



*Coos County*

*Public Health*

# **COMPREHENSIVE PLAN**

## **2010 – 2012**

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## I. Executive Summary

The Oregon Legislative Assembly enacted into law that “each citizen of this state is entitled to basic public health services which promote and preserve the health of the people of Oregon.” Coos County Public Health continues to provide the 5 essential services required by Oregon law to meet the health needs of the community. Through these mandated services, we are addressing important social and health problems and state benchmarks: teen pregnancy prevention, child abuse prevention, adequate prenatal care, adequate immunizations for children, protection from communicable diseases, and assurance of safe food and drinking water for the public. We also record vital statistics and provide health information and referral sources. We have set goals and action plans for the 5 basic services and have also included an additional action plan to address emergency preparedness. Completion of these plans as submitted, and provision of services is contingent upon the receipt of adequate funding from the state and federal government.

The recent nation-wide county health ranking project found that our county is one of the least healthy in Oregon. Some health indicators have been consistent over recent years, showing little improvement or worsening of poverty, hunger, child abuse, cancer, smoking, diabetes, and sexually transmitted diseases. We know that our efforts have helped individuals in some of these areas, and through our programs and services, we are attempting to also improve the health of the population as a whole. The leading causes of preventable death in our county continue to be tobacco use, followed by diet, obesity and inactivity—individual behaviors that can be influenced by policy and system changes.

We are seeing some progress. Our county-wide immunization rates and our teen pregnancy rates are lower than the state average. Families served in our parent child health home visiting programs have been helped by our expert staff, and are nurturing their children. Our WIC program is serving an increasing number of women and children (over 3200 annually) to help them get the nourishment needed for proper development. We are helping the small public water systems address their water quality issues. And we continue to improve our response plans for pandemic illness and natural disasters as we build on our experience this past year in immunizing our most vulnerable population against H1N1.

Our budget is projected to be \$2.69 M for FY 2010/11. We expect to carry out our public health mission with the work of 28.15 FTE employees, including extra help. The loss of 25% of our staff positions over the past 5 years means that we will be unable to respond to significant public health emergencies without additional funding. Further reductions in staffing would threaten our ability to meet our “everyday” mandates. Our highly trained and dedicated public health employees have worked harder than ever to meet the mandated requirements, and they have accomplished a lot with the minimal resources.

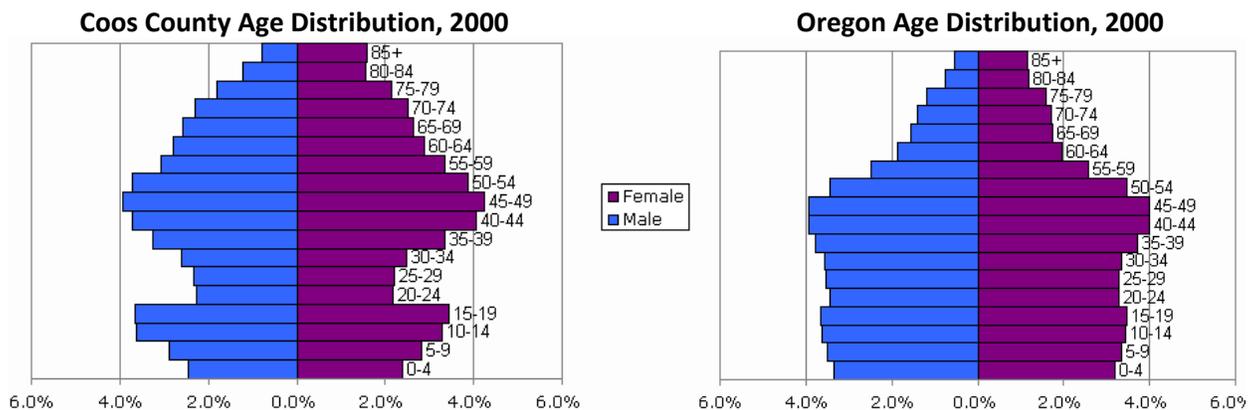
## II. Assessment

Note: Much of the following information is reprinted from the Coos County Annual Report 2008-2009, which is found on the website, [www.co.coos.or.us/ph](http://www.co.coos.or.us/ph). Some statistics have been updated.

### Demographics and Public Health Indicators

The **63,453** persons living in Coos County on the southern Oregon coast have a **median age of 43.1 years**. Residents in this mostly rural county live as part of one of the seven communities spread over **1,629** square miles. The average household size is **2.3** and the average family size is **2.84**. In 2008, Coos County's ethnicity was comprised of:

- **92.5%** white, or **88.3%** white non-Hispanic,
- **4.8%** Hispanic or Latino,
- **3.1%** persons reporting two or more races,
- **2.6%** Native Americans,
- **1.1%** Asians,
- **0.5%** Black or African Americans, and
- **0.2%** Hawaiian/Pacific Islanders.



It is common for some Coos County youth to leave the area after high school to obtain higher education and to get jobs.

According to the 2006-2008 American Community Survey from the US Census Bureau, in Coos County, of those 25 years old and older:

- **85.6%** have a high school diploma or equivalent (State: 88.1%).
- **26.8%** have some college, no degree (State: 25.6%).
- **7.0%** have an associate's degree (State: 8.0%).
- **17.6%** have a bachelor's degree or higher (State: 28%).

According to the 2008 U.S. Census Bureau statistics, in Coos County:

- The median household income was **\$37,128**. (State: \$50,165).
- **17.8%** of the population live below the poverty line. (State: 13.5%)
- **26.2%** of children, under age 18 years old, live below the poverty line. (State: 17.8%).

According to the Oregon Labor Market Information System, as of March 2010 Coos County seasonally adjusted unemployment rate was **12.1%** (State: 10.6%).

**HEALTH INSURANCE:** As of July 2009, **15.2%** of the population (9,647 people) were eligible for the Oregon Health Plan (Medicaid); of those, **87.6%** were enrolled. In 2007, **53.9%** of the birth deliveries in the county were paid by the Oregon Health Plan (40% statewide).

According to the 2004-2007 Behavioral Risk Factor Surveillance System (BRFSS) **20.1%** of Coos County adults reported to be without health insurance (State: 17.2%). And **16%** of children (1,839 total children) were without health insurance (State: 12%).

According to the 2007-2008 Oregon Healthy Teens survey, in Coos County **16%** of 8th graders and **22.1%** of 11<sup>th</sup> graders reported physical health care needs that had not been met in the previous 12 months.

**HUNGER:** The US Department of Agriculture reports that for 2006-2008, Oregon had the second highest rate of hunger in the nation. The Oregon Food Bank Network distributed 66.2 million pounds of food in 2008/09 – the highest amount distributed by the statewide network in a single year. Locally in Coos County in 2008:

- **18,537** food boxes were distributed.
- **11,194** people received food stamps (State: 438,817 people).
- **53.4%** of school children qualified for Free and Reduced Lunch Programs, which is up from 48.2% in 2007/08 (State: 46.1%); of those, **76%** received school breakfast (State: 36%), and **40%** ate meals through the Summer Food Program (State: 31%).

## Behavioral Factors

Public Health concerns in Coos County have multiple causes. Some major issues are:

**ALCOHOL AND DRUG USE:** Among Coos County adults, according to the 2004-2007 BRFSS, **65.3%** of males and **50.2%** of females reported having at least one drink in the last 30 days. And on the 2007-2008 Oregon Healthy Teens survey (OHT):

- **33.9%** of 8<sup>th</sup> graders and **51.5%** of 11<sup>th</sup> graders reported having consumed beer, wine or liquor in the previous 30 days;
- **13.1%** of 8<sup>th</sup> graders and **30.4%** of 11<sup>th</sup> graders have reported having 5 or more drinks in a short period of time during the last 30 days; and
- **14.9%** of 8<sup>th</sup> graders and **25.6%** of 11<sup>th</sup> graders reported use of illicit drugs including marijuana, inhalants, prescription drugs, stimulants, cocaine, heroin, ecstasy and/or LSD, during the past 30 days.

**TOBACCO USE:** The 2004 to 2007 aggregated data on smoking prevalence shows Coos County with an adult prevalence of **26.6%** which was the 6<sup>th</sup> highest in the State. (State: 18.7 %) The 8th grade smoking rate was **13%** (State: 9%) and the 11<sup>th</sup> grade rate was **19%** (State: 17%). Also **8%** of 8<sup>th</sup> graders and **15%** of 11<sup>th</sup> graders chewed tobacco (State: 5% and 12% respectively).

In Coos County in 2007, **23.4%** of pregnant women smoked, double the State rate of 11.7 %. The smoking rate in Medicaid clients in Coos County was **37%**. An estimated **26%** of all deaths in our county are smoking related (27% in 2005). The annual death rate from tobacco related diseases in Coos County from 2002-2005 was **243.6 per 100,000**, sixth highest in the State. (State: 184.8) The incidence of

tobacco related cancers at **186.6 per 100,000** was third highest in the state, with a tobacco related cancer death rate of **120.1** which was the highest in the state. The state rate was 87.5.

## Disease Burden

**CANCER:** Figures for 1997-2006 show an annual percentage change of -1.5 over the 10 year period. As of 2006, Coos County has the **2<sup>nd</sup> highest** age adjusted rate of all cancer incidences (new cases) in the State at **534.7** per 100,000 individuals. (State: 481.5) Much of this is a consequence of historically high smoking rates. All the following rates are age adjusted for Coos County (ranking based on 36 counties in Oregon):

- Achieved age adjusted death rate of all cancers of **224.7** (State: 196.2), ranking **2<sup>nd</sup> highest** in the State.
- Ranked **highest** in State for incidence of lung cancer at **91.1** per 100,000 (State: 70.3) and **highest** for lung cancer deaths at **76.5** per 100,000 (State: 56.4); **84** invasive cases per year.
- Ranked **highest** for oral and pharyngeal cancer with an average yearly rate of **14.9** per 100,000 (State: 11.1) and **highest** for related deaths at **4.2** (State: 2.8).
- Ranked **2<sup>nd</sup> highest** in the State for bladder cancer, with an average yearly rate of **29.2** per 100,000 (State: 23.5) and the highest for bladder cancer deaths at **6.9** (State: 4.8).
- Ranked **3<sup>rd</sup> highest** in the State for age adjusted rate of malignant melanoma with a rate of **28.2** per 100,000 (State: 23.2; Douglas and Deschutes were 1<sup>st</sup> and 2<sup>nd</sup>).
- Had the **9<sup>th</sup> highest** incidence rates of **178.8** (State: 158.4) for prostate cancer, with age adjusted related deaths at **26.5** (State: 29.4).
- Had the **18<sup>th</sup> highest** rate of breast cancer, at **132.5**, lower than the State levels of 139.8, for an annual percentage decline over 10 years of -3.7.
- Was **25<sup>th</sup>** in the State for colon and rectal cancer incidence at **46.2** (State: 48.5).

**OTHER CHRONIC DISEASES:** **Asthma** continues to present a health burden to residents of Coos County with a population prevalence of **9.3%** as measured by a combined 2004-2007 BRFSS survey. This means over **5,901 people in Coos County suffer from asthma**. The State asthma prevalence is 9.9%. According to the 2007-2008 Oregon Healthy Teens survey, **19.7 %** of 8<sup>th</sup> graders and **22.4%** of 11<sup>th</sup> graders have been diagnosed with asthma. The asthma rate for the Medicaid population is more than double that of privately insured persons. Of Oregon counties, Coos County had the **3<sup>rd</sup>** highest rate of hospitalization for asthma, at **13.5** per 10,000 residents, with a total of **438** hospitalizations for asthma from 2001-2005.

- Data from the 2004-2007 BRFSS surveys show that **46.2%** of adult Oregonians experienced chronic joint symptoms that were not formally diagnosed as arthritis in the last 30 days; **26.9%** of adult Oregonians reported to suffer from diagnosed **arthritis**. Of those diagnosed, 31.7% reported limitations in usual activities and only 13.1% have ever taken a class in management of their condition. **28.7%** of Coos County adults (age adjusted) have arthritis (State: 26.9%). **Arthritis is the leading cause of disability in the U.S.**
- The age adjusted **death rate from diabetes** in Coos County in 2007 was **33.2** per hundred thousand compared to 27.7 for the state. Diabetes provides a significant contribution to poor

health in Coos County. The age adjusted **diabetes rate in Coos County** is **8.4%** (State rate 6.5%). It is estimated that 2.4% of the residents have undiagnosed diabetes. This means that currently well over 9%, or 5,700 of the people in Coos County, could have diabetes. This number is expected to grow markedly as a result of our high rates of smoking and obesity. Smoking a pack of cigarettes a day is associated with a 61% increased risk of diabetes.

- **Cardiovascular disease** is the number one cause of death in Coos County. From 2004-2007, the average annual age adjusted prevalence rates were **3.5%** (State: same) for heart attack, **4.5%** for coronary heart disease (State: 3.6%), **2.2%** for stroke (State: 2.3%), **29.8%** for elevated cholesterol (State: 32.3%), and **32.7%** for high blood pressure (State: 24.8%). The unadjusted death rate from heart disease in 2006 was **345** per 100,000, or a total of 219 people in Coos County.

**OVERWEIGHT AND OBESITY:** Obesity has become the second most important preventable cause of disease, disability and death after smoking. The latest reported figures (2004 to 2007) indicate **36.2%** of Coos County adults are overweight and **27.8%** are obese compared to 36.3% and 24.1% respectively for the State. The 2007-2008 Oregon Healthy Teen Survey reports that in Coos County **15.7%** of 8<sup>th</sup> graders are overweight (State: 15.2%) and **10.8%** obese (State: 10.7%); and **17.4%** of 11<sup>th</sup> graders are overweight (State: 14.9%) and **10.9%** obese (State: 11.9%).

**COMMUNICABLE DISEASE:** During FY 08/09, 790 reports of communicable disease were received by the public health department, and 213 were confirmed cases. The number of Chlamydia cases reported to the Health Department has been consistently high over the years, with **96** new cases in FY 2008/09. There were **9** new cases of gonorrhea, and no new cases of syphilis. Other reportable diseases included: **180** reports of chronic hepatitis C; **5** new confirmed cases of salmonella; **1** confirmed case of meningococcal disease; and **1** active case of tuberculosis, with **6** latent cases. There were four outbreaks of GI illness involving many people at 4 facilities, with 2 of those outbreaks confirmed as caused by norovirus. Gastro-intestinal illness was also the affliction in the cases of campylobacter (13), giardia (10), and salmonella (5). The fall of 2009 was also the season of H1N1 influenza, and flu cases were added to the list of reportable diseases. Coos had 31 hospitalizations for H1N1 flu, (county rate: 49 per 100,000; state rate: 31.2) and 1 death.

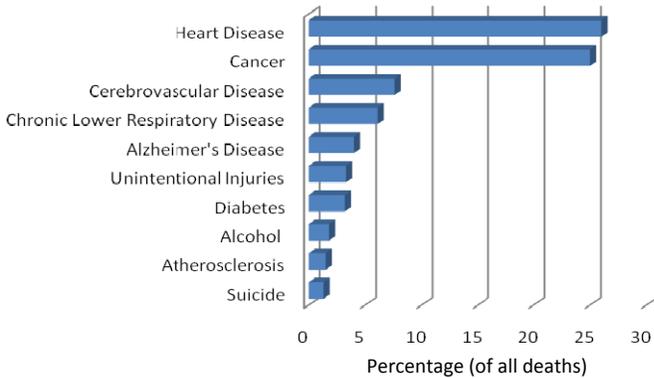
## Causes of Death

**INFANT MORTALITY:** In 2007, the infant mortality rate for Coos County was 6.1 per 1,000 or a total of 4 infant deaths. Coos County ranked 22nd in the state which had a rate of 5.6.

