary annual plan submitted, it would be a misnomer to call it a comprehensive assessment of the health and well being of the community. Lack of funding has prevented the Department from completing this kind of critical assessment of the health status of the community. Such an undertaking would need to be funded at levels comparable to those provided to the local Commissions on Children and Families. Therefore this document will provide a global overview of the public health related issues faced by the community, in the framework of the ten essential public health services or areas of concern.

### A. DESCRIPTION OF PUBLIC HEALTH ISSUES AND NEEDS IN KLAMATH COUNTY

#### 1. Communicable, Infectious and Vaccine-Preventable Diseases:

- a) Hepatitis C continues to be of great concern in the community. Our struggle is reaching this high risk population and getting them in for testing.
- b) Enteric pathogens such as noroviruses continue to occur in outbreaks in our population, demanding intensive and time-consuming investigations to determine source of infection. Although the number of outbreaks declined in 06-07, the numbers of persons affected increased,
- c) Even though Klamath County is relatively rural, we have predicted the possibility of imported diseases occurring here, with an ever-increasing mobile population engaged in international commerce (i.e. Jeld-Wen Inc., Masami Foods), as well as military travel in and out of our Kingsley Air Base.
- d) Except for the year 2003, our vaccine preventable disease rates were significantly lower than the States, reflecting better immunization rates and lower exposure opportunities.



## **2. Child and Youth Well Being Health Issues:**

- a) As in national findings, Klamath County's elevated poverty rates and low rates of advanced education correlate with a variety of poorer health indicators, the most troubling of which is Klamath County's current ranking of third worst in the State on the OREGON BENCHMARKS' Child Well-Being Index, the most significant public health issue in Klamath County.
- b) According to an analysis by the Office of Community Health and Health Planning in April of 2007, Klamath County's infant mortality rate of 8.8% over the last three years is significantly higher than the State average, higher than the rural average and trending worse. This finding is attributed by the Office of Community Health in large part to Klamath County being ranked second highest in the State for alcohol and other drug use during pregnancy. This continued elevation in our infant mortality rate is recognized as a priority public health concern in our county, calling for a public health investigation and the development of a community action plan. Low Birth Weight rates of 8.1% for our county in 2007 are higher than the State rate of 6.1% for the same year. This finding also demonstrates a need for action. Rates of prematurity for Klamath County at 8.5% are comparable to the State rate of 8.4% for the same time period.
- c) Teen pregnancy rates in Klamath County continue to show an increase. At present, our rates are over the state average. Despite our efforts in preventing unintended pregnancies, our rates have continued to increase over the last three years. One attributing factor to this may be federal regulation requiring teens to provide proof of documentation, i.e., Birth certificate, social security card, and picture I.D. Although the services are still available to teens through other funding sources, the word among the teen population is that now you need these documents to acquire our services.
- d) Other Klamath County youth risky behavior reports reflect need for concern and intervention. According to the ALCOHOL, ILLICIT DRUG & TOBACCO CONSUMPTION REPORT, IN KLAMATH COUNTY, 2000-2006, Klamath County 8th graders surveyed in this period reported increasing occasional use of alcohol to a new high rate of 35%, and an increase in gambling rates to 31%. Occasional alcohol use among surveyed 11th graders reached a new high of 57% in 2006, while gambling rates dropped to 37%. Tobacco use by 8th graders, while still higher than other rural counties as well as the State average, does show the signs of improvement that adequate funding can produce.

## **3. Family Well Being Health Issues:**

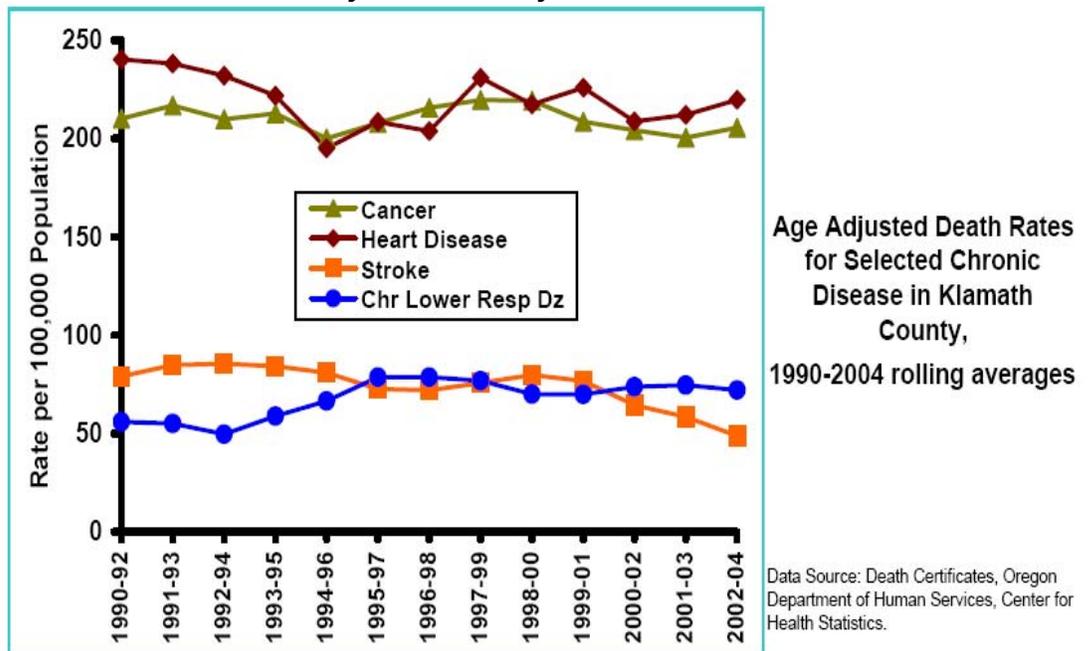
- a) Families in Klamath County continue to experience high rates of distress associated with their poverty status. More than 30% of families in Klamath County continue to be plagued by the stresses of being under 100% of the Federal Poverty Level. In spite of millions of dollars spent to assist economically and socially disadvantaged families, poverty remains an intractable problem due to the lack of "family wage" jobs and the ability to compete successfully for them.

- b) Traditional, self reliant, industrious “farm values” prevail among the families who have lived in the County for several generations. The Latino population and culture, with its strong traditions of family orientation, is having the largest impact in the Basin and in the population growth in younger age groups.

**4. Aging Populations Well Being Issues:**

- a) The post 65 population in Klamath County demonstrates the most economically secure segment in Klamath County comparable with the rest of the State. In-migration is composed of relatively affluent retirees and well educated middle aged couples with either enough income to afford a second home or able to take advantage of comparatively lower property prices in Klamath County. Correspondingly, more senior residents of Klamath County are able to maintain independent living arrangements than in the rest of Oregon.

**5. Chronic Disease Morbidity and Mortality:**



- a) Local physicians anecdotally report increased numbers of overweight pediatric patients, a finding supported by YRBSS data, also. Lack of enough physical activity combined with poor diet obviously plays an important role in this growing problem. Obesity is being seen on an increasing basis in younger children in our WIC program. The local program continues efforts in education regarding health diet, and has recently started physical activity promotion classes for kids.
- b) As the graph indicates, Heart Disease is the leading cause of deaths in Klamath County. Heart Disease rates for the years 2000-2004 were 217.6 (per 100,000) compared to the state rate of 191.8.
- c) Significantly fewer deaths attributable to stroke are reported by Klamath County than the state. Stroke rates for the years 2000-2004 were 56.4 (per 100,000) compared to the state rate of 68.8.
- d) The rate of cancer deaths was 204.8 (per 100,000) compared to Oregon’s rate of 198.4 for the years 2000-2004.

e) Klamath County’s rate of chronic lower respiratory disease is significantly higher than the state at 70.5 (per 100,000) compared to the state rate of 49.1 (2000-2004). A history of unhealthy outdoor air quality in the Basin, couple with high smoking rates contribute to this phenomenon, but needs further epidemiological analysis.

f) **Diabetes**

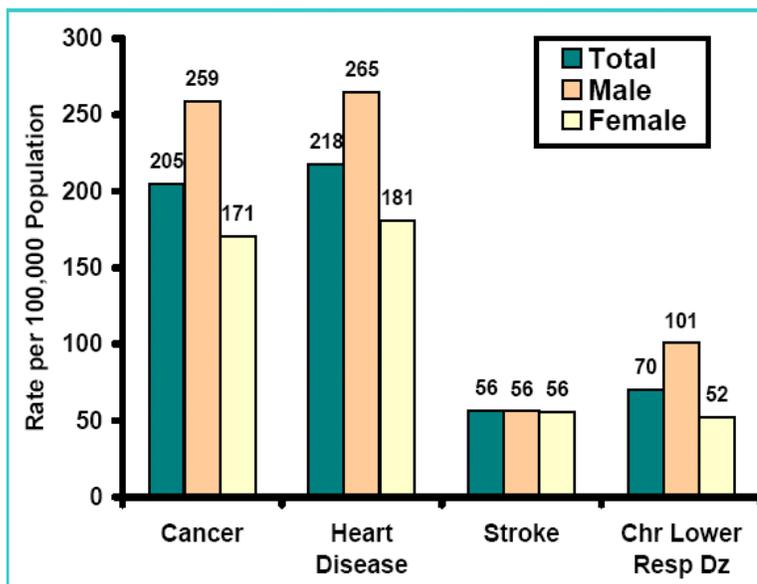
As with the rest of Oregon, Klamath County has witnessed the development of an epidemic of overweight population during the past three decades. Local physicians report anecdotally that for the first time in their practice, they are seeing the expression of type 2 diabetes in youth, a finding also supported by the most recent Youth Risk Behavioral Survey problem of childhood and adult obesity increases, the incidence of Type II diabetes .An environment that is not conducive to year round outdoor activity and exercise limits opportunities for physical activity.