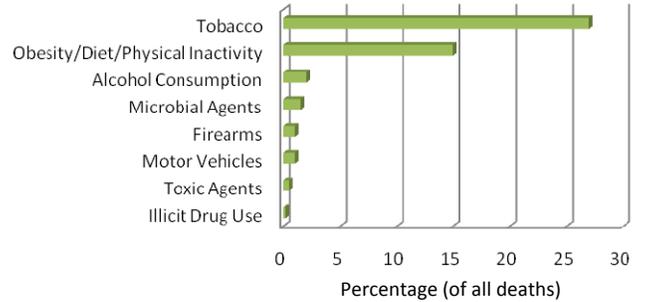
**LEADING CAUSES OF DEATH** in Coos in 2006 (most recent state data), in rank order were:

1. heart disease
2. cancer
3. chronic lower respiratory disease
4. cerebrovascular disease
5. unintentional injuries
6. diabetes
7. alzheimers
8. suicide
9. alcohol induced disease, and
10. flu and pneumonia

### Top 10 Causes of Death in Coos County

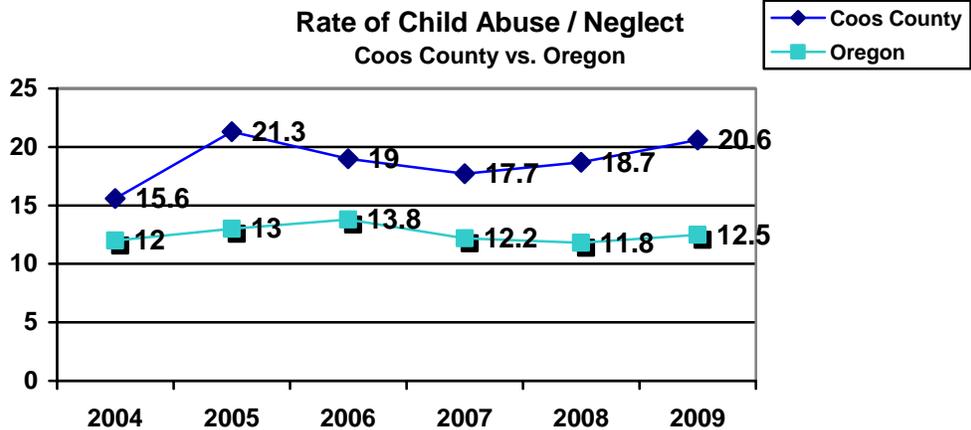


### Actual Leading Preventable Causes of Death in Coos County



## Family Health

**CHILD ABUSE:** Coos County’s rate of child abuse and neglect had declined over a three-year span from 2005-2007. However the Coos rate rose in 2008 and again in 2009 to **20.6** per 1,000 children (State:12.5). Coos was ranked 9<sup>th</sup> (highest) of the 36 counties for victims of abuse/neglect. In 2009, there were **376** incidents of child abuse and neglect (254 children, some with >1 incident) and **145** foster care entrants in Coos County, compared to 292 incidents of abuse and 127 foster care entrants in 2008 respectively. Most of the abuse in Coos was characterized as *neglect* and *threat of harm*, with younger children being most affected.



## PREGNANCY & BIRTH:

Of the **654** total births (preliminary data) in Coos County in the 2008 calendar year:

- **86%** were to women 20 years old or older (State: 91%),
- **11%** were to women 18 to 19 years old (State: 6%),
- **2%** were to girls 10 to 17 years old (State: 3%),
- **7.8 %** gave birth to low birthright infants (State: 6%).
- **43.9%** were to unmarried mothers (State: 36.2%).

Statistically, unmarried women, as a group, have lower incomes, are more likely to smoke than married women, and have a greater proportion of low-birth weight babies. Compared to infants of normal weight, low birth weight and very low birth weight infants are at increased risk for impaired development and infant death. Smoking during pregnancy is the single greatest risk factor for low birth weight.

Coos County reached the highest rate in the state of inadequate prenatal care in 2006 and 2007 with rates of 14.6% and 14.9% (state: 6.2% and 6.4%, respectively). The preliminary data shows improvement, with a rate of 10% inadequate care in 2008 and 8.7% in 2009 (state 6.9% and 6.1%). Preliminary data for 2009 also show 72.6% of pregnant women starting care in the first trimester (state: 71.6%)

### **TEEN PREGNANCY:**

There were 26 pregnancies in Coos County teens aged 15-17 in 2007, a rate of **19.6** (state 25.7). The preliminary rate for 2008 is **13.9 per 1,000 with 17 pregnancies**, and the preliminary rate for 2009 is 19.8 with 24 pregnancies. Both of these preliminary rates are below the state rates and surpass the 2010 benchmark of 20 pregnancies per 1,000. (The teen pregnancy rate includes both births and abortions; the number of miscarriages is unknown.)

The drop in teen pregnancy cannot be attributed to an increase in abstinence, as 61.5% of Coos County 11th grade females report that they have “had sexual intercourse” (50.1% statewide). Of those 11th grade females in Coos County who had sex, 82.8% of the females and 89% of the males reported using a method to prevent pregnancy. (The Oregon Healthy Teen Survey, 2007/08.)

The birth rate in teens ages 15-17 decreased in 2007 to **12 per 1,000**, (n=16) which was lower than the state’s rate of 16.6. The previous year’s birth rate for Coos teens 15-17 was **21.1**. The 2007 abortion rate for teens, ages 15-17 was **7.5** (n = 10), which continues to be lower than the state rate of 9.1 for that age group.

## **Environmental Health Issues**

During FY 2008/09:

- On **14** separate occasions, alerts were issued for bacteria in public water systems used for drinking water systems.
- On **8** separate occasions, alerts were issued for chemical contaminants found in public drinking water systems.
- **5** municipal sewage treatment systems reported outflows of untreated sewage into fresh water.
- **4** health advisories (ranging from 1-20 days) discouraged recreational water contact on two ocean beaches as a result of elevated bacteria levels.
- **4** properties were maintained on the “**unfit for use list**” due to methamphetamine drug lab contamination.

### III. Description of and Adequacy of the 5 Basic Services

(Required by ORS 431.416)

#### 1. Epidemiology & Control of Preventable Diseases & Disorders

**COMMUNICABLE DISEASES.** Public Health staff (public health nurses, environmental health specialists, and the health officer) follow up on any confirmed or suspected cases of over 50 diseases and conditions for which medical providers and labs in Coos County are required by law to report to the health department. The environmental health specialists assist with investigation and prevention of food and water borne illness. We coordinate these reports with state public health. Our health department also reports any clients that we have diagnosed with reportable conditions in our clinic.

Funding is insufficient to have staff dedicated solely to investigation of communicable disease reports (n=790 reports in FY 09/10). Our communicable disease nurse also serves as the immunization coordinator, family planning coordinator, clinic supervisor, and assists with direct client services in the clinic. The other clinic nurse who serves as back-up investigator is also the family planning nurse. The required completion of investigations by Fridays, especially when the case is reported on a Friday, is an ongoing challenge. Communicable diseases that require an immediate response, such as meningococcal disease, do take priority over other duties assigned to clinic staff.

Nurses are assigned to respond to the CD calls and investigations 24 hours a day, 7 days a week. After hours, calls are relayed to public health through our dispatch 911 service. (An updated contact schedule for public health personnel is provided each Friday to the Sheriff's office 911 dispatch office.) As we learned during the H1N1 pandemic of 2009/10, a large outbreak or public health emergency would require far greater resources than this department has available. Federal dollars were provided for the H1N1 response. County dollars are not available to support a response to a significant local outbreak.

**IMMUNIZATIONS** are provided to children and adults, with an emphasis on timely immunization of infants and young children, as they are most vulnerable to illness and disability from vaccine preventable diseases. Rabies immunizations are available through Bay Area Hospital.

**SEXUALLY TRANSMITTED DISEASES** which are reported by other agencies and clinicians to the Health Department are investigated, and medications are provided to contacts. There is no state or county funding for persons who are seeking initial diagnosis or screening for STIs through the Health Department. Several foundations have provided vouchers to help fill this need, and the Coquille Tribal Community Fund has been the greatest benefactor for the past 2 years.

**OTHER PREVENTABLE CONDITIONS.** We are a contract provider for the breast and cervical cancer screening program. The number of women we serve (ages 50-64) is strictly limited, based on the funding through that contract. Our efforts continue to address the prevention of tobacco related illness through our state funded tobacco prevention program, where the coordinator focuses on population based strategies in collaboration with community partners. We have been one of the 12 counties with funding to address the burden of chronic disease in our community, and staff who work in the *Healthy Communities* program work closely with the tobacco prevention coordinator on policy and system changes.

## 2. Parent & Child Health Services, Including Family Planning Clinics

(Required by: ORS 435.205)

**PARENT HOME VISITING SERVICES** for families are provided in Healthy Start / Healthy Families America (funded through the Commission on Children & Families), Babies First! and the CaCoon programs. In these programs, 233 clients were served during the last fiscal year. Current staffing in the public home visiting programs include 2.4 FTE of public health nurses, with additional nurse time contracted at .6 FTE to work with DHS's Self Sufficiency JOBS Program. In addition, we have three full time professional parent educators (who are not nurses), only one of which is now dedicated full time to Healthy Start/Healthy Families America, due to state budget cuts in that program. Our home visiting programs are highly accessible as we provide services throughout Coos County. Our programs are in demand, and we usually have clients on a waiting list.

All Parent Educators provide parent education, advocacy, and support to parents. In addition, we focus on prevention of family violence, prevention and intervention for substance abuse, SIDS risk reduction, child nutrition, immunizations, child safety, developmental screening, and case management. All home visitors in the Maternal Child Health Home Visiting programs are supervised by an experienced Public Health Nurse with a Masters in Public Health, who also serves a limited caseload. All parent educators (nurses and public health aides) are certified in and use the *Parents As Teachers* curriculum, in addition to the program specific protocols.

All of our home visiting programs are based on best-practice models and work to prevent child maltreatment through the provision of services that strengthen families. In addition to our primary prevention programs, our home visiting staff are a partner with State Child Welfare and the *Zero to Three* Court team, where we help families develop parenting skills as they prepare to regain custody of their children.

Oregon's Public Health home visiting programs are currently in the process of being reframed to align with evidence-based models, standardization, evaluation, and statewide applicability. Coos County Public Health anticipates there will be significant changes in the structure of our current home visiting programs. We anticipate that we will, once again, provide home visiting services to expectant women during the prenatal period and immediate post partum period. Based on eligibility criteria, home visiting services to these families can continue until the child turns two years of age. Public Health will be working closely with other local home visiting programs (such as Healthy Start/Healthy families, the hospital's MOMS program, and Early Head Start) to coordinate services. The Nursing Manager is actively involved in the *Linkages and Referral* work group, which is striving to develop a universal screening/referral process.

**WOMEN, INFANT & CHILDREN NUTRITION PROGRAM** Our WIC program staff of 4.4 FTE efficiently served over 3200 participants last year, including 52% of the pregnant women in the county (statewide 38%), and issued \$1.2 million in WIC food vouchers. Although 89% of WIC mothers in Coos County start out breast feeding, our program has received WIC funding to initiate a peer led breastfeeding support project to improve the duration of breastfeeding in WIC participants. Our WIC program is currently compliant with all WIC requirements.

**OTHER PERINATAL SERVICES** Our nurses are unable to provide maternity case management home visiting services to pregnant women at this time, due to the inadequate Medicaid reimbursement rates. We refer to the Bay Area Hospital MOMs program and the newly initiated Early Head Start program in Coos County. Through our *Oregon MothersCare* program, assistance is offered to pregnant women for enrolling in the Oregon Health Plan for health insurance and in obtaining prenatal care with local physicians. We also continue to partner with other agencies interested in improving the perinatal outcomes of pregnant and postpartum women through the Coos County Perinatal Task Force.

**FAMILY PLANNING** Our department provides Title X Family Planning services through the DHS contract, and also contracts with the Oregon Medical Assistance Program to provide contraceptive services through the Medicaid Family Planning Expansion Project (FPEP), newly named Oregon Contraceptive Care. The administrative burden to meet the requirements of the Title X program is greater than for any other program provided by our department, and the costs exceed the resources provided by the state and federal government. We have seen a decline in the number of FPEP clients served in our clinic each year since the local Federal Qualified Health Center, Waterfall Community Health Center, became a contractor for the FPEP program. A nurse practitioner is available 3 days a week in our clinic. Currently, persons seeking contraceptive services are able to get an appointment at the Health Department's North Bend Annex clinic within 2 weeks. Services are also provided once a month at the Coquille satellite office.

**ADOLESCENT SERVICES** Teens are served in all of the programs listed above. Also, this past year we received funding for a certified school based health center (SBHC), located on the Marshfield High School Campus. In addition, we received funding for a planning grant to create a school-based health center in the rural town of Powers. This second site is expected to become operational in 2011. Public Health was instrumental as a pass through agency for funds to supplement the SBHC budget needs.

### 3. Collection & Reporting of Health Statistics

We register all deaths in Coos County, using the automated OVERS system, and forward the information to the state, as required by administrative rules. Births are now registered by the hospitals directly with the state through the automated system. Three deputy registrars are available to provide birth and death certificates within 24 hours of request, and often can respond immediately to walk-in requests for certificates.

Each program within the department is charged with collection of data to track services provided, demographics, and outcomes, which is compiled into an annual report each year found at [www.co.coos.or.us/ph](http://www.co.coos.or.us/ph). We enter data into the state data bases, including TWIST, Ahlers, ALERT, IRIS, OVERS, ORPHEUS, ORCHIDS, Phoenix, and WebRad. However, we are unable to retrieve local data from some of these systems, and must await state reports which may not be published until several years after the events, and at inconsistent time intervals.

Our public health staff do participate in numerous community coalitions and the comprehensive planning process conducted by the Coos County Commission on Children and Families. However, funding is not available for the Health Department to take the lead in a comprehensive planning for

community health improvement, with the exception for the assessment of chronic disease through the Healthy Communities program.

#### **4. Health Information & Referral Services**

All health department programs provide health information and referrals to programs within our agency and to other county departments, since the County no longer has a switchboard operator. Our support staff who answer the main switchboard spend significant time as a referral source to outside agencies that can help meet needs that are beyond the scope of our agency. Examples include referring to local resources for primary care, referring a pregnant woman to a medical doctor for prenatal care, referring a young parent for food stamps. We strive to keep up-to-date on our community resources and keep our referral lists current. Health education, with a prevention focus, is also a key component of our public health programs.

To enlighten the community about public health services, we continue to publish an annual report, post messages on our electronic sign on the front of the County Annex, send public service announcements regarding services and new developments, post educational bulletins, and speak to groups on various public health topics. Our expectations to complete our website may be realized within the next year, due to an increase in county IT staffing.

#### **5. Environmental Health Services**

The Environmental Health program licenses and inspects restaurants, motels, RV parks, pools, spas, and organizational camps. Our environmental health specialists teach and certify food handlers and also provide food service manager training. To protect from food-borne illnesses, we license and inspect temporary food events that are open to the public. We also investigate reported cases of food-borne and water-borne illnesses. We monitor over 70 small public water systems in our county. For a fee, we can perform assessments of septic and water systems for loan transactions. We also inspect correctional facilities, school kitchens, and daycare centers.