(1) We are concerned about the rate of obesity and Diabetes Mellitus in this county. Programs are promoted by the Healthy Active Klamath Coalition, funded in part by Klamath Medical Service Bureau. Plans for future include developing and implementing activities that work toward the development of policies in the school, worksite and community that encourage “Making the Healthy Choice the Easy Choice”.

(2) Representatives from various local agencies held community forums on worksite wellness, school wellness, local food networks, and resources.

**6. Mortality Indicators:**

a) Age adjusted death rates for stroke compare favorably with the state average however rates for heart disease, cancer, stroke and chronic lower respiratory diseases are higher than the state averages. Suicide, homicide and deaths from motor vehicle accidents reflect rates above the state average of the same years.

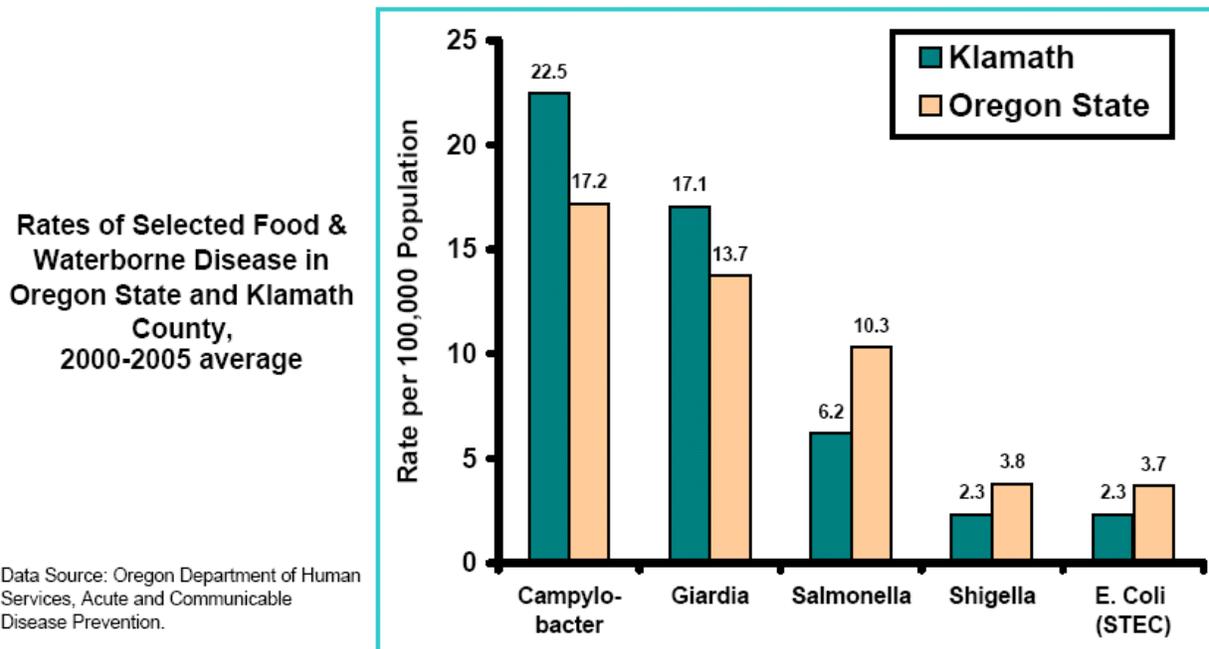
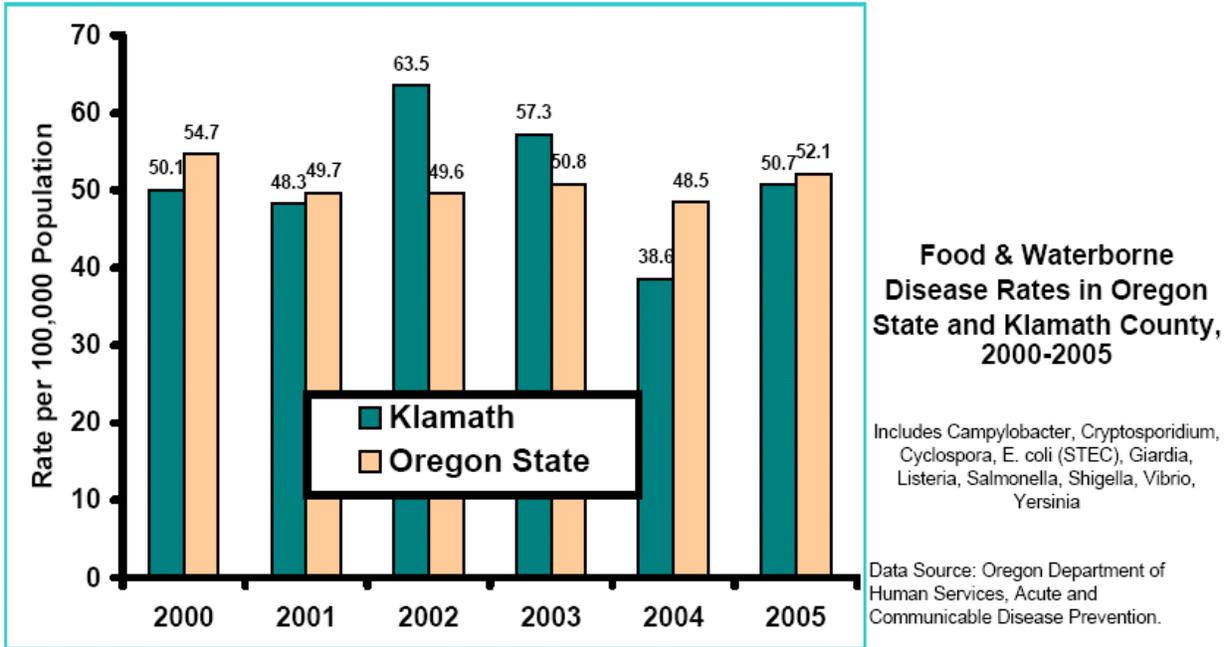


Age Adjusted Death Rates for Selected Chronic Disease By Gender in Klamath County, 2000-2004 average

Data Source: Death Certificates, Oregon Department of Human Services, Center for Health Statistics.

**7. Environmental Health Indicators and Issues:**

- a) Food and waterborne disease rates for Klamath County for the years 2000-2005 show wide variation in incidence as the following chart from the Office of Community Health and Health Planning demonstrates:



- b) Rates of Campylobacter for Klamath County continue to surpass the rates for Oregon State. Cases reported have not been attributable to either public food service or public drinking water supplies. We attribute the elevated number of Giardia cases to inadequate hand

washing in daycare settings. Funding is not available for the preventive education that daycare settings in Klamath County warrant, but all cases in daycare settings receive a follow up investigation/education visit by Health Department staff to mitigate against reoccurrence.

- c) We have noted an increase the number of maximum containment level violations in public drinking water systems. The increases have been noted in arsenic and nitrate. Shallow public wells in old lake bed areas have had difficulty in complying with the newer arsenic standards. Two facilities have had elevated nitrate levels in their water. The concentration seems to fluctuate with the season making source identification more difficult. We attribute the increase in critical violations in our Food Inspection Program activities over the past five years primarily to increasing standards and better inspection activities. The lack of readily available aggregate data for these important environmental health indicators need to be addressed by the State of Oregon.
- d) Outdoor air quality is viewed as the dominant environmental health issue in Klamath County, given Klamath County's designation of "Non-Attainment" with new federal air quality standards for very small particulate matter (PM 2.5). Unfortunately, the unintended effects of current Environmental Protection Agency regulations may actually inhibit local strategies to correct and eliminate the primary sources of this pollution from non-certified woodstoves. Officials predicted that "non attainment" status will produce an almost complete cessation of family wage job growth opportunities in the affected areas, which in turn will severely curtail the opportunity for working families to upgrade the wood fueled heating devices relied on for providing adequate warmth in the County's very cold winters.

## 8. Death by Intended and Unintended Injuries

### a) **Suicide**

Data from recent studies indicate that suicide rates for 2000-2004 averaged 23 per 100,000 in Klamath County, versus a rate of 15 for the State as a whole. Three year rolling averages remain at 21.08% for 2003-05 compared to 15.83% for the state. The suicide attempt rate per 100,000 is even higher with 24.21% for the State population and 27.26% for Klamath County. It is commonly believed that these rates reflect the stresses of a large group of low income individuals and families compounded by their self-medicating behavior.

### b) **Motor Vehicle Accidents:**

The significantly high motor vehicle death rate in Klamath County is largely associated with impaired driving. Twice as many motor vehicle fatalities in Klamath County were related to alcohol as in the rest of the State.

## 9. Preventable Deaths and Injuries:

- a) The rate of alcohol related deaths has nearly doubled in the past decade in Klamath County, now representing 2.47% of all deaths in Klamath County. The tobacco-related disease death rate for Klamath County is 235.5 (per 100,000), which is significantly higher than Oregon's rate of 184.8. As with infant mortality rates, Klamath County

experienced a dramatic reversal of improvement when, in 2005, a sudden spike in the number of preventable deaths occurred, raising the latest two year rolling average about the rural county average, and well about the state average. It is hypothesized that lack of access to adequate medical care is affecting this trend, but further epidemiological analysis is needed.

**10. Drug, Alcohol Abuse and Crime:**

- a) The Oregon Benchmarks rank Klamath County above the State average in public safety (14<sup>th</sup> out of 36 counties.) Personal crime rates in Klamath County exceed both rural and state rates, according to data from the Oregon Benchmarks, but Klamath County is significantly lower than these other entities in both property and behavioral crimes.
- b) According to the Klamath County Drug Task Force, Klamath County experiences a high rate of **methamphetamine related crime**, representing about 75% of all drug offences during 2004-2005 which actually reflects a downward trend from previous years.
- c) A United Way survey completed by approximately 600 Klamath County residents placed substance abuse second only to child abuse as the leading causes of community concern.

**11. Mental Health**

- a) We continue to see many family planning clients with mental health issues, primarily depression. The 9-1-1 Call Center reports that they have observed an increase in the numbers of calls from persons in psychological distress over the past several years. These calls are attributed to the increase in the numbers of residents without mental health insurance, as well as difficulty in accessing appropriate and consistent mental health resources. Klamath County does have an access center for patients in need of immediate assistance. Recently, Klamath County Mental Health received a grant to start a new building to be used for Mental Health Services. The site of this building is much more accessible than the previous site. Mental Health also sees a high number (estimated at 50%) of their total patients who have dual diagnosis of Mental Health / Substance Abuse (primarily methamphetamine).

**B. DESCRIPTION OF THE ADEQUACY AND EXTENT OF THE FIVE BASIC PUBLIC HEALTH SERVICES AND OF THE EXTENT TO WHICH THE LOCAL HEALTH DEPARTMENT PROVIDES THE FIVE BASIC SERVICES CONTAINED IN STATUTE (ORS 431.416) AND RULE**

**1. Epidemiology and Control of Communicable Diseases and Preventable Hazards:**

- a) Klamath County provides above average epidemiology and control of communicable diseases. Since our last triannual review, the Department was presented with a major tuberculosis outbreak affecting several hundred people at a local meat processing plant, which we handled with additional resources from the State TB program. During the same period, our Communicable Disease staff

and Environmental Health staff collaborated in investigation and stopping the transmission of a norovirus, which also sickened several hundred people at a popular local food facility. Both of these interventions were supported with the availability of public health preparedness funding, plus emergency funds from the Oregon Public Health Division. Reoccurrence of similar outbreaks will threaten the stability of Departmental operations, unless such events can be similarly funded.

- b) Program reviews have found the Communicable Disease program is in compliance with State and CLHO standards, except for minor delays in reporting. Changes in the Communicable Disease Coordinators schedule will help to resolve this issue. The loss and restoration of Klamath County's Secure, Rural School funding has and will continue to have a critical impact on communicable disease program staffing. But due to lack of funding, we are unable to perform the level of proactive interventions needed to slow our elevated rates of Hepatitis C.
- c) All Department public health nurses have completed at least Epidemiology 101, and are well versed in communicable disease outbreak investigation and control measures. This includes reporting, monitoring, investigation, treating, and preventing further illness. We work closely with local health care providers, and the Oregon's State epidemiologists and Oregon State Lab, as referenced above.
- d) Klamath County Health Department provides immunizations against common preventable diseases as required by statute and rule. Childhood vaccinations and adult vaccinations are given as indicated and desired. For quality assurance and efficiency purposes, patients can access immunizations by appointment for all of the state and federally mandated public health services including communicable disease, childhood and adult vaccinations.
- e) Since our last triannual review, the Department has continued to assure a steadily increasing rate of County two-year-olds up to date on recommended vaccination schedules over the state-wide average. We are continuing raising our immunization rates in effort to meet the Healthy People 2010 goal of 90%.
- f) Our school exclusion rate for unimmunized or under immunized children continues to decline, from 543 exclusions in 2005-06, 387 exclusions in 2006-07, and 254 exclusions in 2007-08.
- g) **Ryan White Case Management** - There are currently 23 people living with AIDS in the community that take part in the Ryan White Case Management program, up from 12 participants just three years ago.
- h) **HIV Testing** - While we have always offered HIV testing and counseling, we are not receiving funding for this program for the next fiscal year. This will limit the number of no charge tests we are able to provide.
- i) **Sexual Transmitted Infection Program** - Men and women can access testing for sexually transmitted infections in a timely manner. Clients with symptoms are seen promptly by a trained RN or NP. A total of 71 Chlamydia cases and five Gonorrhea cases are identified

and treated annually. Local medical professionals also report other STI's and we initiate treatment and partner treatment if not already done.

- j) **Immunizations** - Klamath County's most recent childhood immunization rates are that 68% of 24-35 month olds are fully covered with the 4:3:1:3:3:1 series. This is a decrease of 10% from 2007. We are continuing raising our immunization rates in effort to meet the Healthy People 2010 goal of 90%. Our school exclusion rate for unimmunized or under immunized children shows 543 exclusions in 2005-2006; 387 exclusions in 2006-07, 254 exclusions in 2007-08, and 127 exclusions in 2008-09. This shows a steady decline in the number of children needing immunizations to stay in school, and again is making strides to making the goal of 90 % completely immunized by 2010.
- k) Klamath County Health Department provides immunizations against common preventable diseases identified as being required childhood vaccinations, and adult vaccinations as indicated and desired. Patients can access immunizations by appointment all of the state and federally mandated public health services including communicable disease, childhood and adult vaccinations, family planning services, and environmental health services.
- l) The nurses have all completed at least Epidemiology 101, and are well versed in communicable disease outbreak. This includes reporting, monitoring, investigating, treating and preventing further illness. We work closely with local health care providers, and the Oregon's State epidemiologists and Oregon State Lab. Pertussis and Norwalk are still the most common communicable diseases identified, although tuberculosis is becoming more prominent.

## 2. Parent and Child Health Services

### a) Family Planning:

- (1) The Klamath County Health Department provides a full range of family planning services to all women of childbearing age who have not had permanent sterilization. In addition to well-woman exams and discussion and distribution of birth control methods, we offer IUD/IUS inserts, colposcopy, endometrial biopsy, and cryotherapy. We are working to include men in the family planning program, since at 0.3% currently we are below the state rate of 2.6%. One of our goals is to increase male utilization of family planning services.
- (2) In calendar year 2007, the Klamath County Health Department experienced a 5.1% drop in clients seen overall from previous years, but our decrease was significantly lower than Oregon's statewide change of -22.3%. The estimate of 15-17 year olds who are sexually active is 56%, of which the Klamath County Health Department sees almost 39%. According to information retrieved from Ahlers reports, the Klamath County Health Department prevents over 100 teen pregnancies and over 200 adult pregnancies annually. Since the last triannual review, Klamath County's birth rate among 10-19 year olds has exceeded the state average, but we have accomplished a

steady decrease in pregnancies in youth 10-17 to below the state rate. We have secured a grant from our local Commission on Children and Families to fund family planning services to teens who are unable to provide the documentation needed to recoup full reimbursement.

- (3) As mentioned earlier, Klamath County Health Department provides excellent family planning services to the entire community in need. Unfortunately, we find the ever increasing federal regulations cost prohibitive to implement at the rate we are being reimbursed from family planning grants and fees. We look forward to consultation with the Office of Family Health Services to identify acceptable strategies to reduce the high rate of local subsidy of this program.
- (4) The Health Educator also goes to the City Schools and speaks to new teen parents about family planning in an effort to prevent subsequent pregnancies.
- (5) Pregnancy testing is available Monday through Friday on an appointment or walk-in basis. Women who have a positive pregnancy test are counseled regarding all of their options, and referred to other agencies including Oregon Health Plan, medical care, and WIC, or termination services. Women who have a negative pregnancy test are given birth control options, often to start immediately. They are referred for further family planning services or other medical interventions based on need.
- (6) Family Planning clinics offer a full exam including breast exam and pelvic, PAP smear and screening for sexually transmitted diseases. This clinic is offered 2 ½ days per week. The late afternoon hours are designated for teens so that they may access care after school. Birth control methods are discussed and dispensed, along with condoms for STI prevention.
- (7) One of the challenges we have been facing this past year is the requirement that all family planning participants show proof of citizenship. This can be very difficult for adolescents seeking confidential services. We have 4 notaries on staff to assist teens in getting a copy of their birth certificates.

**b) Prenatal Care**

- (1) Pregnant women are more likely to begin prenatal care in the first trimester if they have insurance. The Klamath County Health Department is able to offer pregnancy testing on-site and provide a date-stamped application for the Oregon Health Plan to assist women in getting insurance and into prenatal care. In Klamath County, over half of the births are paid for by the Oregon Health Plan. Additionally, education is provided about nutrition, drug, alcohol, tobacco and other lifestyle issues during pregnancy and facilitates pregnant women to access WIC services. Pregnant women are also provided a referral list of prenatal care providers.

- (2) We received an \$18,000.00 grant from March of Dimes to provide 5 A's training to prenatal care providers to reduce the rates of women who continue to smoke during pregnancy.
- (3) Approximately 22 women are referred to the Oregon Health Plan each month.