For the **on-site sewage disposal system** within Coos County, the Oregon Department of Environmental Quality (DEQ) maintains all regulatory oversight.

**SOLID WASTE** is not regulated by this department. Individual cities have independent solid waste ordinances, as does Coos County. Our staff frequently receive nuisance complaints related to illegal dumping and refer those calls to the applicable jurisdiction. Privately operated Sanitation/Garbage companies handle the majority of domestic solid waste within Coos County. Beaver Hill Disposal Site is the only solid waste disposal site within the county and is operated by Coos County. Regulatory oversight is provided by the DEQ.

**OTHER ENVIRONMENTAL HEALTH CONCERNS** expressed by our constituents (e.g. pollution, algae in water, mold) cannot be addressed by the staff, although they are capable, because there is no source of funding for these activities.

Staff consist of an Environmental Health (EH) Program Manager, who does his share of field work, and two EH Specialist trainees (1.4 FTE), with .9 FTE clerical support.

## IV. Adequacy of Other Services Important to Our Community

- Dental:** The water system serving our largest populated area has fluoridated water. Many others in our rural county are on small water systems without fluoridation or have private wells. Some dental education is conducted through WIC, OregonMothers Care, and home visiting programs, and nurses conduct visual "lift the lip" exams with children 0-5 during home visits. Care for children's teeth is discussed, and brochures on baby bottle tooth decay and toothbrushes are distributed. The maternal / child health staff are continuing to work with local dentists and community partners to increase access to dental care for pregnant women and children. We share educational resources with the dental hygiene society and provide "lift the lip" screening/referral services to children and parents in Healthy Start, WIC, SSP/TANF, and the Southern Oregon Community College's Family Center. Coos and Curry Counties recently received a \$500,000 grant from the Oregon Community Foundation to address the oral health needs of children grades K-3 through coordinating existing dental services, identifying gaps, and working to reduce the gaps. Implementation of that grant is expected by fall of 2010.
- Emergency Preparedness:** Our department's role in a declared emergency is to coordinate the health system response throughout the county. In response to a bioterrorist event or other public health emergency, we would also work to protect the public's health by preventing additional exposure to communicable agents and provide counter measures, such as vaccine and antibiotics. Staff have worked with the County Emergency Management staff to update the medical portion of the County's Emergency Response Plan and have drafted numerous plan specific to the public health response. We meet monthly with community partners to work on health system issues in emergency response.
- Health Education and Health Promotion:** Health education and promotion are components in all Health Department programs. Examples that we will continue to provide include breastfeeding support in WIC; food handler training; parent education for parents of newborns; safer sex practices for persons with STDs.
- Laboratory Services:** Our department has a CLIA waived lab, currently licensed as a PPM lab. We provide limited diagnostic and screening tests for our clients in the family planning and sexually transmitted disease programs.
- Medical Examiner:** The Medical Examiner in Coos County works out of the District Attorney's office.
- Nutrition:** Nutrition education and counseling is the primary focus of the WIC program. Nutrition counseling is also a component in our maternal child services, and family planning services. Our department is beginning activities to encourage system changes that will support weight control and prevention of heart disease.
- Older Adult Health:** This department provides flu shots and other immunizations to our older population. We currently are a contracted provider for the Breast and Cervical Prevention Program, which serves women (and men) ages 50-64 who meet the eligibility criteria. Through the Healthy Communities program, and a special grant, our department will help to support the *Living Well*

chronic disease self management program, which does provide interventions for elders with conditions such as arthritis and cardiovascular health problems.

8. **Primary Health Care:** Our department does not provide primary health care. We assist with the application process for the Oregon Health Plan, and we refer to local medical providers, including the local safety net providers in the Waterfall Community Health Center. We continue to provide limited assistance to persons seeking publicly funded insurance, and prescription assistance. Through Oregon MothersCare, we help pregnant women get appointments for prenatal care and apply for financial assistance. With the increase in enrollment in the Oregon Healthy Kids program, our department also assists some families with that application process.
  
9. **Shellfish Sanitation:** Services are provided locally through the Oregon Department of Agriculture (ODA). Commercial shellfish harvesting is regulated by ODA under ORS 622 and standards set by U.S. Food and Drug Administration. ODA provides routine updates to the public and Coos County Public Health on status of shellfish harvesting in specific coastal areas. If circumstances warrant, Coos County Public Health may take additional steps to alert the public to related sanitation issues.

## V. Action Plans for Public Health Services

### 1. Epidemiology & Control of Preventable Diseases & Disorders

#### COMMUNICABLE DISEASE INVESTIGATION & CONTROL

##### Current Conditions

In our communicable disease program, investigations of reportable conditions and communicable diseases are conducted, prophylactic treatment (if available) is provided for close contacts of a reportable disease, and investigation report forms are completed and submitted as per the Investigative Disease Guidelines. Staff in this program work closely with the hospitals, and provide consultation to health providers in the community and education to the general public on communicable diseases.

##### **Highlights:**

- Processed **790** reports of communicable diseases in FY 2008/09; investigations found **213** confirmed cases.
- Investigated **3** reports of **meningococcal disease**; **1** confirmed case. Each positive case requires in-depth, quick follow-up with prophylactic antibiotic treatment to prevent serious illness.
- Investigated 4 outbreaks of GI illness, involving many people at 4 facilities; 2 outbreaks were confirmed as caused by noro-virus.

Three Year Comparison of Selected Reportable Diseases in Coos County:

<b>Disease:</b>	<b>2008/09</b>	<b>2007/08</b>	<b>2006/07</b>
Campylobacter	13	12	13
Chlamydia	96	86	77
Giardiasis	10	9	14
Gonorrhea	9	3	2
Hepatitis B	5	1	8
Hepatitis C (chronic)	180	79	191
Pertussis	8	0	2
Salmonella	5	8	7
Syphilis	0	0	3

Sexually transmitted diseases continue to be the diseases reported most often, followed by gastrointestinal afflictions (campylobacter, giardia, and salmonella). Although the lab reports of chronic Hepatitis C are numerous, we are not required to investigate these cases.

**Continuing Activities:**

- Coos County Public Health (CCPH) continues to respond to communicable disease calls 24/7. We have trained individuals in CD 101, and also CD 303. One Environmental Health Specialist is also trained in CD 101 and 303, and the other EH specialists are in the process of being trained.
- We investigate all reported communicable diseases/condition within the investigative guidelines, and meet the compliance requirements. We will be improving our data collection on demographics for race and ethnicity, complete address of cases, and also hospitalization outcomes.
- We perform active & passive surveillance of community illness/reportable diseases and/or syndromes.
- We continue to receive and distribute public health alerts received from CDC, Health Alert Network, and other sources, as appropriate, to other community partners. Information is provided to the local providers via fax broadcast, e-mail and local media. This system is also in place for contacting city municipalities, public safety officers (fire & police), and veterinarians.

**Action Plan**

<b>FY:</b> July 2010-June 2011				
<b>Goal:</b> Control of reportable communicable disease which includes responding to communicable disease reports 24/7, investigation, education, prophylaxis, and prevention activities to assure the health of the public.				
<b>Objectives</b>	<b>Methods/Tasks</b>	<b>Outcome Measure/s</b>	<b>Outcome Measures Results</b>	<b>Progress Notes</b>
<b>A.</b> Continue to respond to communicable disease calls 24/7	Test the Coos County Public Health and dispatch procedures for reporting communicable disease two times a year.  Contact local labs, medical providers, and infection control professionals twice a year to encourage communicable disease reporting.	Coos County staff will respond to communicable disease reports and/or testing of the reporting system within 30 minutes of receipt of the report.  Documentation of contacts with local labs, medical providers, and infection control professionals at least twice a year.		
<b>B.</b> Investigate reportable diseases/conditions and carry out control measures in a timely manner according to the Oregon Investigative Disease Guidelines.	Using ORPHEUS, all diseases/ conditions will be investigated within the timelines provided in the state investigative guidelines and reported to the state communicable disease program.  Develop a procedure for the process and interaction between communicable disease staff and environmental health staff.	≥80% of cases will be investigated and reported within the timeline for the specific disease/condition.  Perform a test of the process with EH staff by using a discussion exercise for an E. coli outbreak and take corrective actions by 6/30/11.		

## TUBERCULOSIS CASE MANAGEMENT

### Current Conditions

Ongoing activities of our TB program include:

- Working cooperatively with Department of Human Services/Health Services and local medical providers to provide evaluation of positive PPD skin tests.
- Providing testing and treatment for any contacts to a person with known or suspected active TB, using the investigative guidelines.
- Ensuring that the active tuberculosis cases receive Directly Observed Therapy (DOT), as necessary, for the duration of therapy appropriate to their cases.
- Providing state supplied medication at no cost to those clients without medical insurance and/or limited resources when appropriate.
- Ensuring that follow-up sputum testing is done at the appropriate intervals during treatment of active TB.
- Submitting appropriate completed forms to the state TB division at the initiation of therapy, as further information is available, and at the completion of therapy for both active and latent disease.

In 2008/09, our CD staff investigated **5 possible cases** of tuberculosis, of which **one was determined to be active tuberculosis** with **10** contacts. Our Communicable Disease nurses performed **75 TB skin tests on 74 individuals**, not including staff members or close contact testing of potential active cases. **6 individuals were diagnosed with latent tuberculosis**; 1 refused treatment, and 5 individuals accepted treatment. However, since one individual moved out of the country, only 4 persons received ongoing antibiotic treatment and monthly evaluations.

### ACTION PLAN

<p><b>FY:</b> July 2010-June 2011</p> <p><b>Goal:</b> Prevent and control the spread of active Tuberculosis which includes identifying cases, treating cases, evaluating contacts of active cases, and screening of high-risk populations for TB infection.</p>				
<b>Objectives</b>	<b>Activities</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
Identify and treat active and latent Tuberculosis cases.	<p>a. Contact local labs, medical providers, and infection control professionals twice a year to encourage communicable disease reporting, including TB.</p> <p>b. Update the Tuberculosis policy and procedure (P&amp;P).</p> <p>c. Liaison with local homeless shelters and correctional facilities regarding P&amp;P for TB assessment/evaluation.</p>	<p>a. Documentation of contacts with local labs, medical providers, and infection control professionals at least twice a year.</p> <p>b. The TB P&amp;P will be updated using the current template from the state TB program. This will be completed by 12/31/2010.</p> <p>c. These institutions will include T.H.E. House, The Mission, and Coos County Jail. This will be completed by 6/30/2011.</p>		

## SEXUALLY TRANSMITTED INFECTIONS

### Current Conditions

- Chlamydia is Oregon's and Coos County's most common treatable STI.
- In FY 2008/09, 5.4% of teens and young adults that visited the Coos County Public Health family planning and STI clinics were infected with Chlamydia. This positivity rate meets the state's testing guideline for efficient use of publicly funded testing.
- Practitioners in Coos County identified 96 cases of Chlamydia, 0 cases of Syphilis, and 9 cases of Gonorrhea. Neither genital herpes nor genital warts are reportable, and therefore, statistics are not kept on these very prevalent STIs.
- Funding provided by the State for STI exams and treatment has been eliminated, which shifts costs to the clients who are seeking exams for initial evaluation. The Coquille Tribal Community Fund provided a \$5,000 grant to pay for exams for young people who otherwise had no means to pay for services.
- Communicable disease nurses follow-up on any STI cases and contacts which are required to be reported to public health, including those generated from our agency.

In FY 2008/09 our public health clinic provided:

- 540 Chlamydia tests,
- 40 Herpes tests.
- 10 Gonorrhea tests,
- 6 Syphilis tests, and
- 4,000 condoms for disease prevention, including the non-latex variety.

### Action Plan

<b>FY:</b> July 2010-June 2011				
<b>Goal:</b> Prevent and control the spread of sexually transmitted disease (chlamydia, gonorrhea, syphilis, & HIV)				
<b>Objectives</b>	<b>Activities</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
A. Provide STD case management service including surveillance case finding, and prevention activities.	Investigate reportable diseases/conditions and carry out control measures in a timely manner according to the Oregon Investigative Disease Guidelines.  Develop a policy/procedure (P&P) for Expedited Partner Treatment (EPT).  Offer free chlamydia testing in the Family Planning and STD clinics according to the state screening criteria.	At least 80% of gonorrhea and 50% of chlamydia cases are interviewed and counseled. Seventy-five percent of contacts are evaluated and treated.  A P&P for EPT will be developed by 12/31/2010.  The positivity rate for chlamydia testing will stay above 3% in FP and STD clinic.		

## **HIV PREVENTION**

### **Current Conditions**

In Coos County this past year, there were no new cases of HIV found through testing. Our department had received funding in FY 2009-10 for HIV prevention, after a lapse of funding in FY 2008-09. We have already received notice that our agency will not receive any prevention funding for FY 2010-11. We have found that once an outreach program has been discontinued, it takes extra effort to reestablish community contacts and retrain staff, and better outcomes are obtained with a program that continues from year to year. Case management services for persons living with HIV disease are contracted by the state with HIV Alliance from Lane County. After the case management program left our department, we lost an important connection with the HIV community that was useful for outreach efforts.

### **Action Plan**

**Time Period:** July 2010 – June 2011

**Goal:** Prevent transmission of HIV disease.

#### **Activities:**

- Continue to provide the state-funded HIV lab test to those who seek testing who meet the state's criteria for high risk. The fee for the office visit will be charged to the client, in the absence of prevention dollars paying for the nurse's time.
- Continue to offer condoms to high risk clients through the STD program, and for an affordable price at the front intake desk.

**Evaluation:** The number of positive HIV tests annually in Coos County.

## **TOBACCO PREVENTION, EDUCATION AND CONTROL**

### **Current Conditions**

In 2009, statistics from the DHS Tobacco Prevention and Education Program revealed that in Coos County:

- 27% of Coos County adults smoke tobacco (Statewide the rate is under 19%)
- 224 people die each year, on average, from tobacco use in Coos County
- More than 1 out of 4 county deaths are tobacco related.
- Each year, 4,378 county residents suffer from a serious illness caused by tobacco use.

The economic burden due to tobacco use disorder alone is substantial. Each year, over \$35 million is spent on medical care for tobacco-related illnesses and over \$37 million in productivity is lost due to tobacco-related deaths.

Tobacco use harms every tissue and organ in the body, contributing to a wide range of chronic diseases, and is the single greatest preventable risk factor for chronic disease. The greatest toll of chronic disease

from tobacco is from its contribution to cardiovascular disease. Tobacco smokers have 2 to 4 times the rate of coronary artery disease, the leading cause of death, and about twice the risk of stroke.

Cancer is the second leading cause of death. Tobacco use causes cancers of the bladder, oral cavity, pharynx, larynx (voice box), esophagus, cervix, kidney, lung, pancreas, and stomach, and causes acute myeloid leukemia. Ninety percent of lung cancer in women, and greater than 80% of lung cancer in men is attributable to tobacco use.

Cigarette smoking is associated with a tenfold increase in the risk of dying from chronic obstructive lung disease, and accounts for about 90% of these deaths.

Tobacco use is the single greatest cause of adverse pregnancy outcomes. Coos County's prevalence of smoking during pregnancy is twice the state level.

**Progress.** Coos County has made great progress towards reducing the burden of tobacco use through creating a tobacco free county. All three hospitals (Bay Area Hospital, Coquille Valley Hospital, and Southern Coos Hospital) have voluntarily created smoke free campuses; the City of Bandon has declared all city facilities, including parks, to be smoke free; several of the largest property managers have made all their properties smoke free; and SWOCC, the community college, is working towards a smoke-free campus.