**c) Early Childhood Public Health Interventions**

- (1) Klamath County has a high rate of low birth weight babies: 84.1 / 1000 births compared to the State average of 61/ 1000 births for the year 2007. In addition, the department has observed an unusual number of infants identified with anomalies before the first birthday. These occurrences have produced a consistent demand for nearly 2.0 public health nurses to provide both Babies First! and CaCoon services to over 275 unduplicated clients in 2007. OHSU Pediatric Cardiology offers quarterly clinics in Klamath County that are always fully booked.
- (2) Dental disease is the most prevalent chronic health problem among children in Oregon, five times more common than asthma. Oral health problems have routinely been identified as the largest unmet health need in Klamath County. In 2002, Klamath County received a Robert Wood Johnson grant to provide pregnant women with free dental screening and repair of their teeth, as well as education about baby bottle mouth and decay. Additionally, infants were screened from the time of tooth eruption to the age of two and treated with fluoride varnish as needed. The participants in this program were recruited from the WIC program in a very successful collaboration, for which Klamath County received national attention and recognition. More than 90 percent of the children who participated in this early prevention program have remained cavity free. The National Institutes of Health have awarded funding to replicate this community collaboration in four other rural Oregon counties over the next five years.
- (3) The Lead Free Klamath Kids Project is a Klamath County Public Health Program funded by a \$50,000 grant from the Environmental Protection Agency. The grant period is from 10/01/2007 through 09/30/2009. The parameters of the grant are to identify children at 1 year of age who lived in pre-1950 housing at the time of birth and to offer free tests for lead exposure to them and their siblings aged 5 or younger. The goal of the grant is to screen 480 families and test 96 children. In the first 6 quarters of the grant 578 families have been screened and 197 children have been tested. Testing is performed by a Registered Nurse via capillary sampling for blood collection. Klamath County is proud that we are exceeding the parameters of the grant and that the testing goal was reached in the first 8 months of the grant period .
- (4) The Klamath County Health Department offers home visiting programs for high risk infants in the community. The Babies First! Program identifies infants born at risk for developmental

delay and provides services to these families according to program guidelines. Risk of developmental delay can be from medical factors, social factors or a combination. A new component of the program allows for a one-time, short-term intervention with families to increase their awareness of and ability to access community resources. This program is administered by The Office of Family Health through all Oregon county health departments. The CaCoon Program provides services to families who have children with special health needs per program guidelines. The target age is birth up to 21 years of age with the priority being infants born with special needs or children with newly diagnosed conditions that meet program elements. The outreach nurse, in both programs, coordinates and collaborates with local health care providers and other community agencies to help meet the needs of the family.

### **3. Environmental Health**

#### **a) Food Safety**

- (1) The Department licenses and inspects approximately 250 food facilities annually, as well as nearly 100 temporary non benevolent events. Since our last triannual review, staff reassignments have assured that we are in compliance with quantitative and qualitative inspection standards. We continue to see a steady increase in food facilities with staff fluent only in Spanish, which creates concern for adequate communication regarding food safety issues.

#### **b) Air Quality**

- (1) Air quality advisories are in effect between mid October and mid March annually. In the past, we have averaged more than 20 days of poor air quality, primarily attributed to wood burning with non certified appliances. Klamath County is expected to be in violation of the new federal regulations when poor air quality days exceed six annually now, as measured by an air quality monitor at one of the local Klamath Falls elementary schools.
- (2) The Air Quality program relies extensively on education to solicit compliance from our populace. However, we do use both direct observation and a mobile heat detecting unit throughout Klamath Falls to detect persons using fireplaces and wood stoves as their main source of heat. We have received \$250,000 in funds from the EPA and the City of Klamath Falls to provide woodstove change-out for those people who use wood heat as their primary source. The funds enable us to either replace or provide financial incentives to remove old wood stoves and replace them with certified wood stoves or other alternate heating sources. The program also makes compliance or enforcement surveys and responds to complaints received. In 2008 -09 heating season, the staff

issued over 210 Notices of Violation for the improper use of a wood stove or fireplace.

**c) Safe Drinking Water**

(1) Klamath County has over 140 EPA Regulated Public Water Supplies. Many of these are small systems serving seasonal operations, campgrounds, small businesses and small housing developments. While most of the county's population is served by a public system, there are many private residential systems. Some of these small systems obtain their water from shallow aquifers that are maintained by leakage from the irrigation canal system. One small community does not have a community water system and its residents depend upon shallow wells that are easily contaminated. With the addition of State regulated drinking water systems, our Environmental Health division now expects to regulate over 170 public drinking water systems annually.

**d) Liquid and Solid Waste**

(1) Klamath County has an active program dealing with Onsite Sewage Treatment and Disposal for those flows less than 2500 gallons per day and of the strength equal to or less strong than residential waste. Onsite sewage flows greater than 2500 gallons per day or of a stronger than residential strength is regulated by the Department of Environmental Quality. In a typical year, Klamath County Environmental Health conducts more than 160 site evaluations and issues more than 180 construction permits. Most of these Site Evaluations and Construction Permits are for single family of small commercial development. Klamath County Public Health does not actively work in the areas of solid waste or hazardous waste. This is addressed by the County Community Development Department and by the cities of Klamath County.

**e) Travelers Accommodations, Organizational Camps, and Public Swimming Pools and Spas**

Klamath County has 52 motel/hotels, 33 recreation (RV) parks and six organizational camps. The hotels/motels are inspected biannually, the recreation parks semi-annually and the camps annually.

(1) Klamath County has a total of 36 public swimming pools and spas. Eighteen are operated year round and the others are operated seasonally. The year round facilities are inspected semi-annually, the seasonally facilities are inspected once during the season. Follow up inspections are made as needed based upon the violations observed.

#### **4. Health statistics**

##### **a) Collection and Reporting**

(1) Birth and death certificates are collected and recorded, and pertinent information is relayed to the Oregon Health Division. Birth and death certificates are available to family members who require these for services – often within 24 hours. We have three employees on staff who are certified to provide these certificates.

##### **b) Medical Examiner**

(1) Klamath County has contracted with a new regional medical examiner during this triennium, and employed an experienced deputy medical examiner to augment the services. Autopsies are now performed locally more frequently and with better reporting. But, we have been unsuccessful in obtaining the allowed state reimbursement to offset the costs of autopsies, which results in another unfunded mandate for cash-strapped local government.

#### **5. Information and Referral**

##### **a) Health Education**

(1) In addition to providing information and referral service to the public nine hours per business day, we employ 2 Health Educators that provide information and education about the STARS program (Students Today Aren't Ready for Sex), tobacco prevention, chronic disease prevention, hygiene, family planning services, and the services offered at the Klamath County Health Department.

(2) We enjoy a good rapport with the local media and have utilized them to get health messages to the public. The health department lobby has a large bulletin board that the Health Educator updates at least monthly with information about timely topics.

### **C. OTHER - DESCRIPTION OF THE ADEQUACY OF OTHER SERVICES OF IMPORTANCE TO THE COMMUNITY**

#### **1. Nutrition and Physical Activity**

- a) The WIC program continues to be our flagship program in providing trusted nutrition and other health information and education, assessment and referrals to families under 185% of the FPL. Pregnant women and children at high nutrition risk are referred to a Registered Dietician for individual counseling. Nutrition based classes are offered approximately weekly.
- b) A nutritional assessment is completed for family planning clients, and dietary changes are suggested if needed.
- c) Being overweight continues to be a significant problem for many of our younger and poorer clients. The Klamath County Public Health Department is the lead agency for the Healthy Active Klamath

Coalition (HAK). HAK has been funded by health care trusts in the past several years to develop successful strategies to improve the nutritional and physical status of the entire population, but particularly of those at most risk of developing chronic diseases.

## **2. Emergency Preparedness**

- a) This department has made major strides in integrating itself into the general Emergency Management and Emergency Services Community during the past few years. Regular communications occur between departments, we regularly attend meetings of various emergency agencies, are included in multi-agency plans, routinely participate in multi-agency exercises, etc. Other agencies routinely include Public Health in their thought processes and planning. Concurrent with these activities is a major realization by the Public Health Department staff of the changing role of Public Health. A well-functioning public health emergency notification system is in place. Participation in the Oregon Health Alert Network is active and up to date, with regular testing occurring. We are in the process of integrating our activities with the incident management activities of the county as a whole. This includes our participation in the establishment of a local Type III Incident Command system, coordinated by an Incident Management Team.

## **3. Older Adult Health**

- a) The Klamath County Health Department does not offer health services specifically targeted for older adults. We do, however, orchestrate the provision of flu vaccine availability for older persons and others with immune suppressed status. If additional unrestricted funding should become available, we are entertaining the merits of fostering a “freedom from in-home falls” for the more vulnerable elderly in our communities.

## **4. School Based Health Clinic**

- a) Klamath County recognizes the effectiveness of making health care available where children are; the schools. We have a school based health clinic in, Gilchrist, Klamath County, providing quality comprehensive care to K-12 school children and their preschool siblings.
- b) We meet monthly with a citizens group in Gilchrist to continue planning expansion of this center, which opened in February, 2009.

## **5. Partners**

- a) Klamath County is a close knit community and we are fortunate to partner with several agencies in providing comprehensive services to our clients. We are able to date-stamp Oregon Health Plan applications to ease access to prenatal care for pregnant women. Our local Federally Qualified Health Center (FQHC), Klamath Open Door Family Practice, shares referrals with us and assists us in helping meet the needs of our clients. Oregon Health Sciences University has a family practice residency program for physicians and a nursing school in Klamath Falls. The health department is able to serve as a training site for new physicians and nursing students.

- b) In the Environmental Health Division of the department, partnering occurs with the US EPA, Oregon Department of Environmental Quality (DEQ,) Oregon Department of Forestry (ODF,) the US Forest Service, Oregon Department of Education, Oregon Department of Labor, County and City School Districts, and local Fire Districts.

#### **6. Dental**

- a) Dental infection continues to be a major problem in Klamath County. Klamath County also has only one dentist per 2200 persons, which makes access to care very difficult for our citizens, even with the added resources of community health centers. Lack of dental care is routinely the most needed, least available health care service identified in every community health survey conducted. Klamath County has continued its nationally recognized work to prevent the transmission of strep mutans infection from mothers to infants. Data from the Robert Woods Johnson grant we received demonstrate that to date 96% of the mothers who participated in the model program have cavity free children at ages two and three.

#### **D. ADEQUACY OF BASIC SERVICES: NO CHANGE IN STATUS EXCEPT AS REFERENCED IN EXECUTIVE SUMMARY**

### **III. ACTION PLAN AMENDMENT**

#### **A. EPIDEMIOLOGY AND CONTROL OF PREVENTABLE DISEASES DISORDERS**

**Goal: Continue to control all communicable/reportable diseases through prompt investigation, with needed interventions and public education.**

- 1. **OBJECTIVE 1:** The Klamath County Health Department will continue providing timely epidemiological investigations of reportable conditions per OAR 333-018-0015.
  - a) **ACTION PLAN:**
    - (1) Assigned and relief Communicable Disease PHN will review submitted reports daily, print investigative report and guidelines from ODHS website and complete investigative report per the guidelines.
    - (2) Assigned and relief Communicable Disease PHN will contact affected individuals, their care providers and families as needed for investigation, to provide education, ensure correct treatment and follow up.
    - (3) Assigned and relief Communicable Disease PHN will submit completed investigation forms to ODHS Epidemiology department per established time line (90% of case forms submitted weekly).
  - b) **EVALUATION:**
    - (1) Quarterly audits of Disease Investigations will be done by QA Coordinator to check for time/date of initial report, investigation initiation, client contact, notification of ODHS Epidemiology, completion of form and submission to ODHS
    - (2) All members of the clinical nursing staff will continue participating in current communicable disease training made

available via regional sessions facilitated by Oregon Health Services (OHS) such as CD 101; distance-based learning such as CDC web or netcast; CD-Rom (“Botulism in Argentina”). All employees with occupational exposures will participate in Blood Borne Pathogen training annually.

(3) The clinical services coordinator will maintain a log of CD continuing education training and Blood Borne Pathogen completed for integrating record into annual performance evaluation and review.

2. **OBJECTIVE 2:** To improve reporting practices by local private providers that will continually improve surveillance and investigative efforts.

a) **ACTION PLAN:**

(1) The Communicable Disease Coordinator will provide education/information to all local medical providers on communicable disease reporting. Annually, an explanatory cover letter accompanying a confidential morbidity report form will be sent to each provider, with follow-up by the Communicable Disease Coordinator either in person or by phone. Results of contacts will be logged.

b) **EVALUATION:**

(1) Annual review of timelines of morbidity reports from private providers.

3. **OBJECTIVE 3:** Improve community awareness regarding emergency CD issues.

a) **ACTION PLAN:**

(1) The Communicable Disease Coordinator will actively promote educational outreach activities via contact with service organizations, medical providers, interest groups and special populations. The CD Coordinator will collaborate with the Health Officer to publish local articles regarding issues at least annually in the local newspapers or electronic media.

b) **EVALUATION:**

(1) Communicable Disease PHN will report on accomplishments at annual personnel evaluation.

4. **OBJECTIVE 4:** Address problem of lack of testing/ follow up in populations at high risk for Hepatitis C.

a) **ACTION PLAN:**

(1) The Klamath County Health Department will expand screening and offer testing to high risk populations for Hepatitis C through available grant funds.

b) **EVALUATION:**

(1) Documentation of a 10% increase in testing for Hepatitis C in high risk populations annually by QA Coordinator.

**B. PARENT AND CHILD HEALTH SERVICES, INCLUDING FAMILY PLANNING CLINICS AS DESCRIBED IN ORS 435.205:**

As referenced elsewhere throughout this document, our parent and child health services have been judged as excellent by a variety of reviewers. But as excellent as they are, these programs on their own are not adequate to address the scope of the social problems driven by the scale of the culture of poverty here in Klamath County. The Department intends to stay actively involved with other proven and demonstration efforts to address the root problems which contribute to Klamath County's abysmal rankings in the well being of its younger populations by the Oregon Progress Board.

We would welcome the opportunity to replicate the success of the Olds Home Visiting model as our expert contribution to the community's primary prevention efforts, so we remain hopeful that the Nurse-Family Partnership initiative will be funded in Oregon.

Over the next three years the Department will explore how we can build on and leverage the successes of both our Family Planning and WIC programs to improve our progress toward attainment of Healthy People 2010 Maternal and Child Health objectives.

One opportunity that we will evaluate will be whether our direct provisions of early prenatal care to our poorest populations will improve our low birth weight outcomes by reducing alcohol and tobacco usage during pregnancy. Klamath County Health Department has received a grant from the March of Dimes, Greater Oregon Chapter to provide training to local providers who provide obstetrics and their staff to implement the 5 A's model of smoking cessation. A 5 A's training will take place for the providers to assist them in implementation. Recent longitudinal European studies evidence the correlation between birth weight and susceptibility to later stage chronic diseases. These studies provide a compelling argument for communities to undertake as a priority health initiative a comprehensive campaign to ensure all birth weights for term pregnancies meet or exceed 2500 grams. We will seek grant funding to analyze the causes and research best practices to improve our low birth weight phenomenon in 2009, and, if appropriate, develop a business plan by 2010. If the private health care community can support our plan, we expect that a serendipitous result of our adding health care staffing will be to increase medical provider capacity for other populations in need. During this timeframe we will continue to provide our mandated parent and child health services to the extent possible with approved funding levels.

**B1. FAMILY PLANNING SERVICES**

1. **OBJECTIVE 1:** To offer and provide clinical, informational, educational, social and referral services to anyone of reproductive age requesting family planning and reproductive health care. In addition to the Annual Family Planning plans that have been and will be submitted annually under separate cover, the Klamath County Public Health Department intends to:

a) **ACTION PLAN:**

- (1) Through staffing changes, secure compliance with the remaining Family Planning Grant requirement to provide each

client documentation of her/his visit costs and the fees assessed for those costs to the client.

b) **EVALUATION:**

- (1) Office manager will assess compliance annually at the close of the fiscal year.

**B2. IMMUNIZATIONS** - (See attached plan submitted under separate cover)

**B3. WIC** - (See attached plan submitted under separate cover)

**B4. BABIES FIRST!** - Will continue to offer and provide comprehensive services to all infants and children at risk for developmental delay.

1. **OBJECTIVE 1:** Developmental screenings will be completed at 4, 8, 12, 18, 24 and 36 months of age to identify all children in the Babies First! And CaCoon Programs with developmental delays and that their families will receive appropriate interventions for their child's condition.

a) **ACTION PLAN:**

- (1) PNN's working in Babies First! And CaCoon will receive instruction on the use of the ASQ and the ASQ-SE
- (2) Clients enrolled into the Babies First! Program will be screened using the required program screening tools for the age of the child being screened. The **Babies First! High Risk Infant Tracking Reference Tool** designates the screens required at each milestone
  - (a) The PHN will do an initial assessment from birth to six weeks or at any age the child is referred into the program
  - (b) Developmental screens can be done within a month before, during, or after the 4<sup>th</sup> month, 8<sup>th</sup> month, 12<sup>th</sup> month, 18<sup>th</sup> month, 24<sup>th</sup> month, and 36<sup>th</sup> month or up until the child is discharged from the program. The DOB or the CDOB will be used to determine when the developmental screenings will be completed per program protocol. Screenings with questionable results will be rescreened according to program guidelines
- (3) The home environment will be evaluated for issues causing delays in development
- (4) The PHN will work with the families to improve the development of any child with environmental issues causing impact on development
- (5) The PHN will refer families with a child with altered growth and development (as determined by the scores received on the screening tools) to Early Intervention unless the family declines the referral. The PHN will provide anticipatory guidance to those families who decline a referral for further evaluation
- (6) The PHN will monitor the family's ability to access needed resources and monitor their compliance and follow-through with recommended referrals
- (7) Babies First! And CaCoon charts will include documentation of developmental assessments according to HRI protocol and **will reflect the consistent recording of weight, height, and weight/height as part of the child's assessment.**

b) **EVALUATION:**

- (1) Weekly meetings with home visit nurses on caseload
- (2) Annual ORCHIDS data assessment
- (3) Quarterly chart review by MCH nursing services coordinator.

**B5. MATERNAL, INFANT, CHILD AND ADOLESCENT HEALTH PERINATAL**

**GOALS:** Focus perinatal funding on documented interventions with pregnant women to ensure their compliance with best dental practices to eliminate oral infection at time of delivery.

1. **OBJECTIVE 1:** 10% of Klamath County WIC enrollees on the Oregon Health Plan will participate in assessment/treatments to eliminate oral infection while pregnant.

a) **EVALUATION:**

- (1) Monitoring of annual Klamath County numbers of OHP pregnant eligibles and number of Klamath County OHP pregnant women receiving a dental visit annually.

2. **OBJECTIVE 2:** Replicate RWJ funded project with the University of Washington in four other rural Oregon counties.

3. **OBJECTIVE 3:** Continue to lead, participate in community collaborations to reduce alcohol, tobacco use by pregnant women to Oregon Rural Benchmark.

a) **ACTION PLAN:**

- (1) Increase support for women who are pregnant and trying to quit tobacco and alcohol by offering educational materials and support through local physician's offices. Use funding secured through the March of Dimes, Greater Oregon Chapter to provide training to local providers who provide obstetrics and their staff to implement the 5 A's model of smoking cessation. A 5 A's training will take place for the providers to assist them in implementation. Continue to educate women in WIC and during pregnancy testing about the importance of smoking cessation and the health of their infant. Collaborate with Klamath County Mental Health department and substance abuse prevention intervention program to increase intervention and screening for women using drugs and alcohol during their pregnancies. Provide information at all WIC visits and pregnancy check visits. Provide support for women seeking help with substance abuse issues, including referrals for counseling, in and outpatient treatment.

b) **EVALUATION:**

- (1) Securing of funds for community campaign to reduce prenatal risks associated with low birth weight and infant mortality.

**B6. ADOLESCENT HEALTH**

1. **OBJECTIVE 1:** Continue to participate in Mental Health Department's collaborative to reduce teen suicide attempts and deaths to Oregon rate of 2.2 per 1000.

a) **ACTION PLAN:**

- (1) Offer assessment and support during family planning and STI clinics

- (2) Collaborate with community partners to develop a written protocol for identification, intervention, and referral of suicidal youth.

**B) EVALUATION:**

- (1) Review Klamath County youth suicide rate annually for trend analysis and send findings to Klamath County Mental Health.