### **Action Plan**

**Time Period:** July 2010 – June 2011

**Goal:** To reduce the burden of tobacco use in Coos County, using evidence based practices involving policy change, to create environments where the healthy choice is the easy choice.

Best practices research indicates that one of the most effective ways for communities to bring about sustainable changes in social norms about tobacco use is to create smoke free environments. Coos County's Tobacco Prevention and Education Program (TPEP), through funding from the state, is working to promote and create smoke free environments through sustainable policy changes.

### **Objectives:**

- By June 2011, a one day chronic disease summit will be held, bringing together community leaders, organizations, coalitions, businesses and individuals whose work impacts chronic disease. The focus will be on tobacco related and other chronic diseases, and the promotion and integration of the concept of using policy to create systems and environment change to make the healthy choice the easy choice.
- By June 2011, 4 of twelve county worksites will have adopted smoke free campus policies except for one designated smoking area per site, and 4 will have adopted physical activity or nutrition related policies.
- By June 2011, Coos County will have responded to all complaints of violation of the Smoke-free Workplace law according to the protocol specified in the intergovernmental agreement.
- By June 2011, 10 additional multi-unit rental housing properties will have adopted smoke-free policies.

- By June 2011, Southwestern Oregon Community College will have adopted a tobacco free policy with plans to implement the policy as of September 2011
- By June 2011, at least two additional opportunities to promote smoke free parks or events, other than in the City of Coos Bay, will have been identified, and campaigns to bring about smoke free policies in those venues will have occurred.
- By June 2011, Coos County Mental Health, Adapt, and Coos County Correctional Training Center will have forms and policies in place to assess each client's tobacco use status at each visit and will either integrate tobacco use counseling into each visit or refer clients to effective counseling resources.

Local program plans, with specific activities and evaluations, have been developed for each of the above objectives and have been submitted to the DHS-TPEP program.

## **CHRONIC DISEASE PREVENTION / HEALTHY COMMUNITIES PROGRAM**

### **Current Conditions**

During 2008-2009, Coos County Public Health's Healthy Communities Program completed a community-wide health assessment. The assessment found that the leading causes of death in Coos County are heart disease, cancer, and cerebrovascular disease. To a great extent, the actual causes of these diseases are preventable. Tobacco use is the number one preventable cause of death in Coos County, with poor nutrition and physical inactivity coming in at a close second. For 2009-2010, the Healthy Communities Program has been working on smoke-free areas/events, establishing chronic disease self-management programs, healthy worksites, and incorporating healthier food at the Coos County Fair.

### **Action Plan**

**Time Period:** July 2010 – June 2011

**Goal:** Reduce the burden of chronic disease in Coos County through policy and system changes.

### **Objectives:**

- Bay Area Hospital, Waterfall Clinic, and North Bend Medical Center will have an automatic referral process to Living Well Programs and the Tobacco Quit Line.
- A one day Chronic Disease Summit will be held, bringing together community leaders, organizations, coalitions, businesses and individuals whose work impacts chronic disease. Chronic disease self management will be included, but the primary focus will be primary prevention.
- Coos County will have two Arthritis Foundation Exercise Program leaders and have at least one active program.
- Coos County Public Health will have developed and implemented a policy for a Worksite Wellness Committee.

- Coos County Public Health Wellness Committee will have reviewed and promoted current health benefits to employees of the Coos County Public Health Department.
- Three of the six school districts (Coquille, Coos Bay, and Bandon) will have an active district wellness committee with at least one health representative on each committee.

Local program plans, with specific activities and evaluations, have been developed for each of the above objectives and have been submitted to the DHS – Healthy Communities program.

## 2. Parent & Child Health Services

### WOMEN, INFANTS, AND CHILDREN (WIC)

#### Current Condition

For 2006-2008, Oregon placed as the **second** most *food insecure with hunger* state in the nation at **13.1%** of Oregon households. This is a 1.2 % increase since the 2003-2005 time period. Over 25% of children in Coos County under the age of 18 live below the poverty line. In 2009, WIC foods helped to feed 3200 participants, and \$1.2 million in WIC foods were distributed in Coos County, at a value of about \$45 a month for each woman and child. The formula allotment for infants is worth about \$126 per month. Even though WIC provides infant formula, 89% of our Coos County WIC mothers start out breast-feeding their newborn babies. The duration of breast-feeding could be improved, however.

WIC participants are receiving nutrition education and nutritious foods at critical times in their lives—during pregnancy and infancy--when good nutrition can make a significant difference in brain development of babies and can make a difference in whether babies will grow into adults with health problems. Our WIC program embraces the *Oregon WIC Listens* concepts of participant centered counseling. Our nutrition education plan addresses how our program staff will offer quality education to help our clients make positive choices to improve their health.

#### Evaluation: FY 2009-2010

**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 module by December 31, 2009.*

**Evaluation criteria:** Please address the following questions in your response.

- Did staff complete the module by December 31, 2009?
- Were completion dates entered into TWIST?

**Response:** All staff completed the new Food Package module by December 31, 2009, and the data was entered into TWIST.

**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.*

**Evaluation criteria:** Please address the following questions in your response.

- How were staff who did not attend the 2009 WIC Statewide Meeting trained on the topic of infant feeding cues?
- How has your agency incorporated the infant cues information into ‘front desk’, one-on-one, and/or group interactions with participants?

**Response:** All staff attended the 2009 WIC Statewide Meeting with training on the topic of infant feeding cues. Infant cues information has been incorporated into intake, one on one, and group interactions with clients by using anticipatory guidance, client counseling, posters and handouts.

Clients requesting formula/breastfeeding changes are referred to CPA for exploration of issues involved.

**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.

**Evaluation criteria:** Please address the following questions in your response.

- Were nutrition education lesson plans and written materials reviewed and revised?
- What changes, if any, were made?

**Response:** Revision of nutrition education lesson plans is an ongoing process. 3 lesson plans have been revised: *Marketing to Kids, Fruits and Veggies, and Breastfeeding.*

Written materials are being reviewed and several have been discontinued.

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

**Evaluation criteria:** Please use the table below to address the following question in your response.

- How did your staff in-services address the core areas of the CPA Competency Model (Policy 660, Appendix A)?
- What was the desired outcome of each in-service?

<b>WIC Staff In-services</b>		
<b>In-Service Topic &amp; Method of Training</b>	<b>Core Competencies Addressed</b>	<b>Desired Outcome</b>
Food package assignment module reviewed- State provided materials July 2009	Knows how to synthesize and analyze data to draw appropriate conclusions.	Works with participants to select food package most appropriate for needs
Infant feeding cues- State Meeting	Understands normal nutrition issues for infancy.	Supports participants with Infant Feeding and Breastfeeding and provides anticipatory guidance
Review core components of participant centered services utilized by staff and which components need further developing. January, 2010	Knows how to develop rapport and foster open communication with participants and caretakers.	Renewed commitment to provide PCE services.
Facilitated discussion for strategies for improving support for Breastfeeding exclusivity and duration. April, 2010	Understands normal nutrition issues for lactation and the postpartum period	Increase Breastfeeding exclusivity and duration. Also encouraged dialogue with Breastfeeding partners

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

**Year 3 Objective:** During plan period, 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.*

**Evaluation criteria:** Please address the following questions in your response:

- Which core components of participant centered services are used most consistently with your staff? What has made those the most easily to adopt?
- Which core components have the least buy-in? What are the factors that make these components difficult to adopt?

**Response:** Opening and closing the conversation, open ended questions and affirmations are used the most consistently with our staff. Previous training has made these the easiest.

Reflections and summarizing have been the most difficult. I believe this is also due to previous practices and our habit of being the information giver.

*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.*

**Evaluation criteria:** Please address the following questions in your response.

- What strategy has been implemented to maintain the core components of participant centered services during a time of change?
- What strategy has been implemented to advance staff skills with participant centered services?

**Response:** Our clinic has used frequent review of the core components of PCE during this time of change. Monthly meeting always include discussion of successes and need more work. As time has allowed we have used peer to peer observation. We will be using PCE sustainability grant to plan regularly scheduled mentoring.

**Goal 3: Improve the health outcomes of WIC clients & 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.

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

**Evaluation criteria:** Please address the following questions in your response.

- Which community partners did your agency select?
- Which strategies did you use to promote the positive changes with Fresh Choices?
- What went well and what would you do differently?

**Response:** Our community partners were Head Start and the Farmers market. We made written materials available to them, provided Farmers checks and education. We participated in the Head Start Health Advisory Committee. More time would be the only difference.

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

**Evaluation criteria:** Please address the following questions in your response.

- How did your agency collaborate with the state WIC Research Analysts in evaluating Fresh Choices?
- How were you able to utilize, if appropriate, information collected from your agency?

**Response:** We will collaborate with the state WIC Research Analysts for Fresh Choices Evaluation.

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

**Year 3 Objective:** During plan 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.*

**Evaluation Criteria:** Please address the following questions in your response.

- What strengths and weaknesses were identified from your assessment?
- What strategies were identified to improve the support for breastfeeding exclusivity and duration in your agency?

**Response:** The Coos County initiation rate for breastfeeding is good, however it declines rapidly. We continue to meet weekly with our Breastfeeding coalition and with their assistance have added a twice monthly breastfeeding support group in the WIC environment. Attendance has been weak; however, we will continue. Bay Area Hospital is becoming a Baby Friendly Hospital and our coordination is important.

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

**Evaluation criteria:** Please address the following questions in your response.

- Which strategy or strategies did your agency implement to improve breastfeeding exclusivity and duration?
- Based on what you saw, what might be a next step to further the progress?

**Response:** Breastfeeding support group as mentioned previously. We have been selected to become a part of the WIC Breastfeeding Peer Support Program and this will help our progress.

**Action Plan: FY 2010-2011**

**Goal 1: Oregon WIC Staff will continue to develop their knowledge, skills and abilities for providing quality participant centered services.**

**Year 1 Objective:** During planning period, staff will learn and utilize participant centered education skills and strategies in group settings.

*Activity 1: WIC Training Supervisors will complete the Participant Centered Education e-Learning Modules by July 31, 2010.*

**Implementation Plan & Timeline:** Using state PCE sustainability grant, staff will be scheduled time in July, 2010, to complete PCE e-learning tests.

*Activity 2: WIC Certifiers who participated in Oregon WIC Listens training 2007-2009 will pass the posttest of the Participant Centered Education e-Learning Modules by December 31, 2010.*

**Implementation Plan & Timeline:** As above, staff will complete e-learning module tests by July 31, 2010. This will be accomplished by using PCE grant for back fill time.

*Activity 3: Local agency staff will attend a regional Group Participant Centered Education training in the fall of 2010.*

**Implementation Plan and Timeline:** CPAs will attend a PCE regional training in the fall of 2010 as scheduled by the state.

**Goal 2: Oregon WIC staff will improve breastfeeding support for women in the prenatal and post partum time period.**

**Year 1 Objective:** During planning period, each agency will identify strategies to enhance their breastfeeding education, promotion and support.

*Activity 1: Each agency will continue to implement strategies identified on the checklist entitled "Supporting Breastfeeding through Oregon WIC Listens" by March 31, 2011.*

**Implementation Plan & Timeline:** The Supporting Breastfeeding checklist will be evaluated, and four strategies identified will be implemented by March 31, 2010.

*Activity 2: Local agency breastfeeding education will include evidence-based concepts from the state-developed Prenatal and Breastfeeding Class by March 31, 2011.*

**Implementation Plan & Timeline:** Evidence –based concepts from the state developed Prenatal and Breastfeeding Class will be included in local agency breastfeeding education by March 31, 2010.

**Goal 3: Strengthen partnerships with organization that serve WIC populations and provide nutrition and/or breastfeeding education.**

**Year 1 Objective:** During planning period, each agency will identify organizations in their community that serve WIC participants and develop strategies to enhance partnerships with these organization by offering opportunities to strengthen their nutrition and/or breastfeeding education.

*Activity 1: Each agency will invite partners that serve WIC participants and provide nutrition education to attend a regional Group Participant Centered Education training fall 2010.*

**Implementation Plan & Timeline:** Head Start and Public Health partners will be invited to attend regional group PCE training in the fall 2010

*Activity 2: Each agency will invite community partners that provide breastfeeding education to WIC participants to attend a Breastfeeding Basics training and/or complete the online Oregon WIC Breastfeeding Module.*

**Implementation Plan & Timeline:** Community partners will be invited to attend a Breastfeeding Basics training and/or complete the online Oregon WIC Breastfeeding Module.

**Goal 4: Oregon WIC staff will increase their understanding of the factors influencing health outcomes in order to provide quality nutrition education.**

**Year 1 Objective:** During planning period, each agency will increase staff understanding of the factors influencing health outcomes.

*Activity 1: Local agency staff will complete the new online Child Nutrition Module by March 31, 2011.*

**Implementation Plan & Timeline:** All staff will complete the new online Child Nutrition Module by March 31, 2010.

*Activity 2: Identify your agency training supervisor(s) and projected staff quarterly in-service training dates and topics for FY 2010-2011. Complete and return Attachment A by May 1, 2010.*

**Agency Training Supervisor(s):** Phyllis Olson

**Attachment A: WIC Nutrition Education Plan**

Based on planned program initiatives, program goals, and identified staff needs, the following quarterly in-services and or continuing education are planned for existing WIC staff.

<b>WIC Staff Training Plan – 7/1/2010 through 6/30/2011</b>			
<b>Quarter</b>	<b>Month</b>	<b>In-Service Topic</b>	<b>In-Service Objective</b>
<b>1<sup>st</sup> Quarter</b>	July - 2010	PCE sustainability	Develop plan to provide mentoring, peer to peer evaluation and review of participant printed materials.
<b>2<sup>nd</sup> Quarter</b>	October - 2010	State Meeting-PCE	Advance PCE information and skills
<b>3<sup>rd</sup> Quarter</b>	December - 2010	PCE post-test review and complete	PCE competency
<b>4<sup>th</sup> Quarter</b>	March - 2011	Review strategies identified on Breastfeeding checklist	Implement strategies to increase breastfeeding duration

**Attachment B: Supporting Breastfeeding through Oregon WIC Listens**

\* 1. Not doing and not ready to start; 2. Want to start; 3. Started and may want to do more; 4. Already doing quite a bit with room for improvement; 5. We're superstars!