**2. OBJECTIVE 2:** Improve adolescent health status in underserved communities by implementing school based health services

**a) ACTION PLAN:**

- (1) Open school based health center in Gilchrist, OR in February, 2009.

**b) EVALUATION:**

- (1) Annual certification of school based health center operation in Gilchrist.

**C. ENVIRONMENTAL HEALTH GOAL:** To provide all of the services mandated under ORS 446, 448, and 624 in addition to OAR 333-012.

**C1. DRINKING WATER PROGRAM GOALS:** To protect the public drinking water supplies for all Klamath County residents whose drinking water is provided by public water systems.

**1. OBJECTIVE 1:** To be in compliance with EPA and Drinking water priorities and protocols for EPA and state regulated systems by July 1, 2009

**a) ACTION PLAN 1**

- (1) Investigate and have a plan to bring into compliance within assigned timeline any water systems that are significant non compliers. Investigations and resolution will be documented according to state rules and protocols.

**b) EVALUATION 1:**

- (1) Written confirmation by state drinking water authorities of recognized resolution of each significant non complier.

**c) ACTION PLAN 2:**

- (1) In conjunction with the state drinking water program, develop a database to predict or identify and monitor any/ all locally regulated system testing problems. Regimen failures in order to assure compliance with requirements.

**d) EVALUATION 2:**

- (1) Demonstration of database operation and use by July, 2009

**e) ACTION PLAN 3:**

- (1) Conduct the assigned Water System Surveys each calendar or fiscal year.

f) **EVALUATION 3:**

- (1) Review and count the number of surveys submitted for payment. Demonstration of database operation and use by July 2009.

**C2. FOODBORNE ILLNESS PREVENTION PLAN GOAL:** To protect the health of the public by preventing and investigating occurrence of food borne illness in public food facilities.

1. **OBJECTIVE** to bring LPHA program activities with compliance with state rules by maintaining performance of required inspections

a) **ACTION PLAN:**

- (1) Perform re-inspection of facilities with critical violation within specified timelines.

b) **EVALUATION:**

- (2) Quarterly review by EH program manager to ensure that all re-inspections did so occur.

**D. HEALTH STATISTICS GOAL:** To continue to collect, record and analyze birth and death information, issue certifications and monitor health status of county residents, in compliance with applicable state laws.

1. **OBJECTIVE 1:** Provide information pertaining to paternity affidavits to parents.

a) **ACTION PLAN:**

- (1) Offer Rights and Responsibility DVD to all parents seeking birth certificates

b) **EVALUATION:**

- (2) Annual review of log of parents who accepted or rejected DVD on Rights and Responsibilities, beginning July, 2009.

2. **OBJECTIVE 2:** Registrar will send weekly reports of protected death information to the County Clerk's Office and send monthly reports of public death information to the County Assessor's Office.

a) **ACTION PLAN 2**

- (1) Implement a log of death notices provided weekly to the clerk.

b) **EVALUATION 2:**

- (1) Compare number of deaths in county with number of death notices provided annually.

3. **OBJECTIVE 3:** Maintain current service level during transition to electronic records and improve error rate on record.

a) **ACTION PLAN 3:**

- (1) Records registrar or supervisor will contact funeral homes and Sky Lakes Medical Center informing and educating them about the services available with EDRS and EBRS.

b) **EVALUATION 3:**

- (1) Records processed will have decreased possibility of human error due to the EDRS and EBRS system resulting in fewer queries and corrections.
- (2) Compliance during the Triennial Review.
- (3) Number of website "hits"

4. **OBJECTIVE 4:** Issue 100% of birth and death certificates accurately within 24 hours of request.

a) **ACTION PLAN 4:**

- (1) Train all deputy registrars on the EDRS and EBRS system.

b) **EVALUATION 4:**

- (1) All birth and death certificates will be issued within 24 business hours of request on corrected certificate.

**E. HEALTH INFORMATION AND REFERRAL GOAL:** Continue to provide timely and accurate health information referrals to Klamath County residents within 25 hours of request.

1. **OBJECTIVE:** Enhance clearing house function by identifying and sorting nature of calls logged.

a) **ACTION PLAN:**

- (1) Create and enter key Information & Referral indicators into database for analysis by decision makers and possible program development.

b) **EVALUATION:**

- (1) Annual review by LPHA Management Team.

**F. OTHER ISSUES**

**F1. PREPAREDNESS** will continue to develop and improve community emergency preparedness per PE-12 requirements.

1. **OBJECTIVE 1:** KCHD will complete all required PE-12 elements by date specified in contract.

a) **ACTION PLAN:**

- (1) Preparedness Coordinator will attend monthly scheduled conference calls.
- (2) Preparedness Coordinator will attend scheduled Region 7 meetings.
- (3) Preparedness Coordinator will maintain local HAN user directory and ensure all user profiles are current
- (4) Preparedness Coordinator will ensure all KCHD employees have completed ICS courses- 100, 200, 700 and 800, as appropriate.
- (5) Preparedness Coordinator will ensure all employee profiles are current in Learning Center

(6) Preparedness Coordinator, or designate, will test local HAN notification system quarterly.

b) **EVALUATION**

(1) Annual review by LPHA Preparedness Team.

**F2. Chronic Disease Prevention and Control**

(See plans attached plan submitted under separate cover)

**IV. ADDITIONAL REQUIREMENTS:**

The Klamath County Public Health Department and the Klamath County Commission on Children and Families have a cooperative and productive working and planning relationship. Both Departments are overseen by the Board of County Commissioners, which is also the Local Public Health Authority. Both Departments participate in the development of county human service priorities, based on mutually respected data and community input. The Health Department is the lead agency in the provision and analysis of data used by the Commission for relevant critical benchmarks. The Commission has awarded the Health Department a multi-year grant to expand family planning services for adolescents unable to provide documentation of eligibility for the Family Planning Expansion program.

**V. UNMET NEEDS:**

Like many other counties, the Klamath County Public Health Authority struggles to maintain mandated and needed services with decreasing funding from the State, and increasing costs of operation. Because of its size, the Family Planning program continues to be our “loss leader”, requiring infusion of other funding because of its requirement that all family planning eligibles be provided the same level of comprehensive services, regardless of the clients’ ability to pay, or the program’s ability to fund the costs. Consequently, the Department has been forced to curtail its provision of newer, but costlier, reproductive methods. Tuberculosis control funding continues to be woefully inadequate to manage the expense of even one active case per year. Immunization practice requirements cost this Department three to four times the amount of funding received from the State Immunization Program. Reductions in the federal funding of public health preparedness programs have resulted in “trickle down” reductions of local preparedness funding, with ominous implications for the future of public health preparedness. All of these funding deficiencies are magnified by the absence of integrated state reporting systems, from cost accounting to electronic unduplicated program reporting.

Klamath County has historically had pockets of medically underserved or health care professional shortages. These shortages have recently “snowballed” into a crisis with the announced retirements and relocations of a number of local physicians (attributed to the anticipated uncompetitive federal reimbursement rates). The result of these shortages have exacerbated the deficiency in health care resources, with many practices unable or unwilling to accept new patients, or provide previous levels of uncompensated care. Therefore, we have added a primary care goal in our plan to meet one of the assurances of the ten essential services: insure access to adequate primary care. Our objectives will to continue its collaboration and leadership role in increasing the availability and accessibility of primary medical homes for all county residents. Our action plan will be to continue participation in the Klamath County 100% Access Coalition’s effort to provide basic health care insurance coverage for all residents. We will also continue to support the Klamath County Family Practices Consortium’s planning to increase the number of health care providers practicing in the county.

Attaining compliance with the EPA standards for Particulate Matter 2.5 microns and smaller is a major concern for Klamath County. The major source of these emissions is old wood-burning stoves. These units are often in the homes of lower income residents who do not have the money to replace the stove. The stoves generally are very solidly built and last many years and are not replaced with more efficient and less polluting units. Unlike automobiles that are also a source of air pollution, wood stoves are not replaced because they do not wear out as rapidly as motor vehicles.

## VI. BUDGET

*(Budget and Projected Revenue information will be submitted in July, 2009 under a separate cover)*

**Copies of the LPHA's public health budget can be obtained through the following contact information:**

Mike Long, *Klamath County Tax Collector*  
 305 Main Street, Room 121  
 Klamath Falls, OR 97601  
 Phone: (541) 883-4297 | (800) 697-8087 | Fax: (541) 883-5165  
<http://www.co.klamath.or.us/tax/index.html>

## VII. MINIMUM STANDARDS

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

### ORGANIZATION

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

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

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

**CONTROL OF COMMUNICABLE DISEASES**

- 37. Yes  No  There is a mechanism for reporting communicable disease cases to the health department.
- 38. Yes  No  Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
- 39. Yes  No  Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.
- 40. Yes  No  Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.
- 41. Yes  No  There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
- 42. Yes  No  There is a mechanism for reporting and following up on zoonotic diseases to the local health department.

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

### **ENVIRONMENTAL HEALTH**

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

60. Yes  No  Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes  No  A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste. (We currently do not have a solid waste program at KCPHD. The program is administered by the Community Development Department.)
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. **(If within our authority-Yes, if not within our authority, referred to who might have authority.)**
64. Yes  No  The health and safety of the public is being protected through hazardous incidence investigation and response. **(Not currently one of our activities, we are not funded, trained, or equipped to do this. Authority and responsibility are DEQ and Klamath County Fire District #1)**
65. Yes  No  Emergency environmental health and sanitation guidance are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control. (Except for solid waste disposal, shelter sanitation and vector control activities. Information and referral are provided for these.)
66. Yes  No  All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448. (Added per G.S. request, not in program indicators)

## HEALTH EDUCATION AND HEALTH PROMOTION

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

**NUTRITION**

- 73. Yes  No  Local health department reviews population data to promote appropriate nutritional services.
  
- 74. The following health department programs include an assessment of nutritional status:
  - a. Yes  No  WIC
  - b. Yes  No  Family Planning
  - c. Yes  No  Parent and Child Health
  - d. Yes  No  Older Adult Health **N/A**
  - e. Yes  No  Corrections Health **N/A**
  
- 75. Yes  No  Clients identified at nutritional risk are provided with or referred for appropriate interventions.
  
- 76. Yes  No  Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.
  
- 77. Yes  No  Local health department supports continuing education and training of staff to provide effective nutritional education.

**OLDER ADULT HEALTH**

- 78. Yes  No  Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.
  
- 79. Yes  No  A mechanism exists for intervening where there is reported elder abuse or neglect.
  
- 80. Yes  No  Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.
  
- 81. Yes  No  Prevention oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education.

**PARENT AND CHILD HEALTH**

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

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

### **PRIMARY HEALTH CARE**

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

### **CULTURAL COMPETENCY**

99. Yes  No  The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.
100. Yes  No  The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.
101. Yes  No  The local health department assures that advisory groups reflect the population to be served.
102. Yes  No  The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

## Health Department Personnel Qualifications

### Local health department Health Administrator minimum qualifications:

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

Answer the following questions:

Administrator name: Marilynn Sutherland

Does the Administrator have a Bachelor degree?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Does the Administrator have at least 3 years experience in public health or a related field?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Has the Administrator taken a graduate level course in biostatistics?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Has the Administrator taken a graduate level course in epidemiology?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Has the Administrator taken a graduate level course in environmental health?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Has the Administrator taken a graduate level course in health services administration?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

a. Yes  No  The local health department Health Administrator meets minimum qualifications: **Partially**

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

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

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

AND

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

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

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

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

OR

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

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

d. Yes  No  **The local health department Health Officer meets minimum qualifications:**

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

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

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

<http://WWW.dhs.state.or.us/publichealth/lhd/lhd-annual-plan.cfm>

**is complete and current for our county, with the addition of amendments submitted for 2009-2010 fiscal year.**

  
Local Public Health Authority

Klamath County  
County

04/23/2009  
Date

**EVALUATION OF WIC NUTRITION EDUCATION PLAN**  
**FY 2008-2009**

WIC Agency:\_\_\_Klamath County WIC\_\_\_\_\_

Person Completing Form:\_\_\_Sue Schiess\_\_\_\_\_

Date:\_\_\_04/02/2009\_\_\_\_\_ Phone:\_\_\_541-883-4276\_\_

Return this form, attached to email to: [sara.e.sloan@state.or.us](mailto: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: [We held a staff in-service on September 16, 2008 regarding the WIC Key Nutrition Messages. We reviewed all the messages and discussed](#)

which ones staff desired more training on. Staff desired additional training on why whole milk is recommended until age 2. There was also a desire for further information on the limit of 4 oz of juice for children, as we have heard varying amounts as recommendations. We did follow-up with updates on these topics in subsequent staff meetings.

*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: Staff has been following updates as provided on how the food packages will be changing. We discuss Fresh Choices and the upcoming changes weekly in our staff meetings. We held a specific in-service on the change to low fat milk on January 13, 2009. We also held an in-service on the food package changes relating to postpartum women and infants on February 17, 2009. Nutrition education messages identified that will need to change for clients: Offer low fat milk for all family members after age 2. Breastfeeding is the standard, the amount of breastfeeding determines mom's and baby's food package. We will focus more on breastfeeding and not on the amount of formula the baby is getting. There are other food package changes as well, which we will be exploring further in the coming months (i.e. incorporating whole grains, new offerings of soy milk in certain situations, etc.)

These messages will be shared with clients in a variety of ways: anticipatory guidance during individual sessions as well as in the classroom. We will also have posters and client handouts to help inform clients of the changes. We currently are utilizing the bulletin board materials provided by the state to introduce the idea of switching to low fat milk. We also plan to use this to promote including whole grains and to promote breastfeeding.

*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: We did conduct quarterly staff in-services, but not exactly as identified in our plan. We conducted in-services as follows:

July 24, 2008	Civil Rights Training
September 15, 2008	Key Nutrition Messages Update
January 13, 2009	Switching to Low-fat milk
February 17, 2009	What is happening with PP women and Their babies starting 2009?
April, 2009	Planned in-service on the new Medical Documentation form

Objectives were met for each in-service held to date. In-service topics chosen are related to core CPA needs.

**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 using the state provided self assessment tool. Each certifier filled out the assessment tool. It was determined that staff did not identify anything needing additional training on, but appreciated continuing to receive reminders and overviews on the diet assessment steps at staff meetings. As part of our Oregon WIC listens training, we are planning to incorporate regular discussions in our weekly staff meetings including reminders on the diet assessment process.

*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: Yes, staff has definitely changed their approach to individual counseling. This change is due in part to completing the Nutrition Risk and Dietary Risk Modules and also to our participation in the Fruit and Vegetable grant and change to motivational interviewing style. Our approach to individual counseling has changed to a client centered approach with the client doing more of the talking and the certifier listening more and assessing from the information provided. We are using probing questions to learn more from our clients. We are assessing our client's readiness to

change and providing support in the areas that are most important to our client.

**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 chose to increase the availability and promotion of fruits and vegetables at our worksite. We did not end up pursuing the exact strategy as proposed in our plan. We did as a group, however, continue to promote the use of fresh fruits and vegetables in our work area. In the summertime particularly we regularly brought fruits and veggies to share with co-workers such as grapes, zucchini and banana bread, etc. We also did much better this holiday season with not having a lot of sweets around throughout the season and really only had one bad week where we were inundated with goodies. That's a big improvement from the usual month of sweets between Thanksgiving and Christmas.

*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 chose the objective to decrease television and screen time for children. Our strategy was to offer the self paced lesson “Cut Back on Screen Time” for our F3 (voucher pick-up) and general nutrition classes for a period of 6 mos. We use F3 appointments for outreach clinic clients and also for clients in our main clinic who have a difficult time making it to classes.

We began offering this option in September 2008 and continued through February 2009. Results of the last page of the lesson were tallied from those that were turned in (clients had the option of keeping the lesson). Results show overwhelmingly that clients gained knowledge from working through the lesson. The answers were almost always correct, with the most likely incorrect answer related to the best amount of screen time for their child’s age. The self paced lesson was very well received by clients and we did a nice job of increasing awareness with our clients by using the lesson for a 6 month period.

**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:** The strategy that we chose worked very well for us. We have been dedicating time in our staff meetings for Linda Frei, our breastfeeding coordinator to discuss breastfeeding related information with us. We originally intended to do this the first staff meeting of each month, but ended up incorporating this into almost every staff meeting. This has worked well to keep staff up to date, as well as to encourage staff to promote breastfeeding in all WIC interactions when appropriate. I compared similar time periods in the current fiscal year with the last fiscal year and ran the report for Breastfeeding Initiation. Our initiation rate increased slightly from 83.8% to 84.6% in these reports. We are hoping to increase our duration rates in the years to come.

## FY 2009 - 2010 WIC Nutrition Education Plan Form

**County/Agency:** Klamath County  
**Person Completing Form:** Sue Schiess  
**Date:** 04/02/2009  
**Phone Number:** 541-883-4276  
**Email Address:** sschiess@co.klamath.or.us

Return this form electronically (attached to email) to: [sara.e.sloan@state.or.us](mailto:sara.e.sloan@state.or.us)  
by May 1, 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:**

Staff will complete the appropriate sections of the new Food Package Assignment Module by December 31, 2009. We will most likely complete this module as a group as soon as possible after it's release. Records of when and who completed the module will be kept.

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

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

**Implementation Plan and Timeline:**

Staff will attend the WIC Statewide Meeting in June 2009 and will also attend sessions on Infant Feeding Cues at that time. Staff who are unable to attend will receive the training in another manner, by December 31, 2009.

**Activity 3:** Each local agency will review and revise as necessary their nutrition education lesson plans and written education materials to assure consistency with the Key Nutrition Messages and changes with the new WIC food packages by August 1, 2009.

**Example:** Pregnant women will no longer be able to routinely purchase whole milk with their WIC FIs. If the nutrition education materials your agency uses indicates all pregnant women should drink whole milk, those materials would need to be revised.

**Implementation Plan and Timeline:**

Our local agency will review and revise our nutrition education lesson plans and written education materials to assure consistency with the Key Nutrition Messages and upcoming changes with the new WIC food packages. We will complete this review and revision 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:**

Attachment A will identify our training supervisor and our projected staff in-service training dates and topics. This will be completed and returned by May 1, 2009.

**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:**

Using state provided resources we will identify participant centered services skills that staff are using on a regular basis, as well as skills staff are working on and want to improve on. This will be accomplished by October 31,2009.

**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:**

Our weekly staff meetings will include a segment related to participant centered services. At least quarterly, we will review Continuing Education activities.

We will schedule time for staff to conduct peer to peer observations to enhance skills in participant centered services.

Both of these strategies will be implemented by December 31, 2009.

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

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

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

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

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

**Implementation Plan and Timeline:**

We will work with local partners in the community such as medical providers, the food bank, the local hospital, and head start to inform and update them on the changes with Fresh Choices. We will use a variety of methods for these interactions, written materials, phone conversations, in-service trainings, or whatever is appropriate for that particular partner. These contacts will be accomplished by October 31, 2009.

**Activity 2:** Each agency will collaborate with the state WIC Research Analysts for Fresh Choices evaluation by April 30, 2010.

**Example:** Your agency is a cooperative partner in a state led evaluation of Fresh Choices such as hosting focus groups or administering questionnaires with participants.

**Implementation Plan and Timeline:**

We will collaborate with the state WIC Research Analysts as requested by April 30, 2010.