<b>Assessment Area</b>	<b>Readiness level</b> <i>See Key Above*</i>					<b>Current Status</b>	<b>Ideas for Future Efforts</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		
<b>A. Breastfeeding Policies and Procedures</b>							
1. Our WIC agency breastfeeding policy affirms the value of breastfeeding and influences all aspects of clinic operations.			x			Written policy needs update	Update Policy
2. Our WIC agency/county health department has applied for and received the state designation as a <i>breastfeeding mother friendly employer</i> and displays the certificate on site.			x			Paperwork completed	Review and send to state
3. Breastfeeding promotion knowledge, skills and attitudes are part of position descriptions and the employee evaluation process.		x				Not fully explained in writing	Include in written documents
<b>B. Staff roles, skills and training</b>							
1. All WIC staff use Oregon WIC Listens skills when talking with pregnant women and mothers about breastfeeding.				x		Doing well	Reinforce in staff meetings

Assessment Area	Readiness level <i>See Key Above*</i>					Current Status	Ideas for Future Efforts
	1	2	3	4	5		
2. All WIC staff have completed the breastfeeding module level appropriate for their position.					x	Done	Reinforce information
3. Our WIC agency has a sufficient number of staff who have completed a 5 or 6 day advanced breastfeeding training such as the Portland Community College Lactation Management course. (Note: A sufficient number based on your agency's caseload and the need for breastfeeding services.)					x	3 WIC staff	Include 1 more
4. Our WIC agency has an IBCLC on staff.							
<b>C. Prenatal Breastfeeding Education &amp; Support</b>							
1. WIC staff use Oregon WIC Listens skills to encourage pregnant women to share their hopes and beliefs about breastfeeding and respond accordingly.			x			IBCLC on Nursing Home Visiting staff	Hire for WIC BF peer counseling
2. WIC staff help women to recognize their own unique strengths which will help them breastfeed successfully.			x			Asking	Explain more
3. WIC staff prepare women to advocate for themselves and their infants during the hospital or home birth experience.			x			Encouraging	More training
4. WIC staff encourage women to fully breastfeed, unless contraindicated.				x		Helping plan	BF peer counseling
5. Women planning to combine breastfeeding and formula feeding are informed of the impact on breastfeeding and potential health risks.				x		CPA counsels	Continue efforts
6. WIC staff teach women infant behavioral cues and how these relate to breastfeeding success.			x			Covered in BF class	Review information
7. WIC staff help women prepare for breastfeeding after returning to work or school.				x		Included in Postpartum discussion	BF peer counseling
<b>D. Postpartum Education and Support</b>							
1. Our WIC agency offers breastfeeding support throughout the postpartum period.				x		Individual counseling and group meeting	Encourage group meeting
2. Staff members contact each breastfeeding mother within 1-2 weeks of expected delivery to assess any concerns or problems and to provide assistance.		x				If attending BF class	BF peer counseling
3. WIC staff with advanced breastfeeding training are available to assess, assist and/or refer all mothers requesting breastfeeding help within 1 business day of her contacting the WIC office.					x	Priority	BF peer counseling
4. WIC staff encourage and support mothers to fully breastfeed throughout the postpartum period, unless contraindicated.					x	Strongly support	Encourage group meeting

Assessment Area	Readiness level <i>See Key Above*</i>					Current Status	Ideas for Future Efforts
	1	2	3	4	5		
5. Breastfeeding mothers wanting to combine breastfeeding and formula feeding are informed of the impact on breastfeeding and potential health risks				x		Counsel with CPA with advanced BF training	Encourage group meeting
6. WIC staff teach women about infant behavioral cues and how these relate to breastfeeding success.			x			BF class and PP apts.	Peer counseling
7. Our agency provides breast pumps when needed.					x	Priority with 1 Lactina stationed to loan at hospital	2 pumps at hospital
<b>E. Breastfeeding Food Packages</b>							
1. WIC staff assess each pregnant woman's breastfeeding intentions and provide information about how WIC supports breastfeeding including no formula issuance in the first month postpartum.				x		Individual appointments & breastfeeding class	Peer counseling
2. A WIC CPA completes an assessment when a breastfeeding mother requests formula and tailors the amount of formula provided. Breastfeeding assistance is also provided to help the mother protect her milk supply.				x		Individual counseling	BF peer counseling
<b>F. Creating a community that supports breastfeeding.</b>							
1. Our agency participates in a local breastfeeding coalition, task force, and/or the statewide Breastfeeding Coalition of Oregon (BCO).				x		Active, monthly meetings	Continue, invite Coquille Valley Hospital
2. Our agency staff collaborate with nurses, lactation staff and physicians at area hospitals to support breastfeeding in the community.				x		Included in monthly BF coalition meetings	Continue
3. Our agency staff communicate with local medical providers on a regular basis to promote breastfeeding and WIC services.			x			Medical providers hard to access	Continue coalition partnership
4. Our agency works with breastfeeding peer support organizations in the community such as La Leche. If no organizations are available, write in N/A						NA	
5. Our agency promotes breastfeeding through local media.			x			PH readerboard; occasional articles & public TV interviews	As available

## IMMUNIZATION PROGRAM

### Current Conditions

The CCPH Immunization program strives to improve the immunization rate coverage of children and adults in Coos County. This past fiscal year, the total number of immunizations given by our department was 1,581. In the fall, an additional 830 seasonal flu shots were administered, plus 6,950 H1N1 vaccines during the flu season.

In 2008, the up-to-date rate for 2-year olds seen at Coos County Public Health Department was 71% (n= 58 children). This was a decrease from the previous year's rate of 75% for our department (n= 70 children). However we note that since fewer children were served in 2008, the up to date rate would have remained the same if there had been timely immunizations for 2 additional children. Many of the children in Coos County receive vaccines from pediatricians at private medical offices. The rate for 2 year olds immunized county-wide (by all providers) was 75.1% (State: 73.8%). Public Health will continue to strive to improve the up-to-date rate for 2-year olds in the community, and have been fortunate to have the support from the Bay Area Rotary Club for the *Shots for Tots & Teens* program.

### Action Plan:

**Time Period:** Calendar Years 2010-2012

**Goal:** To Improve the Immunization Rate for Two Year Old Children

<b>Plan A - Continuous Quality Improvement: Reduce Vaccine Preventable Disease Year 1: January-December 2010</b>					
<b>Objectives</b>	<b>Activities</b>	<b>Date Due / Staff Resp.</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
A. Increase the 4 <sup>th</sup> DTaP rate by 2%	Monthly reminders will be mailed to the parents of children 12-35 mo. who are due for a 4th DTaP, using reports from the ALERT IIS.	12/31/10 Lena Hawtin	Reminder system in place by December 31, 2010	To be completed for the CY 2010 Report	To be completed for the CY 2010 Report
	Assess the 4 <sup>th</sup> DTaP rate quarterly, using reports from the ALERT IIS	9/30/10 & 12/31/10 Lena Hawtin	The 4 <sup>th</sup> DTaP rate increases by 0.5% each quarter.		
	Meet with all CCPH immunization nurses quarterly to discuss the 4 <sup>th</sup> DTaP rate and ways to increase the rate.	7/31/10 and 12/31/10 Lena Hawtin	The 1 <sup>st</sup> quarterly meeting with the immunization nurses will take place by July 31, 2010. The 2 <sup>nd</sup> quarterly meeting with the nurses will take place by December 31, 2010.		

<b>Plan A - Continuous Quality Improvement: Reduce Vaccine Preventable Disease Year 2: January-December 2011</b>					
<b>Objectives</b>	<b>Activities</b>	<b>Date Due / Staff Resp.</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
A. Increase the 4 <sup>th</sup> DTaP rate by 2%	Monthly reminders will be mailed to the parents of children 12-35 mo. who are due for a 4 <sup>th</sup> DTaP, using reports from the ALERT IIS.	12/31/11 Lena Hawtin	Reminders will be mailed 12 of 12 months	To be completed for the CY 2011 Report	To be completed for the CY 2011 Report
	Assess the 4 <sup>th</sup> DTaP rate quarterly, using reports from the ALERT IIS	3/31, 6/30, 9/30, 12/31 in 2011 Lena Hawtin	The 4 <sup>th</sup> DTaP rate increases by 0.5% each quarter.		
	Meet with all CCPH immunization nurses quarterly to discuss the 4 <sup>th</sup> DTaP rate and ways to increase the rate.	3/31, 6/30, 9/30, 12/31 in 2011 Lena Hawtin	A meeting with all immunization nurses will take place each quarter.		

<b>Plan A - Continuous Quality Improvement: Reduce Vaccine Preventable Disease Year 3: January-December 2012</b>					
<b>Objectives</b>	<b>Activities</b>	<b>Date Due / Staff Resp.</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
A. Increase the 4 <sup>th</sup> DTaP rate by 2%	Monthly reminders will be mailed to the parents of children 12-35 mo. who are due for a 4 <sup>th</sup> DTaP, using reports from the ALERT IIS.	12/31/12 Lena Hawtin	Reminders will be mailed 12 of 12 months	To be completed for the CY 2012 Report	To be completed for the CY 2012 Report
	Assess the 4 <sup>th</sup> DTaP rate quarterly, using reports from the ALERT IIS	3/31, 6/30, 9/30, 12/31 in 2012 Lena Hawtin	The 4 <sup>th</sup> DTaP rate increases by 0.5% each quarter.		
	Meet with all CCHP immunization nurses quarterly to discuss the 4 <sup>th</sup> DTaP rate and ways to increase the rate.	3/31, 6/30, 9/30, 12/31 in 2012 Lena Hawtin	A meeting with all immunization nurses will take place each quarter.		

**Plan B – Community Outreach and Education**

**Year 1: January-December 2010**

<b>Objectives</b>	<b>Activities</b>	<b>Date Due / Staff Resp.</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
<b>A.</b> Educate public and private providers on ways to increase immunization coverage rates.	<p>Assist with the annual AFIX Exchange Luncheon to be hosted by the DHS IZ program AFIX team.</p> <p>Staff from all private and public clinics that provide immunizations will be invited to attend the AFIX Exchange Luncheon.</p>	<p>4/20/10 Lena Hawtin</p>	<p>The annual AFIX meeting will be held in the Spring 2010.</p> <p>There will be attendance from Bay Clinic, NBMC-Bandon, NBMC-Coos Bay, NBMC-Coquille, NBMC-Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC.</p>	<p>The annual AFIX meeting was held on April 20, 2010.</p> <p>Invites were sent to all public and private VFC providers and community partners.</p>	<p>This objective was fulfilled with the 2010 Community AFIX Exchange.</p> <p>The April 20, 2010 luncheon was sponsored by John McNamee from Merck. In attendance were individuals representing Coos County Public Health, Marshfield SBHC, Waterfall Clinic, North Bend Medical Center-Coos Bay, Bay Clinic, Coquille Tribe, Shots for Tots, and DOCS Health Plan.</p> <p>In 2007, the average Coos County IZ up-to-date rate for two year olds was 72%. The rate in 2008 was 75%.</p>

**Plan B – Community Outreach and Education, Cont.**

**Year 1: January-December 2010**

<b>Objectives</b>	<b>Activities</b>	<b>Date Due / Staff Resp.</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
<b>B.</b> Educate private providers on ways to increase immunization coverage rates for two-year-olds	<p>Assist with an AFIX Exchange for an individual private clinic provided by the DHS IZ program Health Educator and AFIX Team.</p>	<p>4/20/10 Lena Hawtin</p>	<p>On 4/20/10, an AFIX Exchange was held to provide private clinics with their UTD rates for two-year-olds and discuss ways to improve the rate.</p>	<p>The annual AFIX meeting was held on April 20, 2010.</p> <p>Invites were sent to all public and private VFC providers and community partners.</p>	<p>This objective was fulfilled with the 2010 Community AFIX Exchange.</p> <p>See above in A.</p>

<b>Plan B – Community Outreach and Education</b>					
<b>Year 2: January-December 2011</b>					
<b>Objectives</b>	<b>Activities</b>	<b>Date Due / Staff Resp.</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measures Results</b>	<b>Progress Notes</b>
<b>A.</b> Educate community partners on current immunization practices and ways to increase immunization coverage rates for two-year-olds.	Approve/ edit printed materials in support of the annual community immunization luncheon.	5/31/11 Lena Hawtin	The annual meeting will be held in the Spring 2011. Maria Grumm from the DHS IZ program will speak on vaccine safety issues and how to talk to parents.	To be completed for the CY 2011 Report	To be completed for the CY 2011 Report
	Assist with the annual community immunization luncheon to be hosted by the DHS IZ program Health Educator		There will be attendance from Coos County Public Health, Marshfield SBHC, Waterfall Clinic, North Bend Medical Center-Coos Bay, Bay Clinic, Coquille Tribe, Shots for Tots, and DOCS Health Plan.		
<b>B.</b> Educate a private provider on ways to increase immunization coverage rates for two-year-olds	Assist with an AFIX Exchange for an individual private clinic provided by the DHS IZ program Health Educator and AFIX Team.	12/31/11 Lena Hawtin	In the Fall of 2011, an AFIX Exchange will be held to provide a private clinic with their UTD rate for two-year-olds and discuss ways to improve the rate.		

<b>Plan B – Community Outreach and Education</b>					
<b>Year 3: January-December 2012</b>					
<b>Objectives</b>	<b>Activities</b>	<b>Date Due / Staff Resp.</b>	<b>Outcome Measure(s)</b>	<b>Outcome Measures Results</b>	<b>Progress Notes</b>
<b>A.</b> Educate community partners on current immunization practices and ways to increase immunization coverage rates for two-year-olds.	Approve/edit printed materials in support of the annual community immunization luncheon.	5/31/12 Lena Hawtin	The annual meeting will be held in the Spring 2012. The speaker and topic are TBA.	To be completed for the CY 2012 Report	To be completed for the CY 2012 Report
	Assist with the annual community immunization luncheon to be hosted by the DHS IZ program Health Educator.		There will be attendance from Coos County Public Health, Marshfield SBHC, Waterfall Clinic, North Bend Medical Center-Coos Bay, Bay Clinic, Coquille Tribe, Shots for Tots, and DOCS Health Plan.		
<b>B.</b> Educate a private provider on ways to increase immunization coverage rates for two-year-olds	Assist with an AFIX Exchange for an individual private clinic provided by the DHS IZ program Health Educator and AFIX Team.	12/31/12 Lena Hawtin	In the Fall of 2012, an AFIX Exchange will be held to provide a private clinic with their UTD rate for two-year-olds and discuss ways to improve the rate.		

## PARENT / CHILD HEALTH HOME VISITING SERVICES

### Current Conditions

Coos County's rates for victims of child abuse and neglect have worsened, as has the rate state-wide. In 2009, Coos County was ranked 9<sup>th</sup> highest, with a rate of 20.6 per 1000 (state rate of 12.5 per 1,000). This reflects a worsening from the 2007 statistics which showed that Coos County had a rate of 17.7 per 1000. In addition, Coos County's child maltreatment reoccurrence rate in 2009 is 13.4%, compared to the state rate of 7.8%.

Major family stressors that contribute to Coos County's child abuse/neglect rates are drug and/or alcohol abuse, domestic violence, financial distress, head of household unemployment, parental involvement with a law enforcement agency, and inadequate housing. Other contributing factors are: limited education, and poor parenting (the most prevalent factor according to the Child Welfare System), a history of child welfare involvement in the past, and caring for multiple children under the age of 5. However, poor parenting is often generational and may be influenced also by the factors listed above. The major reasons for placement in foster care were threat of harm, drug and alcohol abuse, physical abuse, neglect, the child's behavior, inability to cope, and inadequate housing.

Research shows that early intervention into the lives of families, beginning in and including the prenatal period, has a high impact on parental success and lessens child maltreatment. "What happens in the first three years of life can lay the foundation for becoming a productive, contributing member of society, or it can lay the foundation for intergenerational cycles of abuse, neglect, violence, dysfunction, and mental illness." (Indiana Association for Infant Toddler Mental Health)

Our department continues to provide services through the Babies First! and CaCoon programs, and to first birth families through Healthy Start, which is funded by the Commission on Children & Families (CCF). Family Outcomes served by these programs in 2008-09 were the following:

- **100%** of families' needs were identified.
- **98.5%** of children had health care providers.
- **92%** of children served by our programs were free of child abuse and neglect after enrollment.
- **83%** of children were up to date on their immunizations.
- **38%** of children screened for health or behavioral problems were referred for further evaluation.
  - **Of these, 82% received follow-up services.**
- **11.5%** of families were referred into our home visiting services because of suspected child abuse.