**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 use the state provided resources to assess our breastfeeding promotion and support activities and then will identify our strengths and weaknesses and strategies for improvement 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:**

By April 30, 2010, we will have implemented at least one identified strategy from Goal 4, activity 1.

**Local Health Department: Klamath County**

**Plan A – Chosen Focus Area: **Increase the Official Health Department Clinic Rate****

**March 2008-April 2011**

<b>Year 1: March 2008-April 2009</b>				
<b>Objectives</b>	<b>Methods / Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sub>1</sub></b>	<b>Progress Notes<sub>2</sub></b>
<p><b>A)</b> Increase the <i>Official Health Department Clinic Rate</i>* for the Klamath County Health Department (KCHD) by 6% over three years. The 2007 rate was 78%.</p> <p>* The <i>Official Health Department Clinic Rate</i> is defined as the number of 24-35 month olds fully covered with the 4:3:1:3:3:1 series on December first of each year. The <i>Rate</i> is published each March by OIP in the Annual Assessment of Immunization Practices.</p>	<p><b>A1)</b> Expand the current recall and reminder system to include all clients beginning at 20 months of age and continuing until the December 1<sup>st</sup> after their 2<sup>nd</sup> birthday at which time they are no longer included in the <i>Official Health Department Clinic Rate</i>.</p> <p><b>A2)</b> Work with the Oregon Immunization Program to obtain an accurate list of all children included in the <i>2008 Official Health Department Clinic Rate</i>. KCHD will review the list in detail and correct any inaccuracies before the <i>Rate</i> is published.</p>	<p><b>A)</b> The <i>2008 Official Health Department Clinic Rate</i> provided by OIP will increase by 2% over the <i>2007 Rate</i>.</p>	<p><b>A)</b> The <i>2008 Official Health Department Clinic Rate</i> provided by OIP decreased 10% below the <i>2007 Rate</i>.</p>	<p><b>A)</b> The <b>Methods / Tasks</b> were implemented as planned, however immunization decreased instead of increased.</p>

<p><b>B)</b> Increase immunization rates* for 2-year-old WIC participants by 4% over three years. The 2005 rate was 71.1%.</p> <p>* Up-to-date rate for 4:3:1:3:3:1 series for children age two residing in our county and registered with WIC.</p>	<p><b>B1)</b> Ask OIP for a current 2007 rate for use as baseline.</p> <p><b>B2)</b> Ask for support and participation from KCHD Director. Open dialog with WIC Management and employees.</p> <p><b>B3)</b> Create office protocol on how to receive WIC clients. Policy will take into account differences in office hours between WIC and KCHD and standardize the flow between the two offices.</p>	<p><b>B1)</b> No increase in rates is expected the first year. An ongoing dialog with WIC staff will be considered a positive outcome the first year.</p> <p><b>B2)</b> Any vouchers collected will be counted and documented as a year 1 baseline.</p> <p><b>B3)</b> Patient flow protocol; will be adopted and put into practice by KCHD and WIC.</p>	<p><b>B1)</b> No increase in rates is expected the first year.</p>	<p><b>B)</b> We have reached agreement with WIC and HD Management to increase immunization assessments during WIC visits and to facilitate referrals of clients from WIC to H.D. Clinic for immunizations. We are currently working on a protocol, a voucher system, and on solving a technical problem that is hindering progress.</p>
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<sup>1</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>2</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

<b>Year 2: March 2009 – April 2010</b>				
<b>Objectives</b>	<b>Methods / Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>3</sup></b>	<b>Progress Notes<sup>4</sup></b>
<b>A)</b> Increase the <i>Official Health Department Clinic Rate</i> for the Klamath	<b>A1)</b> Reevaluate effectiveness of current Methods and Tasks.	<b>A)</b> The <i>2009 Official Health Department Clinic Rate</i> will increase by 2% over the <i>2008</i>		

<p>County Health Department (KCHD) by 6% over three years.</p>	<p><b>A2)</b> Continue Methods and Tasks that seem to be working.</p> <p><b>A3)</b> Adjust or replace those Methods and Tasks that do not seem to be working.</p>	<p><i>Rate.</i></p>		
<p><b>B)</b> Increase immunization rates for 2-year-old WIC participants by 4% over three years.</p>	<p><b>B1)</b> In addition to counting Dtap's, WIC personnel will be downloading and distributing ALERT records to parent of each client as part of their immunization screening and referral process.</p> <p><b>B2)</b> WIC staff will refer client to KCHD immunization clinic using voucher system or client's PCP as indicated by ALERT forecast.</p> <p><b>B3)</b> Patient flow protocol will be reviewed with WIC and KCHD staff and changed as needed.</p>	<p><b>B)</b> Immunization rates for 2-year-old WIC participants will increase by 2% over the previous year.</p> <p><b>B2)</b> WIC vouchers will be collected and counted to determine an increase in referrals directly to KCHD.</p>		

<sup>3</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>4</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

<b>Year 3: March 2010 – April 2011</b>				
<b>Objectives</b>	<b>Methods / Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes<sup>6</sup></b>
<p><b>A)</b> Increase the <i>Official Health Department Clinic Rate</i> for the Klamath County Health Department (KCHD) by 6% over three years.</p>	<p><b>A1)</b> Reevaluate effectiveness of current Methods and Tasks.</p> <p><b>A2)</b> Continue Methods and Tasks that seem to be working.</p> <p><b>A3)</b> Adjust or replace those Methods and Tasks that do not seem to be working.</p>	<p><b>A)</b> The <i>2010 Official Health Department Clinic Rate</i> will increase by 2% over the <i>2009 Rate</i>.</p>		
<p><b>B)</b> Increase immunization rates for 2-year-old WIC participants by 4% over three years.</p>	<p><b>A1)</b> Reevaluate effectiveness of current Methods and Tasks.</p> <p><b>A2)</b> Continue Methods and Tasks that seem to be working.</p> <p><b>A3)</b> Adjust or replace those Methods and Tasks that do not seem</p>	<p><b>B)</b> Immunization rates for 2-year-old WIC participants will increase by 2% over the previous year.</p> <p><b>B2)</b> WIC vouchers will be collected and counted to determine an increase in referrals directly to KCHD.</p>		

	to be working.			
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<sup>5</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>6</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

**Local Health Department: Klamath County**

**Plan B – Chosen Focus Area: Increase Promotion of the ALERT Immunization Registry**

**March 2008-April 2011**

<b>Year 1: March 2008-April 2009</b>				
<b>Objectives</b>	<b>Methods / Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>7</sup></b>	<b>Progress Notes</b>
<p><b>A)</b> Transition from our current ALERT reporting system (CMHC) to IRIS (or the replacement registry when IRIS and ALERT are replaced).</p>	<p><b>A1)</b> Create agreement with KCHD Management to transition to IRIS.</p> <p><b>A2)</b> Identify key personnel and obtain the training they need to report immunizations to IRIS. Amanda Timmons has indicated she can provide the training here in Klamath Falls.</p> <p><b>A3)</b> Obtain the necessary software, hardware, security clearance, etc. for key personnel to access and report to the IRIS system.</p> <p><b>A4)</b> Begin reporting to IRIS.</p>	<p><b>A)</b> Be reporting the majority of vaccines we give to IRIS by March, 2009.</p>	<p><b>A)</b> We are reporting the majority of vaccines we give to IRIS as of March, 2009.</p>	<p><b>A)</b> The transition to IRIS has been accomplished.</p>

<p><b>B)</b> Monitor data quality using IRIS reporting functions.</p>	<p><b>B1)</b> Ask OIP for a current 2007 rate for use as baseline.</p> <p><b>B2)</b> Improve timeliness of data reporting to IRIS.</p>	<p><b>B)</b> Rate will increase to 90% timely data entry as measured by OIP by December 31, 2008.</p>		
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<sup>7</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>8</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

<b>Year 2: March 2009-April 2010</b>				
<b>Objectives</b>	<b>Methods / Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>9</sup></b>	<b>Progress Notes<sup>10</sup></b>
<p><b>A)</b> Transition from our current ALERT reporting system (CMHC) to IRIS (or the replacement registry when IRIS and ALERT are replaced).</p>	<p><b>A1)</b> Transition to the IRIS/ALERT replacement system currently scheduled to deploy in late 2009.</p>	<p><b>A)</b> Be reporting the majority of vaccines we give to the IRIS/ALERT replacement system by March, 2010.</p>		
<p><b>B)</b> Monitor data quality using IRIS reporting functions.</p>	<p><b>B1)</b> Run “Forecast Shots Not Given” every 4 months.</p>	<p><b>B)</b> Conduct training with staff as needed.</p>		

	<p><b>B2)</b> Review data for patterns or things that stand out.</p> <p><b>B3)</b> Train or discuss issues with staff.</p> <p><b>B4)</b> If year 2 seems successful, continues into year 3.</p>			
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<sup>9</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>10</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

<b>Year 3: March 2010-April 2011</b>				
<b>Objectives</b>	<b>Methods / Tasks</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results<sup>11</sup></b>	<b>Progress Notes<sup>12</sup></b>
<p><b>A)</b> Transition from our current ALERT reporting system (CMHC) to IRIS (or the replacement registry when IRIS or ALERT are replaced).</p>	<p><b>A1)</b> Reevaluate effectiveness of current Methods and Tasks.</p> <p><b>A2)</b> Continue Methods and Tasks that seem to be working.</p> <p><b>A3)</b> Adjust or replace those Methods and Tasks that do not seem to be working.</p>	<p><b>A)</b> Be reporting 100% of vaccines we give to the IRIS replacement system by March, 2011.</p>		
<p><b>B)</b> Monitor data quality using IRIS reporting functions.</p>	<p><b>B)</b> Continue year 2 activities. Modify as needed.</p>	<p><b>B)</b> Conduct training with staff as needed.</p>		

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<sup>11</sup> **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

<sup>12</sup> **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.