Parents participating in our Babies First! (Parents As Teachers) program stated:

*"I was raised in low income housing and I didn't want to raise my daughter like that."*

*"I have been involved with the Parents As Teachers program and have gotten so much out of it. I have been able to receive valuable information regarding my daughter's development. We have also built a healthy and trusting relationship."*

*“[Our parent educator] has been a tremendous help to me in understanding how to cope with everyday parenting techniques. I am pleased that programs like this exist because I need all the help I can get when it comes to parenting. I am a single mother with a small child and the skills that I have learned will make our lives better, healthier, and happier. Thank you!”*

Parents participating in our CaCoon program stated:

*“My little one had a lot of special needs. CaCoon is a great, great program that should go on and on. If it can help one child, it can help hundreds of children.”*

*“It’s important to have CaCoon in our area. I strongly think any little or big support should be given because this is a child’s life, the beginning of their life, and our future leaders.”*

### **Action Plan**

**Goal:** Strong nurturing families and healthy thriving children.

#### **Objectives:**

- Reduce child abuse and neglect.
- Promote readiness to learn.

#### **Babies First! Activities:**

- Provide regularly scheduled home visits through the **Babies First!** program for children through age 4 years who are at risk of developmental delay due to a variety of risk factors including: premature birth; drug exposed infant during pregnancy; low birth weight; age of the parent/caregiver; low income/ poverty and many other factors.
- Using the Parents As Teachers best practice curriculum, and following the Babies First protocols, nurses and public health aides (under the supervision of a nurse) help parents learn positive parent-child interactions, child development, realistic expectations, and coping skills. This parenting program provides information and guidance to reduce child abuse and neglect and promote “readiness to learn.” During the visits, educators help parents understand what to expect in each stage of their child’s development, and offer practical tips on ways to encourage learning, manage challenging behavior, and promote strong parent-child relationships.
- Conduct in-home health and developmental screening for participating children on a regular basis, detect potential problems, start interventions, and monitor child regularly. Screening is done for overall development, language, hearing, and vision.
- Case management activities help link families to needed community resources and providers.

#### **CaCoon Program Activities:**

Nurses provide nursing case management for children from birth to age 21 years with special health care needs during home visits.

- Nurses assist parent with medical, nutritional, and developmental issues and promote positive coping skills.
- Parents are helped to identify and prevent problems related to their child’s special health condition.
- Screening is done for growth and development and referrals are made into early intervention when needed.
- Nurses also coordinate health care and specialty services. CaCoon Nurses will participate in Community Connections as needed and as able, considering the limitations of funding.

**Healthy Start Program Activities:**

Parent educators under the supervision of a nurse provide the **Healthy Start/Healthy Families** services to first time families identified as eligible to receive intensive home visiting services. Staff adhere to the state Healthy Start/Healthy Families policies and procedures, Healthy Families America best practice guidelines, and state/county CCF protocols. This program fits well into CCPH’s existing continuum of home visiting programs.

**Collaboration Activities with Community Partners to Improve Maternal Child Health Outcomes”**

- Continue to assist with the perinatal depression group, “Parenting Survival Skills: Adjusting to Your New Baby,” which was formed through a collaborative effort of our local Perinatal Task Force. The depression group consists of a 4 week curriculum focusing on coping with depression, steps to take to improve mood, reducing stigma of depression, and referrals to medical providers. Since research shows that new moms who have a history of depression often miss or misinterpret their babies’ cues, this intervention for the mothers’ depression can be important for the ultimate development of positive mother/child attachments.
- Continue to seek funding to host an infant massage class for early childhood providers. Infant massage has been shown to help infants self-soothe and self-regulate. Benefits for the caregiver (such as improved recognition of infant cues) and society as a whole have also been identified in the research.
- Continue to participate in the Coos County Breastfeeding Coalition to promote breastfeeding and improve breastfeeding rates among county residents.
- Collaborate with local WIC program to provide nursing/breastfeeding support to women.
- Continue to develop relationships with local and regional dental community to improve access and treatment of pregnant women and young children to promote early childhood cavities prevention.
- Seek funding or a volunteer agency which would be willing to continue Public Health’s no-cost dental hygiene program that targets pregnant women and children under the age of 5 years old. Services include oral health screenings, prophylaxis, fluoride varnish applications, and referrals to dental homes for additional services through a contract with an LAP hygienist. Education and prevention care are key components of this project.
- Continue to seek funding opportunities through grants and/or contracts to help support our maternal child health services through local agency partners such as CWS, Coos Bay/North Bend Rotary, and Bay Area Hospital.

- Continue to participate in local MDT and Child Fatality Review Board.
- Continue to participate in DHS: Child Welfare Services’ System of Care meetings, Family Decision Meetings, etc. as appropriate.
- Continue to participate in Family Violence Council meetings.
- Continue to be active participants on the Coos County *Zero to Three Court Team* pilot program, providing administrative support as well as direct services to enrolled families via our Healthy Start, Babies First! and CaCoon programs.

**Activities to Assure Training and Continuing Education Opportunities for MCH Staff**

- Consider sending the Maternal Child Health Home Visiting Supervisor or other delegate to “Circle of Security” training to then be able to provide more in-depth training to remainder of staff on issues related to attachment.
- Plan on sending at least 1-2 field staff to annual Child Abuse Summit, if funding available.
- Continue to offer in-service trainings to staff, on topics such as infant-toddler mental health, self regulation, domestic violence, and child abuse.

**Evaluation**

For families served by **Babies First!:**

- Families’ needs will be identified in 100% of clients.
- 80% of parents will demonstrate positive child-rearing competencies and improved parenting skills
- 80% of parents will demonstrate positive parent-child interactions.
- 80% of parents will demonstrate increased knowledge about child development.
- 80% of parents will demonstrate developmentally appropriate expectations.
- 90% of parents will have no confirmed case of abuse/neglect after enrollment into Parents as Teachers
- 90% of enrolled parents will self report improved access and utilization of services
- 90% of parents will report supportive relationships with others
- Additional evaluations will be conducted by the state, and our staff will participate as needed.

For families served by **CaCoon:**

- Additional evaluations will be conducted by the state, and our staff will participate as needed.

For families served by **Healthy Start:**

- Evaluations will be conducted by the state and local Commission on Children and Families.

## SERVICES FOR PREGNANT WOMEN

### Current Conditions

Early prenatal care is a benchmark to ensure healthy birth outcomes. Inadequate prenatal care is defined as care that begins after the second trimester of pregnancy or that involves fewer than 5 prenatal visits.

- In 2006 and 2007, Coos County had the unfavorable designation of the highest rate of **inadequate prenatal care** in the state (15%).
- Preliminary data for 2008 and 2009 indicates that the inadequate prenatal care rate has dropped to 10.0% in 2008, and 8.7% in 2009, compared to the state rates of 6.9% and 6.1%.

Some of this improvement in the prenatal care rate is attributed to our OregonMothers Care program. In Coos County in FY 2008-09, **over 90%** of women who contacted our Oregon Mothers Care program in their first trimester were able to begin prenatal care with a provider during their 1<sup>st</sup> trimester, which exceeded the Oregon benchmark of 90% adequate prenatal care rate. Through OregonMothers Care, **243** pregnant women were helped with applying for the Oregon Health Plan, obtaining prenatal care, and referrals to other prenatal services.

In FY 2007-2008, Coos County Public Health stopped offering home visiting services to pregnant women through the Healthy Beginning /Maternity Case Management (MCM) program. MCM services had assisted pregnant women with obtaining early prenatal care, referral to other social programs, and guidance on improving behaviors to assure a healthy baby and pregnancy. Our efforts have shifted towards working with community partners to help identify and reduce barriers to receiving adequate and/or early prenatal care. Through a grant from the Commission on Children and Families, Public Health performed a community needs assessment that identified barriers and access problems that were varied and wide ranging. We continue to meet monthly and work with the Perinatal Task Force to assess and plan ways to improve the early prenatal care rates in Coos County.

### Action Plan

**Goal:** Strong nurturing families and healthy thriving children

**Objective:** Increase access to adequate and early prenatal care and community support services.

#### **Activities:**

- Assist pregnant clients with applications to the Oregon Health Plan and facilitate pregnant women's first appointments with prenatal care providers, through the Oregon Mother's Care (OMC) Program.
- Refer pregnant clients from internal Public Health Department programs such as WIC and pregnancy testing to Oregon Mothers Care (OMC) and outside agencies which provide support during the prenatal period such as The MOMS program through Bay Area Hospital, Coquille Valley Hospital's perinatal outreach program, and Pregnancy Resource Center.
- Continue to meet monthly and work with the Perinatal Task Force (PNTF) to assess and plan ways to improve the early prenatal care rates in Coos County. The PNTF includes representatives from Bay Area Hospital, Public Health, DOCS – Independent Practice Association, A & D

treatment, DHS Food Stamps/Temporary Aid to Needy Families, and physicians and other organizations.

- Continue to assist with the Perinatal Task Force’s new perinatal depression group, “Parenting Survival Skills: Adjusting to Your New Baby,” that provides 4 weeks of education to pregnant and postpartum mothers, and a follow-up support group.
- Continue to meet with the Coos County Breastfeeding Coalition.
- Seek grants to fund Perinatal projects such as the CAWEM-plus program, postpartum depression support group, prenatal vitamin distribution, dental care services for pregnant women, etc.
- Participate in the State’s Public Health’s workgroup(s) as home visiting programs are re-designed, and realigned with best practice and evidence-based programs, including advocating for adequately-reimbursed prenatal home visiting services.

**Evaluation:**

- Number of pregnant women served through Oregon MothersCare who have successfully initiated prenatal care.
- Log of the number of community outreach activities. The following work groups and outreach activities were performed in FY 2008-2009:
  - Perinatal Task Force
  - Breastfeeding Coalition
  - Early Childhood Coalition
  - Coos/Curry Dental Services
  - Early Head Start in-service
  - Even Start in-service
  - Coquille Valley Hospital in-service
  - Pregnancy Resource Center in-service
  - Various educational outreach tables at employee health fairs, community college student orientations, high school career day, and community health fairs

**Challenges:**

- The state support for perinatal services is insufficient for the number of women who can be served with Maternity Case Management (MCM).
- The Medicaid reimbursement rate for MCM services does not reflect the actual cost of providing these services. Lack of financial support has resulted in our phasing out this effective service.

## FAMILY PLANNING PROGRAM

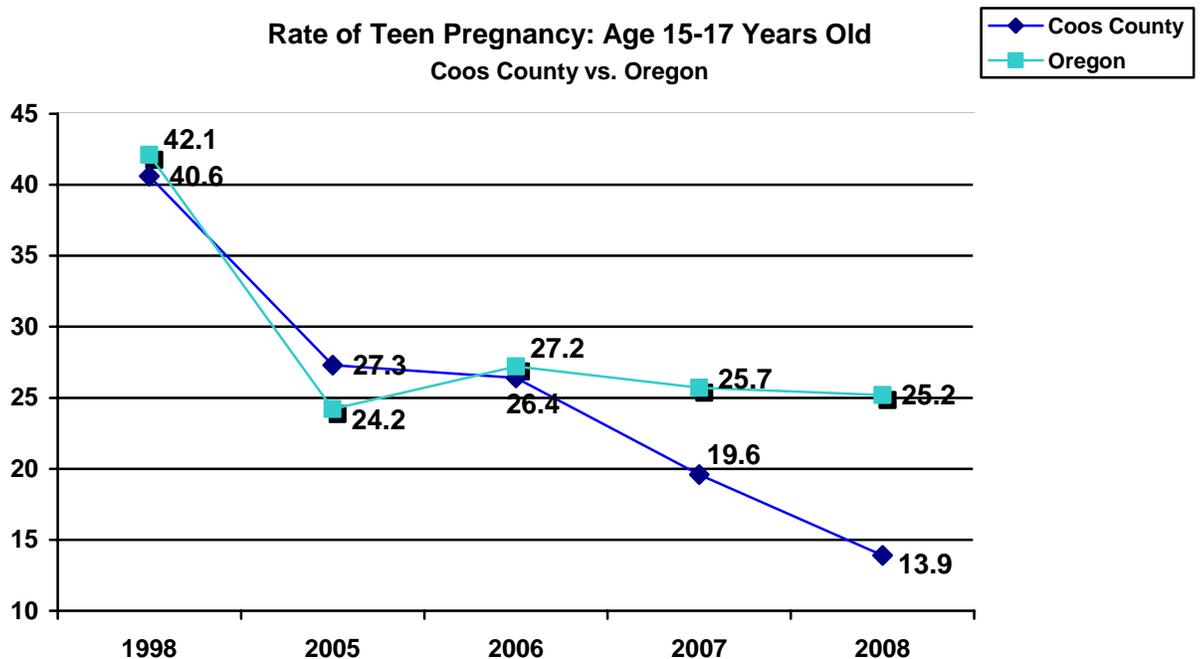
### Current Conditions

According to the service data for Oregon Title X Family Planning Agencies, in 2009 there are **4,120 women in need** (WIN) in our county between the ages of 14 and 44. We served 1,069 of those WIN clients in 2009, or **25.9 %**, (*State average 23.3%*), which is a decrease for our department from the previous year. The number of women served by other FPEP providers in our county was not available for this report.

Of the estimated number of teens in Coos County in need of services ages 15-17 (n=611), we served **18%** (n=110), which is also a decrease from previous years. However, our department does pass through funding for a school based health center (SBHC) through a contract with Waterfall Community Health Center. This SBHC provides contraceptive services on-site to the largest high school in our county.

The contraceptive services provided by our department are estimated to have **prevented 220 pregnancies**. The teen pregnancy rate in the county has declined over recent years and continues to be below the state average.

In 2007, there were 26 pregnancies in Coos County teens aged 15-17, a rate of **19.6** (state 25.7). The preliminary rate for 2008 is **13.9 per 1,000 with 17 pregnancies**, and the preliminary rate for 2009 is **19.8 with 24 pregnancies**. Both of these preliminary rates are below the state rates and surpass the 2010 benchmark of 20 pregnancies per 1,000. (The teen pregnancy rate includes both births and abortions; the number of miscarriages is unknown.)



Our Title X program provides a wide variety of contraceptives, including IUD insertion, and refers males for vasectomy. State and federal nurse consultants recently reviewed over 80 policies and procedures (addressing administrative functions such as scope of work for clinicians, record keeping, client and

insurance billing, civil rights, laboratory procedures, emergency protocols, client evaluation and screening protocols, dispensing and use of contraceptive methods, client education, STI protocols, pharmacy procedures, medical records and confidentiality with HIPAA compliance. Our department was told to write an additional 18 policies for the Title X program, which are in process. As of this writing, the process for limiting enrollment in family planning based on the limitation of available resources, as discussed in ORS 435.205, is under review.

The following describe the progress on the goals for the current fiscal year (FY 2009-10) and the plans for FY 2010-2011.

**Action Plan**

**Current Progress on Goals: July 1, 2009 to June 30, 2010.**

Goal / Objective	Progress on Activities
#1: Assure continued high quality clinical family planning and related preventive health services to improve overall individual community health.	A policy and procedure for donations was developed in 2006/07. A process continues to be in place for client donations. In 2007/08 and 2008/09 donations increased 10-15% each fiscal year. Thus far in 2009/10, donations have decreased 50%. This may be a result of fewer clients and/or the increased rate of unemployment and poverty. A customer satisfaction survey reveals positive comments from over 90% of the respondents. Staff have been very grateful for the donations received.
#2: Assure ongoing access to a broad range of effective family planning methods and related preventive health services	The NP received IUD training and preceptorship in 2006/07. In 2006/07, there were 12 IUD/IUS Insertion visits. In 2007/2008 and 2008/2009, there were 27 and 28 IUD/IUS Insertion visits, respectively. Thus far in 2009/10, there have been 16 IUD/IUS Insertion visits.
#3: Assure ongoing access to continuing education on contraceptive methods.	In 2008/09, FP staff attended 8 webinars regarding FP/Title X issues. Thus far in 2009/2010, FP staff have attended 3 webinars.

**Current Progress on Use of Title X Expansion Funds:**

These supplemental “expansion funds” were awarded as part of your agency’s regular Title X grant again this year for the purpose of increasing the number of new, low-income clients by expanding the availability of clinical family planning services.

1. **Goal:** Increase the range of contraceptive methods on your formulary and/or the available number of high-end methods (IUDs and Implanon)  
**Progress:** IUD/IUS Insertion visits were increased as stated above in Goal #2. In the FP clinic, 178 clients were provided Nuvaring and 70 clients were provided the OrthoEvra transdermal patch.
  
2. **Goal:** Add other related preventive health services, such as diagnosis and treatment of STIs:  
**Progress:** In the FP clinic, 537 Chlamydia tests were performed.

**Title X Current Progress on Goals:**

**Action Plan: July 1, 2010 to June 30, 2011**

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

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Decreased number of clients seen in Family Planning clinic.	Increase the number of clients seen in Family Planning clinic while continuing to provide required services.	<ul style="list-style-type: none"> <li>Assess clinic flow and duties of aides, RNs, and NP.</li> <li>Determine amount of time needed per visit type, to determine scheduling needs.</li> </ul>	<ul style="list-style-type: none"> <li>A P&amp;P for clinic flow and staff duties will be created by July 30, 2010.</li> <li>After approval of the P&amp;P, all FP visits will be assessed for a 3 month period. Eighty percent of these visits will be completed within time allotted for visit type, while continuing to provide required service.</li> </ul>

**Goal #2:** To promote awareness and access to Emergency Contraception (EC) among Oregonians at risk for unintended pregnancy.

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Lack of awareness of access to EC in Coos County.	Increase awareness in the community regarding access to EC.	<ul style="list-style-type: none"> <li>Provide information to the community via county website, e-mail, and the Advisory Committee.</li> <li>Continue to offer EC at each FP visit.</li> </ul>	<ul style="list-style-type: none"> <li>Information on the county website will be updated quarterly.</li> <li>Information will be e-mailed to local medical providers and high schools quarterly.</li> <li>Posters will be developed and distributed by the Advisory Committee at least twice a year.</li> <li>FP Clinic will continue to offer one EC at each FP visit for immediate use, as needed, and two for future use.</li> </ul>

### 3. Collection & Reporting of Health Statistics

#### **Current Conditions**

As one of the services required by Oregon law, our department registers all births and deaths in the county. We also review the health statistics which have been compiled by the state related to program areas that we provide. We have made progress this past year in developing more systematic approaches to collecting health data or outcome measures for the services that we provide, in addition to the required data mandated by certain programs, such as WIC and ALERT. We have recently begun using the ORPHEUS program for communicable disease reporting. Although this is a cost shift to our department to input the data instead of sending it to the state for data entry, we expect to have greater control over the accuracy of the data that is entered.

#### **ACTION PLAN**

**Goal:** Continued improvement in departmental statistics gathering on health indicators or outcome objectives.

#### **Activities:**

- Each program supervisor will review tools and methods for collecting outcome data related to targeted program objectives.
- Where there are gaps in data collection, supervisors will develop tools or processes for measuring program effectiveness.

#### **Evaluation:**

- Achievement of improved data collection in program areas.
- Publication of Annual Report.

## 4. Health Information and Referral Services

### Current Conditions

Public Health clients often have needs that are out of the range of services offered within our department. Some are aware of the information or services they are seeking, and call asking for contacts and phone numbers. Many, however, are unaware of services available, and therefore do not inquire. These clients are dependent on Coos County Public Health staff to take the initiative and suggest services and opportunities that might be beneficial to them.

All Department programs are currently involved in providing information and making referrals to clients for services offered at the Health Department, as well as services of other agencies. The following are examples of common information and referrals provided by our department.

- The Family Planning Clinic provides options counseling to clients who become pregnant, and refers the client to the appropriate agency.
- The Oregon Health Plan / Oregon Mothers Care outreach specialist assists clients in applying for publicly funded health insurances, and in locating affordable primary healthcare services.
- WIC ensures that client's vaccinations are current by referring to the Coos County Public Health Immunization Clinic when scheduled immunizations are due.
- Home visiting nurses regularly refer parents of young children and pregnant women to free smoking cessation classes offered by the local hospital.

Information about public health services is provided to the community at large through media releases, the county website, electronic reader board, presentations through the cable channel and for community organizations, and many printed materials, including our annual report.

### ACTION PLAN

#### **Goals:**

Persons will be connected with the many services available through Coos County Public Health and the other public and private agencies designed to improve their quality of life.

Community constituents, decision makers, and leaders will be informed about the role of public health and the services available.

#### **Activities:**

To enable our staff to continue to improve their abilities to successfully refer our clients within our department and to other agencies for appropriate services:

- Invite agency representatives to make presentations at our monthly all-staff meetings, so that our staff will become familiar with services provided by other agencies.
- Participate in agency health fairs, for networking opportunities.
- Orient new employees about public health services and provide program updates at staff meetings.

To disseminate information about public health services and the public health mission:

- Post health information and our department's services on our electronic sign.
- Publish an annual report describing our services by December.
- Work with county IT staff to complete the health department website and include more links to state and federal agencies, such as the CDC. Add website to media releases.
- Seek invitations for speaking engagements on public health topics.

**Evaluation:**

- track the agency presentations made at our staff meetings
- review orientation checklists to see that the proper emphasis on information and referral services has actually been included in all incoming staff orientations.
- monitor our website for progress being made, checking for completeness and currency of the information.
- review advertising to insure the website address is included.
- track community presentations

## 5. Environmental Health (EH) Program

### CURRENT CONDITIONS

- Approximately 400 facilities in Coos County provide eating, lodging and recreational accommodations for public use.
- There are approximately 80 recognized public water systems in Coos County, most of which receive some regulatory oversight or assistance from the County's Environmental Health (EH) staff.
- County EH and Communicable Disease (CD) staff collaborate regarding food borne investigations, animal bites and numerous other communicable disease issues.
- The EH program provides service with 2 full-time and 1 part-time Environmental Health Specialists (EHS), a 1 person support staff, plus 3 EHS, who work intermittently on contract.
- One EHS has been certified as a ServeSafe (manager certification) Trainer and each regular EHS employee is ServeSafe Certified.
- One EHS has attained national training in [swimming] Pool Operator Certification.
- Two EHS along with support staff have access to the ORPHEUS CD log and 1 EHS has completed training for CD 101 and CD 303.

The following text separates the goals, activities and program evaluation components of the Environmental Health Program into three parts: Licensed Facilities, Drinking Water and Communicable Disease work.

### LICENSED FACILITIES SERVICES

A recent categorization (and count) of Licensed Facilities in Coos County included: Food Service (228), Public Pools (24), Travelers' Accommodations (92), Bed & Breakfasts (7), RV Parks (39) and Organizational Camps (3). Travelers' Accommodations and Bed & Breakfasts are routinely inspected annually. State law requires the other facilities to be inspected twice annually. Additional inspections come from concerned calls from the public, disease outbreak investigations or when unsafe conditions are found during a routine inspection.

The Licensed Facility inspection program is based on expecting and educating facility operators to be pro-active in preventing injury and prevention of disease transmission.

### Action Plan

#### Long-Term Goals:

- Ensuring licensed facilities in Coos County are free from factors leading to transmission of communicable disease and hazards leading to injury.
- See a decrease or elimination of forced closures of public pools for lack of control of pH, disinfection, unsafe water temperatures or turbidity.
- See a decrease or elimination of violations cited resulting in closure to a tourist facility, or part of it, due to gross issues of sanitation or physical threats to the safety of patrons.

- See a decrease in food service violations cited relative to the 5 CDC Risk Factors most prominent in causing food borne illness.
- Provide remedial training for person(s) in charge of pools that can be shared with co-workers with maintenance duties.
- Provide an education focus during inspections on safety and risk training for person(s) responsible for cleaning and maintaining tourist facility operations.
- Focus attention on training supervisors in food service operations, particularly in taking advantage of Restaurant Manager Certification.
- As an office, complete the FDA Program Standards.
- Make licensed facility inspection reports available via the internet, particularly restaurant reports.

**Short-Term Goals:**

- Assure all food service, tourist facilities and public pools are appropriately licensed.
- Achieve 100% of required inspections for all licensed facilities in a timely manner.
- Coordinate epidemiological investigation in licensed facilities, including food-borne investigations with communicable disease staff.
- Follow-up on citizen complaints relative to licensed facilities in a timely manner.
- Make education for food handlers and food facility managers easily accessible.

**Activities:**

- Conduct health based licensing inspections of all licensed facilities.
- Promote food handler certification testing by providing walk-in testing weekly, promoting on-line testing at EZFOODCARD.com, plus monthly scheduled classes.
- Offer ServSafe Manager Certification training on a semi-annual basis.
- Offer remedial pool operator's training on an annual basis.
- Investigate citizen complaints of potential health hazards in licensed facilities.
- Initiate enforcement action against facilities illegally operating without a license.
- Answer environmental service questions asked by the public.
- Document, follow-up and communicate with DHS on animal bites. Coordinate with local jurisdictions regarding animal bites.
- Dedicate 1 day a month toward meeting the FDA Program Standards.
- Stay abreast of current rules and rule interpretations by attending regional Food, Pool and Lodging educational meetings as well as annual training meetings and participation with the Conference of Local Environmental Health Supervisors (CLEHS).
- Assure food service inspectors work monthly with a standardized inspector.

**Evaluation:**

- A file record will be maintained of all routine inspections performed at tourist facilities and public pools.
- A log is maintained of extra inspections performed to re-open a tourist facility following closure due to unsafe conditions.
- A log is maintained of extra inspections performed to re-open a public pool following a forced closure.
- There will be a record and numerical score maintained in a file for each food service inspection.
- The PHOENIX data base for restaurant inspections will be routinely queried to count the separate violations most closely related to the 5 CDC risk factors.
- Number of food handler cards issued will be tracked, including whether the card was issued via the internet or some other means. EH support staff maintains a running log of individuals taking advantage of county provided Manager Certification training.
- Environmental Health staff will maintain files on all epidemiological investigations and will send documentation to Oregon Health Services as required.
- EHS personnel will provide health education to staff of licensed facilities while conducting inspections – comments will be noted in facility file where pertinent.
- Environmental Health Specialists will also provide health education to the public as requests/calls are made. Comments will be logged in the [complaint] data-base.
- A log will be kept of all animal bites (includes incident, victim name and follow-up completed).
- A summary log including any resolution found will be kept of all citizen complaints regarding licensed facilities.
- All drinking water work will be documented as required in contract with DHS.

**DRINKING WATER SERVICES**

Illness and death resulting from water borne disease outbreaks around the country help us appreciate safe drinking water. Drinking water services provided by Coos County are intended to assure good quality water with an overarching goal of “assuring the availability of safe drinking water, meaning water which is sufficiently free from biological, chemical, radiological, or physical impurities such that individuals will not be exposed to disease or harmful physiological effects.”

The Environmental Health (EH) program receives contract funds from Oregon’s Drinking Water Program (DWP) to offer on-going local assistance to operators of most of the 80 public water systems providing water to approximately 50,000 Coos County residents.

It is an imperfect system, as most of the remaining 12,000 residents (20% of the county) live where they rely on private water supplies. As the DWP contract dollars are specifically for public water systems, no government entity provides safety oversight for private water sources.

Another potential service gap exists when the need for service from public water systems exceeds the allocation of funds from the DWP to the county. After the terms of a contract have been met, and with no ability to re-negotiate a mid-year contract, any acute needs of local water system operators would have to be addressed by DWP staff in either the Portland or Springfield regional office.

By law, water systems operators are required to take steps to physically protect the water and regularly sample for potential contaminants. County services for this program are primarily directed toward helping public water system operators sort through the maze of rules which help to assure quality drinking water.

### **Action Plan**

**Vision:** Safe water for consumption throughout Coos County.

#### **Goals:**

1. Work with Communicable Disease Staff to identify water borne illness/enteric disease.
2. 90% of [community] water systems will provide water that meets all applicable health-based drinking water standards during the year (EPA 2015 National Drinking Water Objective).

#### **Activities:**

1. The following activities are specified as “required services” in contract:
  - a. Develop, maintain and carry out an EH Program emergency response plan in case of public water system emergencies.
  - b. Take enforcement action against any licensed facility, also acting as a public water system and failing to comply with safe drinking water rules.
  - c. Provide regulatory assistance to water system operators seeking interpretation of regulatory requirements.
2. As specified in contract, the following activities may be invoiced for payment to the DWP:
  - a. Investigation of Water Quality Alerts, when questionable levels of chemical or microbiological contaminants are found in sample results.
  - b. Investigation and resolution of water systems found to be in chronic non-compliance with drinking water rules.
  - c. Follow-up for any enforcement action initiated by DWP.
  - d. Scheduling and performing water system surveys on a routine basis.
  - e. Resolution of violations for failure to sample or submit required treatment reports.
  - f. Identification of previously unrecognized public water systems.
  - g. Assistance to operators to develop their water system Emergency Response Plans.
3. Other activities which are not covered by the DWP contract:
  - a. Follow-up on lab confirmed enteric illness resulting from contaminated water and provide logical water treatment options.

- b. Refer questions from citizens regarding safe development of a private water source to: Oregon Association of Water Utilities, Oregon State University Extension Service, private contractors, internet websites, and other resources.

**Evaluation:**

1. The percentage of water systems meeting health-based drinking water standards. This will be approximated by (1) Subtracting out the number of separate public water systems that had maximum contaminant level (MCL) violations found in “Investigation of Water Quality Alerts” from (2) the total number of public water systems and (3) dividing the balance by the total number of public water systems.
2. Lab confirmed enteric illness reports, which are individually reviewed by staff on a routine basis as well as part of an annual report.
3. Citizen questions (deferred elsewhere) regarding private water sources, which are logged on the EH data base.
4. Documentation, as required by DWP contract for all work done for the DWP. Work that may be invoiced to the DWP is tracked per the state’s internet data base system. At year’s end individual tasks that could have been completed can be tabulated by contract category. Actual work accomplished, may be totaled in each category by reviewing individual invoices sent to the DWP.

**FOOD-BORNE COMMUNICABLE DISEASE SERVICES**

County Environmental Health (EH) and Communicable Disease (CD) staff collaborate regarding food borne investigations, norovirus outbreaks, animal bites, plus numerous other communicable disease issues. EH generally takes the lead with animal bites; otherwise CD staff maintain the predominate role, with EH involvement increasing when there is a facility inspection component with an investigation.

**Action Plan**

**Goals:**

1. Maintain a zero incidence rate for rabies in humans.
2. Assure at-risk bite victims are screened by a medical or public health professional in a timely way.
3. Provide outreach material to affected facilities to minimize the spread of norovirus illness.
4. Initiate immediate investigation of enteric illness as per DHS Acute & Communicable Disease Program time frames.
5. Develop an on-line mechanism for the collection of enteric illness/food-borne illness reports.

**Activities:**

1. Coordinate with local community professionals, law enforcement, veterinarians and medical professionals to provide animal bite reports.
2. Develop institution training regarding preventing the spread of norovirus.

3. Coordinate with CD staff for investigation of lab confirmed enteric illness or other illness as warranted.

**Evaluation:**

1. A file will be maintained and kept available for periodic review of all reported animal bites and associated follow-up.
2. EH staff will maintain files on epidemiological investigations and send summaries to DHS as necessary.
3. All lab confirmed illness may be summarized by reviewing the ORPHEUS database.

## 6. Public Health Emergency Preparedness

### Current Conditions

During 2009-2010, Coos County Public Health's preparedness activities were focused on the preparation for and response to the H1N1 flu pandemic. In preparation for the response to the pandemic, the Mass Prophylaxis, Strategic National Stockpile, and Pandemic Influenza Plans were reviewed and updated. During the response, antivirals and vaccine were distributed to pharmacies and hospitals. School-based vaccine clinics were held in each of the public schools and multiple public clinics were held throughout the county. The H1N1 response was used to satisfy the exercise requirements for 2009-2010; the after action reports are available on the Health Alert Network.

### Action Plan

**Time Period:** July 2010 – June 2011

**Goal:** To prepare for, respond to, and recover from natural or man-made disasters in collaboration with other county, city, state, and tribal response partners.

**Objective 1:** Continue to develop, update, and review Emergency Response Plans (EOPs) for ESF #8; specifically, the CCPH's Base Plan, Resource Management Plan, and Direction and Control Plan.

- Plan for Methods/Activities/Practice:
  - Review finalized plans yearly and update as needed.
  - Draft new EOPs for review and approval from the Public Health Administrator.

**Outcome Measure(s):**

- All completed and finalized EOPs will be posted on the Health Alert Network.

**Objective 2:** CCPH will participate in at least two exercises per year as in accordance with the PE 12 state requirements.

Plan for Methods/Activities/Practice in Coordination with Coos County Emergency Management:

- 2010 Natural hazard, disease outbreak, actual occurrence.
- 2011 Natural hazard, flood, full scale exercise.
- 2012 Terrorism, explosive (WMD), functional exercise.
- 2013 Technological, communication failure, functional exercise.

**Outcome Measure(s):** After Action Reports with Improvement Plans completed within 60 days post exercise and posted on the Health Alert Network.

**Objective 3:** CCPH staff will continue to be trained in their respective Incident Command System (ICS) response roles, and will continue to be compliant to requirements of the National Incident Management System (NIMS).

Plan for Methods/Activities/Practice:

- Online ICS trainings, workshops, and exercises.

- Completion of NIMSCAST tool yearly.
- Annual review of staff training record.

**Outcome Measure(s):**

- NIMSCAST completion – 100% compliant.
- Updated staff training record.

**Objective 4:** Maintain communication capabilities while continuing to test the 24/7 contact number, the Health Alert Network, satellite phones, HAM radio, and police radio.

Plan for Methods/Activities/Practice: Coordinator and other identified public health staff will participate in all state and local tests, drills, and exercises.

**Outcome Measure(s):**

Coos County Public Health will be at least 90% compliant on all tests.

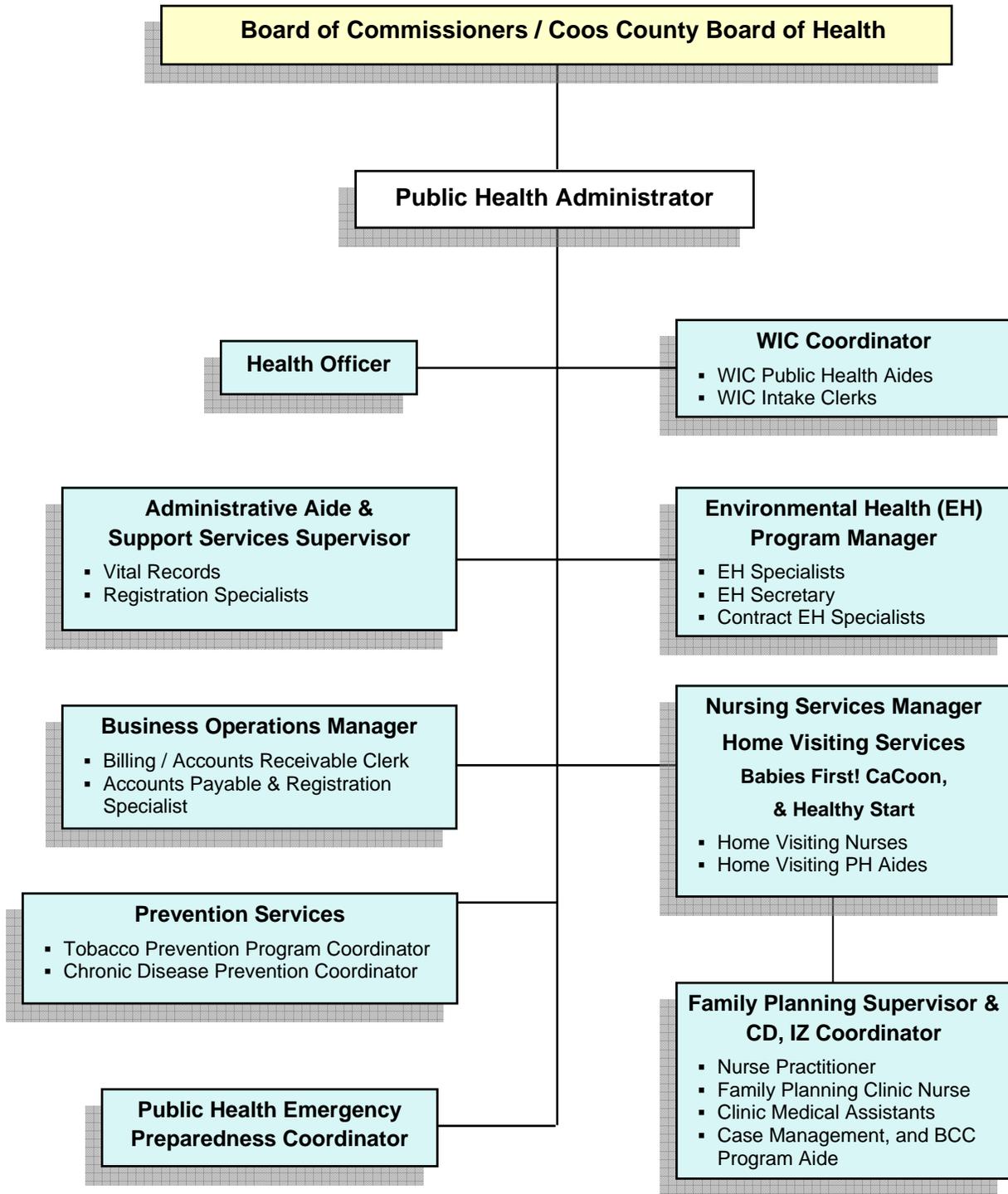
**Objective 5:** Continue to work with local, regional, tribal, and state response partners in planning for the health and medical response to disasters.

Plan for Methods/Activities/Practice: Monthly meetings with the Health Emergency Response Team – HERT.

**Outcome Measure(s):**

A description of information shared, education, and collaborative efforts on planning and exercises, as documented in meeting minutes.

## VI. Organizational Chart



## **Board of Health**

The Board of Health is comprised of the three Coos County Commissioners. Regular board meetings are held at least twice a month and often weekly, and public health issues are often on the agenda, as needed. Meetings are televised on the local cable access channel. The Commissioners occasionally meet as the Board of Health, when need arises for a special meeting. The Board liaison to the Health Department is Commissioner Kevin Stufflebean.

## **Public Health Advisory Board**

No Advisory Board exists at this time.

## **Senate Bill 555**

The Coos County Board of Commissioners, who are the Local Public Health Authority, also oversee the Coos County Commission on Children and Families, which was responsible for coordinating the comprehensive planning process in Coos county. The current Chair of the Board of Commissioners is also the Chair of the Coos County Commission of Children and Families. The Health Administrator also sits on the local CCF. Health Department staff have participated in the most recent update to the comprehensive plan. Annual plan topics which are also included in the comprehensive plan include: prenatal care, immunizations, child abuse use of alcohol, tobacco and other drugs, and teen pregnancy.

## VII. Unmet Needs

The unmet needs are generally the same as have been discussed in recent years. Funding from the state and federal government for most of the mandated public health programs is insufficient to meet the demands that come with those dollars. (An exception has been the federal funds available for our local H1N1 response.) Our local dollars are in short supply for all county services. Coos County Public Health lacks discretionary dollars from either state or county sources to address public health needs specific to our county, unless we are able to obtain special grants from foundations, service clubs, or individuals. With the loss of our grant writing position in 2006 and a nurse manager position in 2008, the full workload of the remaining managers leaves little time for grant writing. Stable funding to maintain a grant writing position could bring in additional dollars to enhance programs and services. However, the expectation that *mandated* public health programs can be maintained on “soft” grant money is unrealistic. Unlike a business that can charge the true cost for a product or service, public health programs that are mandated to serve everyone, regardless of ability to pay, or that do not have a billable component that reimburses the cost of the service, require a stable source of government funding. So far our staff have weathered the stress of working in multiple programs—as multiple funding streams are necessary to create full time positions—but fatigue is especially evident in our managers and supervisors who also are providing direct service while managing the administrative burden that government imposes on itself. For example, one supervisor who used to coordinate one program now has six programs to manage. And as we look towards the challenge of accreditation that is setting a high standard for public health in this country, we see a deep chasm between the high expectations for a fully functioning health department and the funding necessary for achievement.

Our constituents ask for assistance with environmental health concerns, such as nuisance complaints, problems with mold, blue-green algae, and malfunctioning private wells. Our environmental health specialists are funded only to administer the licensed facilities program and to monitor public water systems. We charge fees to inspect schools and day care facilities. An additional source of funding would enable these environmental health experts to assist with these other community concerns. The ability to do proactive environmental community assessments is virtually non-existent. Some of these activities were done in the past, when the Health Department received County general fund contributions for the environmental health program.

People continue to seek diagnosis for sexually transmitted diseases (STDs) at the Health Department (a traditional public health service that is now unfunded), and clients often lack funds to pay for the exams. Through the continued generosity of the Coquille Tribal Community Grant, vouchers have helped these clients. We have no funding dedicated this next year for prevention outreach for STDs, including HIV. The rate of new infection with HIV is very low, but there is potential for this disease to be introduced into our sexually active population who have not adopted pro-health behaviors.

Interventions by public health nurses with new mothers before and after they give birth are a cost effective way to help babies get a better start in life, especially for families who are at risk due to health problems, poverty (inability to pay rent and utilities), poor nutrition, drug use, domestic violence, mental health problems, disabilities, and generational lack of parenting knowledge. We currently have a significantly reduced capacity to address these perinatal needs in our county. We discontinued our maternity case management home visits, due to the inadequate reimbursement rate paid by Medicaid for this service (and the lack of other funding). We have had to strictly limit the number of families we can

enroll in CaCoon, which serves medically fragile children with nurse consultation and screening. Healthy Start services for first birth families were reduced due to budget cuts. We continue to have high rates of child abuse and neglect in our county, but also see positive outcomes in the families who receive our services, and wish we could serve more.

We note that Coos County has a high rate of maternal depression, ranging between 40-45% of women seen through the hospital's prenatal support program (MOMs). Services are severely limited for women with depression, especially for those who do not have health or mental health insurance to pay for medication and/or therapy. Women with Oregon Health Plan insurance (Medicaid) are also at a disadvantage, as counseling services typically do not extend beyond the initial assessment.

The importance of infant-toddler mental health to the long-term positive outcomes of children is becoming increasingly recognized. As neuroscience research helps illuminate the extremely vulnerable period of brain development in these children, preventive services focusing on improving the infant-parent attachment and parenting skills for nurturing should be considered. Currently there is only one licensed mental health professional in our county who works with these very young children. Specialized infant/toddler mental health training should be provided to interventionists working with infants and toddlers.

The expectation by the federal government for comprehensive family planning services under the federal Title X program exceeds what can be accomplished with the federal grant award, and the reimbursement rates for the Medicaid funded Oregon Contraceptive Care have been cut too deeply to keep this program out of the red. This mismatch between funding and program requirements results in an administrative burden that is untenable.

Data about our community's needs and the services that we provide help us to evaluate our effectiveness and guide us in our efforts. We are expected to enter information into multiple state data bases, which can be labor intensive. However, we find that we continue to be unable to extract the local information that we need from some state data bases, (e.g., ORCHIDS and OVERS). We continue to lack the funds to purchase a good business/accounting software that would interface with our County's accounting system, and that would improve efficiency for our business processes and mandated record keeping.

And finally, the lack of medical and dental care for many who live here continues to be a problem that is mirrored at the state and national level. Dental care is especially important for the health of pregnant women and children. While our state and federal governments implement health reform that will provide health insurance for more people, we are hopeful that public health prevention efforts will be included in the solution.

## VIII. Budget Information

Contact to receive a copy of our approved budge document:

**Sherrill Lorenzo**

*Business Operations Manager*

Coos County Public Health

541-756-2020, ext. 539

slorenzo@co.coos.or.us

## IX. Minimum Standards

### 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. (To a limited extent.)
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 (or according to County policy)
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. (Birth records are now registered by the state.)
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. (Only as needed.)
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. (The importance of taking first aid training for choking is discussed, but no actual training is done.)
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. (A couple have been non-compliant.)
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. (DEQ)
58. Yes  No  Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes  No  School and public facilities food service operations are inspected for health and safety risks.
60. Yes  No  Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes  No  A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes  No  Indoor clean air complaints in licensed facilities are investigated. (This is done by the tobacco prevention coordinator, if related to smoking.)
63. Yes  No  Environmental contamination potentially impacting public health or the environment is investigated. (by the DEQ. Our EH staff have no funding for this work.)
64. Yes  No  The health and safety of the public is being protected through hazardous incidence investigation and response. (by the DEQ)
65. Yes  No  Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control. (Other agencies contribute to regulation. We don't have vector control.)
66. Yes  No  All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

## Health Education and Health Promotion

67. Yes  No  Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.
68. Yes  No  The health department provides and/or refers to community resources for health education/health promotion.
69. Yes  No  The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.
70. Yes  No  Local health department supports healthy behaviors among employees.

71. Yes  No  Local health department supports continued education and training of staff to provide effective health education.
72. Yes  No  All health department facilities are smoke free.

## Nutrition

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

## 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.

## X. 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: Frances Smith

Does the Administrator have a Bachelor degree? Yes x No \_\_\_

Does the Administrator have at least 3 years experience in public health or a related field? Yes x No \_\_\_

Has the Administrator taken a graduate level course in biostatistics? Yes \_\_\_ No x

Has the Administrator taken a graduate level course in epidemiology? Yes x No \_\_\_

Has the Administrator taken a graduate level course in environmental health? Yes x No \_\_\_

Has the Administrator taken a graduate level course in health services administration? Yes x No \_\_\_

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

a. Yes \_\_\_ No x **The local health department Health Administrator meets minimum qualifications:**

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

**Plan:** Take a course in biostatics by 12/31/2011.

b. Yes x 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.

**Note:** Our Supervising Public Health Nurse has the following degrees: Associate in Applied Science in Nursing, Bachelors in Human Biology, Masters in Public Health, and Graduate Certificate in Infant Toddler Mental Health. This should comply with the intent of 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.

## XI. Local Health Authority Signature

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

  
\_\_\_\_\_  
Local Health Authority  
Kevin Stufflebean, Chair

Coos  
County

5/12/10  
Date